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

In the Matter of the First Amended Accusation Against:	)	
STUART H. TUBIS, M.D.	)	**Case No. 800-2016-025718**
Physician's and Surgeon's Certificate No. G13754	)	OAH No. 2018080331
Respondent	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on February 1, 2019

IT IS SO ORDERED January 3, 2019.

MEDICAL BOARD OF CALIFORNIA

By: _____
KRISTINA D. LAWSON, J.D., Chair
Panel B

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

In the Matter of the First Amended Accusation Against: STUART H. TUBIS, M.D. Physician's and Surgeon's Certificate No. G 13754 Respondent.	Case No. 800-2016-025718 OAH No. 2018080331

PROPOSED DECISION

This matter was heard before Administrative Law Judge Marcie Larson, Office of Administrative Hearings, State of California, on September 10, October 3, 4, and 26, 2018, in Sacramento, California.

Jane Zack Simon, Supervising Deputy Attorney General, and Joshua Templet, Deputy Attorney General, represented complainant Kim Kirchmeyer, Executive Director of the Medical Board of California (Board).

Robert W. Hodges, Attorney at Law, represented respondent Stuart H. Tubis, M.D., who was present at the hearing.

Evidence was received and the record remained open for submission of written closing arguments. Complainant's closing brief was filed on November 9, 2018, and marked as Exhibit 36. Respondent's closing brief was filed on November 17, 2018, and marked as Exhibit J. Complainant's reply brief was filed on November 28, 2018, and marked as Exhibit 37. The matter was submitted for decision on November 28, 2018.

FACTUAL FINDINGS

1. On August 11, 1967, the Board issued respondent Physician's and Surgeon's Certificate No. G 13754 (certificate). The certificate was current at all times pertinent to this matter and will expire on January 31, 2019, if not renewed or revoked.

2. On August 17, 2018, complainant, acting in her official capacity, signed and thereafter filed the First Amended Accusation (Accusation) against respondent. Complainant seeks to revoke respondent's certificate based on his alleged conduct in connection with his treatment of six patients, self-prescribing medications and violation of an Interim Order of Suspension (Order). Generally, complainant alleged respondent prescribed four patients dangerous drugs and controlled substances without performing adequate assessments and examinations. Complainant also alleged respondent's medical records for all six patients are not accurate or adequate. Respondent also prescribed himself dangerous drugs and controlled substances, without adequate justification.

Complainant further alleged that after an Order was issued on June 28, 2018, respondent continued to practice medicine and prescribe medications to patients, before surrendering his Drug Enforcement Administration (DEA) Certificate of Registration and prescription forms, in violation of the Order. Complainant contends respondent's conduct constitutes gross negligence, repeated acts of negligence, failure to maintain adequate and accurate medical records, violation of the Medical Practices Act, practicing with a suspended license and engaging in dishonest or corrupt acts.

3. Respondent timely filed a Notice of Defense, pursuant to Government Code section 11506. The matter was set for an evidentiary hearing before an Administrative Law Judge of the Office of Administrative Hearings, an independent adjudicative agency of the State of California, pursuant to Government Code section 11500 et seq.

Respondent's Background

4. Respondent completed his Bachelor of Arts degree in chemistry at Haverford College in 1959. He obtained his Master's Degree from Harvard University, Graduate School of Arts and Sciences in 1961. Thereafter, he attended medical school at the University of Southern California (USC), School of Medicine. Respondent graduated from medical school in 1966. He obtained his certificate to practice medicine in California in 1967. Respondent then completed an internship at USC School of Medicine and the Hospital of the Good Samaritan in Los Angeles. In 1968, respondent completed his psychiatry residence through USC School of Medicine and Los Angeles County Hospital. Respondent completed a fellowship at Harvard Medical School in 1971. In 1972, respondent completed a psychiatry residency at Menninger School of Psychiatry (Menninger) in Topeka, Kansas. In 1976, respondent obtained his board certification from the American Board of Psychiatry and Neurology. In 1982, respondent obtained a Ph.D. "equivalent" from Menninger.

5. From 1977 until 1982, respondent operated a psychiatry private practice in Kansas City, Missouri. He was also a professor at the University of Kanas and University of Missouri. Since 1982, respondent has operated a psychiatry private practice in Sacramento and Vacaville. Since that time, respondent also worked as a consultant to public, private and nonprofit community agencies and mental health centers. From 1997 until 2011, respondent was a psychiatrist for the California Department of Mental Health. He also served as a professor at University of California, Davis.

6. In approximately September 2013, respondent began working as a psychiatrist for Fair Oaks Psychiatric Association (Fair Oaks). He worked as an independent contractor two days per week. On or about July 1, 2016, respondent became the Medical Director for Fair Oaks. Janak Mehtani, M.D. owned Fair Oaks and had previously worked as the Medical Director. Respondent's duties as the Medical Director included adherence to the standardized procedures and supervising staff, nurse practitioners and physician assistants. Respondent held the Medical Director position until approximately July 27, 2018.

Board Investigation

7. On September 2, 2016, the Board received an online complaint filed by the aunt of Patient-1 A.S., who was treated by respondent. The aunt alleged that A.S. had a history of heroin and prescription drug abuse. A.S. informed his aunt that he obtained prescriptions for "Xanax[1]" and "Norco[2]" from respondent. A.S.'s aunt further stated that in May 2016, A.S. overdosed on Ambien[3]. She requested the Board investigate respondent's prescribing of medications to A.S.

8. On or about October 31, 2016, Dennis Scully, an Investigator for the Department of Consumer Affairs, was assigned to investigate the complaint filed by A.S.'s aunt. Mr. Scully testified at hearing. As part of his investigation, Mr. Scully obtained Controlled Substance Utilization Review and Evaluation System (CURES) reports for controlled substance prescriptions issued by respondent beginning in 2013, which lists in part, the names of patients, medication, and dosage. Based on the CURES reports, the Board's medical consultant, Vincent Yap, M.D., requested respondent's medical records for specific patients, including Patient-1 A.S., Patient-2 K.F., Patient-3 B.D., Patient-4 F.T., Patient-5 M.Z. and Patient-6 A.B. Mr. Scully obtained respondent's records for these patients.

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[1] Xanax is the brand name for alprazolam, which is a benzodiazepine. Alprazolam is a psychotropic drug prescribed to treat anxiety and panic disorders. Alprazolam is a dangerous drug as defined in Business and Professions Code section 4022, and is a schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1). For consistency, the term "Xanax" is used in the Proposed Decision, rather than alprazolam.

[2] Norco is the brand name for hydrocodone with acetaminophen. Hydrocodone is a semisynthetic narcotic analgesic medication prescribed to treat pain. Hydrocodone is a dangerous drug as defined in Business and Professions Code section 4022, and is a schedule III controlled substance pursuant to Health and Safety Code section 11056.

[3] Ambien is the brand name for zolpidem tartrate. Zolpidem tartrate is a sedative used to treat insomnia. Zolpidem tartrate is a dangerous drug as defined in Business and Professions Code section 4022, and is a schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(32). For consistency, the term "Ambien" is used in the Proposed Decision rather than zolpidem tartrate.

Mr. Scully also obtained copies of a CURES report and pharmacy records listing medications respondent prescribed himself, including Xanax, hydrocodone and antihypertensive medications. Mr. Scully provided the medical records to Dr. Yap for review. On November 13, 2017, Mr. Scully and Dr. Yap interviewed respondent.

9. After respondent's interview, Mr. Scully sent the medical records and CURES reports for the six patients, CURES reports and pharmacy records related to respondent's self-prescribing and a transcript of respondent's interview, to Board expert reviewer Alex Sahba, M.D., who is a board-certified psychiatrist and forensic psychiatrist. On January 8, 2018, Dr. Sahba issued a report in which he opined that respondent's conduct related to his treatment of the six patients, medical record documentation and self-prescribing medication constitutes extreme departures from the standard of care.

Treatment History of Patients

PATIENT-1 A.S.

10. A.S. first saw respondent on March 23, 2016. A.S. was 25 years old. A.S. reported to respondent that he moved from Michigan to California, and was living with his aunt. A.S. worked as a cook. A.S. informed respondent that he had "always been an anxious person" and that he is "always on edge." A.S. explained his issues with anxiety began when he was 13 years old. A.S. told respondent that while he was in Michigan, he was taking Xanax two milligrams (mg), three times per day (2 mg TID) to treat his anxiety. Respondent also noted "RX Insomnia Ambien" with no explanation. Respondent prescribed A.S. a 30-day supply[4] of Xanax 2 mg TID and Ambien 10 mg daily. Respondent prepared a handwritten medication record for A.S. Respondent only listed the Xanax prescription on A.S.'s medication record.

The handwritten medical notes respondent prepared for the evaluation of A.S. on March 23, 2016, is less than one-half of a page. The notes are illegible in parts and difficult to decipher. The medical notes do not include a past medical history, past psychiatric history other than reports of anxiety and panic attacks, past or current substance use history, educational, vocational, social, family or legal history, a mental status examination, a list of current medications or drug allergies. Other than noting A.S.'s complaint of anxiety and panic attacks, there is no working diagnosis or treatment plan listed. Additionally, respondent prescribed A.S. Xanax 2 mg TID, without documented explanation or rationale, and no documentation indicating he had a discussion with A.S. about the dangers of taking Xanax and Ambien, such as the sedating effects and risk of addiction.

11. Respondent was registered to obtain prescription histories for his patients through the CURES database. Respondent did not run a CURES report on A.S. before prescribing Xanax and Ambien, because he did not believe it was necessary. Respondent did

[4] All of the prescriptions issued by respondent for the six patients are 30-day supplies unless otherwise noted.

not see any "red flags" that A.S. may be abusing or diverting Xanax and Ambien. Respondent did not request A.S. to provide his medical records from past treaters and respondent did not obtain a medical release from A.S. to contact his past treaters or obtain his medical records.

12. On August 1, 2016, A.S. saw respondent for a second appointment. He informed respondent that the Xanax 2 mg TID "works wonders." Respondent noted that A.S. reported that "SSRI's did not help [with] depression." There is no information listed in the medical notes concerning a history of depression. A.S. requested prescriptions of Xanax 2 mg TID and Ambien 10 mg daily. Respondent also prescribed A.S. Viibryd 40 mg which is used to treat depression.[5] Respondent diagnosed respondent with generalized anxiety disorder and depression.

The medical notes for the appointment are approximately one-third of a page and are difficult to decipher due to the illegible writing. Other than the diagnosis of generalized anxiety disorder and depression there is no documented rationale for the prescriptions. Additionally, the medications were not added to A.S.'s medication record for the visit.

13. On October 3, 2016, respondent saw A.S. for a follow-up appointment. The medical note for the visit is approximately six lines. Respondent noted that A.S. "no longer needs Ambien." However, A.S. requested Xanax. Respondent wrote on A.S.'s medication record for the visit that he prescribed Xanax 2 mg TID, Valium[6], and Ambien 10 mg. A.S. filled prescriptions for Xanax and Ambien.

14. A.S. had an appointment with respondent on July 25, 2017. Respondent informed A.S. of the investigation being conducted by the Board. Respondent documented that A.S. was using all of the Xanax he prescribed and was not "selling or giving anyone his meds." A.S. insisted he needed Xanax 2 mg TID. For the first time, respondent documented a mental status examination of A.S. He diagnosed respondent with generalized anxiety disorder and "excessive reliance" on Xanax. Respondent prescribed A.S. Xanax 2 mg TID.

Respondent had no further medical treatment notes for A.S. past July 25, 2017. However, on September 11, 2017, A.S. filled a prescription for Xanax 2 mg TID. He also filled a prescription for Adderall, authorized by respondent. There is no information in respondent's medical record explaining the rational for the medication, or that the medication

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[5] Viibryd is the brand name for vilazodone hydrochloride, a selective serotonin reuptake inhibitor (SSRI) used to treat depression. Vilazodone is a dangerous drug defined in Business and Professions Code section 4022.

[6] Valium is the brand name for diazepam, which is a benzodiazepine used to treat anxiety disorders. Diazepam is a dangerous drug defined in Business and Professions Code section 4022 and a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d)(9). For consistency, the term "Valium" is used in the Proposed Decision, rather than diazepam.

was prescribed. Respondent informed Dr. Yap during his interview that he prescribed A.S. Adderall because he asked for it.

15. Respondent never ran a CURES report for A.S. or obtained a medical release to review his medical records from other treaters. A CURES report for A.S. from January 22, 2015, through September 25, 2017, demonstrates that A.S. obtained prescriptions in Michigan, but none of the prescriptions were for Xanax or Ambien. However, he was prescribed Zubsolv which can be used to treat opioid dependence. The first prescription of Xanax listed on the CURES report was from respondent. Additionally, between March and September 25, 2017, A.S. obtained from other treatment providers, prescriptions for buprenorphine-naloxone, which can be used to treat opioid dependence.

PATIENT-2 K.F.

16. K.F. first saw respondent on March 23, 2016. K.F. was 22 years old. He explained to respondent he suffered from social anxiety that started in seventh grade. Respondent noted K.F. reported his grandmother and mother both had anxiety. He also noted the K.F.'s brother and sister do not have anxiety. Respondent also noted that K.F. reported "Klonopin[7] worked but Xanax 2 mg worked better." Respondent documented that K.F. reported his anxiety level was at "7/10" when using Klonopin and "3/10" when using Xanax. Respondent prescribed K.F. Xanax 2 mg TID and Ambien 10 mg daily.

Respondent wrote a half-page of notes for K.F.'s evaluation. The medical notes are difficult to decipher. The medical notes do not include a past medical history, past psychiatric history other than reports of anxiety, substance use history, a mental status examination, a list of current medications or drug allergies. Other than noting K.F.'s complaint of anxiety, there is no working diagnosis or treatment plan listed. Additionally, respondent prescribed K.F. Xanax 2 mg TID and Ambien 10 mg daily, without documented rationale and without obtaining informed consent documenting that he had a discussion with K.F. about the dangers of taking Xanax and Ambien.

17. Respondent did not run a CURES report on K.F. before prescribing Xanax and Ambien. K.F. did not provide respondent his medical records from past treaters. Respondent did not obtain a medical release from K.F. to speak to his past treaters or obtain his medical records.

18. K.F.'s CURES report shows that one week after K.F. filled a one-month supply of Xanax, on April 1, 2016, respondent wrote K.F prescriptions for another 30-day

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[7] Klonopin is the brand name for clonazepam, a benzodiazepine used to treat various conditions, including panic disorders. Klonopin is a dangerous drug as defined in Business and Professions Code section 4022, and a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d)(6).

supply of Xanax 2 mg TID and Adderall.[8] There is no information in K.F.'s medical record for this date documenting K.F. was prescribed these medications or the reason for the prescriptions.

19. Respondent saw K.F. again on July 6, 2016. Respondent's medical notes for the visit are partially illegible and difficult decipher. Respondent noted that K.F. was a professional skateboarder and broke his ankle when he was 19 years old. His current job was in sales. Respondent also noted that K.F.'s pain doctor was in Roseville and that K.F. had missed an appointment. K.F. requested a prescription for "Norco 10/325." Respondent noted that he wrote K.F. a "onetime" prescription for Norco. Respondent also prescribed K.F. Xanax 2 mg TID. Respondent did not list any information concerning the rationale for the Xanax. K.F.'s medication record did not list the Norco or Xanax prescriptions. Rather, respondent listed Klonopin and Ambien prescriptions which are not mentioned in the medical notes for the visit.

20. On July 14, 2016, Michael McAndrew, M.D. faxed respondent a printout of a CURES report concerning K.F.'s prescription history. The CURES report showed between March and July 2016, respondent wrote K.F. prescriptions for Xanax, Ambien, Adderall, and Norco. During the same period, Dr. McAndrew prescribed K.F. suboxone[9]. Dr. McAndrew noted on the bottom of the CURES report that K.F. "is opiate addict." He also wrote that K.F. is "under suboxone contract" and that he has been "referred to substance abuse therapy" and should "not use benzos/opioids." "Benzos" refers to benzodiazepines. Respondent did not contact Dr. McAndrew to discuss K.F.'s treatment or substance abuse history. Respondent also did not contact K.F. to discuss the information he received from Dr. McAndrew.

