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

In the Matter of the Accusation Against: **Edmundo S. Jesalva, M.D.** **4165 E. Thousand Oaks Blvd., Suite 345** **Westlake Village, CA 91362-3814** **Physician's and Surgeon's Certificate No. G 58063,** Respondent.	Case No. 800-2022-086324 **ACCUSATION**

PARTIES

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

2. On or about August 4, 1986, the Board issued Physician's and Surgeon's Certificate Number G 58063 to Edmundo S. Jesalva, 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 September 30, 2025, unless renewed.

JURISDICTION

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

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

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

(b) The administration and hearing of disciplinary actions.

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

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

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

(f) Approving undergraduate and graduate medical education programs.

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

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

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

5. Section 2220 of the Code states:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

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

STATUTORY PROVISIONS

7. Section 2234 of the Code states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
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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.
>
> (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.
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> . . . .
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
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> . . . .

8. Section 2266 of the Code states:

> The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

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9. Health and Safety Code section 11165.4, effective January 1, 2017 to December 31, 2019, stated:

(a)(1)(A)(i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(ii) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption described in subdivision (c), to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a controlled substance to a patient, he or she shall consult the CURES database to review the patient's controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(B) For purposes of this paragraph, "first time" means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

(2) A health care practitioner shall obtain a patient's controlled substance history from the CURES database no earlier than 24 hours, or the previous business day, before he or she prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians or pharmacists.

(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

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(2) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital and the quantity of the controlled substance does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use.

(3) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient's treatment for a surgical procedure and the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

(4) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care, as defined in Section 1339.40.

(5)(A) If all of the following circumstances are satisfied:

(i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

(ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

(iii) The quantity of controlled substance prescribed, ordered, administered, or furnished does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason he or she did not consult the database in the patient's medical record.

(6) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within his or her control.

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(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

(8) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient's inability to obtain a prescription in a timely manner and thereby adversely impact the patient's medical condition, provided that the quantity of the controlled substance does not exceed a nonrefillable five-day supply if the controlled substance were used in accordance with the directions for use.

(d)(1) A health care practitioner who fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

(2) This section does not create a private cause of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

(e) This section is not operative until six months after the Department of Justice certifies that the CURES database is ready for statewide use and that the department has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in Schedule (6) of Item 0820-001-0001 of the Budget Act of 2016 (Chapter 23 of the Statutes of 2016), user support, and education. The department shall notify the Secretary of State and the office of the Legislative Counsel of the date of that certification.

(f) All applicable state and federal privacy laws govern the duties required by this section.

(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

10. Health and Safety Code § 11165.4, effective January 1, 2020 to June 30, 2021, stated:

(a)(1)(A)(i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(ii) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption described in subdivision (c), to consult the CURES database the first time the health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient, the health care practitioner shall consult the CURES database to review the patient's controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.

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(B) For purposes of this paragraph, "first time" means the initial occurrence in which a health care practitioner, in their role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

(2) A health care practitioner shall obtain a patient's controlled substance history from the CURES database no earlier than 24 hours, or the previous business day, before the health care practitioner prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians or pharmacists.

(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(2) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital and the quantity of the controlled substance does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use.

(3) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient's treatment for a surgical procedure and the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

(4) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care, as defined in Section 1339.40.

(5)(A) If all of the following circumstances are satisfied:

(i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

(ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

(iii) The quantity of controlled substance prescribed, ordered, administered, or furnished does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason they did not consult the database in the patient's medical record.

(6) If the CURES database is not operational, as determined by the department, or cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within the health care practitioner's control.

(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

(8) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient's inability to obtain a prescription in a timely manner and thereby adversely impact the patient's medical condition, provided that the quantity of the controlled substance does not exceed a nonrefillable five-day supply if the controlled substance were used in accordance with the directions for use.

(d)(1) A health care practitioner who fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

(2) This section does not create a private cause of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

(e) This section is not operative until six months after the Department of Justice certifies that the CURES database is ready for statewide use and that the department has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in Schedule (6) of Item 0820-001-0001 of the Budget Act of 2016

(Chapter 23 of the Statutes of 2016), user support, and education. The department shall notify the Secretary of State and the office of the Legislative Counsel of the date of that certification.

