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

In the Matter of the Accusation Against:	)	
JANAK KUMAR MEHTANI, M.D.	)	Case No. 02-2012-224474
Physician's and Surgeon's Certificate No. A 32632	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order 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 September 16, 2016.

IT IS SO ORDERED: August 18, 2016.

MEDICAL BOARD OF CALIFORNIA

Howard Krauss, M.D., Chair
Panel B

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Attorney General of California
JOSE R. GUERRERO
Supervising Deputy Attorney General
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JANAK K. MEHTANI, M.D.** 2951 Fulton Ave. Sacramento, CA 95821 Physician's and Surgeon's Certificate No. A 32632 Respondent.	Case No. 02-2012-224474 OAH No. 2015030544 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Jannsen Tan, Deputy Attorney General.

2. Respondent Janak K. Mehtani, M.D. ("Respondent") is represented in this proceeding by attorney Robert B. Zaro, whose address is: 1315 "I" Street, Suite 200 Sacramento, CA 95814.

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3. On or about July 5, 1978, the Medical Board of California issued Physician's and Surgeon's Certificate No. A 32632 to Janak K. Mehtani, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 02-2012-224474, and will expire on April 30, 2016, unless renewed.

JURISDICTION

4. Accusation No. 02-2012-224474 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on January 13, 2015. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 02-2012-224474 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 02-2012-224474. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 02-2012-224474, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him, before the Medical Board of California, all of the charges and allegations contained in Accusation No. 02-2012-224474 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

12. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

RESERVATION

13. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

14. The parties agree that this Stipulated Settlement and Disciplinary Order shall be submitted to the Board for its consideration in the above-entitled matter and, further, that the Board shall have a reasonable period of time in which to consider and act on this Stipulated Settlement and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time that the Board considers and acts upon it.

15. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Settlement and

Disciplinary Order, the Board may receive oral and written communications from its staff and/or the Attorney General's office. Communications pursuant to this paragraph shall not disqualify the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Board, in its discretion, does not approve and adopt this Stipulated Settlement and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should the Board reject this Stipulated Settlement and Disciplinary Order for any reason, Respondent will assert no claim that the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Settlement and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

16. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

17. The parties agree that pdf or facsimile copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

18. In consideration of the foregoing admissions and stipulations, the parties agree the Board may, without further notice to or opportunity to be heard by Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 32632 issued to Respondent Janak K. Mehtani, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES- MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled

substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

3. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of

the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its

designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which

includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

8. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

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Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the

probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

13. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Robert B. Zaro. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 4/27/16

JANAK K. MEHTANI, M.D.
Respondent

I have read and fully discussed with Respondent Janak K. Mehtani, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 5/13/16

ROBERT B. ZARO
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: May 17/2016

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
JOSE R. GUERRERO
Supervising Deputy Attorney General

JANNSEN TAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 02-2012-224474

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO January 13 2015
BY ANALYST

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

In the Matter of the Accusation Against: **JANAK K. MEHTANI, M.D.** 2951 Fulton Ave. Sacramento, CA 95821 Physician's and Surgeon's Certificate No. A 32632 Respondent.	Case No. 02-2012-224474 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about July 5, 1978, the Medical Board of California issued Physician's and Surgeon's Certificate Number A 32632 to Janak K. Mehtani, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2016, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

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

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

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

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

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

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

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

5. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview scheduled by the mutual agreement of the certificate holder and the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

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6. Section 2242 of the Code provides:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct."

"..."

7. Section 4021 of the Code states:

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

8. Section 4022 of the Code states:

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

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

"...

"(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."

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."

DRUGS AT ISSUE

10. Ambien (Zolpidem Tartrate) is a sedative and hypnotic used for short term treatment of insomnia. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

11. Clonazepam (Klonopin) is an anti-anxiety medication in the benzodiazepine family. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

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12. Xanax, Niravam (Alprazolam) is used to treat anxiety disorders and panic disorders. It belongs in the benzodiazepine group of drugs. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

13. Abilify (Aripiprazole) is an antipsychotic medication. It is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic depression). It is also used together with other medications to treat major depressive disorder in adults. It is a dangerous drug pursuant to Business and Professions Code section 4022.