21. Respondent saw K.F. again on November 15, 2016. Respondent discussed with K.F. the information he received from Dr. McAndrew. Respondent noted K.F. "went off suboxone." K.F. complained that the suboxone made him a different person. K.F. also reported that he first started using Norco when it was given to him by his older brother after K.F. suffered an ankle injury. Respondent noted in the medical record that he encouraged K.F. to see a pain specialist. K.F. also reported he suffered the same level of anxiety as an adult as he did as a child. He described getting a feeling of "pressure." K.F. reported the Xanax helped him work. Respondent prescribed K.F. Cymbalta for depression, Valium for

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[8] Adderall is the brand name for a combination of amphetamine and dextroamphetamine. The drug is used to treat attention deficit hyperactive disorder. Adderall is a dangerous drug as defined in Business and Professions Code section 4022, and a Schedule II controlled substance under Health and Safety Code section 11055

[9] Suboxone is the brand name for a combination of buprenorphine and naloxone. Suboxone is used to treat narcotic addiction. Suboxone is a dangerous drug as defined in Business and Professions Code section 4022, and a Schedule III controlled substance under Health and Safety Code section 11056.

anxiety and Ambien for sleep. Respondent believed Valium was longer acting and would be less likely to be abused.

22. Respondent last documented a visit from K.F. on July 11, 2017. For the first time, respondent documented a mental status examination. K.F. requested Xanax 2 mg. TID. Respondent noted on the medical record the fax from Dr. McAndrew sent a year earlier on July 14, 2016. He also noted that K.F. explained he was on suboxone but that Xanax was "ok with Dr. McAndrew." Respondent prescribed K.F. Xanax 2 mg TID and Adderall 10 mg TID. Respondent did not contact Dr. McAndrew to confirm K.F.'s statement or obtain a CURES report.

23. Respondent had no further medical treatment notes or medication record entries for K.F. past July 11, 2017. However, K.F.'s CURES report shows that on July 21, 2017, 10 days after he received and filled a prescription for Xanax 2 mg TID, he filled another prescription from respondent for Xanax 1 mg TID. On August 7, 2017, he filled a prescription from respondent for Ambien 10 mg daily. On August 18, 2017, he filled a prescription from respondent for Xanax 2 mg TID. K.F. continued to fill prescriptions for Xanax, Ambien and Adderall authorized by respondent, through November 1, 2017.

24. Respondent never ran a CURES report to check K.F.'s prescription history. He did not obtain a medical release from K.F. to speak to his other treaters or request his medical records.

PATIENT-3 B.D.

25. B.D. first saw respondent on October 22, 2014. B.D. was 34 years old. He was referred to respondent by his marriage and family therapist. Respondent prepared approximately one page of notes regarding the visit. The notes are illegible in parts and difficult to decipher. B.D. reported he was an army veteran and a student studying human services. B.D. complained that his girlfriend harassed him and called him "lazy." B.D. also reported he was "angry all the time." Respondent noted that B.D. stated he needed medication. Respondent also noted that it was "not clear what he wants."

B.D.'s medical record does not contain a past medical history, substance use history, drug allergies, a mental status exam, a working diagnosis, or a plan for treatment. Respondent listed three medications B.D. reported he was taking. There is no indication that respondent prescribed B.D. any medication during this visit.

26. Respondent saw B.D again on October 29, 2014. Respondent wrote a half page of mostly illegible notes. Respondent noted a diagnosis of anxiety and bipolar disorder, with no facts or explanation to support the diagnosis. Respondent prescribe B.D. Seroquel[10],

[10] Seroquel is the brand name for quetiapine, an antipsychotic medicine used to treat bipolar disorder. Seroquel is a dangerous drug defined in Business and Professions Code section 4022.

an antipsychotic medication used to treat bipolar disorder and Ativan[11], a medication used to treat anxiety. Respondent again saw B.D. on November 4, 2014. Respondent wrote four illegible sentences about the visit. The short notes for a visit on January 6 and 25, 2015, are likewise illegible.

27. During a visit on March 3, 2015, B.D. explained that he wanted an anti-depressant medication. He also wanted his medical records sent to the Veterans Administration. B.D. explained he was seeking higher service-connected disability payments. In response, respondent prepared a handwritten letter dated March 23, 2015, outlining B.D.'s military history and resulting mental illness. Respondent explained that B.D. sought treatment for "depression, mood swings, [and] insomnia." Respondent also noted that B.D. was afraid he was paranoid and that people are watching him. B.D. reported memory loss and that his "mind is messed up."

28. On March 24, 2015, respondent wrote a note outlining B.D.'s mental status exam results, diagnosis and list of medication. Respondent recommended an increase in service-connected disability payments.

29. Respondent prepared a handwritten note dated December 22, 2015, explaining that B.D. was "fixated on gaining more disability compensation." Respondent noted B.D. needed to go the Veterans Administration and Social Security Administration for a qualified psychiatric or medical evaluation.

30. Respondent's last treatment notes for B.D. were in February 2016. Treatment notes from February 3, 2016, contain a single statement that B.D. was "not as angry." Notes from February 24, 2016, are illegible.

PATIENT-4 F.T.

31. F.T. visited Fair Oaks on February 23, 2016. F.T. was 25 years old. Fair Oaks utilized an electronic medical record that contained information completed by F.T. The information included his chief complaint of post-traumatic stress disorder (PTSD) and attention deficit disorder (ADD). F.T. was referred from University of California, Davis Hospital, after seeking treatment for fourth degree burns that occurred after a vaporizer pen exploded in his pants on December 1, 2015. F.T. complained of trouble sleeping, sweating while sleeping, hypervigilance, and being easily startled. F.T. also reported a diagnosis of ADD and that he had been taking Adderall 20 mg per day. Lab tests were ordered. F.T. did not see respondent on this first visit.

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[11] Ativan is the brand name for lorazepam, which is a benzodiazepine used to treat anxiety disorders or anxiety associated with depression. Ativan is a dangerous drug defined in Business and Professions Code section 4022, and a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d)(16).

32. On March 24, 2016, respondent saw F.T. for the first time. Respondent prepared a half-page of written notes that are mostly illegible. Respondent did not document any history of substance use, no family history and no mental status examination. F.T. reported the circumstances of his burn injury and the effects including anxiety and sleep disturbance. Respondent also noted a "pre-existing" ADD diagnosis. Respondent prescribed F.T. Adderall. The note does not include a treatment plan.

33. Respondent saw F.T. again on April 22, 2016. Respondent wrote approximately five lines of information from the visit. Respondent noted that F.T. was "doing better, more sleep." He also noted that F.T. enjoyed his job as a manager. The note does not include a mental status exam, diagnosis or treatment plan.

34. Respondent's notes for a June 2, 2016 visit contains one sentence that is illegible. Notes for an August 19, 2016, visit are half a page and difficult to decipher. The notes do not include a mental status exam, diagnosis or treatment plan.

PATIENT-5 M.Z.

35. On November 12, 2014, M.Z., a 54-year-old man, called respondent's office and requested an appointment to get a prescription for Klonopin "6 mg per day." An appointment with respondent was scheduled for December 3, 2014. The medical record for M.Z.'s first appointment with respondent noted that M.Z.'s chief complaint was anxiety. M.Z. reported that his previous doctor in Davis, California had prescribed him Klonopin .25 mg per day to taper him off the medication. M.Z. explained he did not want to be tapered off Klonopin.

The medical notes for the visit do not include a past medical history, past psychiatric history other than reports of anxiety, substance use history, educational, vocational, social, family or legal history, a mental status examination, or a list of drug allergies. Other than noting M.Z.'s complaint of anxiety, there is no working diagnosis or treatment plan listed. Additionally, respondent prescribed M.Z. Klonopin 2 mg TID and Ambien 10 mg daily, without documented rationale and without obtaining informed consent documenting that he had a discussion with M.Z. about the dangers of taking Klonopin and Ambien. Respondent also did not obtain a CURES report on M.Z. before prescribing him medication. He also did not obtain a medical release from M.Z. to contact his past treaters or obtain his medical records.

36. On December 31, 2014, respondent saw M.Z. again and diagnosed him with generalized anxiety disorder. Respondent continued to prescribe M.Z. the same dosage of Klonopin and Ambien through July 25, 2017. The treatment notes for M.Z.'s appointments between December 31 2014, and July 25, 2017, are mostly illegible and difficult to decipher. For example, notes from visits on December 19, 2016, March 20, May 8 and June 19, 2017, comprise a few illegible words. The first-time respondent documented the rationale for Ambien was on July 25, 2017, when he noted M.Z. needed the medication to sleep.

37. Respondent did not taper M.Z. off of Klonopin. There is no information in M.Z.'s medical record that respondent discussed with him the risk of continued use of the medication. There is also no indication that respondent recommended other forms of treatment such as psychotherapy, cognitive behavioral therapy or the use of SSRIs. Respondent never ran a CURES report to check M.Z.'s prescription history.

PATIENT-6 A.B.

38. A.B. completed a new patient registration form on August 1, 2014, but did not have her initial evaluation with respondent until September 30, 2014. She was 28 years old. Respondent prepared one page of handwritten notes concerning his evaluation, which are mostly illegible and difficult to decipher. A.B. reported that she was a victim of rape. She also was involved in a car accident. She suffered flashbacks. A.B. reported she had been taking Xanax, but her previous physician would no longer prescribe her the medication. As a result, she called the police on her doctor. A.B. requested that respondent prescribe her Xanax.

The medical notes for the visit do not include a complete past medical history, past or current substance use history, education, a mental status examination, or a list of drug allergies. Respondent did not document a working diagnosis or treatment plan. Respondent prescribed A.B. Xanax 1 mg TID, without documented rationale and without obtaining informed consent documenting that he had a discussion with A.B. about the dangers of taking Xanax. Respondent also did not run a CURES report on A.B. before prescribing her medication. He also did not obtain a medical release from A.B. to speak to her past treaters or obtain her medical records.

39. On October 14, 2014, A.B. had an appointment with respondent. A.B. complained she was overwhelmed and scared she was going to die. The remainder of the notes respondent wrote for the appointment are illegible. Respondent wrote that he prescribed A.B. Ambien 10 mg and Viibryd. The medications were not listed in A.B.'s medication record. A.B.'s CURES report shows that respondent prescribed A.B. Xanax 1 mg twice a day and Ambien 10 mg daily. No prescription for Viibryd was filled.

40. On October 17, 2014, a pain management nurse called respondent's office to report that A.B. had a "Xanax problem." The same day NorthBay Healthcare faxed respondent a CURES report listing medications A.B. was prescribed from April 28 until October 4, 2014. The CURES report showed that during that time A.B. received prescriptions of Xanax and oxycodone,[12] an opioid used to treat pain, from multiple prescribers. A handwritten note on the CURES report indicated that the pharmacist did not agree with September 30, 2014 early fill of a 30-day supply of Xanax 1 mg TID prescribed by respondent, because of a previously filled Xanax prescription by another provider, but

[12] Oxycodone is an opioid pain medication. Oxycodone is a dangerous drug defined in Business and Professions Code section 4022, and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M).

that respondent called to release the medication to A.B. early. The CURES report showed that A.B. had been prescribed Xanax by two different doctors on September 11 and 16, 2014, in addition to the prescriptions written by respondent.

41. On or about October 25 or 27, 2014, respondent also received a telephone call reporting A.B. was selling methadone[13] and Xanax in the parking lot of the pharmacy. Respondent was also informed A.B.'s drug test at the pain clinic where she received treatment was negative, suggesting that she was not taking the medications prescribed to her at the clinic. Respondent prepared a handwritten note concerning the information and noted he told A.B. about the call he received. A.B. denied selling her medications and claimed that her drug test was negative because she ran out of her medication. Respondent took no further action to investigate the issue. He continued to prescribe A.B. Xanax. On October 28, 2014, A.B. filled a prescription for Xanax 1 mg TID, written by respondent.

42. A.B. saw respondent for a follow-up appointment on November 12, 2014. Respondent wrote on her medical record for this date that the "pharmacy called" and A.B. "wants too much Xanax." A.B. told respondent that the pain management clinic would no longer treat her pain. She disclosed that the pain clinic had given her oxycodone for back pain. She also disclosed that she "shake[s] without the pain medicine." She also reported "extreme anxiety." Respondent wrote that he "set down" rules which included Xanax 2 mg per day "no more" and Ambien 5 mg daily. Respondent gave A.B. a prescription for Xanax 1 mg twice per day and Ambien 5 mg daily.

43. On December 10, 2014, A.B. filled a prescription for Xanax 1 mg twice per day and Ambien 5 mg daily, authorized by respondent. Respondent did not include any notes in A.B.'s medical record indicating A.B. had an appointment with him on that date.

44. On December 31, 2014, A.B. had an appointment with respondent. A.B. reported having panic attacks at work. Respondent wrote one page of notes which are mostly illegible. Respondent did not document in A.B.'s medical notes for the visit that he prescribed any medication. However, in the medication record he noted prescriptions for Ambien 10 mg and Xanax 2 mg twice per day. A.B.'s CURES report shows she was given Xanax 2 mg twice per day and Ambien 10 mg daily. There is no information in A.B.'s medical record which explained the rationale for the increase in the Ambien dosage.

45. A.B. had an appointment with respondent on January 14, 2015. Respondent wrote a half-page of notes which are mostly illegible. The medical notes do not indicate if respondent prescribed A.B. any medication. However, her medication record lists prescriptions for Valium 10 mg twice per day, Seroquel and Zoloft 50 mg, an antidepressant. Respondent did not include any rationale or explanation for the prescriptions. A.B.'s

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[13] Methadone is an opioid prescribed to treat pain and to help individuals with opioid dependence tapper off of opioids. Methadone is a dangerous drug defined in Business and Professions Code section 4022, and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(14).

CURES reports show respondent prescribed A.B. Xanax 2 mg twice per day and Valium 10 mg twice per day. Three days before she had also been given a prescription of Valium from another treater.

46. A.B. saw respondent on February 10, March 2, March 24, May 13, July 6, September 16 and November 2, 2015. The medical notes for these visits are mostly illegible. During this period respondent continued to prescribe A.B. Xanax, Valium, and Ambien. On March 31, 2015, A.B. filled a prescription authorized by respondent, for Ativan, 1 mg TID. There is no information in A.B.'s medical records explaining the reason or justification for the medication.

47. Respondent wrote in A.B.'s medication record on December 2, 2015, she wanted Adderall 30 mg and she made a "plea for Xanax" 1 mg twice day. Respondent again wrote "too much reliance on benzos." He also wrote "does she really have ADHD [and] need Adderall which she continues to request." A.B.'s CURES report shows on or about December 7, 2015, respondent prescribed her Adderall, 30 mg twice per day. However, there is no explanation or rationale explained in A.B.'s medical record for the medication. He continued to prescribe the medication to A.B. until June 13, 2016.

48. On March 1, 2016, respondent listed on A.B.'s medication record prescriptions for Ambien, Adderall, Ativan and Valium. He noted "too much reliance on benzos [and] Adderall. Does she have ADD? [and] need Adderall?" He also noted "borderline personality disorder refer to county mental health discussed this w[ith] PT."

49. On April 12, 2016, A.B. filled a prescription written by respondent for Klonopin 2 mg TID, and Valium 10 mg TID. She continued to obtain prescriptions for these medications from respondent through August 8, 2016.

50. Respondent never ran a CURES report for A.B. He did not obtain copies of her medical records from her other treaters, obtain a release to request those records or contact her other medical providers.

Respondent's Self-Prescribing

51. On June 25, 2014, respondent prescribed himself 20 pills of hydrocodone 325/5 mg. Respondent prescribed himself the medication in anticipation of dental work. On August 16, 2014, his dentist Frank Chen, DDS also prescribed him hydrocodone.

52. On April 2, 2016, respondent prescribed himself Xanax .5 mg, 60 pills. During his interview with Mr. Scully and Dr. Yap, respondent stated he "heard so much about" the benefits of the medication he decided to keep a bottle of the medication to use in the future. He denied taking the medication. He did not request the medication from his doctor because it would take him three months to get an appointment. At hearing, respondent added that he prescribed himself Xanax because he thought it could be useful to

keep a bottle in his office if a patient had a panic attack and needed the medication immediately.

53. Between 2012 and 2016, respondent prescribed himself dozens of non-controlled medications, including antihypertensive medications. He prescribed himself the medications because it took many months to get an appointment with a doctor, and once he obtained the appointment the doctor only spent a few minutes with him.

Violation of Order

54. In December 2017, Dr. Sahba contacted Mr. Scully expressing concern about respondent's medication prescribing practices. Dr. Sahba had reviewed respondent's interview transcript, medical records for the six patients and CURES reports. He opined that respondent's prescribing practices were not safe and departed from the standard of care. In January 2018, Dr. Sahba sent his report to Mr. Scully. As a result of Dr. Sahba's opinions, on June 1, 2018, complainant filed a Petition for Interim Order of Suspension (Petition). Complainant alleged respondent engaged in unprofessional conduct by prescribing dangerous and addictive control substances without conducting proper examinations and without medical indication. Complainant also alleged respondent failed to maintain accurate adequate medical records. Complainant requested respondent's certificate be suspended pending the filing of an Accusation, a hearing and decision.