(f) All applicable state and federal privacy laws govern the duties required by this section.

(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(h) This section shall become inoperative on July 1, 2021, or upon the date the department promulgates regulations to implement this section and posts those regulations on its internet website, whichever date is earlier, and, as of January 1, 2022, is repealed.

11. Health and Safety Code § 11165.4, effective July, 2021 to December 31, 2023, stated:

(a)(1)(A)(i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the patient activity report or information from the patient activity report obtained from the CURES database to review a patient's controlled substance history for the past 12 months before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every six months thereafter if the prescriber renews the prescription and the substance remains part of the treatment of the patient.

(ii) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption described in subdivision (c), to consult the patient activity report from the CURES database the first time the health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient, the health care practitioner shall consult the patient activity report from the CURES database to review the patient's controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every six months thereafter if the prescriber renews the prescription and the substance remains part of the treatment of the patient.

(iii) A health care practitioner who did not directly access the CURES database to perform the required review of the controlled substance use report shall document in the patient's medical record that they reviewed the CURES database generated report within 24 hours of the controlled substance prescription that was provided to them by another authorized user of the CURES database.

(B) For purposes of this paragraph, "first time" means the initial occurrence in which a health care practitioner, in their role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

(2) A health care practitioner shall review a patient's controlled substance history that has been obtained from the CURES database no earlier than 24 hours, or the previous business day, before the health care practitioner prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians or pharmacists.

(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient in any of the following facilities or during a transfer between any of the following facilities, or for use while on facility premises:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(E) Another medical facility, including, but not limited to, an office of a health care practitioner and an imaging center.

(F) A correctional clinic, as described in Section 4187 of the Business and Professions Code, or a correctional pharmacy, as described in Section 4021.5 of the Business and Professions Code.

(2) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital and the quantity of the controlled substance does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use.

(3) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient's treatment for a surgical, radiotherapeutic, therapeutic, or diagnostic procedure and the quantity of the controlled substance does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

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(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

(F) Another medical facility where surgical procedures are permitted to take place, including, but not limited to, the office of a health care practitioner.

(4) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient who is terminally ill, as defined in subdivision (c) of Section 11159.2.

(5)(A) If all of the following circumstances are satisfied:

(i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

(ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

(iii) The quantity of controlled substance prescribed, ordered, administered, or furnished does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason they did not consult the database in the patient's medical record.

(6) If the CURES database is not operational, as determined by the department, or cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct the cause of the temporary technological or electrical failure that is reasonably within the health care practitioner's control.

(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

(8) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient's inability to obtain a prescription in a timely manner and thereby adversely impact the patient's medical condition, provided that the quantity of the controlled substance does not exceed a nonrefillable seven-day supply if the controlled substance were used in accordance with the directions for use.

(d)(1) A health care practitioner who fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

(2) This section does not create a private cause of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

(e) All applicable state and federal privacy laws govern the duties required by this section.

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(f) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(g) This section shall become operative on July 1, 2021, or upon the date the department promulgates regulations to implement this section and posts those regulations on its internet website, whichever date is earlier.

COST RECOVERY

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

DEFINITIONS

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

"Adderall," a mixture of amphetamine and amphetamine salts, is a central nervous system stimulant of the amphetamine class. Adderall is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for attention-deficit hyperactivity disorder and narcolepsy. Adderall has a black box warning which states "Adderall has a high potential for abuse and misuse, which can lead to the development of a substance use disorder, including addiction. Misuse and abuse of CNS stimulants, including Adderall, can result in overdose and death, and this risk is increased with higher doses or unapproved methods of administration, such as snorting or injection."

"Alprazolam" (brand name Xanax), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders.

"Gabapentin" (brand name Neurontin), is used to treat neuralgia in adults and as adjunctive therapy in the treatment of partial seizures for patients over the age of twelve (12) with epilepsy, and is a dangerous drug pursuant to Business and Professions Code section 4022. Gabapentin includes a warning that "Antiepileptic drugs (AEDs), including gabapentin, increase the risk of suicidal thoughts or behavior in patients taking these drugs for any indication. Patients treated with any AED for any indication should be monitored for the emergence or worsening of depression, suicidal thoughts or behavior, and/or any unusual changes in mood or behavior."