14. Zyprexa (Olanzapine) is an atypical antipsychotic that belongs to thienobenzodiazepine class of drugs, approved by the U.S. Food and Drug Administration (FDA) for the treatment of schizophrenia and bipolar disorder. It is a dangerous drug pursuant to Business and Professions Code section 4022.

15. Pristiq's (Desvenlafaxine) primary use in medicine is in the treatment of major depressive disorder. It is a dangerous drug pursuant to Business and Professions Code section 4022.

16. Cymbalta (Duloxetine) the main uses of duloxetine are in major depressive disorder, general anxiety disorder, urinary incontinence, painful peripheral neuropathy, fibromyalgia, and chronic musculoskeletal pain associated with osteoarthritis and chronic lower back pain. It is a dangerous drug pursuant to Business and Professions Code section 4022.

17. Latuda (Lurasidone) is an atypical antipsychotic approved for the treatment of depressive episodes associated with bipolar I disorder (bipolar depression) in adults when used alone or in combination with lithium or valproate. It is a dangerous drug pursuant to Business and Professions Code section 4022.

18. Provigil (Modafinil) is a vigilance promoting drug for treatment of the wakefulness disorders of narcolepsy, shift work sleep disorder and excessive daytime sleepiness associated with obstructive sleep apnea. It is a Schedule IV controlled substance pursuant to the Controlled Substances Act.

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19. Wellbutrin (Bupropion) is a drug primarily used as an antidepressant and smoking cessation aid. It is a dangerous drug pursuant to Business and Professions Code section 4022.

20. Restoril (Temazepam) is an intermediate-acting 3-hydroxy hypnotic of the benzodiazepine class of psychoactive drugs. Temazepam is approved for the short-term treatment of insomnia. In addition, temazepam has anxiolytic (antianxiety), anticonvulsant, and skeletal muscle relaxant properties. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

21. Valium (Diazepam) is used to treat a wide range of conditions, including anxiety, panic attacks, insomnia, seizures (including status epilepticus), muscle spasms (such as in tetanus cases), restless legs syndrome, alcohol withdrawal, benzodiazepine withdrawal, opiate withdrawal syndrome and Ménière's disease. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

22. Nuvigil (Armodafinil) is the enantiopure of the vigilance-promoting drug, or eugeroic, Modafinil (Provigil). It is a Schedule IV controlled substance pursuant to the Controlled Substances Act. It is a dangerous drug pursuant to Business and Professions Code section 4022.

23. Norco (Hydrocodone) s a semi-synthetic opioid derived from codeine. It is commonly used in combination with Acetaminophen. It is a schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

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FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)

24. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed grossly negligent acts in his care and treatment of Patients GC, JC, RW[1], as more particularly alleged hereinafter:

25. Respondent is a psychiatrist who practiced in an office clinic under the business name Fair Oaks Psychiatric Associates.

Patient GC:

26. Patient GC is a 47-year-old female with a history of hypertension and chronic pain who first presented with Respondent on October 6, 2008. Respondent documented that Patient GC did not speak English and was employed at a warehouse where she was injured on a number of different occasions and has had cumulative injuries since then. The first injury took place on September 17, 2003, when she fell on the floor and injured her back. Subsequently she had another injury to her neck and right elbow while lifting heavy boxes. Respondent noted that she has had chronic pain in her neck, back, and shoulders. Respondent documented that she also had become increasingly more depressed and anxious in the past 2-3 years and that she is on a lot of pain medications. Respondent documented that she has not been able to function with chronic pain and that her depression is getting worse. Respondent documented Patient GC having spontaneous crying spells and that she thinks about suicide but has not made any suicide attempts so far. Respondent noted that Patient GC cannot sleep at night and wakes up often with nightmares and bad dreams. Respondent documented very poor appetite and weight loss of about 15 pounds.