55. On June 18, 2018, a hearing was held before Administrative Law Judge (ALJ) Dena Coggins, Office of Administrative Hearings. On June 28, 2018, ALJ Coggins issued an Order granting the Petition and suspending respondent's license. However, ALJ Coggins stayed the suspension under the following terms:

> [T]he suspension is stayed so long as respondent complies with the following restrictions and conditions:
>
> 1. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined in the California Uniform Controlled Substances Act.
>
> 2. Respondent is prohibited from practicing medicine until respondent provides documentary proof to the Board or its designee that respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any state prescription forms and all controlled substance order forms. Thereafter, respondent shall not reapply for a new DEA permit without prior written consent of the Board or its designee.

3. If respondent fails to comply in any respect with the restrictions and conditions set forth above, the stay shall be lifted and the suspension go into immediate effect.

56. On July 2, 2018, the Order was delivered to respondent's attorney. On July 4, 2018, respondent spoke to his attorney about the terms of the Order. He reviewed the Order in early July 2018.

57. In late July 2018, the Board received an anonymous phone call reporting respondent was practicing medicine in violation of the Order. Mr. Scully was assigned to investigate the allegation. Mr. Scully contacted the DEA to find out if respondent had surrendered his DEA permit. Mr. Scully was informed that respondent had not surrendered his permit. Mr. Scully ran a CURES report and discovered respondent was prescribing controlled substances. Mr. Scully obtained copies of some of the prescriptions listed on the CURES. For example, on July 2, 2018, respondent wrote prescriptions for R.S., a new patient, including Xanax 2 mg twice a day. The same day he wrote C.H. a prescription for Adderall. On July 11, 2018, he wrote B.M. prescriptions for Xanax 2 mg TID, Wellbutrin, a medication used to treat depression, and Seroquel. On July 31, 2018, respondent wrote B.M. another prescription for Xanax 2 mg TID, Adderall 30 mg. twice a day, Ambien 10 mg daily, and Trazadone, a medication used to treat depression.

Mr. Scully also discovered that in July 2018, respondent's DEA permit number was used by providers at Fair Oaks to prescribe controlled substances for patients. Telephone prescriptions were called in by staff at Fair Oaks using respondent's DEA permit number on July 5, 6, 9, 10, 11, 12 and 16, 2018.

58. On July 31, 2018, Mr. Scully travelled to respondent's office in Vacaville. Mr. Scully discovered respondent no longer had an office at the same address previously provided to the Board. Mr. Scully learned respondent opened an office across the street from his old office. Mr. Scully located respondent in his office. Mr. Scully informed respondent that the Board received information that he continued to practice medicine in violation of the Order. Mr. Scully read respondent the Order. Respondent admitted he had not surrendered his prescription pad because he needed it to write non-controlled substance prescriptions. He also had not surrendered his DEA permit. Respondent informed Mr. Scully the Order was stayed and he was told he could practice medicine.

Respondent admitted to Mr. Scully he saw one patient that morning and he was planning to see more patients that day. At first respondent denied he was prescribing controlled substances. Mr. Scully showed respondent a copy of a prescription written by him on July 2, 2018. Respondent claimed he may have written the prescription but it could have been forged. Mr. Scully also explained the CURES report also showed that he had authorized prescriptions. Mr. Scully gave respondent the telephone number for the DEA investigator to contact regarding surrendering his DEA permit and prescription pads.

As Mr. Scully was leaving respondent's office he saw a woman in the building that he recognized as respondent's patient. Mr. Scully ask the woman if she was seeing respondent and if he was prescribing her Xanax. She admitted that he was prescribing her Xanax.

59. On August 2, 2018, respondent treated a patient, N.B., and wrote him prescriptions for several medications, including Soma, a controlled substance used to treat pain. The same day respondent surrendered his DEA permit.

60. Complainant filed an Ex Parte Petition for Modification of the Interim Order of Suspension to Lift Stay of Suspension. On August 3, 2018, ALJ Coggins granted the Ex Parte Petition and issued a Modified Order lifting the stay and immediately suspending respondent's certificate based upon his failure to comply with the Order. On August 8, 2018, respondent waived his right to a hearing on the Modified Order.

Complainant's Expert - Alex Sahba, M.D.

61. Dr. Sahba is board-certified in psychiatry and forensic psychiatry. He is licensed by the Board to practice medicine in California. Dr. Sahba graduated from Ross University School of Medicine in 2000. He completed a psychiatry residency at Louisiana State University Health Sciences Center in 2005. He also completed a fellowship in forensic psychiatry at the University of California, Los Angeles, in 2006.

Since 2006, Dr. Sahba has worked at the Metropolitan State Hospital in Norwalk, California. He was the President of the Medical Staff from 2009 through 2014. He was the Chair of the Medical Records Committee from 2015 until 2016. He was Chief of Medical Staff from 2016 through 2018. As the President of the Medical staff his duties included enforcing bylaws, rule and regulations. He ensured staff compliance with procedural safeguards. As part of the psychiatry staff his duties include diagnosing and treating patients. Dr. Shaba also operated a private outpatient practice from 2005 through 2014. He has reviewed cases for the Board for several years.

62. Following referral from Mr. Scully, Dr. Sahba authored a report dated January 8, 2018, concerning his evaluation of respondent's conduct related to the treatment of the six patients and self-prescribing medications. In the report, Dr. Sahba listed the documents he reviewed to reach his opinions and conclusions. Dr. Sahba reviewed in part, the certified medical records and CURES reports for all six patients. He reviewed the CURES report for controlled substances prescribed to respondent and other pharmacy records related to non-controlled substances. He also reviewed a transcript of respondent's interview with Mr. Scully and Dr. Yap. Dr. Sahba testified at hearing consistent with his report.

63. Dr. Sahba opined that respondent engaged in extreme departures from the standard of care concerning his treatment of the six patients, and that such departures fell into two categories: medical record keeping and prescribing issues. Dr. Sahba defined an extreme departure from the standard of care as conduct no reasonably prudent psychiatrist would engage in under the same circumstances.

STANDARD OF CARE FOR MEDICAL RECORDS

64. Dr. Sahba opined the standard of care for medical record keeping requires a treating psychiatrist to include the following legible information to be kept in a patient's chart: for an "initial psychiatric evaluation of a new patient include several components including chief complaint; past medical history, past psychiatric history, past substance/alcohol use/abuse history, current substance/alcohol use/abuse history, past suicidal ideation or attempts, educational history, vocational history, social history, family history, legal history, mental status examination, list of current medications prescribed by other physicians, and drug allergies." Additionally, there should be documentation of a "patient's current issues, a working diagnosis, and a plan for treatment."

After the initial evaluation, follow-up appointments should be documented with an explanation of how the patient has been doing since the last appointment, whether the medication prescribed, if any, has been effective, any side effects from the medication, a treatment plan and rationale for any changes to medication.

65. Dr. Sahba explained the purpose of documenting the components of an initial evaluation and subsequent visits is to provide the treating psychiatrist with a record to evaluate treatment rendered. The information is also important for other treaters who may need to utilize the records. Dr. Sahba also explained the information may be needed by an investigative body such as the Board or in a malpractice matter. He opined that information should be kept in the patient's medical chart and be either electronic or legibly handwritten.

STANDARD OF CARE FOR PRESCRIBING MEDICATIONS

66. Concerning prescribing of medication, Dr. Sahba opined the standard of care requires a psychiatrist to "prescribe the correct medications and correct amount of each medication to a patient." The determination of the correct medication and dose should be made based on the "patient's presenting symptomology and working diagnosis," which should be set forth in the patient's medical record. Additionally, if a patient was receiving psychotropic medication or controlled substances from a primary care treater or another psychiatrist, that information should be considered and documented in the patient's medical record. The psychiatrist should inquire with the patient the reasons for the previously prescribed medications and document the information shared.

67. Dr. Sahba opined if a patient reports to the psychiatrist receiving large doses of controlled medications from another physician and requests the same medication and dose from the psychiatrist, the standard of care requires the psychiatrist to obtain a release of information from the patient allowing the psychiatrist to contact the previous prescribing physician to inquire about the treatment rendered to the patient. To do so, the psychiatrist must obtain the name and contact information for the prescriber.

68. Additionally, Dr. Sahba opined the standard of care requires a psychiatrist to obtain from a patient, written informed consent for treatment, which means that the patient

must be informed about the reason a medication is prescribed, the risks and benefits of the medication, and whether there are alternatives to the medication. He opined informed consent is important for any medication, but is particularly important when prescribing controlled substances. Dr. Sabha opined controlled substances can be addictive or habit-forming and can impair judgment. Part of obtaining informed consent is informing a patient of other non-habituating medication, psychotherapy or behavioral therapy, based on the patient's symptoms and a working diagnosis.

69. Dr. Sahba opined if a psychiatrist determines "benzodiazepines are indicated for a patient's symptoms and diagnosis, the dosing should start as low as possible." Xanax, Klonopin, Valium and Ativan are benzodiazepines. If the psychiatrist determines an increased dose is needed, the "dose should be gradually increased throughout follow up visits depending on presenting symptomology and effectiveness of the drugs being prescribed." He also opined that a patient who is not taking "moderate to high doses of benzodiazepines" at the time of the initial evaluation, should not be prescribed Xanax 2 mg TID, which is the highest dose recommended by the Food and Drug Administration (FDA). Additionally, the psychiatrist should consider and offer patients alternatives to benzodiazepines, such as SSRIs, which are less habit-forming medications and "have the same efficacy as benzodiazepines with much less addicting properties and less additive effects when combined with alcohol or other sedating drugs."

70. Additionally, Dr. Sahba opined that if a patient is seen by a psychiatrist for an initial evaluation and reports a history of "getting large doses of benzodiazepines from other prescribers" and requests the same drug and dose, the standard of care requires the psychiatrist to make "every effort" to contact the previous prescriber to obtain the treatment history. If the psychiatrist cannot reach the previous prescriber, the standard of care requires the psychiatrist to verify the patient's claim by obtaining a CURES report to check the veracity of the patient's statement. If the CURES report confirms the patient's report, and there is no indication from the report the patient may be abusing drugs, the "psychiatrist could prescribe the same dose of benzodiazepines but emphasize that contact with the previous provider is still requested."

71. Dr. Sahba also explained that certain information on a patient's CURES report should be a "red flag" to a psychiatrist. For example, if a patient requests "high doses of benzodiazepines and the CURES report shows that the same patient has been obtaining same/similar or other addicting and potentially abusive medications from other physicians." Dr. Sahba opined the psychiatrist should ask the patient to explain the prescriptions on the CURES report and not prescribe the patient benzodiazepines. Based on the psychiatrist evaluation if it appears the patient is suffering with withdrawal symptoms, the patient should be referred to a hospital for treatment, rather than continue to prescribe the medication.

OPINIONS REGARDING PATIENT-1 A.S.

72. Dr. Sahba opined respondent's documentation of his initial evaluation of A.S. on March 23, 2016, departed from the standard of care. He opined the medical notes were

"less than a half a page of poorly handwritten notes." The medical record did not contain the components required for an initial evaluation. There was no mental status examination, past medical history, past psychiatric history, past substance/alcohol use/abuse history, list of current medications prescribed by other physicians or informed consent. Dr. Sahba opined that despite failing to obtain this information, respondent prescribed A.S. Xanax 2 mg TID.

73. He also opined that respondent's medical notes for the follow-up visits on August 1 and October 3, 2016, departed from the standard of care. The August 1, 2016 visit notes were a quarter of a page without sufficient information to determine what occurred at the appointment. Respondent prescribed A.S. Xanax, Ambien and Viiryd without sufficient explanation for the reason. Dr. Sahba noted that respondent failed to include the drugs on A.S.'s medication record. Likewise, the notes for A.S.'s appointment on October 3, 2016, are less than a quarter of a page and difficult to read. Respondent noted that he prescribed Xanax 2 mg TID, but also noted he prescribed Valium and Ambien, even though he noted that A.S. no longer needed Ambien.

74. Dr. Sahba opined that respondent's medical record keeping for A.S. constitutes an extreme departure from the standard of care. Respondent's medical notes are mostly illegible, important components of initial evaluation are missing, follow-up visit notes are inadequate, there is no rationale for the high doses of medication, and respondent listed medication in A.S.'s record that were not prescribed and failed to document medications that were prescribed.

75. Dr. Sahba also opined respondent's prescribing of controlled substances to A.S constitutes an extreme departure from the standard of care. Dr. Sahba opined that the standard of care requires starting doses of Xanax to treat a patient with anxiety at .25 mg twice per day. An increase of .50 mg twice per day may be indicated depending on the patient's reports at follow-up appointments. During the initial visit on March 23, 2016, A.S. asked for Xanax 2 mg TID. Dr. Sahba opined that this should have been a "red flag" to respondent to inquire and assess whether A.S. had a substance abuse problem. However, respondent did not inquire. Instead, respondent prescribed A.S. the highest dose of Xanax recommended by the FDA, based on A.S.'s statement that he had previously taken the same dose.

Dr. Sahba opined respondent prescribed the high level of Xanax without completing a full assessment, obtaining a substance use/abuse history, contacting his previous physician, obtaining his past treatment records, obtaining a waiver or release to contact his previous treaters or obtaining a CURES report. Dr. Sahba opined that respondent should not have prescribed A.S. Xanax until he confirmed his statement through independent sources. Respondent also prescribed A.S. Ambien without conducting an assessment of his symptoms and providing a rationale for the medication.

76. Dr. Sahba also opined that respondent failed to inform A.S. of the risks of taking Ambien and Xanax. Dr. Sahba explained that Xanax is one of the most highly addictive, short acting medications that can be prescribed, which means when the medication

is taken, the levels of Xanax "shoot up" in the patient blood creating a high. Additionally, Ambien and Xanax can affect judgment, the ability to drive a vehicle, and can have a sedating effect.

77. Dr. Sahba also opined respondent prescribed A.S. highly addictive controlled substances without obtaining a substance use/abuse history, and obtaining a CURES report. Had respondent obtained a CURES report he would have seen that he was the first physician to prescribe A.S. Xanax and Ambien. He would have also discovered A.S. was prescribed buprenorphine-naloxone, which would have alerted respondent to A.S.'s substance abuse problem.

78. Dr. Sahba opined that respondent's failure to have a follow-up appointment with A.S. one to four weeks after the initial appointment, after prescribing controlled substances, is an extreme departure from the standard of care. The purpose of the follow-up visit is to check the effectiveness of the medication and to document the symptoms. A.S. did not have a second appointment with respondent until August 1, 2006, over four months after his initial visit. Additionally, respondent failed to document a complete assessment. Respondent's notes for the visits do not describe what occurred during the visit or any explanation or rationale justifying the continued prescribing of Ambien and high level of Xanax. Additionally, respondent noted a prescription of Viibryd, an anti-depressant medication, with no documented reasons for the medication.

79. Additionally, on October 3, 2016, respondent noted that A.S. no longer needed Ambien, but he continued to prescribe him the medication, without any rationale. Respondent also continued to prescribe A.S. Xanax with no rationale. Dr. Sahba also opined that on July 25, 2017, when A.S. insisted he needed Xanax 2 mg TID, respondent should have seen his conduct as a "red flag." Instead, respondent took no action to obtain a CURES report or determine if A.S. had a substance dependence issue. Rather he continued to prescribe him Xanax and Ambien.

80. Dr. Sahba also opined prescribing A.S. Adderall in September 2017, because A.S. asked for the medication, is an extreme departure from the standard of care. Dr. Sahba explained Adderall is a mixed amphetamine salt used to treat ADHD. The drug is addictive and has a "street value" which means it can be sold. Respondent did not diagnosis A.S. with ADHD, document any rationale for prescribing the medication, or obtain informed consent from A.S.

OPINIONS REGARDING PATIENT-2 K.F.

81. Dr. Sahba opined respondent's medical record keeping for K.F. constitutes an extreme departure from the standard of care. He opined respondent's notes of his initial evaluation of K.F. on March 23, 2016, are mostly illegible. The evaluation is missing required information including a complete past medical history, substance use history, current medications, a mental status examination and informed consent. Respondent

prescribed K.F. Xanax 2 mg TID and Ambien without documenting a rationale for prescribing the highly addictive medication.