L-methylfolate (brand names include[1] Denovo and Deplin), is a medical food dispensed by prescription for the clinical dietary management of metabolic imbalances associated with depression and schizophrenia, and a dangerous drug pursuant to Business and Professions Code section 4022.

"Pristiq" (generic name desvenlafaxine) is an antidepressant that belongs to a group of medicines called serotonin-norepinephrine reuptake inhibitors (SNRI's), and a dangerous drug pursuant to Business and Professions Code section 4022. Pristiq has a black box warning that "[a]ntidepressants increased the risk of suicidal thoughts and behavior in children, adolescents, and young adults in short-term studies" and "that patients of all ages who are started on antidepressant therapy, [should be] monitor[ed] closely for worsening, and for emergence of suicidal thoughts and behaviors. Advise families and caregivers of the need for close observation and communication with the prescriber."

"Trazadone" (brand names include Desyrel and Oleptro), an antidepressant that belongs to a group of medicines called serotonin modulators, is a dangerous drug pursuant to Business and Professions Code section 4022, that increases the amount of serotonin, a natural chemical in the brain. When properly prescribed and indicated, it is used for the management of depression with and without prominent anxiety. Trazadone has a black box warning regarding possible suicidality with antidepressant drugs, such as trazadone, which can increase the risk of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults and advises that anyone considering the use of trazodone or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need.

"Viibryd (generic name vilazodone), an antidepressant that belongs to a group of drugs called selective serotonin reuptake inhibitors (SSRI's), is a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of major depressive disorder (MDD) in adults. Viibryd has a black box warning regarding possible suicidal thoughts and behaviors in young adult patients and the need to closely monitor all antidepressant-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors.

"Wellbutrin" (generic name bupropion), an antidepressant medication, is a dangerous drug as defined in Code section 4022, which is generally used to treat major depression and seasonal affective disorder. Possible associated risks include, but are not limited to, increased restlessness, agitation, anxiety, and insomnia, especially shortly after initiation of treatment; neuropsychiatric signs and symptoms when prescribed for depressed patients, including delusions, hallucinations, psychosis, concentration disturbance, paranoia, and/or confusion (which abate with dose reduction or withdrawal of treatment); precipitation of manic episodes in bipolar disorder patients during a depressed phase and activation of psychosis in susceptible patients; altered appetite and weight; and other concerns more fully in the package inserts for this medication. This medication comes in sustained release (SR) and extended release (XR) form.

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[1] As used herein, the terms "include," "including" and "included" mean without limitation such as including, but not limited to, in context with the subject matter being discussed.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

14. Respondent is subject 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,[2] as more particularly alleged hereinafter:

15. On or about April 19, 2019, Patient A, a 47-year-old female, had a follow-up visit with Respondent who documented "I'm doing OK," as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient was stable, had no medication side effects, and that there was a discussion of treatment options which included no changes to the patient's current medications of Xanax (alprazolam) 0.25 mg 1-tab t.i.d., trazadone 50 mg (#30) 1-tab q.h.s. (before sleep), and Adderall 30 mg (#90) 1-tab t.i.d. Respondent electronically signed his Progress Note for this visit on December 15, 2022.

16. On or about July 10, 2019, Patient A had a follow-up visit with Respondent who again documented a chief complaint of, "I'm doing OK." Respondent did a "[w]ellness check" which noted, among other things, that the patient was stable, had no medication side effects; the patient's "duration of action" (DOA) was 5 hours per dose; the patient's mental status exam was normal; and Respondent's assessment for the patient of ADHD and anxiety disorder remained the same. Respondent discussed treatment options with the patient which included no changes to the patient's current medications of Xanax (alprazolam) 0.25 mg 1-tab t.i.d., trazadone 50 mg (#30) 1-tab q.h.s., and Adderall 30 mg (#90) 1-tab t.i.d. Respondent electronically signed his Progress Note for this visit on December 15, 2022.

