

1 ROB BONTA
Attorney General of California
2 MATTHEW M. DAVIS
Supervising Deputy Attorney General
3 LEANNA E. SHIELDS
Deputy Attorney General
4 State Bar No. 239872
600 West Broadway, Suite 1800
5 San Diego, CA 92101
P.O. Box 85266
6 San Diego, CA 92186-5266
Telephone: (619) 738-9401
7 Facsimile: (619) 645-2061

8 *Attorneys for Complainant*

9
10 **BEFORE THE**
11 **MEDICAL BOARD OF CALIFORNIA**
12 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

13 In the Matter of the Accusation Against:

Case No. 800-2020-071427

14 **JEFFREY EDWIN MAX, M.D.**
15 **5755 Oberlin Drive, Suite 301**
San Diego, CA 92121-4717

A C C U S A T I O N

16 **Physician's and Surgeon's Certificate**
17 **No. C 50120,**

Respondent.

18
19
20 Complainant alleges:

21 **PARTIES**

22 1. William Prasifka (Complainant) brings this Accusation solely in his official capacity
23 as the Executive Director of the Medical Board of California, Department of Consumer Affairs
24 (Board).

25 2. On or about June 5, 1998, the Medical Board issued Physician's and Surgeon's
26 Certificate No. C 50120 to Jeffrey Edwin Max, M.D. (Respondent). The Physician's and
27 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
28 herein and will expire on February 29, 2024, unless renewed.

JURISDICTION

1
2 3. This Accusation is brought before the Board, under the authority of the following
3 laws. All section references are to the Business and Professions Code (Code) unless otherwise
4 indicated.

5 4. Section 2227 of the Code states:

6 (a) A licensee whose matter has been heard by an administrative law judge of
7 the Medical Quality Hearing Panel as designated in Section 11371 of the Government
8 Code, or whose default has been entered, and who is found guilty, or who has entered
9 into a stipulation for disciplinary action with the board, may, in accordance with the
10 provisions of this chapter:

11 (1) Have his or her license revoked upon order of the board.

12 (2) Have his or her right to practice suspended for a period not to exceed one
13 year upon order of the board.

14 (3) Be placed on probation and be required to pay the costs of probation
15 monitoring upon order of the board.

16 (4) Be publicly reprimanded by the board. The public reprimand may include a
17 requirement that the licensee complete relevant educational courses approved by the
18 board.

19 (5) Have any other action taken in relation to discipline as part of an order of
20 probation, as the board or an administrative law judge may deem proper.

21 (b) Any matter heard pursuant to subdivision (a), except for warning letters,
22 medical review or advisory conferences, professional competency examinations,
23 continuing education activities, and cost reimbursement associated therewith that are
24 agreed to with the board and successfully completed by the licensee, or other matters
25 made confidential or privileged by existing law, is deemed public, and shall be made
26 available to the public by the board pursuant to Section 803.1.

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

28 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:

...

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

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

9 ...

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

13 COST RECOVERY

14 7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
15 administrative law judge to direct a licensee found to have committed a violation or violations of
16 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
17 enforcement of the case, with failure of the licensee to comply subjecting the license to not being
18 renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be
19 included in a stipulated settlement.

20 FACTUAL ALLEGATIONS

21 Patient A¹

22 8. On or about October 6, 2015,² Patient A, a then 59-year-old male, first presented for
23 treatment with Respondent. According to records, Patient A had a diagnosis of bipolar I disorder
24 and was receiving treatment from another physician (Dr. T.J.), for his medication management.
25 At the time of Patient A's first visit with Respondent, Patient A's medication regimen included,
26

27 ¹ For patient privacy purposes, the patient's true name is not used in the instant
28 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.

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

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

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

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

12 12. On or about January 29, 2016, Patient A presented for treatment with Respondent.
13 According to records, Patient A informed Respondent that he wanted Respondent to take over
14

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

17 ⁴ Seroquel is a brand name for quetiapine, it is a dangerous drug pursuant to Code section
18 4022. When properly prescribed and indicated, it is an antipsychotic drug commonly used for the
treatment of bipolar disorder and schizophrenia.

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

21 ⁶ Gabapentin, common brand names Neurontin and Gralise, is a dangerous drug pursuant
22 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.

23 ⁷ Clonazepam, common brand name Klonopin, is a Schedule IV controlled substance
24 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
25 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
26 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
27 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
28 respiratory depression and sedation."

1 Patient A's medication management. According to records, Patient A's medication regimen
2 included, but was not limited to, gabapentin (900 mg, four times per day); Trileptal (300 mg,
3 three times per day); clonazepam (4 mg once a day and 2 mg three times per day, for a total of 10
4 mg per day); and Saphris⁸ (10 mg, two times per day).