82. Dr. Sahba also opined respondent's medical notes for the visits on July 6, 2016, indicated respondent prescribed K.F. Xanax and Norco, with "little documentation." Dr. Sahba opined it is unusual for a psychiatrist to prescribe a patient Norco especially if Xanax is also prescribed. Norco is a narcotic used to treat pain. Although respondent noted that K.F. had missed an appointment with a pain specialist and respondent noted it was a one-time prescription, respondent failed to document a rationale for the hydrocodone. Dr. Sahba also opined K.F.'s medication record contains errors. K.F.'s medication record did not list the Norco or Xanax prescriptions. Rather, respondent listed Klonopin and Ambien prescriptions which are not mentioned in the medical notes for the visit.

83. Additionally, respondent only included a "few words" concerning K.F.'s appointment on November 1, 2016. The information is insufficient to determine what occurred during the visit. The medication record lists prescriptions for Xanax and Ambien given during the appointment. However, respondent did not document an appropriate rationale or justification for the Xanax other than noting that K.F. wanted the medication. Respondent also did not mention the prescription for Ambien in the medical notes.

84. Dr. Sahba also opined respondent's prescribing of controlled substances to K.F. constitutes an extreme departure from the standard of care. During the initial visit on March 23, 2016, respondent prescribed K.F. Xanax 2 mg TID, without justification for the high dose. There was no information that K.F. was taking the same dose of Xanax when he was first seen by respondent. Additionally, respondent did not contact his previous physician, obtain his past treatment records, or review a CURES report. Dr. Sahba opined that respondent should not have prescribed K.F. Xanax until he checked K.F.'s treatment history through other sources. Respondent also prescribed K.F. Ambien without providing a rationale for the medication. Ambien is also not listed in the medication record as being prescribed. Dr. Sahba also opined that respondent failed to inform A.S. of the risks of taking Ambien and Xanax.

85. Dr. Sahba explained K.F.'s CURES report shows that on April 1, 2016,[14] respondent wrote K.F prescriptions for Xanax and Adderall. There is no information in K.F.'s medical record for this date documenting K.F. was prescribed the medications or the reason for the prescriptions.

86. On July 6, 2016, respondent again prescribed K.F. Xanax 2 mg TID, but he did not explain his rationale for prescribing the medication. Respondent also noted that K.F. requested a prescription for Norco. Dr. Sabha opined that Norco is addictive, habit-forming and sedating. The medication can impair judgement. Respondent failed to obtain informed

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[14] Dr. Sahba's report lists a date of "1-4-16." At hearing, he explained the date should read April 1, 2016.

consent from K.F. concerning the risks of the medications. Respondent also did not obtain a CURES report to check if K.F. had obtained a Norco prescription from another treater.

87. Dr. Sahba opined that when respondent received a fax on July 14, 2016, from Dr. McAndrew disclosing K.F. was an opiate addict under his care, taking suboxone and contracted not to take benzodiazepines and opioids, the standard of care required that he take action. Dr. Sahba explained suboxone is prescribed for the treatment of heroin and opioid addiction. Suboxone contains a narcotic. There are risks associated with taking suboxone and Xanax at the same time. Dr. Sahba opined when respondent was notified by Dr. McAndrew that K.F. was enrolled in a substance abuse program and under contract, respondent should have contacted Dr. McAndrew to collaborate and communicate concerning treatment of their patient to determine what was best for K.F.

Additionally, Dr. Sahba opined the standard of care also required respondent to confront K.F. with the information and question him about why he did not disclose his participation in the program. Respondent should have also tapered K.F. off the Xanax to ensure there was no withdrawal and referred him back to the substance abuse treatment program.

88. Dr. Sahba opined respondent's failure to run a CURES report, contact Dr. McAndrew or stop prescribing controlled medications to K.F. was an extreme departure from the standard of care. Dr. Sahba opined the information respondent received about K.F. was a "red flag" that he was abusing drugs. On July 11, 2017, respondent noted in K.F.'s medical record for the visit that K.F. reported that "alprazolam is ok with Dr. McAndrew." Respondent accepted this information as true. He did not contact Dr. McAndrew to confirm the statement. Despite the information provided by Dr. McAndrew, respondent continued to prescribe K.F. the same high dose of Xanax through November 1, 2017, without documented rationale, which Dr. Sahba opined demonstrated extremely careless and reckless behavior.

OPINIONS REGARDING PATIENT-3 B.D. AND PATIENT-4 F.T.

89. Dr. Sahba opined respondent's medical record keeping for B.D. and F.T. constitutes extreme departures from the standard of care. Respondent conducted an initial evaluation of B.D. on October 22, 2014. Dr. Sahba opined that parts of respondent's notes are illegible and difficult to understand. The required components of the evaluation are also missing, including a mental status examination, informed consent, substance and alcohol use and abuse history, medical history and past medications.

Additionally, notes for a follow-up visit on January 6, 2015, "is literally only a few words and it is not clear why was done during that visit." Respondent's notes for a visit on January 25, 2015, do not provide any explanation for why medication was prescribed, or the effectiveness of previously prescribed medications.

90. Respondent's initial evaluation of F.T. took place on March 14, 2016. Dr. Sahba opined respondent's notes are a half-page and do not include the required components

of the evaluation. There is no documented mental status examination, informed consent, past substance and alcohol use and abuse history, and family history. Dr. Sahba explained the documents F.T. completed at Fair Oaks on February 23, 2016, did not include informed consent for respondent to treat him.

Additionally, notes for follow up visits on June 2, 2016, only contain a few words. Dr. Sahba opined that respondent's entries for F.T. are inadequate and his handwriting is "poor and illegible."

OPINIONS REGARDING PATIENT-5 M.Z.

91. Dr. Sahba opined respondent's medical record keeping for M.Z. constitutes an extreme departure from the standard of care, because respondent's "overall record keeping and documentation is inadequate." Dr. Sahba opined respondent's notes for visits on December 8, 2015, April 11, June, 6, December 19, 2016, March 20, May 8, and June 19, 2017, only contain a few words. As a result, it is unclear what occurred during the visits or the reason for treatment.

92. Dr. Sahba also opined respondent's prescribing of controlled substances to M.Z. constitutes an extreme departure from the standard of care. M.Z. reported to respondent during his initial visit that he stopped treatment with his last physician because she wanted to take him off of Klonopin. Dr. Sahba opined that based on this information, the standard of care required respondent to obtain the name of the physician, and ask M.Z. to sign a release to allow respondent to talk to the physician to determine why she wanted to take him off the Klonopin. Additionally, respondent should have obtained a CURES report to determine if M.Z. had been prescribed Klonopin or other habit-forming drugs.

Dr. Sahba opined respondent took none of the required steps before prescribing M.Z. Klonopin 2 mg TID, which he explained is a high dose. Respondent did not contact M.Z.'s past treater, did not request him to sign a release, did not review past medical records and did not review a CURES report. His failure to do so was an extreme departure from the standard of care.

93. Additionally, Dr. Sahba opined that when used for anxiety, Klonopin should be prescribed at a lower dose and then "slowly titrated up as needed." Respondent did not follow this practice. Instead he prescribed a total of six mg of Klonopin per day, even though M.Z. reported that his previous physician had tapered him down to a significantly lower dose. Dr. Sabha opined that the significant increase in the dose of medication by respondent was dangerous. Additionally, respondent also prescribed M.Z. Ambien, which Dr. Sahba opined has "additive properties when mixed with Klonopin." Respondent did not obtain informed consent from M.Z. explaining these risks.

94. Dr. Sahba also opined the standard of care required respondent to discuss with a patient alternative medications and types of treatment such as psychotherapy or group therapy. Respondent did not provide this information to M.Z. Dr. Sahba opined that for

approximately three years, respondent prescribed M.Z. Klonopin 2 mg TID, without trying to taper him to a lower dose or alternative treatment, which is an extreme departure from the standard of care.

OPINIONS REGARDING PATIENT-6 A.B.

95. Dr. Sahba opined respondent's medical record keeping for A.B. constitutes an extreme departure from the standard of care. On September 30, 2014, respondent conducted an initial evaluation of A.B. Dr. Sahba opined respondent's notes for the evaluation are difficult to read and illegible in parts. His notes do not include the required components of an initial evaluation. Respondent noted that A.B. "wants Xanax." However, he did not document a working diagnosis. Respondent prescribed A.B. Xanax, but did not include the information on a medication record for that date.

96. Dr. Sahba opined respondent failed to document a rationale for continuing to prescribe A.B. Xanax after he received a call from a pharmacy in October 2014, stating that she was selling Xanax and Methadone in the parking lot.

97. Dr. Sahba further opined that over the course of treating A.B., respondent prescribed Xanax, Valium, Ambien, Adderall, and Ativan, without adequate explanation for why the medications were prescribed. On March 1, 2016, respondent prescribed A.B. Ambien, Adderall, Ativan and Valium, concurrently with no documented rationale. Additionally, respondent's medical notes from follow up visits on November 12, 2014, March 24, May 13 and December 7, 2015, are mostly illegible, and do not provide sufficient explanation of the treatment or rationale for the prescriptions.

98. Dr. Sahba opined respondent prescribed A.B. medications that are habit-forming, addictive, impair judgment and sedatives. Respondent failed to inform A.B. of the risks of the medication and obtain informed consent.

99. Dr. Sahba also opined respondent's prescribing of controlled substances to A.B. constitutes an extreme departure from the standard of care. During the initial visit, respondent prescribed A.B. controlled substances without conducting an adequate evaluation. Dr. Sabha opined that the standard of care requires that before respondent prescribed A.B. Xanax based on a patient's report of taking the medication in the past, he obtain consent from A.B. to contact her past treaters, obtain her medical records or at a minimum obtain a CURES report to confirm whether she had been prescribed a high dose of Xanax and to check if there are any red flags that may suggest substance abuse. Dr. Sahba opined that respondent could not rely on A.B.'s self-report. Respondent failed to take any of the required steps before prescribing A.B. Xanax 1 mg TID.

100. Dr. Sahba also opined that when respondent received a call from a nurse at a pain clinic reporting that A.B. had a "Xanax problem" and from a pharmacy reporting that A.B. was selling Xanax and Methadone in the parking lot, the standard of care required respondent to take action. Respondent was required to immediately speak to A.B. about the

claims. However, he should not have taken A.B.'s word alone. Respondent should have obtained a CURES report to look for any "red flags" that may suggest substance abuse or diversion. Additionally, the pharmacy should have been contacted to obtain information about the basis for the report, which should then be documented. Dr. Sahba also opined respondent could have required A.B. to provide a biological fluid sample to obtain a toxicology report. Dr. Sahba opined that respondent did not take the required action. He did not contact the pharmacy, obtain a CURES report or obtain a toxicology report. Rather, he continued to prescribe A.B. controlled substances until 2016. Dr. Sahba opined that respondent's failure to take the required actions and his continued prescribing to A.B. was an extreme departure of the standard of care.

101. Dr. Sahba also opined that respondent began prescribing A.B. Adderall, without any rationale for prescribing the medication. Additionally, respondent was prescribing several medications without justification. He explained that pharmacy records show that on March 24, 2015, A.B. filled prescriptions for Xanax and Ambien, but there is no information in A.B.'s medical notes explaining the prescriptions. He also opined that the quality and frequency of the prescriptions is "highly suspicious" because there are one to two-week periods when multiple 30-day supplies of medications were prescribed. Respondent failed to document the reason for the prescriptions. Dr. Sahba opined that prescribing the medications in this manner is dangerous because A.B. could have overdosed.

Dr. Sahba also opined that on March 1, 2016, respondent prescribed A.B. Ambien, Adderall, Valium, and Ativan concurrently. Respondent noted on A.B.'s medication record for the March 1, 2016 visit, "too much reliance on benzos and Adderall does she have ADD? Needs Adderall?" Dr. Sahba opined respondent did not answer the questions and continued to prescribe her the medications. Dr. Sahba explained the medications respondent concurrently prescribed A.B. are in the same "class" and have risks of causing impairment of judgment and sedation. The medications are also habit-forming and addictive. Respondent did not document any rationale for prescribing both Valium and Ativan. Dr. Sahba opined respondent did not obtain informed consent from A.B. concerning the risks of taking the medications.

102. Dr. Sahba also opined that respondent never obtained a CURES report for A.B. Had respondent done so he would have seen there were times when A.B. was receiving benzodiazepines and oxycodone from other treaters. Respondent failed to inquire about other medications A.B. was taking or her treatment history. Dr. Sahba opined respondent's prescribing practices placed A.B. at risk, and constitutes an extreme departure from the standard of care.

OPINIONS REGARDING SELF-PRESCRIBING

103. Concerning respondent's self-prescribing, Dr. Sahba opined the standard of care provides "[i]n general physicians should not self-prescribe medication." There are "rare occasions such as running out of medications by accident, forgetting to take medications on a short vacation, or in an emergency situation where quick access to a physician is not

possible" when self-prescribing would be appropriate and within the standard of care. However, "[r]outine self-prescribing should not be out of convenience." Additionally, "[s]elf-prescribing a controlled medication for the purpose of finding out what it would do or what effects it has without clinical indication is never permitted."

104. Dr. Sahba opined that respondent's self-prescribing of Xanax, hydrocodone and antihypertensive medications is an extreme departure from the standard of care. Dr. Sahba explained that respondent's explanation for self-prescribing Xanax because he wanted to try it because he "heard so much about it" was "bizarre and unacceptable." Dr. Sahba also opined respondent did not have an explanation for why he prescribed himself hydrocodone for a tooth extraction, in addition to a prescription of hydrocodone prescribed by his dentist. Finally, respondent explained he self-prescribed antihypertensive medications because it took "months to get in" and the doctor only had a few minutes to spend in the appointment. Dr. Sahba opined that respondent's justifications for self-prescribing the medications did not fall within the exceptions allowed for under the standard of care.

Respondent's Expert - David Kan, M.D.

105. David Kan, M.D. is psychiatrist board-certified by the American Board of Psychiatry and Neurology and the American Board of Addiction Medicine. Dr. Kan has a Certificate of Added Qualifications in Forensic Psychiatry from the American Board of Psychiatry and Neurology. He is licensed by the Board to practice medicine in California. Dr. Kan graduated from Northwestern University Medical School in 1999. He completed a psychiatry residency at the University of California, San Francisco (UCSF), in 2003. He also completed a fellowship in Psychiatry and Law Program at UCSF in 2004.

Since 2004, Dr. Kan has operated a private practice specializing in criminal and civil forensic psychiatry, addiction psychiatry, general adult psychiatry and psychopharmacology. Since that time he has also worked for San Francisco Community Behavioral Health working as an assessment evaluator for the City and County of San Francisco. He is also part of the clinical faculty at UCSF. Dr. Kan sees patients in both the inpatient and outpatient setting. He treats patients struggling with addiction and co-occurring mental illness. He is licensed to treat patients addicted to opioids with suboxone. He also treats patients with general psychiatric issues with no addiction.

106. Dr. Kan was asked to render an opinion as to whether respondent's treatment of the six patients and his self-prescribing departed from the standard of care. Dr. Kan relied on the Board's guidelines for expert reviewers when determining the standard of care. He opined the standard of care is what a reasonable prudent physician would do in the same or similar circumstances. A simple departure from the standard of care is a mistake or error which a reasonable prudent physician may make. An extreme departure from the standard of care is conduct which no reasonable prudent physician would do under the same or similar circumstances, in the care and treatment of a patient. Dr. Kan reviewed the Accusation, the patients' medical records, CURES reports and prescription for the patients, the transcript of

respondent's interview with Mr. Scully and Dr. Yap, CURES reports and records regarding respondent's self-prescribing.

Dr. Kan explained that after he received the six patients' medical records, he requested typed written summaries of the handwritten notes in the medical records, because parts of the medical records were "difficult if not impossible to read." Dr. Kan further stated that in order to "make sense" of the records he needed a translation of the records from respondent. After Dr. Kan received the typed notes, he spoke to respondent two times for a total of approximately five hours about his treatment of the patients. Dr. Kan took notes of his conversations with respondent. Dr. Kan explained his opinions are based on all information that he considered. He did not parse out which opinions were based on the handwritten medical records, typed records, or information he obtained from respondent during their conversations. However, the typewritten summary of the medical notes were his primary source when he wrote his report.

107. Dr. Kan opined he found two general areas in which respondent's conduct departed from the standard of care. He opined respondent's medical record documentation for Patient-1 A.S., Patient-2 K.F., Patient-5 M.Z. and Patient-6 A.B., constitute simple departures from the standard of care. Respondent's prescribing practices for patients A.S., K.F., M.Z. and A.B. constitute extreme departures from the standard of care. Dr. Kan opined there were no departures in the standard of care related to Patient-3 B.D. or Patient-4 F.T. He also opined respondent's self-prescribing Xanax was an extreme departure from the standard of care.