27. Respondent found that the patient is clinically depressed and that her depression is directly and temporarily related to the injuries she sustained during the course of her employment. Respondent noted that because of chronic pain, she is not able to function and has become increasingly more depressed and despondent. Respondent prescribed Pristiq 50 mg a day and a low-dose of Klonopin 0.5 mg for anxiety, Ambien CR 12.5 mg at bedtime for

[1] Patient and provider names are abbreviated to protect patient confidentiality. Full patient names will be provided upon receipt of a Request for Discovery.

insomnia, and referred her out for pain management. Respondent also referred Patient GC to see a therapist for cognitive behavior management. Respondent noted that he will see Patient GC for medication management and supportive psychotherapy once a month for 12 months.

28. Patient GC was prescribed Zolpidem Tartrate, from January 5, 2011 through June 8, 2013. She was prescribed Hydrocodone, an opiate pain medication from July 20, 2010 until August 28, 2012. She was prescribed Alprazolam, from August 3, 2011 until June 8, 2013. She was prescribed Zyprexa from December 2009 until June 2, 2011. She was prescribed Abilify from August 25, 2011 until November 7, 2013. She was prescribed Xanax from August 3, 2011 until June 8, 2013.

29. Respondent saw Patient GC for "Medical Psychoanalysis" on the following dates:

March 25, 2010	September 22, 2011	November 19, 2012
May 6, 2010	October 20, 2011	December 17, 2012
June 21, 2010	November 21, 2011	January 14, 2013
July 19, 2010	December 19, 2011	February 11, 2013
August 19, 2010	January 19, 2012	March 11, 2013
September 20, 2010	February 23, 2012	April 11, 2013
October 21, 2010	March 22, 2012	May 2, 2013
January 6, 2011	April 19, 2012	June 6, 2013
February 4, 2011	May 17, 2012	July 8, 2013
March 4, 2011	June 14, 2012	September 5, 2013
April 14, 2011	July 16, 2012	October 10, 2013
June 2, 2011	August 16, 2012	November 7, 2013
July 14, 2011	September 20, 2012	
August 25, 2011	October 18, 2012	

30. On or about August 25, 2011, Respondent saw Patient GC for a follow up visit. Patient GC was seen with Respondent's medical assistant, as translator. Respondent documented that the Zyprexa was "turned down" by Patient GC's insurer and that she is not feeling very well at all. Respondent explained to her that the reason Zyprexa has been "cut down" is that "in general, one does not think of visual hallucinations as coming from posttraumatic stress disorder or depression caused by an industrial injury." Patient GC was having visual hallucinations of seeing rats or little animals. Respondent prescribed Abilify 5mg for depression to replace

Zyprexa, Pristiq and Xanax for anxiety and Ambien for her inability to sleep. Respondent prescribed atypical antipsychotics without clear indication for their necessity. Respondent inappropriately prescribed antipsychotics to Patient GC who has diabetes, to treat problems for sleep, depression and anxiety.

31. On or about September 11, 2011, Respondent saw Patient GC for a follow up visit. Respondent again used his medical assistant to act as translator. Respondent documented that there is still no professional interpreter. Respondent failed to provide an interpreter in order for Patient GC to freely share her feelings and be open to psychotherapeutic interventions.

32. On or about February 23, 2012, Respondent saw Patient GC for a follow up visit. Respondent documented that Patient GC's interpreter was not notified of the appointment so she was seen without one. Respondent documented that Patient GC's "English is limited, but with slow conversation, she does understand and is able to express herself and her needs." Respondent failed to provide an interpreter in order for Patient GC to freely share her feelings and be open to psychotherapeutic interventions.

33. On or about April 19, 2012, Respondent saw Patient GC for a follow up visit. At this point in time, Patient GC has been in treatment with Respondent since March 25, 2010. Respondent noted that he has requested lab work to rule out high lipids and diabetes. Respondent failed to document and/or address Patient GC's complications with her type II Diabetes after being prescribed Olanzapine for 18 months. Respondent documented that Patient GC is gaining weight which makes her more depressed. However, there has been no documentation of Respondent's discussion of her weight gain. There was no documentation of her diet, exercise, weight or anything that addresses the risk of weight gain associated with psychotropic medications. In addition, Respondent failed to test quarterly for complications with her diabetes which may have been directly related to Olanzapine.