17. On or about November 4, 2019, Patient A had a follow-up visit with Respondent who again documented a chief complaint of, "I'm doing OK." Respondent did a "[w]ellness check" which noted, among other things, that the patient was stable, had no medication side effects, and that the medication had a DOA of 5 hours per dose. The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. Respondent's

[2] The patient in this Accusation is identified as Patient A to address privacy concerns. The patient's identity is known to Respondent or will be disclosed to Respondent upon a duly issued request for discovery and in accordance with Government Code section 11507.6.

documented plan was to continue the patient's current therapy which included, Xanax (alprazolam) 0.25 mg 1-tab t.i.d., trazadone 50 mg (#30) 1-tab q.h.s., and Adderall 30 mg (#90) 1-tab t.i.d., and to consider genomic testing. Respondent electronically signed his Progress Note for this visit on December 15, 2022.

18. On or about February 24, 2020, Patient A had a follow-up visit with Respondent who again documented a chief complaint of, "I'm doing OK." Respondent did a "[w]ellness check" which noted, among other things, that the patient was stable, had no medication side effects, and that the medication had a DOA of 4 hours per dose (one hour less than previously reported), and that the patient suffered from a "subsequent increase in anxiety." The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder for the patient remained the same. The documented plan was to "continue current therapy" which included Xanax (alprazolam) 0.25 mg 1-tab t.i.d., trazadone 50 mg (#30) 1-tab q.h.s., and Adderall 30 mg (#90) 1-tab t.i.d., "monitor Xanax DOA and anxiety level, [and] consider increasing dose." Respondent electronically signed his Progress Note for this visit on December 15, 2022.

19. On or about March 25, 2020, Patient A had a follow-up visit with Respondent who documented, "Telephone appointment [and] [n]o changes since last visit," as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient was generally stable, and had no medication side effects. Respondent documented that he "discussed treatment options agree with no changes with medication at this time," and that the patient "reports DOA about 2-3 hours for each [X]anax dose, worries more thereafter but tolerable, not a cause of any impairment in functioning." The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. Respondent's plan was to "continue current therapy" which included Xanax (alprazolam) 0.25 mg 1-tab t.i.d., trazadone 50 mg (#30) 1-tab q.h.s., and Adderall 30 mg (#90) 1-tab t.i.d. Respondent electronically signed his Progress Note for this visit on December 15, 2022.

20. On or about May 18, 2020, Patient A had a follow-up visit with Respondent who documented, "Telephone appointment [and] I'm doing OK," as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient was stable,

no medication side effects, and "discussed treatment options [and] agree with no changes with medication at this time." The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. The documented plan included "continue current therapy" which included Xanax (alprazolam) 0.25 mg 1-tab t.i.d., trazadone 50 mg (#30) 1-tab q.h.s., and Adderall 30 mg (#90) 1-tab t.i.d. Respondent electronically signed his Progress Note for this visit on December 15, 2022.

21. On or about August 17, 2020, Patient A had a follow-up visit with Respondent who documented, "Telephone appointment [and] I'm depressed and anxious," as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient experienced changes in stability including, lethargy, decreased motivation, feeling lazy and unproductive, and social anxiety (overthinking, overanalyzing, and worrying which adversely affected the patient's ability to function and find work). Respondent documented that the patient denied any medication side effects, but his progress note also documented that the patient "Self tried pristiq 100 mg but did not tolerate." The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. Respondent's documented plan noted "genomic testing kit sent" with no changes to the current medications of Xanax (alprazolam) 0.25 mg 1-tab t.i.d., trazadone 50 mg (#30) 1-tab q.h.s., and Adderall 30 mg (#90) 1-tab t.i.d. Respondent electronically signed his Progress Note for this visit on December 15, 2022.

22. On or about September 21, 2020, Patient A had a follow-up visit with Respondent who documented, "Videoconferencing appointment: Zoom," as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient experienced some stability (but noted the patient "remains depressed and anxious") and suffered from a medication side effect of irritability for the self-taken Pristiq. The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. Respondent's documented plan included continuing Xanax (alprazolam) 0.25 mg 1-tab t.i.d., trazadone 50 mg (#30) 1-tab q.h.s., and Adderall 30 mg (#90) 1-tab t.i.d. and starting a trial of Viibryd 10 mg with the dosage to be gradually increased. Respondent electronically signed his

Progress Note for this visit on December 15, 2022.