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

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

10 15. On or about February 16, 2016, Patient A contacted Respondent and informed him he
11 had taken an extra 4 mg of clonazepam to decrease his activation.⁹ According to records, Patient
12 A's medication regimen included, but was not limited to, Risperidone¹⁰ (reduced from 6 mg to 4
13 mg, once every evening); gabapentin (1200 mg, three times per day); Synthroid (0.15 mg, one
14 time per day, and 0.175 mg on Sundays), and Benadryl (150 mg, once every evening). According
15 to records, Patient A informed Respondent he was no longer taking Trileptal, and that he had
16 taken his final dose of Trileptal the night before. According to records, Patient A told
17 Respondent it was "barbaric" for Respondent to not prescribe more than 10 mg of clonazepam per
18 day to Patient A. According to records, Patient A was interested in trying lithium¹¹ at low doses,
19

20 ⁸ Saphris is a brand name for asenapine, it is a dangerous drug pursuant to Code section
21 4022. When properly prescribed and indicated, it is an antipsychotic drug commonly used for the
treatment of bipolar disorder.

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

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

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

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

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

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

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

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

22 ///

23 ///

24
25 ¹² L-Carnitine is a brand name for levocarnitine, it is a dangerous drug pursuant to Code
26 section 4022. When properly prescribed and indicated, it is a nutritional supplement commonly
27 used for the treatment of carnitine deficiency, a condition where nutrients are unable to reach
28 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.

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

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

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

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

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

13 25. On or about May 10, 2016, Patient A contacted Respondent and reported suicidal
14 ideation. According to records, Respondent began prescribing Wellbutrin¹⁴ to Patient A.

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

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

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

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

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

4 30. On or about May 31, 2016, Patient A contacted Respondent and reported he was no
5 longer participating in physical therapy because it was not helping. According to records, Patient
6 A’s medication regimen included, but was not limited to lithium (750 mg per day), Mirapex¹⁶
7 (0.25 mg per day); Trileptal (300 mg, three times per day); gabapentin (900 mg, three times per
8 day); clonazepam (10 mg per day); and Synthroid (0.25 mg per day). Later that same day, Patient
9 A contacted Respondent again and reported he felt he was “ramping up” and was interested in
10 another neuroleptic. According to records, Respondent increased Patient A’s lithium from 750
11 mg per day to 900 mg per day and increased Patient A’s gabapentin from 900 mg three times per
12 day to 900 mg four times per day. Respondent also noted a plan to consider Abilify¹⁷ as another
13 neuroleptic.

14 ///

15 ///

16 ///

17 ///

18 ///

19 ///

20 _____

21 ¹⁵ Ketamine, common brand name Ketalar, is an analgesic sedative that is a Schedule III
22 controlled substances pursuant to Health and Safety Code section 11056, subdivision (g), and a
23 dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is
24 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).

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

27 ¹⁷ Abilify is a brand name for aripiprazole, it is a dangerous drug pursuant to Code section
28 4022. When properly prescribed and indicated, it is an antipsychotic commonly used for the
treatment of bipolar disorder, schizophrenia and major depressive disorder.

1 31. On or about June 13, 2016, Patient A contacted Respondent and reported he was no
2 longer taking Percocet¹⁸ because it caused him to feel depressed. According to records, Patient
3 A's current lithium dose was lowered to 750 mg per day.

4 32. On or about July 25, 2016, Patient A contacted Respondent and reported he had tried
5 Depakote¹⁹ which he believed had a direct myopathic effect on Patient A. According to records,
6 Patient A's medication regimen included, but was not limited to, lithium (750 mg per day);
7 gabapentin (900 mg, three times per day); Trileptal (300 mg, three times per day); clonazepam
8 (10 mg per day); and Synthroid (0.15 mg per day). According to records, Patient A had
9 discontinued taking Mirapex.

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

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

18 ///

19 ///

20 _____
21 ¹⁸ Percocet is a brand name for a combination drug containing oxycodone and
22 acetaminophen, it is a Schedule II controlled substance pursuant to Health and Safety Code
23 section 11055, subdivision (b), and a dangerous drug pursuant to Code section 4022. When
24 properly prescribed and indicated, it is an opioid commonly used for the treatment of pain. The
25 Drug Enforcement Administration (DEA) has identified oxycodone as a drug of abuse. (Drugs of
26 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."

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

1 35. On or about September 21, 2016, Patient A contacted Respondent and reported he
2 was no longer taking Seroquel due to side effects, including myopathy. According to records,
3 Lexapro²⁰ was added to Patient A's medication regimen.