STANDARD OF CARE FOR MEDICAL RECORDS

108. Dr. Kan opined that the "purpose of medical record keeping/documentation is to provide sufficient information such that another treatment provider can use a [*sic*] documentation to continue an individual's treatment plan." The standard of care requires specific information in a patient's medical records for an initial psychiatric evaluation. The elements include: a chief complaint, past psychiatric and medical histories, current medications, drug allergies, substance use history, social history including education, vocation and legal histories, family history, a mental status examination, an assessment which includes a working diagnosis or symptoms to be treated, and a treatment plan. Dr. Kan opined the documentation should be legible whether written or typed.

109. For follow-up visits, the standard of care requires documentation that includes "sufficient information to assess the patient's response to any treatment interventions." Dr. Kan opined "[d]ocumentation of an objective examination such as a mental status examination should be included." "The efficacy of the treatment plan, including therapy and/or medications, should be documented." Also, "[i]f there is a change in the treatment plan, the explanation should be contained." The documentation should be legible.

STANDARD OF CARE FOR PRESCRIBING MEDICATIONS

110. Dr. Kan opined "[m]edications prescribed should be appropriate. Appropriateness is determined by assessing symptoms and the disorder/diagnosis for which medications" are being used to treat. "The amount of the mediations prescribed should be appropriate and documented within the chart." Additionally, "informed consent should be documented for medications." Dr. Kan opined there are several ways informed consent can be documented, including in a "narrative form or a signed informed consent form." He further opined that "[c]ontrolled substances should be prescribed at the lowest effective dose and titrated to effect." Informed consent requires the "patient be informed of the relevant risks, benefits, and alternatives to a controlled substance."

111. Dr. Kan further opined that a "release of information may be necessary if there are other prescribers prescribing other medications," particularly controlled substances. Additionally, the treating psychiatrist should make "reasonable attempts" to "coordinate care with other providers with the patient's consent." If consent cannot be obtained, the psychiatrist should document the refusal.

112. Dr. Kan opined benzodiazepines, which are central nervous system depressants (CNS), "carry the risks of dependence, addiction and withdrawal syndromes." Additionally, "[b]enzodiazepines should be used with caution when combined with other CNS depressants such as alcohol and opioids due to synergistic drug interactions." Dr. Kan opined benzodiazepines are not dangerous if prescribed properly and taken as directed. He also opined benzodiazepines "are reasonable to prescribe for appropriate symptoms such as anxiety or a diagnosis such as panic disorder, [and] generalized anxiety disorder." However, he also opined the standard of care requires when a psychiatrist prescribes benzodiazepines, "it is important to discuss alternatives with the patient," which would include recommending SSRIs or "psychotherapeutic interventions." "Sufficient informed consent is important" when prescribing benzodiazepines.

113. Dr. Kan also opined prescribing stimulants may be appropriate for symptoms or diagnoses such as ADHD, "excessive daytime sedation, as well as off label uses such as depression." However, "[s]timulants carry the risks of dependence, addiction and withdrawal syndromes." Dr. Kan opined benzodiazepines are not a contraindication to stimulants. Informed consent should be obtained when prescribing stimulants and non-stimulant alternatives should be considered and discussed with a patient.

OPINIONS REGARDING PATIENT-1 A.S.

114. Dr. Kan opined respondent's documentation for the treatment he provided to A.S. is difficult to read and "poor in overall quality." Respondent "failed to document sufficient information of an initial assessment to make a diagnosis except for subjective complaints" which included notes that A.S. was an "anxious person" and suffered from insomnia. Respondent's notes regarding the prescribing of Ambien were "confusing." He opined the prescribing of Ambien "may be appropriate for insomnia but was concerning in

the setting of the amount of Xanax." Dr. Khan also opined respondent did not "follow a standard format and the necessary elements are not all documented." Dr. Kan opined that respondent's documentation of A.S.'s treatment constitutes a simple departure from the standard of care because there was some information included in the medical records. Dr. Kan opined no information in the record or fraudulent information would be an extreme departure from the standard of care.

115. Dr. Kan explained "prescribing Xanax 2 mg TID after an initial limited assessment was excessive." He opined there was "inadequate documentation of reasoning and of diagnosis justifying the prescribing of Xanax 2 mg TID." Additionally, respondent did not document informed consent from A.S. No substance abuse history was obtained before prescribing the medication. Dr. Kan opined that starting a patient on a dose of Xanax 2 mg TID requires some documentation that respondent made efforts to contact prior providers or to confirm A.S. had been previously prescribed the dosage. Dr. Kan explained the dose respondent prescribed is the maximum recommended by FDA. He also explained Xanax has a "street value" and can be subject to diversion. Dr. Kan opined many physicians are aware patients will lie to obtain the drug. Dr. Kan opined respondent did not obtain a medical release from A.S. to speak to his past treaters or obtain his medical records. Dr. Kan opined respondent's failure to confirm the prior dosage and lack of documentation to support the dose prescribed is an extreme departure from the standard of care.

116. Dr. Kan disagreed with Dr. Sahba that respondent should have obtained a CURES report for A.S. before prescribing Xanax. Dr. Kan opined in 2016, physicians were required to register with CURES. However, checking CURES was not mandatory. It did not become mandatory until October 2018. Dr. Kan opined "[w]hile checking a CURES report would have represented ideal care, this is not consistent with the known standard of care. The standard of care requires evidence of aberrant behavior being revealed" followed by a "clinical assessment," which "may include a drug test, limiting prescription durations, or a CURES inquiry." Additionally, "[a] clinical response is indicated when there are reports of irregularities for aberrant behaviors." Attempts to contact other healthcare professionals or pharmacies could be done if a report of aberrant behavior is received by those parties." Dr. Kan opined that CURES is a "straightforward, technical approach to exploring aberrant behavior but is not required under the standard of care."

OPINIONS REGARDING PATIENT-2 K.F.

117. Dr. Kan opined respondent's "contemporaneous notes" concerning his treatment of K.F. are "difficult to read." The medical notes do not contain sufficient documentation to "render a diagnosis that would indicate the need for Xanax that was prescribed." Dr. Kan opined that the "documentation is present, but poor in overall quality and does not follow standard format." Dr. Kan opined respondent's documentation constitutes a simple departure from the standard of care, because all but one of K.F.'s appointments had some documentation about the treatment.

118. Dr. Kan opined respondent's prescribing of controlled substances to K.F. constitutes an extreme departure from the standard of care. He opined "prescribing of Xanax 2 mg TID is excessive as an initial prescription" because there was not adequate documentation of a "pre-existing prescription of the same medication." Respondent did not obtain a substance abuse history during the initial evaluation which should have been included in order to make a determination of whether the patient can take the medication. Dr. Kan explained a CURES report would have provided some of that information. There is also no documentation of informed consent.

119. Respondent also prescribed K.F. hydrocodone, without confirmation of a current prescription for the medication. Dr. Kan also explained the standard of care required respondent to obtain a substance abuse history before prescribing hydrocodone. Respondent also did not document the reason for prescribing hydrocodone, other than noting K.F. wanted the prescription. At a later visit respondent documented K.F. had begun taking "hydrocodone for pain after an ankle fracture with plates installed." However, respondent did not document a "good faith physical examination" to confirm K.F.'s reported injury.

120. Dr. Kan explained respondent's lack of an appropriate response to Dr. McAndrew's fax was also a concern. Dr. Kan opined the "standard of care dictated that [respondent] should have made good-faith effort to contact Dr. McAndrew with either a release of information or consent from the patient or a review of the CURES system." Dr. Kan also opined respondent could have obtained a urine drug screen. Dr. Kan also opined that even though K.F. stated he discontinued the suboxone program, it was still important to get information about K.F.'s treatment and prescription history, because it is germane to prescribing medications. Dr. Kan also opined that prescribing Adderall "may have been appropriate however there is insufficient documentation to justify the prescribing of amphetamines."

OPINIONS REGARDING PATIENT-3 B.D. AND PATIENT-4 F.T.

121. Dr. Kan opined respondent's documentation for B.D. and F.T. did not depart from the standard of care. Dr. Kan opined the notes for the treatment he rendered B.D. are difficult to read. However, the "documentation was better" than some of the other patient records. He described the documentation as "variable in quality." Dr. Kan opined respondent documented a chief complaint and history of medication for B.D. Dr. Kan acknowledged respondent did not document in the initial evaluation a history of prior care other than medications. There is no past medical history, history of hospitalizations, effect of past medications, or substance use or abuse history, no mental status examination, no assessment of a working diagnosis or symptoms and no treatment plan. However, Dr. Kan opined the letters respondent wrote to the Veterans Administration were "legible and contained more information about the patient's condition and prognosis." Dr. Kan opined that "taken as a whole" respondent's documentation for B.D. complies with the standard of care.

122. Dr. Kan opined respondent's handwritten notes for the treatment he provided F.T. are "hard to read and lacks a standard format." Dr. Kan opined that respondent's "handwritten notes are barely sufficient." However, "considering the whole chart, the documentation" is "generally" within the standard of care and "does not represent a departure." Dr. Kan also opined respondent was allowed to rely on the information F.T. disclosed to another treater during his initial intake on February 23, 2016, concerning his diagnosis of PTSD and ADD.

OPINIONS REGARDING PATIENT-5 M.Z.

123. Dr. Kan opined respondent's handwritten notes concerning the care provided M.Z. are "hard to read, and lacks specificity or a standard format." He described the documentation as "present but poor in overall quality." Dr. Kan opined respondent's "handwritten documentation" is a simple departure from the standard of care. Dr. Kan opined "[n]o documentation would present an extreme departure."

124. Concerning respondent's prescribing of medication, Dr. Kan opined respondent's "escalation" of Klonopin .25 mg daily to 2 mg TID for M.Z. at the initial evaluation, was excessive and an extreme departure of care. Dr. Kan also opined respondent "co-prescribed Ambien which is a concerning combination of synergistic effects." Dr. Kan opined respondent deviated from the standard of care "insofar as one should start [Klonopin] at a lower dose and titrate the effect." Additionally, respondent failed to document a substance abuse history or obtain informed consent, "including the relevant risks, benefits, and alternatives to the course of treatment."

OPINIONS REGARDING PATIENT-6 A.B.

125. Dr. Kan opined respondent's handwritten documentation concerning the treatment he provided A.B. was "difficult to read" and "poor in overall quality." He opined the documentation "does not follow a standard format and the necessary elements to render a diagnosis and the initial assessment were incomplete." Respondent also did not document a substance history. Dr. Kan opined respondent "failed to document sufficient information to make a diagnosis other than subjective complaints from the patient." "Mental status examinations were not consistently documented in either the initial assessment or follow-up complaints." Dr. Kan opined respondent's documentation is a simple departure from the standard of care. Again, he opined that "[n]o documentation would represent an extreme departure."

126. Dr. Kan also opined respondent's prescribing of benzodiazepines to A.B. was "excessive." Dr. Kan opined respondent "failed to document his reasoning and sufficient evidence to prescribe the medications in the first place." Additionally, Ativan and Valium were prescribed "simultaneously with Adderall and Ambien." Dr. Kan opined "[t]his is an unusual combination but possibly appropriate." However, he opined that documentation is required explaining respondent's "decision-making process to combine multiple

benzodiazepines as well as sedative medications with a stimulant." Additionally, he opined the standard of care requires a substance abuse history to be taken.

127. Dr. Kan also opined when respondent received a report on October 24, 2014, from a pharmacy, that A.B. may be selling Methadone and Xanax in the pharmacy parking lot, the standard of care required he take action. Dr. Kan explained respondent did not make attempts to contact A.B.'s treaters or review a CURES report that showed A.B. was receiving "overlapping prescriptions" by respondent and another doctor. Respondent should have made a "good-faith effort" to obtain a release from A.B., contact the other prescribing doctor, or obtain information from CURES. Respondent could have also requested A.B. to submit to a drug screen. Dr. Kan opined the report from the pharmacy should have alerted respondent "to the need to be judicious with the use of benzodiazepines." Instead, respondent "prescribed multiple coincident benzodiazepines without documenting justification as well as [Ambien]." Dr. Kan opined respondent's conduct constitutes an extreme departure from the standard of care.

OPINIONS REGARDING SELF-PRESCRIBING

128. Concerning respondent's self-prescribing of medication, Dr. Kan opined that "[w]hile there is no rule prohibiting self-prescribing, such prescribing should be done in accordance with usual and customary standards of prescribing, including documentation as well as establishing a diagnosis that is appropriate to justify prescribing." Dr. Kan opined respondent's self-prescribing of Xanax was an extreme departure from the standard of care because there was no "medical justification for prescribing Xanax."

129. Dr. Kan opined the self-prescribing of hydrocodone for a dental procedure may have been "reasonable." However, Dr. Kan was not able to conclude whether it was a departure from the standard of care because he needed to review the "medical or dental records for such prescribing." Dr. Kan also did not opine whether self-prescribing antihypertensive medications was a departure from the standard of care.

Discussion of Accusation Allegations and Expert Opinions

130. Complainant alleges respondent failed to maintain adequate and accurate medical records for all six patients, and his failure to do so constitutes extreme departures from the standard of care and repeated acts of negligence. Additionally, complainant alleges respondent's medication prescribing practices for Patient-1 A.S., Patient-2 K.F., Patient-5 M.Z. and Patient-6 A.B, constitutes gross negligence, repeated acts of negligence, and prescribing dangerous drugs without an appropriate prior examination and medical indication. Complainant also alleges respondent's self-prescribing medications constitutes gross negligence.

131. Both experts agree that the standard of care requires a psychiatrist conducting an initial psychiatric evaluation of a new patient to inquire and document the following information: a chief complaint, past psychiatric and medical histories, current medications,

drug allergies, substance use history, social history including education, vocation and legal histories, family history, a mental status examination, an assessment which includes a working diagnosis or symptoms to be treated, and a treatment plan. Informed consent for treatment must also be obtained, which includes a discussion of the risks, benefits, and alternatives treatments. Informed consent must be documented. The medical documentation should be legible, whether written or typed.

132. The standard of care for follow up visits requires information to be documented explaining how the patient has been doing since the last appointment, the effectiveness of medication prescribed, any side effects from the medication, a treatment plan and rationale for any changes to medication. If medication is changed or added, informed consent must be documented. The medical documentation for follow-up visits should also be should be legible.

133. Both experts further agree that the standard of care for prescribing medication requires a psychiatrist to prescribe the correct medication and the correct dose for a patient based on the patient's symptoms and a working diagnosis, which must be documented. Dr. Sahba explained if a patient reports receiving psychotropic medication or controlled substances from a past treater, the information should be considered and documented in the patient's medical record. The psychiatrist should inquire with the patient the reasons for the previously prescribed medications and document the information shared.

Additionally, both experts opined the standard of care requires a treating psychiatrist to attempt to obtain a medical release from a patient who reports receiving controlled substances from another treater, in order to coordinate care and obtain information about past treatment. If a patient refuses to provide a medical release the refusal should be documented.

134. Both experts also opined if after the psychiatrist conducts an assessment and examination, the psychiatrist determines benzodiazepines are indicated for a patient's symptoms and diagnosis, the dosing should start as low as possible and titrated if indicated, after documenting in follow-up visits the need to increase the medication. Additionally, both experts opined informed consent must be obtained and documented and alternatives to benzodiazepines, such as SSRIs and psychotherapeutic interventions should be considered and discussed with patient.

PATIENT-1 A.S.

135. Both experts agree respondent's medical documentation of the treatment he provided A.S. departed from the standard of care. The experts agree respondent's handwritten notes are mostly illegible. They also agree respondent's initial evaluation of A.S. is missing the required components. There is no past medical history; past psychiatric history; past or current substance/alcohol use/abuse history; educational, vocational, social, family, or legal history; a mental status examination; list of current medications; or drug allergies. The notes do not include a working diagnosis or a plan for treatment. Respondent prescribed A.S. Xanax 2 mg. TID with no documented rationale and no informed consent.

136. Additionally, the experts agreed respondent's medical notes from follow-up visits are likewise illegible and do not include the required information such as notes documenting how A.S. had been doing since the last appointment, the effectiveness of medication prescribed, any side effects from the medication, a treatment plan and rationale for any changes to medication. For example, the medical notes for an August 1, 2016 appointment indicate respondent prescribed A.S. Xanax, Ambien and Viiryd without sufficient explanation for the reason. The notes for A.S.'s appointment on October 3, 2016, indicate he prescribed Xanax 2 mg TID, but also noted he prescribed Valium and Ambien, even though he noted that A.S. no longer needed Ambien. There is no informed consent.