23. On or about November 30, 2020, Patient A had a follow-up visit with Respondent who documented, "Videoconferencing appointment: Zoom [and] Viibryd not approved [by insurance]," as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient experienced some stability and increased anxiety "due to switching pharmacies and getti[ng] different generic manufacturers for her meds" with side effects (insomnia and headache) reported with new generic medications. Respondent encouraged the patient to go back to her previous pharmacy. Respondent reviewed the genomic testing results with the patient, and notated that the patient "will plan trying wellbutrin after the holidays, will wait for her to stabilize back to baseline." The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. Prescribing records show that Respondent continued treatment with Xanax (alprazolam) 0.25 mg 1-tab t.i.d., trazadone 50 mg (#30) 1-tab q.h.s. (with a note to "refill meds to Walgreens"), and Adderall 30 mg (#90) 1-tab t.i.d. Respondent electronically signed his Progress Note for this visit on December 15, 2022.

24. On or about January 27, 2021, Patient A had a follow-up visit with Respondent who documented, "Videoconferencing appointment: Zoom [and] No change since last visit," as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient experienced some stability with the patient experiencing more depression over the last few months (with the Covid quarantine being a possible contributing factor), with no medication side effects reported. The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. Respondent's documented plan included continuing Xanax (alprazolam) 0.25 mg 1-tab t.i.d. and Adderall 30 mg (#90) 1-tab t.i.d., trazadone 50 mg (#30) 1-tab q.h.s., and starting a trial of Wellbutrin XL 150 mg 1-tab every 24 hours. Respondent electronically signed his Progress Note for this visit on December 15, 2022.

25. On or about February 18, 2021, Patient A had a follow-up visit with Respondent who documented, "Videoconferencing appointment: Zoom [and] "I'm doing OK," as the patient's

chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient experienced increased stability and was "feeling a little bit better" and "less depressed overall," with some nausea medication side effects that "improved with time." The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. Respondent's plan included increasing Wellbutrin XL dosage to 300 mg 1-tab every morning and start L-methylfolate 15 mg, 1 capsule once a day and no changes to the current medications of Xanax (alprazolam) 0.25 mg 1-tab t.i.d., Adderall 30 mg (#90) 1-tab t.i.d., and trazadone 50 mg (#30) 1-tab q.h.s. Respondent electronically signed his Progress Note for this visit on December 15, 2022.

26. On or about April 7, 2021, Patient A had a follow-up visit with Respondent who documented, "Videoconferencing appointment: Zoom [and] I'm doing OK," as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient experienced increased stability with "more motivation [and] desire to do things" with a reported medication side effect of "having more problems making decisions." The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. Respondent's documented plan included no changes to the current medications of Xanax (alprazolam) 0.25 mg 1-tab t.i.d., Adderall 30 mg (#90) 1-tab t.i.d., trazadone 50 mg (#30) 1-tab q.h.s., and L-methylfolate 15 mg 1 capsule once a day for the anxiety disorder. Respondent electronically signed his Progress Note for this visit on December 15, 2022.

27. On or about May 19, 2021, Patient A had a follow-up visit with Respondent who documented, "Videoconferencing appointment: Zoom [and] I stopped the methylfolate," as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient experienced stability improved and that the patient was "doing well at home [and] going outdoors more often [and] doing well at work," with a medication side effect of fatigue which improved after not taking the trazadone. The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. Respondent's documented plan included stopping trazadone 50 mg (#30) 1-tab q.h.s., continuing Xanax

(alprazolam) 0.25 mg 1-tab t.i.d. and Adderall 30 mg (#90) 1-tab t.i.d., continuing current therapy and allowing the patient to transition back to baseline.[3] Respondent electronically signed his Progress Note for this visit on December 15, 2022.

28. On or about June 28, 2021, Patient A had a follow-up visit with Respondent who documented, "Videoconferencing appointment: Zoom [and] I'm doing better," as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient was stable, there were no medication side effects, and treatment options were discussed which included no changes to medications. The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. Respondent's documented plan included no changes to the current medications of Xanax (alprazolam) 0.25 mg 1-tab t.i.d., Adderall 30 mg (#90) 1-tab t.i.d., and trazadone 50 mg (#30) 1-tab q.h.s. Respondent electronically signed his Progress Note for this visit on December 15, 2022.