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

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

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

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

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

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

23
24 ²⁰ Lexapro is a brand name for escitalopram, it is a dangerous drug pursuant to Code
25 section 4022. When properly prescribed and indicated, it is a non-benzodiazepine selective
26 serotonin reuptake inhibitor (SSRI) commonly used for the treatment of major depressive
27 disorder and generalized anxiety disorder.

28 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.

1 not limited to, clonazepam (10 mg per day); Trileptal (300 mg, three times per day); gabapentin
2 (900 mg, three times per day); lithium (750 mg per day); Vyvanse (0.5 mg every morning); and
3 Synthroid (0.15 mg per day). According to records, Patient A was not interested in changing his
4 medications.

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

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

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

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

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

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

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

28 ///

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

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

8 51. On or about September 5, 2017, Respondent noted Patient A’s medication regimen
9 included, but was not limited to, clonazepam (14 mg per day); lithium (750 mg per day);
10 gabapentin (900 mg, three times per day); Trileptal (300 mg, three times per day); and Lexapro
11 (0.7 mg per day). According to records, Patient A was willing to try electroconvulsive therapy
12 (ECT) and Respondent provided a referral for ECT.

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

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

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

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

28 ///

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

4 57. On or about December 9, 2017, Patient A contacted Respondent indicating he had a
5 positive response to ketamine, but wanted to reduce his Lexapro from 1.5 mg every morning to
6 1.2 to 1.3 mg every morning.

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

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

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

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

19 62. On or about May 19, 2018, Patient A contacted Respondent with a request to increase
20 his lithium and decrease his mood stabilizers. According to records, Respondent suggested trying
21 a low dose of desipramine²² and contacted a compounding pharmacy to prepare a low dose for
22 Patient A.

23 63. On or about June 7, 2018, Patient A contacted Respondent and reported feeling
24 excessively tired. According to records, Patient A indicated he used his sleep apnea mask and felt
25 well-rested. According to records, Patient A's medication regimen included, but was not limited
26

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

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

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

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

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

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

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

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

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

26 _____
27 ²³ Vraylar is a brand name for cariprazine, it is a dangerous drug pursuant to Code section
28 4022. When properly prescribed and indicated, it is an antipsychotic commonly used for the
treatment of bipolar disorder and schizophrenia.

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

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

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

15 74. On or about November 20, 2018, Respondent documented receiving several phone
16 calls from Patient A over the past several days. According to records, Patient A contacted
17 Respondent and reported feeling depressed. According to records, Patient A agreed to
18 discontinue lithium and discontinue Lexapro. Later, Patient A reported feeling activated and
19 wanted to increase his lithium and gabapentin. According to records, Patient A's medication
20 regimen included, but was not limited to, clonazepam (14 mg per day); lithium (600 mg per day);
21 gabapentin (1,800 mg per day); Trileptal (300 mg, three times per day); Lexapro (1 mg every
22 morning), and Tenuate²⁴ (15 mg, two times per day).

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

26
27 ²⁴ Tenuate is a brand name for diethylpropion, it is a Schedule IV controlled substance
28 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.

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

7 77. On or about December 12, 2018, Respondent documented receiving several phone
8 calls from Patient A over the past several days. According to records, Patient A expressed suicide
9 ideation and reported experiencing severe depression. According to records, Patient A and
10 Respondent discussed the possibility of discontinuing clonazepam which would allow Patient A
11 to be eligible for ECT. According to records, Respondent issued a prescription for nortriptyline²⁵
12 (10 mg every evening), his first tricyclic antidepressant.

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

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

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

25 ///

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

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

6 82. On or about March 21, 2019, Patient A presented for treatment with Respondent.
7 According to records, Patient A reported feeling stable for the past six (6) weeks. According to
8 records, Patient A's medication regimen included, but was not limited to, clonazepam (14 mg per
9 day); nortriptyline (0.4 mg every evening); Trileptal (600 mg, two times per day); gabapentin
10 (300 mg, three times per day); and lithium (150 mg, two times per day).

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

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

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

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

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

27 ///

28 ///

1 clonazepam (3 mg, three times per day, with an additional 3 mg per day as needed); Trileptal (150
2 mg, three times per day); and nortriptyline (0.075 mL every evening). According to records,
3 Respondent issued a new diagnoses of dysarthria²⁶ for Patient A with no known cause.

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

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

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

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

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

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

27
28 ²⁶ Dysarthria is a condition in which one experiences slurred speech or difficulty speaking
as a result of weakness in the muscles.