137. Dr. Kan opined respondent's documentation of A.S.'s treatment constitutes a simple departure from the standard of care because there was some information included in the medical records. He opined no information or fraudulent information would be an extreme departure from the standard of care. However, Dr. Kan's opinion is not persuasive. Dr. Kan admitted respondent medical notes were "difficult if not impossible to read." As a result, he requested the medical notes for the patients to be typed in order for him to "make sense" of the records. Thereafter, he spent approximately five hours speaking to respondent about the information in the typed notes and his treatment of the patients. All of these efforts demonstrate that respondent's failure to maintain legible and adequate documentation was more than a simple departure from the standard of care.

138. Dr. Sahba's opinion that respondent's medical record keeping for A.S. constitutes an extreme departure from the standard of care is more persuasive. The mostly illegible medical records, as well the substance of the medical notes, represent more than an error or mistake. The records are missing required information the standard of care requires a psychiatrist to include and the information that is included fails to support the medications prescribed A.S. The medical records for A.S. show want of even scant care. As a result, complainant established respondent's medical record keeping for A.S. was an extreme departure from the standard of care, and a failure to keep complete and accurate medical records.

139. The evidence also established respondent's prescribing of controlled substances to A.S. is an extreme departure from the standard of care. Both experts agreed respondent's prescribing of Xanax 2 mg TID to A.S constitutes an extreme departure from the standard of care. Dr. Sahba persuasive opined the standard of care requires the starting dose of Xanax to treat a patient with anxiety is .25 mg twice per day. An increase of .50 mg twice per day may be indicated depending on the patient's reports at follow up appointments. Respondent prescribed A.S. Xanax 2 mg TID, based on his request and claim of taking the same dose from another treater. Both experts also agreed the standard of care required respondent to obtain his substance use history prior to prescribing the medication.

140. The experts also agreed the standard of care required respondent to take steps to confirm A.S.'s statement. Actions included obtaining his past treatment records, obtaining a waiver or release to contact his previous treaters, requesting a biological fluid sample, or running a CURES report. Although Dr. Kan opined the standard of care did not require

respondent to obtain a CURES report, he agreed that respondent was required to take steps to confirm A.S.'s statement. However, Dr. Sahba's opinion that obtaining a CURES report was required under the standard of care was more persuasive, particularly considering there may be no other mechanism by which to obtain a controlled substance history for a patient.

141. Additionally, Dr. Sahba persuasively opined that on follow up visits, respondent continued to prescribe A.S. Xanax 2 mg TID and added Ambien, Viiryd and Adderall without sufficient explanation or rationale for prescribing the medications, which is an extreme departure from the standard of care. In fact, respondent noted for a visit on October 3, 2016, respondent no longer needed Ambien. Yet, respondent continued to prescribe him the medication. Respondent also did not obtain informed consent for treatment at any point from A.S.

PATIENT-2 K.F.

142. Both experts agree respondent's medical documentation of the treatment he provided K.F. departed from the standard of care. The experts agree the notes are illegible and difficult to read. The initial evaluation notes do not include the required components. Respondent failed to include a complete past medical history, past psychiatric history other than reports of anxiety, past or current substance or alcohol use or abuse history, a mental status examination, or a list of current medications or drug allergies. The notes also do not include a working diagnosis or a plan for treatment. During the initial evaluation, respondent prescribed K.F. Xanax 2 mg TID and Ambien 10 mg daily, without documented rationale and without obtaining informed consent documenting that he had a discussion with K.F. about the dangers of taking Xanax and Ambien.

143. Additionally, Dr. Sahba opined respondent's medical notes for follow-up visits are also missing the required components. Respondent's medical notes for the visits on July 6, 2016, indicated that respondent prescribed K.F. Xanax and Norco. The experts agree there was insufficient information in the notes to justify the prescriptions. Additionally, K.F.'s medication record is inaccurate. Respondent did not list the Norco or Xanax prescriptions. Rather, he listed Klonopin and Ambien prescriptions which are not mentioned in the medical notes for the visit.

The notes for the November 1, 2016 visit do not contain sufficient information to determine what occurred during the visit. The medication record notes prescriptions given during the appointment for Xanax and Ambien. Dr. Sahba persuasively opined respondent did not document an appropriate rationale or justification for the Xanax. Respondent also did not mention the prescription for Ambien in the medical notes.

144. Dr. Kan opined respondent's medical record documentation for K.F. is a simple departure from the standard of care because all but one of K.F.'s appointments had some documentation about the treatment. However, Dr. Sahba's opinion that respondent's medical record keeping for K.F. constitutes an extreme departure from the standard of care is more persuasive. The mostly illegible medical records demonstrate want of even scant care.

The records are missing required information the standard of care requires a psychiatrist to include and the information that is included fails to support the medications prescribed to K.F. As a result, complainant established respondent's medical record keeping for K.F. is an extreme departure from the standard of care, and a failure to keep complete and accurate medical records.

145. The evidence also established respondent's prescribing of controlled substances to K.F. is an extreme departure from the standard of care. Both experts agreed respondent's prescribing of Xanax 2 mg TID to K.F. constitutes an extreme departure from the standard of care. Both experts agreed there was not adequate documentation or justification for the high dose. There was no information that K.F. was taking the same dose of Xanax when he was first seen by respondent. Additionally, respondent did not take any steps to confirm K.F. was taking the dose he reported, such as obtaining a release to contact previous physicians, obtain his past treatment records, or review a CURES report, as required by the standard of care. Dr. Sahba also persuasively opined respondent prescribed K.F. Ambien on the first visit without documenting a rationale for the medication. Respondent failed to inform A.S. of the risks of taking Ambien and Xanax.

Both experts also agreed respondent's prescribing of Norco to K.F. on July 6, 2016, is an extreme departure from the standard of care. The experts persuasively opined respondent did not include a sufficient rationale for the prescription, did not obtain a substance abuse history before prescribing the medication and failed to obtain informed consent from K.F. concerning the risks of the medications.

146. Both experts also agreed the standard of care required respondent to take action after receiving the July 14, 2016 notice from Dr. McAndrew disclosing K.F. was an opiate addict under his care, taking suboxone and contracted not to take benzodiazepines and opioids. The experts agreed the standard of care required respondent to make an effort to obtain a release from K.F. to speak to Dr. McAndrew, obtain a CURES report, or request a urine drug screen from K.F. The evidence established respondent took none of the required actions and continued to prescribe K.F. the same high dose of Xanax through November 1, 2017, and also prescribed Adderall, without documented rationale, which is an extreme departure from the standard of care.

PATIENT-3 B.D. AND PATIENT-4 F.T.

147. The experts disagree concerning whether respondent's medical record documentation for patients B.D. and F.T. depart from the standard of care. Dr. Kan opined the documentation for B.D. does not depart from the standard of care because the records "taken as a whole" comply with the standard of care. He also opined respondent's handwritten notes for the treatment he rendered F.T. does not depart from the standard of care because handwritten notes are barely sufficient. However, "considering the whole chart, the documentation" is "generally" within the standard of care. Dr. Kan's opinion is not persuasive. The medical records are missing the information Dr. Kan testified is required in order to comply with the standard of care. Additionally, his opinion is based in part on typed

notes and extensive discussions with respondent about his notes and the treatment he rendered the patients.

148. Dr. Sahba's opinion respondent's medical record keeping for B.D. constitutes an extreme departure from the standard of care is more persuasive. The records are missing required information the standard of care requires a psychiatrist to include, and are mostly illegible and difficult to understand. The initial evaluation respondent conducted of B.D. on October 22, 2014, did not document the required components including a mental status exam, informed consent, substance use history, medical history and past medications, which is required under the standard of care articulated by both experts.

Additionally, the follow-up visit on January 6, 2015, contains only a few words with no description of what occurred during the visit. Respondent's notes for a visit on January 25, 2015, do not provide any explanation for why medication was prescribed, or the effectiveness of previously prescribed medications. Treatment notes from February 3, 2016, contain a single statement. Notes from February 24, 2016, are illegible. As a result, complainant established respondent's medical record keeping for B.D. constitutes an extreme departure from the standard of care and a failure to keep complete and accurate medical records.

149. Dr. Sahba's opinion respondent's medical record keeping for F.T. constitutes an extreme departure from the standard of care is also more persuasive. Respondent's initial evaluation of F.T. on March 14, 2016, does not include the required components of the evaluation required under the standard of care articulated by both experts. There is no documented mental status examination, informed consent, substance use history, and family history.

Additionally, notes for follow up visits on June 2, 2016, only contains a few words. The medical notes are also illegible and difficult to understand. As a result, complainant established respondent's medical record keeping for F.T. constitutes an extreme departure from the standard of care and a failure to keep complete and accurate medical records.

PATIENT-5 M.Z.

150. Both experts agreed respondent's medical documentation of the treatment he provided M.Z. departed from the standard of care. The experts agreed respondent's handwritten notes are difficult to read and do not include sufficient information explaining what transpired during the visits to justify the prescriptions issued by respondent. For example, respondent's notes for visits on December 8, 2015, April 11, June, 6, December 19, 2016, March 20, May 8, and June 19, 2017, only contain a few words.

151. Dr. Kan opined respondent's medical record documentation for M.Z. is a simple departure from the standard of care because the documentation is "present but poor in overall quality." However, Dr. Sahba's opinion that respondent's medical record keeping for K.F. constitutes an extreme departure from the standard of care is more persuasive. The

mostly illegible medical records demonstrate want of even scant care. The records are missing information the standard of care requires a psychiatrist to include, and the information that is included fails to support the medications prescribed to M.Z. As a result, complainant established respondent's medical record keeping for M.Z. constitutes an extreme departure from the standard of care and a failure to keep complete and accurate medical records.

152. Both experts agreed respondent's prescribing of Klonopin 2 mg TID to M.Z. constitutes an extreme departure from the standard of care. M.Z. reported to respondent during his initial evaluation with respondent on December 3, 2014, that his prior treater was tapering him off of Klonopin. He reported she had tapered him to .25 mg of Klonopin daily. Dr. Sahba persuasive opined that based on the information provided to respondent by M.Z. the standard of care required respondent to request M.Z. to sign a release so respondent could speak to the treater and determine why she wanted him to stop taking Klonopin. Respondent could have also obtained a CURES report to determine if M.Z. had been taking Klonopin or other habit-forming drugs. Respondent failed to take any steps before he prescribed M.Z. Klonopin 2 mg TID, which the experts opined is an extreme departure from the standard of care.

153. Both experts also opined the standard of care requires a psychiatrist, when using Klonopin to treat anxiety, to start a patient at a low dose and then slowly titrate up the medication as needed over time, based on the patient's response to the medication. Respondent failed to follow the standard of care. Respondent prescribed a significantly higher dose of Klonopin for M.Z. than he reported taking at the time of his initial evaluation, which the experts opined is an extreme departure from the standard of care. Respondent also prescribed M.Z. Ambien, which Dr. Sahba opined has "additive properties when mixed with Klonopin." Additionally, respondent failed to obtain informed consent from M.Z. concerning the risk, benefits and alternative courses of treatment, before prescribing Klonopin and Ambien, which is also an extreme departure from the standard of care.

PATIENT-6 A.B.

154. Both experts agreed respondent's medical documentation of the treatment he provided A.B. departed from the standard of care. The experts agreed respondent's handwritten notes are illegible in parts and difficult to understand. The initial evaluation respondent conducted of A.B. on September 30, 2014, lacked the required components of an initial evaluation. There was not a complete past medical history, substance use history, list of current medications, a mental status examination, working diagnosis or treatment plan. Respondent noted A.B. "wants Xanax." He prescribed her Xanax 1 mg TID without clear rationale and without informed consent. He also did not include the prescription for Xanax on her medication record for that date..

155. Additionally, respondent's medical notes for follow-up visits also depart from the standard of care. Respondent continued to prescribe A.B. multiple medications throughout the course of treatment which lasted approximately two years. Dr. Sahba

persuasively opined respondent prescribed A.B. Xanax, Valium, Ambien, Adderall and Ativan, without adequate explanation or rationale for prescribing the medications. For example, on March 1, 2016, respondent prescribed A.B. Ambien, Valium, Adderall and Ativan concurrently with no documented rationale. Visit notes for November 12, 2014, March 24, May 13 and December 7, 2015, are illegible and do not contain sufficient information concerning the treatment rendered or the rationale for the medications prescribed.

156. Dr. Kan opined respondent's medical record documentation for A.B. is a simple departure from the standard of care because he included some information in the notes. However, Dr. Sahba's opinion that respondent's medical record keeping for A.B. constitutes an extreme departure from the standard of care is more persuasive. Many of the notes are illegible and it is difficult to understand what occurred during the appointments. The records are missing information the standard of care requires a psychiatrist to include and the information that is included fails to support the multiple medications prescribed to A.B. Respondent's failure to include accurate and complete information is significantly more serious than an error or mistake a reasonable prudent psychiatrist would make in the same circumstance. As a result, complainant established respondent's medical record keeping for K.F. is an extreme departure from the standard of care and failure to keep complete and accurate medical records.

157. Both experts also agreed respondent's prescribing of controlled substances to A.B. constituted an extreme departure from the standard of care. Dr. Kan described respondent's prescribing of benzodiazepines to A.B. as "excessive" and that he "failed to document his reasoning and sufficient evidence to prescribe the medications in the first place." The experts also agreed respondent failed to document the rationale for prescribing A.B. benzodiazepines, sedative medications and a stimulant. Additionally, respondent failed to obtain informed consent from A.B. concerning the risk of taking the medications and alternatives, which is an extreme departure from the standard of care.

158. The experts also agree respondent's failure to take action after being informed by a pharmacy in October 2014, that respondent was selling Xanax and Methadone in the pharmacy parking lot, is an extreme departure from the standard of care. The experts agreed the standard of care required respondent to take steps to obtain more information about A.B.'s alleged conduct. Both experts opined the steps included asking for a release from A.B. to speak to her treaters, obtaining a CURES report to review her controlled substance. history or requesting A.B. to submit to a drug screening. Respondent took none of these steps. Respondent told A.B. about the report and took her word that she was not selling her medication. The experts agreed respondent failure to take any action and continue to prescribe her controlled substances until 2016, is an extreme departure from the standard of care.

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RESPONDENT'S SELF-PRESCRIBING MEDICATIONS

159. Dr. Sahba persuasively opined the standard of care provides that a physician should not self-prescribe medication, except for limited exceptions and that self-prescribing a controlled medication without clinical indication is never permitted. Both experts agreed respondent's self-prescribing of Xanax because he "heard so much about it" and was curious about its effects, is an extreme departure from the standard of care.

160. Dr. Kan did not opine whether respondent's self-prescribing of hydrocodone and antihypertensive medications was a departure from the standard of care. However, given the evidence, Dr. Sahba's opinion respondent's self-prescribing of hydrocodone in anticipation of a dental procedure and antihypertensive medications because it took too long to get a doctor's appointment, were not the type of exceptions contemplated under the standard of care, is persuasive. As a result, complainant established respondent's self-prescribing of Xanax, hydrocodone and antihypertensive medications constitutes an extreme departure from the standard of care.

Additional Evidence Submitted by Respondent

161. Respondent has been practicing psychiatry for over 50 years. He has held teaching positons at various universities and maintained a private practice for decades. Respondent explained his private practice combines psychotherapy and medication management. Over the years, respondent has participated in numerous psychiatry trainings and conferences to stay current on the standard of care when treating psychiatric patients. He also belongs to the American Psychiatric Association and the Northern California Psychiatric Society.

162. Respondent admitted the medical records he maintained for his six patients at issue are difficult to read. Respondent contended the medical notes are for his own use and he was not aware his notes would be "scrutinized." He also admitted he did not document mental status examination for each patient at each visit. He explained documenting a mental status examination at every appointment distracts from the "highly important personal interaction" he has with his patients. Respondent explained he recognizes he needed to bring his medical record keeping "more in line" with the standard of care.

163. Respondent also explained that if he is allowed to practice he would implement various changes. He would likely utilize an electronic medical records system. He also obtained a seven-page intake form he would require every patient complete which covers all the required information for an initial evaluation. Respondent would also request his patients to a sign medical release to obtain information from other treaters, so that he can coordinate care. Respondent would also utilize the CURES database, when prescribing controlled substances, which is now mandatory. He would also ask patients to submit to urine screening. If necessary, he would ask his patients to provide prescription bottles or records from pharmacies to show past prescriptions. He would also obtain written informed consent, which respondent contended he has obtained verbally "for years."

For patient follow-up visits, respondent would use a systemic approach to his medical documentation, including ensuring he conducts a medication assessment to determine if medications can be reduced or changed.