29. On or about August 16, 2021, Patient A had a follow-up visit with Respondent who documented, "Videoconferencing appointment: Zoom [and] I'm doing OK. I haven't been vaccinated" as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient was stable, "still focusing well duration of action about 4 hours," had no medication side effects, and that they discussed treatment options which included no changes of medication. The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. Respondent's documented plan included no changes to the current medications of Xanax (alprazolam) 0.25 mg 1-tab t.i.d., Adderall 30 mg (#90) 1-tab t.i.d., and trazadone 50 mg (#30) 1-tab q.h.s. Respondent electronically signed his Progress Note for this visit on December 15, 2022.

30. On or about October 13, 2021, Patient A had a follow-up visit with Respondent who documented, "Videoconferencing appointment: Zoom [and] I'm doing OK," as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient was stable, suffered from a medication side effect of "neck pain with current brand [of

[3] The medications list documented the patient "Not-taking/PRN [as needed] Wellbutrin XL 300 mg..." and "Not-Taking/PRN L-methylfolate 15 mg capsule...."

Adderall]," and that they discussed treatment options which included changing the brand of Adderall and/or pharmacy. The patient's mental status exam was normal; and Respondent's assessment of ADHD and anxiety disorder remained the same. Respondent's documented plan included no changes to the current medications of Xanax (alprazolam) 0.25 mg 1-tab t.i.d., and trying a different brand of Adderall 30 mg (#90) 1-tab t.i.d. Respondent electronically signed his Progress Note for this visit on December 15, 2022.

31. On or about March 14, 2022, Patient A had a follow-up visit with Respondent who documented, "Videoconferencing appointment: Zoom [and] I'm doing OK," as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient was stable, had no medication side effects, and that they discussed treatment options which included no changes to medication. The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. Respondent's documented plan included no changes to the current medications of Xanax (alprazolam) 0.25 mg 1-tab t.i.d. and Adderall 30 mg (#90) 1-tab t.i.d. Respondent electronically signed his Progress Note for this visit on December 15, 2022.

32. On or about May 11, 2022, Patient A had a follow-up visit with Respondent who documented, "Videoconferencing appointment: Zoom [and] I'm doing OK," as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient was stable, "sleeping well uses trazadone 'rarely' about 2x/month," had no medication side effects, and that they discussed treatment options which included no changes to medication. The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. Respondent's documented plan included no changes to the current medications of Xanax (alprazolam) 0.25 mg 1-tab t.i.d., Adderall 30 mg (#90) 1-tab t.i.d., but Respondent failed to document about any future use of trazadone. Respondent electronically signed his Progress Note for this visit on December 15, 2022.

33. On or about July 13, 2022, Patient A had a follow-up visit with Respondent who documented, "Videoconferencing appointment: Zoom [and] I'm doing OK," as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the

patient had decreased stability (patient having difficulty staying on task, following through, and making decisions, with an increase in anxiety), had no medication side effects, and that they discussed treatment options which included a trial of gabapentin 100 mg t.i.d. and the monitoring of anxiety and attention span. The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. Respondent's documented plan included starting a trial of gabapentin 100 mg 1 capsule t.i.d. (along with Xanax [alprazolam] 0.25 mg 1-tab t.i.d. and Adderall 30 mg (#90) 1-tab t.i.d.) Respondent electronically signed his Progress Note for this visit on December 15, 2022.

34. On or about August 15, 2022, Patient A had a follow-up visit with Respondent who documented, "Videoconferencing appointment: Zoom [and] No change since last visit," as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient was somewhat stable, having inconsistent effects (and side effects) with gabapentin, and was "[s]till not focusing well with adderall, thinks its the brand," and that they discussed treatment options which included discontinuing the gabapentin and "switch to adderall at CVS [pharmacy]." The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. Respondent's documented plan included continuing Xanax (alprazolam) 0.25 mg 1-tab t.i.d., switching to the CVS brand of Adderall 30 mg (#90) 1-tab t.i.d, and discontinuing the trial of gabapentin. Respondent electronically signed his Progress Note for this visit on December 15, 2022.

35. On or about September 12, 2022, Patient A had a follow-up visit with Respondent who documented, "Videoconferencing appointment: Zoom [and] Everythings back to normal," as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient was stable, had no medication side effects, and that they discussed treatment options which included not changing medications and "doing better since using the CVS brand [of Adderall]." The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. Respondent's documented plan included continuing Xanax (alprazolam) 0.25 mg 1-tab t.i.d. and Adderall 30 mg (#90) 1-tab t.i.d. Respondent electronically signed his Progress Note for this visit on December 15, 2022.