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

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

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

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

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

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

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

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

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

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

6 103. On or about April 22, 2020, Patient A contacted Respondent and reported
7 discontinuing Trileptal, gabapentin and lithium. According to records, Patient A maintained
8 clonazepam at 12 to 14 mg per day. According to records, Patient A also reported feeling suicidal
9 and taking twelve (12) Percocet pills. According to records, Patient A agreed to resume Lexapro
10 (0.3 mg every morning).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 ///

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

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

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

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

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

25 121. Throughout the month of July 2020, Respondent documented several calls with
26 potential treatment providers. According to records, multiple physicians expressed concern over
27 the high dose of clonazepam prescribed to Patient A and refused to accept Patient A as a patient.
28

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

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

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

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

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

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

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

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

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

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

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

11 132. On or about January 24, 2021, Respondent documented receiving multiple calls from
12 Patient A over the past several days. According to records, Patient A reported continued success
13 with his weekly ketamine infusions. According to records, Patient A's medication regimen
14 included, but was not limited to, clonazepam (14 mg per day); gabapentin (900 mg, three times
15 per day); Trileptal (300 mg, two times per day); lithium (300 mg, two times per day); Lexapro
16 (0.5 mg every morning); Vyvanse (0.5 mg every morning); and ketamine.

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

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

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

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

1 137. On or about February 18, 2021, Patient A contacted Respondent and reported his
2 moods were “cycling.” According to records, Patient A’s medication regimen included, but was
3 not limited to, clonazepam (14 mg per day); gabapentin (1,200 mg, three times per day); Trileptal
4 (600 mg, two times per day); and lithium (300 mg, two times per day).

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

9 139. On or about February 27, 2021, Respondent documented receiving multiple calls
10 from Patient A. According to records, Patient A was in a mixed manic and depressed state.
11 According to records, Patient A agreed to begin perphenazine²⁸ (4 mg every evening) and
12 decrease gabapentin to 600 mg, three times per day, and decrease clonazepam to 12 mg per day.

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

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

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

26
27 ²⁸ Perphenazine, brand name Trilafon, is a dangerous drug pursuant to Code section 4022.
28 When properly prescribed and indicated, it is an antipsychotic commonly used for the treatment
of schizophrenia and nausea.

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

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

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

11 145. In or around 2018, according to the Controlled Substance Utilization Review and
12 Evaluation System (CURES),²⁹ Respondent issued nine (9) monthly prescriptions to Patient A for
13 420 tablets of clonazepam (1 mg).

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

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

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

20 ///

21 ///

22 ///

23
24 ²⁹ The Controlled Substance Utilization Review and Evaluation System (CURES) is a
25 program operated by the California Department of Justice (DOJ) to assist health care practitioners
26 in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement
27 and regulatory agencies in their efforts to control diversion and abuse of controlled substances.
28 (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).)

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

5 150. From on or about October 6, 2015, through on or about March 10, 2021, throughout
6 Patient A's treatment with Respondent, records document a review of Patient A's CURES report
7 on two (2) occasions, including, but not limited to, October 3, 2018, and February 2, 2021.

8 However, the results of these reviews are not documented in Respondent's records for Patient A.

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

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

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

19 ///

20 ///

21 ///

22 ///

23 ///

24 ///

25 ///

26 ///

27 ///

28 ///

1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Gross Negligence)**

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

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

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

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

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

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

19 F. Respondent failed to appropriately utilize CURES to monitor Patient A's
20 prescriptions for controlled substances;

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

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

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

3 **SECOND CAUSE FOR DISCIPLINE**

4 **(Repeated Negligent Acts)**

5 155. Respondent has further subjected his Physician's and Surgeon's Certificate No. C
6 50120 to disciplinary action under sections 2227 and 2234, as defined by section 2234,
7 subdivision (c), of the Code, in that he committed repeated negligent acts in his care and
8 treatment of Patient A, including, but not limited to:

9 A. Paragraphs 8 through 154, above, are hereby incorporated by reference and
10 realleged as if fully set forth herein; and

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

13 **THIRD CAUSE FOR DISCIPLINE**

14 **(General Unprofessional Conduct)**

15 156. Respondent has also subjected his Physician's and Surgeon's Certificate No. C 50120
16 to disciplinary action under section 2227 and 2234, in that he engaged in conduct which breached
17 a rule or ethical code of the medical profession or engaged in conduct which was unbecoming a
18 member in good standing of the medical profession, and which demonstrates an unfitness to
19 practice medicine, as more particularly alleged in paragraphs 8 through 155, above, which are
20 hereby incorporated by reference and realleged as if fully set forth herein.

21 **PRAYER**

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


- 24 1. Revoking or suspending Physician's and Surgeon's Certificate No. C 50120, issued to
25 Respondent Jeffrey Edwin Max, M.D.;
- 26 2. Revoking, suspending or denying approval of Respondent Jeffrey Edwin Max,
27 M.D.'s authority to supervise physician assistants and advanced practice nurses;

28 ///

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

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: SEP 23 2022



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

SD2022801199
83561630.docx