164. Respondent recently completed a two-day medical record keeping course. He also recently attended a conference where prescribing practices were addressed, including the prescribing of benzodiazepines. He also intends to complete a prescribing course to ensure his prescribing practices comply with the standard of care.

165. Respondent also explained in retrospect, he would have taken different steps when treating some of his patients. Concerning the prescribing of Xanax, respondent contended Xanax is not an addictive drug. He has been prescribing Xanax to patients since 1981. Respondent explained he has taken many educational programs about prescribing Xanax. He contended if used properly Xanax is safe and a "marvelous drug" that enables people to function. Respondent admitted Xanax is subject to abuse, but he contended "any drug is subject to abuse." He understands the standard of care requires when he prescribes Xanax to a patient, he must monitor the patient's use more carefully.

Respondent also explained that he understands the standard of care requires if he is going to start a patient on Xanax who has never taken the medication, the dose should be low. However, he explained if a patient comes to him for the first time and reports taking a high dose of Xanax then his practice is to continue the same dose to ensure therapeutic effectiveness. Respondent explained he now understands the standard of care requires him to take steps to verify his patient's report. Respondent further stated that several years ago CURES "was not a big thing" and the standards for obtaining a CURES report were not as "rigorous."

166. Respondent explained with Patient-1 A.S., he should have contacted his prior treater to confirm A.S. had previously been prescribed Xanax 2 mg TID, prior to prescribing him the dose he requested. However, respondent also explained he did not see any "red flags." He further explained that he could have "easily" obtained a CURES report to check A.S.'s controlled substance history, but he did not have reason to do so. He also explained that when he prescribed Xanax 2 mg TID for any patient he always prescribes it to be taken "as needed only" and that A.S.'s pattern of requesting the medication was consistent with a pattern of "stretching out" the medication past the 30-day supply.

167. Respondent also regrets prescribing Patient-2 K.F. hydrocodone. At the time he prescribed the medication it did not seem like a "huge request." Respondent blamed his decision on having too much empathy for his patient. After respondent received notification K.F. was on a suboxone program for opioid addiction, he explained to K.F. the importance of not taking benzodiazepines at the same time. Respondent also explained that he did not see any "red flags" to suggest K.F. was abusing his medications.

168. Respondent believed he provided "excellent care" to Patient-6 A.B., which he contended complied with the standard of care. He described the history he took from A.B. as

the "gold-standard" and his medical documentation for the treatment he provided her as "robust." However, he acknowledged that he should have documented the treatment notes in a more "systematic" manner. Respondent also contended he did a "good faith" evaluation of A.B., diagnosis and treatment plan. He gave A.B. the "benefit of the doubt" by prescribing her Xanax based on her request for the medication, because she refused to take the other medication he suggested. Respondent explained he now understands the standard of care requires that he take steps to confirm a report of taking Xanax from another provider.

Respondent also explained that although he prescribed the Xanax to be taken as needed, she, like many of his patients, "fully availed" herself to the maximum dose. He also denied that the multiple concurrent medications he prescribed A.B. were contraindicated. He tried to reduce the dose of Xanax and prescribed other medications based on her diagnosis of bipolar and borderline personality disorders. Respondent explained that he realized during the time he treated A.B. she needed a higher level of care from County Mental Health, which he recommended she seek.

Respondent also contended when he was informed by a pharmacy A.B. was selling Methadone and Xanax in the parking lot, he addressed the issue. A.B. denied selling her medications. Respondent explained he was "satisfied" with her denial. He also testified if A.B. was selling medication it was likely Methadone, not the Xanax he prescribed.

169. Concerning respondent's role as the Medical Director for Fair Oaks, he explained he has known Dr. Metani for 35 years. In 2013, respondent was working as a psychiatrist at Fair Oaks three days a week. In July 2016, Dr. Metani asked respondent to become the Medical Director. Respondent agreed to take the position. However, respondent contended there was no discussion about the scope of his duties and he was not provided a job description. Rather, respondent contended it was an "informal arrangement" and an "empty title" that required him to "rubber stamp" workers compensation reports. Respondent contended he was not aware he was required to supervise mid-level providers such as nurse practitioners or physician assistants. Respondent explained the mid-level providers had DEA permits and prescribed medication. Respondent contended he did not learn Fair Oaks mid-level providers were using his DEA permit number to issue prescriptions, until he was notified by Mr. Scully in July 2018, he was in violation of the Order. Respondent contended he never authorized anyone else to use his DEA permit number.

170. Respondent had several different explanations regarding his violation of the Order. Respondent testified he learned of the terms of the Order a few days after it was issued on June 28, 2018. He and his attorney discussed the order on July 4, 2018. Shortly thereafter, respondent received a copy of the Order. Respondent initially testified he understood the Order prohibited him from prescribing any controlled substances and that he was required to surrender his DEA permit and prescription pads. He understood that until he complied with the terms of the Order he was prohibited from practicing medicine. Respondent contended as soon as learned the terms of the Order he complied and did not treat patients.

Respondent also initially testified that after the Order was issued and before he surrendered his DEA permit on August 2, 2018, "numerous people" came to his office asking him what to do since he was no longer able to prescribe controlled substances. Respondent testified that he "did not shut door" but he "did not see [the patients] in the capacity as physician." Respondent contended it would have been "inhumane" to deny them the opportunity to talk and tell them where to seek treatment.

At hearing, after respondent was presented with several prescriptions written between July 4 through August 2, 2018, with his handwriting and signature, he suggested the prescriptions may have been forged. However, respondent changed his testimony when several patients' medical records were produced documenting treatment visits and various prescriptions written by him, including prescriptions for Xanax, Adderall, Ambien, and Soma. Thereafter, respondent contended he did not understand he could not practice medicine until he turned in his DEA permit and prescription pads. Respondent testified he thought the suspension of his license was stayed and did not ask for clarification. Respondent contended he would never have purposefully violated the Order and he made a "good faith" effort to comply.

Appropriate Discipline

171. Complainant established by clear and convincing evidence, all of the causes for discipline contained in the Accusation. The multiple violations of the Medical Practices Act occurred, in part, with four patients, involving prescribing of dangerous drugs and controlled substances. Respondent exposed these patients to serious harm by prescribing high doses of controlled substances without performing adequate examinations and without documented indication for the medications. In two instances, with patients A.S. and A.B., respondent was alerted the patients had addiction issues. Despite this information, respondent failed to take the required action to investigate the information. His failure to do so placed his patients in serious risk.

Additionally, respondent's failure to confirm patients A.S., K.F., M.Z. and A.B.'s past controlled substances history likewise placed the patients at risk. Respondent prescribed these patients high doses of medications and multiple medications, without conducting the required assessments, obtaining informed consent, obtaining copies of past medical record, coordinating care with other treaters, or obtaining CURES reports for the patients. Had respondent done so, he would have been alerted to controlled substance histories for the patients that should have informed his care.

172. Additionally, respondent's medical record for all six patients fell far below the standard of care. The records are mostly illegible. The records are inaccurate and fail to provide the required information to substantiate the treatment that was rendered. Respondent's contention that he believed the records were only for his use, demonstrates lack of insight into his role as a treating psychiatrist. Additionally, it is not clear how the inconsistent and inaccurate information in his patients' record could properly inform his treatment for the patients.

173. Of great concern was respondent's resistance to recognizing the potential harm he caused his patients and his efforts to justify his conduct. Despite testimony from both experts that respondent's prescribing practices as to four patients constitutes extreme departures from the standard of care and in some instances was dangerous, respondent defended his practices. Respondent contended that CURES was not a "big thing" at the time he was treating his patients. He also contended Xanax is not addictive and that he only prescribed it for his patients to take "as needed." He also justified not following up on reports of questionable behavior by his patients. For example, respondent implied that he was not overly concerned about the report A.B. was selling Xanax and Methadone, based on his belief that if anything, she was likely selling Methadone, not the Xanax he prescribed.

174. Even more concerning is respondent's apparent willful violation of the Order. Respondent initially contended he did not violate the Order. Rather, he suggested that before he surrendered his DEA permit and prescriptions pads, he only saw patients to provide information on where they should seek treatment, while he is unable to practice. After he was confronted with evidence demonstrating he continued to treat patients and prescribe controlled substances in violation of the Order, respondent contended he did not understand the Order prohibited him from practicing medicine until he turned in his DEA permit and prescription pads.

However, respondent's testimony was not credible. Respondent's counsel spoke to respondent on July 4, 2018, about the terms of the Order. Thereafter, respondent received a copy of the Order and reviewed the terms. Additionally, Mr. Scully visited respondent's office on July 31, 2018, and confronted him about his continued practice of medicine in violation of the Order. Mr. Scully went over the terms of the Order with respondent, including that he was not to practice medicine until he surrendered his DEA permit and prescription pads. Despite this information, on August 2, 2018, the same day respondent surrendered his DEA permit, he treated a patient and prescribed medications, including a controlled substance. Additionally, regardless of whether respondent was aware mid-level providers at Fair Oaks were using his DEA permit to prescribe controlled substances, had respondent surrendered his DEA permit as ordered, no further prescriptions could have been issued with his permit number. Respondent's failure to recognize the seriousness of violating the Order and continuing to practice, demonstrates he lacks the judgment required of a physician and he is a danger to his patients and the public.

175. Respondent has been licensed to practice medicine in California since 1967. He has no record of discipline with the Board. While respondent's lack of discipline is considered, protection of the public is the Board's highest priority. The Board's Disciplinary Guidelines provide the maximum discipline for the causes of discipline alleged against respondent is revocation. There is no basis to deviate from the Disciplinary Guidelines. The overwhelming evidence demonstrates respondent is not safe to practice. The severity of respondent's conduct and proven violations requires that in order to protect the public, his certificate must be revoked.

LEGAL CONCLUSIONS

Burden of Proof

1. Complainant has the burden of proving each of the grounds for discipline alleged in the Accusation, and must do so by clear and convincing evidence. (See, *Ettinger v. Board of* Medical *Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence is evidence that leaves no substantial doubt and is sufficiently strong to command the unhesitating assent of every reasonable mind. (See, *In re Marriage of Weaver* (1990) 224 Cal.App.3d 478.)

Applicable Law

2. Business and Professions Code section 2227 provides in pertinent part that a licensee that has been found "guilty" of violations of the Medical Practices Act, shall:

> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

3. Business and Professions Code section 2234 provides that the Board shall take action against any licensee found to have engaged in unprofessional conduct, which includes but is not limited to the following:

> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the

applicable standard of care shall constitute repeated negligent acts.

> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1) including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

[¶] . . . [¶]

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

4. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care applicable in a medical professional must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal. App.4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280.) The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052. Simple negligence is merely a departure from the standard of care.

5. Pursuant to Business and Profession Code section 2242, subdivision (a), "[p]rescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct."

6. Business and Profession Code section 4022 defines a dangerous drug as:

> . . . any drug or device unsafe for self-use in humans or animals, and includes the following:
>
> (a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

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

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

7. Business and Professions Code section 2266 provides that failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

8. Business and Professions Code section 2306 provides:

If a licensee's right to practice medicine is suspended, he or she shall not engage in the practice of medicine during the term of such suspension. Upon the expiration of the term of suspension, the certificate shall be reinstated by the Division of Medical Quality, unless the licensee during the term of suspension is found to have engaged in the practice of medicine in this state. In that event, the division shall revoke the licensee's certificate to engage in the practice of medicine.

Causes for Discipline

9. Complainant established by clear and convincing evidence, as set forth in Factual Findings 10 through 160, that respondent's conduct and treatment of patients A.S., K.F., B.D., F.T., M.Z. and A.B., self-prescribing of medications, and violation of the Order, constitute violations of the Medical Practice Act. Therefore, cause was established to revoke respondent's certificate pursuant to Business and Professions Code section 2234, subdivision (a).

10. Complainant established by clear and convincing evidence that respondent's conduct and treatment of patients A.S., K.F., B.D., F.T., M.Z. and A.B, and self-prescribing medication, as set forth in Factual Findings 10 through 53, 61 through 120, 123 through 128, 130 through 160, constitutes extreme departures from the standard of care. Therefore, cause was established to revoke respondent's certificate pursuant to Business and Professions Code section 2234, subdivision (b).

11. Complainant established by clear and convincing evidence respondent's conduct and treatment of patients A.S., K.F., B.D., F.T., M.Z. and A.B, and self-prescribing medication, as set forth in Factual Findings 10 through 120, 123 through 128, 130 through 160, constitutes repeated acts of negligence. Therefore, cause was established to revoke

respondent's certificate pursuant to Business and Professions Code section 2234, subdivision (c).

12. Complainant established by clear and convincing evidence that respondent prescribed A.S., K.F., M.Z. and A.B, dangerous drugs without conducting adequate examinations as set forth in Factual Findings 10 through 24, 35 through 50, 64 through 88, 91 through 102, 108 through 120, 123 through 146, and 150 through 158. Therefore, cause was established to revoke respondent's certificate pursuant to Business and Professions Code section 2242.

13. Complainant established by clear and convincing evidence that respondent knowingly violated the Order, as set forth in Factual Findings 54 through 60, 169, 170 and 174. Therefore, cause was established to revoke respondent's certificate pursuant to Business and Professions Code sections 2234, 2234, subdivision (a), 2234, subdivision (e), and 2306.

Conclusion

14. The objective of an administrative proceeding relating to licensing is to protect the public. Such proceedings are not for the primary purpose of punishment. (See *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) The matters set forth in Findings 171 through 175 were considered in determining the appropriate discipline to be imposed in this case. The overwhelming evidence demonstrates respondent is not safe to practice. When all the evidence is considered, in order to protect the public, respondent's certificate must be revoked.

ORDER

Physician's and Surgeon's Certificate No. G 13754 issued to respondent Stuart H. Tubis, M.D. is REVOKED.

DATED: December 20, 2018

DocuSigned by:
Marcie Larson
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MARCIE LARSON
Administrative Law Judge
Office of Administrative Hearings

XAVIER BECERRA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
JOSHUA M. TEMPLET
Deputy Attorney General
State Bar No. 267098
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3533
Facsimile: (415) 703-5480
Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO August 17 2018
BY: Judy Wright ANALYST

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

In the Matter of the First Amended Accusation Against: **Stuart H. Tubis, M.D.** **800 Woodside Lane East** **Sacramento, CA 95825** **Physician's and Surgeon's Certificate No. G 13754,** Respondent.	Case No. 800-2016-025718 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On August 11, 1967, the Medical Board issued Physician's and Surgeon's Certificate Number G 13754 to Stuart H. Tubis, M.D. (Respondent). The Physician's and Surgeon's Certificate will expire on January 31, 2019, unless renewed.

3. Complainant filed a Petition for Interim Order of Suspension on June 1, 2018. After a noticed hearing on Complainant's petition and submission of the matter on June 18, 2018, an Interim Order of Suspension was entered prohibiting Respondent from ordering, prescribing,

dispensing, administering, furnishing, or possessing any controlled substances and from practicing medicine until he provides documentary proof to the Board that his Drug Enforcement Administration (DEA) Certificate of Registration has been surrendered to the DEA for cancellation along with any state prescription forms and all controlled substances order forms.

4. Complainant filed an Ex Parte Petition for Modification of Interim Order of Suspension on August 1, 2018. After a hearing on Complainant's petition, at which Respondent and his attorney appeared, a Modified Interim Order of Suspension was entered which lifted the stay of the suspension of Respondent's Physician's and Surgeon's Certificate and immediately suspended his certificate, based on his failure to comply with the original Interim Order of Suspension. Respondent subsequently entered into a stipulation with Complainant in which he agreed to the suspension of his certificate pending the Board's Decision and Order in this matter. Respondent's certificate remains in suspended status.

JURISDICTION

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

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.

7. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

". . . ."

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

8. Section 2242 of the Code provides, in pertinent part, that "[p]rescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct."

9. 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."

10. Section 2306 of the Code states:

"If a licensee's right to practice medicine is suspended, he or she shall not engage in the practice of medicine during the term of such suspension. Upon the expiration of the term of suspension, the certificate shall be reinstated by the [Board], unless the licensee during the term of suspension is found to have engaged in the practice of medicine in this state. In that event, the division shall revoke the licensee's certificate to engage in the practice of medicine."