36. On or about November 9, 2022, Patient A had a follow-up visit with Respondent who documented, "Videoconferencing appointment: Zoom [and] I'm doing OK," as the patient's chief complaint. Respondent did a "[w]ellness check" which noted, among other things, that the patient was stable, had no medication side effects, and that they discussed treatment options which included not changing medications. The patient's mental status exam was normal and Respondent's assessment of ADHD and anxiety disorder remained the same. Respondent's documented plan was to continue current therapy which included Xanax (alprazolam) 0.25 mg 1-tab t.i.d. and Adderall 30 mg (#90) 1-tab t.i.d. (with a notation of "will try to get [new] brand Adderall, consider [another] pharmacy"). Respondent electronically signed his Progress Note for this visit on December 15, 2022.

37. Respondent authorized early refills for medications without an adequate justification and/or explanation and/or sent prescriptions for the same controlled substance to two different pharmacies on the same day as described below:

a. On or about February 24, 2020, Respondent issued a new prescription for Xanax (alprazolam) 0.25 mg 1-tab t.i.d, without an adequate justification and/or explanation, to Walgreens pharmacy while there was still a refill available on an earlier prescription for the same drug on or about January 15, 2020;

b. On or about May 19, 2021, Respondent issued simultaneous prescriptions for Adderall 30 mg (#90) 1-tab b.i.d. (twice a day) to CVS pharmacy and Walgreens pharmacy, without an adequately justification and/or explanation. The prescription Respondent issued to CVS was filled on or about May 19, 2021 and sold to Patient A on June 15, 2021; and the prescription Respondent issued to Walgreens was filled and sold to Patient A on or about May 19, 2021;

c. On or about August 8, 2021, Patient A filled a prescription for Xanax (alprazolam) 0.25 mg 1-tab t.i.d. and filled another prescription of Xanax (alprazolam) 0.25 mg 1-tab t.i.d., which was an early refill of the drug without an adequate justification and/or explanation; and

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d. On or about November 9, 2021, Respondent issued a prescription for Adderall 30 mg (#60) b.i.d. to CVS pharmacy and the next day issued a prescription for generic Adderall 30 mg t.i.d. to Walgreens pharmacy, without an adequate justification and/or explanation. The prescriptions that Respondent issued to CVS and Walgreens were both filled and sold to Patient A shortly after they were issued.

38. Respondent repeatedly failed to maintain adequate medical record documentation for Patient A, including when he failed to adequately document: (a) his justification for maintaining Patient A on Adderall at 90 mg per day, (b) any intermittent monitoring of Patient A's pulse and blood pressure, (c) any periodic monitoring of CURES as required by California Health and Safety Code Section 11165.4, and (d) a prompt and timely review of his Progress Notes.

39. The acts and/or omissions by Respondent set forth, above, with respect to Patient A, either collectively or in any component or combination thereof, constitute repeated negligent acts.

40. Respondent committed negligence when he repeatedly failed to adequately document an adequate justification and/or explanation for maintaining Patient A on Adderall at 90 mg per day.

41. Respondent committed negligence when he failed to conduct and/or document any intermittent monitoring of Patient A's pulse and blood pressure.

42. Respondent committed negligence when he authorized prescriptions or early refills, without an adequate justification and/or explanation and/or sent prescriptions for the same controlled substance to two different pharmacies on the same day.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

43. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records in connection with his care and treatment of Patient A as follows:

44. The allegations of the First Cause for Discipline are incorporated by reference as if fully set forth herein.

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THIRD CAUSE FOR DISCIPLINE

(Failure to Consult CURES Database)

45. Respondent is further subject to disciplinary action under sections 2227 and 2234 of the Code, and Health and Safety Code section 11165.4, in that he failed to periodically consult CURES to review Patient A's controlled substance history as required by the statute and as follows:

46. The allegations of the First Cause for Discipline are incorporated by reference 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 Number G 58063, issued to Respondent Edmundo S. Jesalva, M.D.;

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

3. Ordering Respondent Edmundo S. Jesalva, 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: FEB 25 2025

REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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