FACTS

11. At all times relevant to this matter, Respondent was licensed and practicing medicine in California.

PATIENT P-1[1]

12. Patient P-1, a 25-year old man, first saw Respondent on March 23, 2016. Respondent's chart notes for his initial evaluation of P-1 was less than half a page of poorly handwritten notes. They do not include a past medical history; past psychiatric history; past or current substance/alcohol use/abuse history; educational, vocational, social, family, or legal

[1] The patients are designated in this document as Patients P-1 through P-6 to protect their privacy. Respondent knows the names of the patients and can confirm their identities through discovery.

history; a mental status examination; list of current medications; or drug allergies. The notes do not include a working diagnosis or a plan for treatment. P-1 told Respondent that he had been taking 2 mg of alprazolam[2] three times a day and Respondent prescribed 2 mg of alprazolam three times a day for him without rationale and without documenting having warned P-1 about alprazolam's sedating effects and habit-forming properties. He also prescribed Ambien for P-1 without noting that the effects of alprazolam and Ambien can be additive.

13. P-1's next documented visit was on August 1, 2016. Again the notes were minimal and inadequate. P-1 requested alprazolam and Respondent prescribed the same amount of alprazolam as before, along with Ambien[3] and Viibryd,[4] with minimal notes and explanation for why he was prescribing them. These medications are not included on Respondent's often illegible Medication Record. At no time did Respondent check a CURES report for P-1.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts and/or Failure to Maintain Adequate Records and/or Prescribing Without an Adequate Examination)

14. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, subdivisions (a) (violation of Medical Practice Act), (b) (gross negligence), and/or (c) (repeated negligent acts); and/or 2242 (prescribing without adequate prior examination); and/or 2266 (inadequate records) of the Code in that Respondent engaged in the conduct described above including, but not limited to, the following:

A. Respondent's chart notes for P-1 are largely illegible and contain no meaningful assessment or examination of P-1, any evaluation of his mental state, and no rationale or justification for the prescriptions issued.

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[2] Alprazolam, also known by the trade name Xanax, is a benzodiazepine. It is a psychotropic drug used to treat anxiety and panic disorders. Alprazolam is contra-indicated in patients with narrow-angle glaucoma or who are taking certain medications. It is a dangerous drug as defined in section 4022, and a schedule IV controlled substance.

[3] Ambien, a trade name for zolpidem tartrate, belongs to a class of drugs called sedative-hypnotics. It is used to treat insomnia in adults. It is a dangerous drug as defined in section 4022, and a schedule IV controlled substance.

[4] Viibryd, a trade name for vilazodone hydrochloride, is a selective serotonin reuptake inhibitor (SSRI) and partial serotonin receptor agonist used to treat depression. It is a dangerous drug as defined in section 4022.

B. Respondent prescribed a high dose of alprazolam for P-1, a drug with high abuse potential, without an adequate examination; without asking him about his substance use/abuse history; without obtaining the names of prior prescribers or a release of information form from him; without obtaining informed consent; and without checking a CURES report for him.

PATIENT P-2

15. Respondent first saw Patient P-2, a 22-year old man, on March 23, 2016. Respondent's chart notes for his initial evaluation of P-2 was a little over half a page of poorly handwritten notes. They do not include a complete past medical history, past or current substance/alcohol use/abuse history, or many other elements of an adequate initial evaluation of a psychiatric patient. There is no list of current medications or drug allergies and the notes do not include a working diagnosis or a plan for treatment. P-2 requested Xanax 2 mg three times a day and Ambien 10 mg at bedtime and Respondent prescribed it for him with little justification and no mention of Ambien's additive effects when taken with Xanax. Respondent's documentation for P-2's treatment continues to be inadequate in handwriting that ranges from difficult to read to illegible.

16. The next documented visit is on July 6, 2016. The notes are only a third of a page long and while the Medication Record reflects that Respondent prescribed Klonopin[5] and Ambien for P-2, the chart notes reflect prescriptions for Xanax and Norco.[6] There is minimal to no justification documented for any of these medications. Respondent never checked CURES to see if P-2 was obtaining controlled substances from other physicians.

17. On July 14, 2016, Respondent received a faxed CURES report from another physician. The physician had written on the CURES report that P-2 was an opiate addict under his care, was taking Suboxone,[7] and was contracted not to take benzodiazepines or opioids.

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[5] Klonopin is a trade name for clonazepam, an anticonvulsant of the benzodiazepine class of drugs. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance. It produces central nervous system depression and should be used with caution with other central nervous system depressant drugs.

[6] Norco is a trade name for hydrocodone bitartrate w/APAP (hydrocodone with acetaminophen) tablets. Hydrocodone is a semisynthetic narcotic analgesic, a dangerous drug as defined in section 4022, and a Schedule III controlled substance.

[7] Suboxone is a trade name for a combination of buprenorphine and naloxone.

Respondent did not contact the physician and continued to prescribe high doses of benzodiazepines for P-2, including Xanax and diazepam.[8]

18. Respondent prescribed Adderall[9] for P-2 on April 1, 2016 without documenting a reason for it or even that he had prescribed it at all.

19. At P-2's last documented visit on July 11, 2017, P-2 advised Respondent that alprazolam was "OK" with the physician with whom he had the Suboxone contract. Respondent prescribed alprazolam for P-2 without contacting the physician and prescribed Adderall for P-2 without documenting any reason other than P-2 "wants amphetamine."

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts and/or Failure to Maintain Adequate Records and/or Prescribing Without an Adequate Examination)

20. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, subdivisions (a) (violation of Medical Practice Act), (b) (gross negligence), and/or (c) (repeated negligent acts); and/or 2242 (prescribing without adequate prior examination); and/or 2266 (inadequate records) of the Code in that Respondent engaged in the conduct described above including, but not limited to, the following:

A. Respondent's chart notes for P-2 are minimal, largely illegible, and contain no rationale or justification for the prescriptions issued.

B. Respondent prescribed a high dose of alprazolam for P-2, a drug with high abuse potential, without an adequate examination; without asking him about his substance use/abuse history; without obtaining the names of prior prescribers or a release of information form from him; without obtaining informed consent; and without checking a CURES report for him.

Buprenorphine is an opioid medication that relieves drug cravings without giving the same high as other opioid drugs and naloxone blocks the effects of opioid medication that can lead to opioid abuse. It is used to treat narcotic addiction. Suboxone is a dangerous drug as defined in section 4022 and a schedule III controlled substance.

[8] Diazepam (trade name Valium) is a benzodiazepine. It is a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance.

[9] Adderall is a trade name for a combination of amphetamine and dextroamphetamine, central nervous system stimulants that is used to treat narcolepsy and attention deficit hyperactivity disorder. Adderall is a dangerous drug as defined in section 4022, and a Schedule II controlled substance.

C. Respondent failed to contact the treating physician who notified him that P-2 was enrolled in a substance abuse program and was under contract not to use any benzodiazepines and continued prescribing high dosages of benzodiazepines for P-2.

D. Without contacting the physician who had previously notified Respondent that P-2 was enrolled in a drug treatment program and should not take benzodiazepines, Respondent accepted the word of P-2, a known addict, that the physician had approved his use of alprazolam.

E. Respondent prescribed Adderall to P-2 without documentation and without justification or rationale.

PATIENT P-3

21. Respondent performed an initial psychiatric evaluation of Patient P-3, a then 34-year old man, on October 22, 2014. The handwritten evaluation is in parts illegible and does not include many elements of an adequate initial evaluation. It does not include a complete past medical history, past or current substance/alcohol use/abuse history, a list of current medications or drug allergies, a working diagnosis, or a plan for treatment.

22. Most of Respondent's notes on P-3 are written in poorly understandable or illegible handwriting. Some follow-up notes, such as those for January 6, 2015, February 3, 2016, and February 24, 2016, include only a few words and do not describe what took place during the visit.

PATIENT P-4

23. Respondent first saw Patient P-4, a then 25-year old man, on February 23, 2016. Respondent's notes on P-4 are minimal and mostly poorly written or illegible. Some follow-up notes, such as those for June 2, 2016 and September 29, 2016, are blank or include only a few words and do not describe what took place during the visit or whether there was a visit at all.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts and/or Inadequate Documentation)

24. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivisions (a) (violating the Medical Practice Act), (b) (gross negligence), and/or (c) (repeated negligent acts), and/or 2266 (inadequate documentation) of the Code in that

Respondent engaged in the conduct described above including, but not limited to, maintaining minimal chart notes for Patients P-3 and P-4 which were poorly written and at times illegible.

PATIENT P-5

25. Respondent first saw Patient P-5, a 54-year old man, on December 3, 2014. Respondent's chart notes for P-5 are difficult to read because the handwriting is very poor and in parts illegible. Some follow up notes, such as those on December 8, 2015, April 11, 2016, June 6, 2016, December 19, 2016, March 20, 2017, May 8, 2017, and June 19, 2017, have only a few words written so it is impossible to know what happened at the visit or the reasoning behind P-5's treatment. There are no records from prior treating physicians or signed release forms in Respondent's records for P-5.

26. Respondent was aware that P-5 had left his prior physician because she was trying to get him off Klonopin. Yet, at P-5's first visit, Respondent prescribed Klonopin 2 mg three times a day and Ambien 10 mg at bedtime. His chart notes document no justification and make no mention of Ambien's additive effects when taken with Klonopin. He continued prescribing the same amounts of Ambien and Klonopin for P-5 through at least July 25, 2017 without re-evaluation or attempting to taper the dosages and without trying other treatment options such as psychotherapy, cognitive behavioral therapy, or the use of selective serotonin reuptake inhibitors (SSRIs). Respondent never checked CURES to see if P-5 was obtaining controlled substances from other physicians.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts and/or Failure to Maintain Adequate Records and/or Prescribing Without an Adequate Examination)

27. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, subdivisions (a) (violation of Medical Practice Act), (b) (gross negligence), and/or (c) (repeated negligent acts); and/or 2242 (prescribing without adequate prior examination); and/or 2266 (inadequate records) of the Code in that Respondent engaged in the conduct described above including, but not limited to, the following:

A. Respondent's chart notes for P-5 are minimal, largely illegible, and contain no rationale or justification for the prescriptions issued.

B. Knowing that P-5 had left his prior physician because she had tried to get him to stop taking Klonopin, Respondent prescribed a high dose of Klonopin for P-5, a drug with high abuse potential, without an adequate examination, without asking him about his substance use/abuse history, without obtaining the names of prior prescribers or a release of information form from him, without obtaining informed consent, and without checking a CURES report for him.

C. Respondent did not try other treatment options for P-5 such as psychotherapy, cognitive behavioral therapy, or the use of SSRIs.

PATIENT P-6

28. The New Patient registration for Patient P-6, a 28-year old woman, is dated August 1, 2014 and Respondent's initial evaluation of P-6 was done on September 30, 2014. Respondent's chart notes for his initial evaluation are poorly handwritten and illegible in parts. They do not include a complete past medical history, past or current substance/alcohol use/abuse history, or many other elements of an adequate initial evaluation of a psychiatric patient. There is no list of current medications or drug allergies and the notes do not include a working diagnosis or a plan for treatment. P-6 requested Xanax and Respondent prescribed 1 mg Xanax three times a day for her with little justification. Respondent's documentation for P-6's treatment continues to be inadequate in handwriting that ranges from difficult to read to illegible. Respondent's Medication Record sheets are difficult to read and incomplete. Treatment goals and rationales for medication are absent.

29. In October 2014, a pharmacy called Respondent's office to report that they believed that P-6 was selling methadone[10] and Xanax in the parking lot. Respondent did not contact the pharmacy and despite this concern, continued prescribing Xanax and other controlled substances to P-6 without so much as requiring toxicology screening tests to make sure that she was taking the medications herself.

[10] Methadone is an opioid used to treat pain and as maintenance therapy or to help with tapering in people with opioid dependence. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance.

30. Respondent prescribed lorazepam,[11] alprazolam, diazepam, and Ambien to P-6 simultaneously with no explanation or justification noted. Respondent never checked CURES to see if P-6 was obtaining controlled substances from other physicians.

31. On December 7, 2015, P-6 asked Respondent for Adderall and he prescribed it for her without documenting a reason for it or even that he had prescribed it at all. He continued prescribing Adderall along with lorazepam, alprazolam, diazepam, and Ambien.

32. Respondent's Medication Record for P-6 dated March 1, 2016 states "too much reliance on benzos and Adderall." Nonetheless, Respondent continued prescribing the same dosage of Adderall and even higher dosages of benzodiazepines for her.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts and/or Failure to Maintain Adequate Records and/or Prescribing Without an Adequate Examination)

33. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, subdivisions (a) (violation of Medical Practice Act); (b) (gross negligence), and/or (c) (repeated negligent acts); and/or 2242 (prescribing without adequate prior examination); and/or 2266 (inadequate records) of the Code in that Respondent engaged in the conduct described above including, but not limited to, the following:

A. Respondent's chart notes for P-6 are minimal, largely illegible, and contain no rationale or justification for the prescriptions issued and no treatment plan.

B. Respondent prescribed multiple benzodiazepines and Adderall, drugs with a high abuse potential, for P-6 at the same time without explanation or justification, without an adequate examination, without asking her about her substance use/abuse history, without obtaining the names of prior prescribers or a release of information form from her, without obtaining informed consent, and without checking a CURES report for her.

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[11] Lorazepam (trade name Ativan) is a benzodiazepine. It is a sedative used to treat anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance. Since lorazepam has a central nervous system (CNS) depressant effect, special care should be taken when prescribing lorazepam with other CNS depressant drugs.

C. Without contacting the pharmacy that reported that P-6 was selling methadone and Xanax in the parking lot, Respondent continued prescribing Xanax and other controlled substances to P-6 without so much as requiring toxicology screening tests to make sure that she was taking the medications herself.

RESPONDENT'S TREATMENT OF HIMSELF

34. Respondent prescribed hydrocodone for himself on June 25, 2014.

35. Respondent prescribed Xanax for himself on April 2, 2016. He explained that he had prescribed it for himself because he had heard so much about it and wanted to try it.

36. Respondent prescribed a number of prescription antihypertensive medications for himself.

SIXTH CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts)

37. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, subdivisions (a) (violation of Medical Practice Act), (b) (gross negligence), and/or (c) (repeated negligent acts), of the Code in that he prescribed medications for himself as described above.

SEVENTH CAUSE FOR DISCIPLINE

(Violation of Order of Suspension)

38. On June 28, 2018, OAH issued a decision granting Complainant's Petition for an Interim Order of Suspension. The Interim Order of Suspension suspended Respondent's Physician's and Surgeon's Certificate but stayed such suspension so long as Respondent complied with restrictions and conditions, including: (i) "Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined in the California Uniform Controlled Substances Act;" and (ii) "Respondent is prohibited from practicing medicine until respondent provides documentary proof to the Board or its designee that respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any state prescription forms and all controlled substances order forms . . . ." OAH served the Interim Order of Suspension on Respondent on June 29, 2018, by overnight mail.

39. After having been served with the Interim Order of Suspension, Respondent continued to prescribe controlled substances. For example, Respondent wrote a prescription for a controlled substance to patients on July 2, July 11, and July 31, 2018. In addition, prescriptions bearing Respondent's name, contact information, and DEA Registration Number were issued by Respondent's mental health practice in Sacramento on July 5, July 6, July 9, July 10, July 11, July 12, and July 16, 2018. Respondent was the medical director of the Sacramento practice and supervised its practitioners.

40. On July 31, 2018, a Medical Board investigator conducted an unannounced visit to another of Respondent's practice locations, in Vacaville. The investigator reviewed the restrictions and conditions of the Interim Order of Suspension with Respondent. Respondent conceded that he had not relinquished his prescription forms as required by the order and told the investigator that he needed them to continue writing prescriptions. Nor had Respondent surrendered his DEA Certificate of Registration.

41. Respondent conceded to the investigator that he had continued to practice medicine since entry of the Interim Order of Suspension, stating that he had already seen a patient that day and was expecting to see more later. The investigator also spoke with a patient arriving to Respondent's office, who confirmed that Respondent was prescribing her Xanax, a controlled substance.

42. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234 (general unprofessional conduct); section 2234, subdivision (a) (violation of Medical Practice Act); section 2334, subdivision (e) (dishonest or corrupt act); and section 2306 (practice while suspended) of the Code in that Respondent engaged in the conduct described above including, but not limited to, the following:

A. Respondent continued to prescribe controlled substances in violation of the Interim Order of Suspension.

B. Respondent failed to surrender his DEA Certificate of Registration, prescription forms, and/or controlled substances order forms while continuing to practice and see patients, in

violation of the Interim Order of Suspension, which suspended his practice pending surrender of these documents.

C. Respondent engaged in the practice of medicine in violation of a duly issued suspension order.

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 13754, issued to Stuart H. Tubis, M.D.;

2. Revoking, suspending or denying approval of Stuart H. Tubis, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Stuart H. Tubis, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: August 17, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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