34. On or about September 5, 2013, Respondent saw patient for a follow up visit. Respondent noted that Patient GC continues to take Cymbalta, Abilify, Ambien, and Xanax on a "p.r.n. basis" for anxiety. Respondent noted that "Lately, she [Patient GC] has been thinking about cutting herself again; at this point she has no plans. She has not been able to see a therapist

for cognitive behavioral therapy. She uses a care(sic) for support. No mood swings. No EPS, akathasia, (sic) or tremors..." Respondent prescribed and increased Patient GC's prescription for Abilify to 14mg one tablet q.d., #30 with one tablet q.d., #30 with one refill and refilled Cymbalta 60mg one a day, #30 with one refill, Xanax .5 mg one b.i.d. p.r.n., #60 with one refill, and Ambien 10mg one h.s., #30 with one refill[2]. Respondent failed to document the reason for prescribing Abilify, Ambien, and Cymbalta. Respondent failed to document and/or identify any concern about the risks of chronic use of a benzodiazepine Xanax and Ambien, which are not recommended for use greater than 60 days.

35. On or about September 5, 2013, Respondent also provided conflicting clinical observations. Respondent noted, "No mood swings", but in another portion of the note documented that "she has been thinking about cutting herself again." Respondent also made recommendations deferring assessment to another facility. In the note, Respondent "strongly recommend[ed]" the patient be "seen in the hospital and their partial program for an evaluation of suicidal ideations" Respondent failed to assess the current clinical status and risk for self-harm and/or dangerousness of Patient GC and instead referred her to another facility. Respondent failed to document that a risk assessment was performed and failed to provide a rationale for treatment in the short and long term. Respondent failed to also document a discussion on triggers, and coping strategies in his "Medical Psychoanalysis."

36. On or about September 5, 2013, Respondent failed to adequately document his findings as it relates to depression. Respondent's charting is vague and suggests that the dose of Abilify was increased because the patient was having thoughts about cutting. Respondent failed to document what is being treated other than reducing anxiety and his concern about cutting. There is no description or identification of target symptoms, no identified measurable signs or symptoms to assess the progress or lack of progress in treatment. Respondent's clinical descriptions are vague and difficult to interpret. Respondent documented that Patient GC "....has

[2] Abbreviation list "qd" – everyday; "bid"- twice a day; "prn" – as needed; "hs" at bedtime

been getting overly depressed" but he failed to provide adequate clinical information regarding how her mood is affecting her day to day activities and functioning.

37. On or about September 5, 2013, Respondent also documented a global statement without providing any clinical justification or explanation. Respondent noted that "She remains disabled from gainful employment" without explaining and documenting exactly what was Patient GC's disability, how the disability affects her life and what are the barriers for progress. Respondent also failed to document and/or provide "supportive therapy" for chronic pain, Respondent failed to document and/or provide education on relaxation training, visual imagery, distraction, medication and dissociation. Respondent failed to document and/or identify target symptoms which could be objectively measurable and how such target symptoms progressed during treatment. Respondent failed to provide documentation which was diagnosis driven establishing clear and objective treatment goals. Respondent failed to note information about the risks for metabolic syndrome and the chronic use of opiates, benzodiazepines and sleep aids.

38. On or about November 7, 2013, Respondent saw Patient GC for a follow up visit. Respondent documented "she had abnormal labs of SGOT 168, STPT 168, and alkaline phosphatase 167. Her total cholesterol level was 239, triglyceride 205, LD 157, HTL was 41, and her hemoglobin A1C 9.3. According to her, she was not able to go to her primary care physician." Respondent failed to document Patient GC's weight, body mass index, waist circumference, fasting blood glucose, or lipid profile. Prior lab results indicate that patient GC had elevated hemoglobin, glucose, elevated cholesterol intermittently during the period of April 2012 and November 2013. Respondent failed to perform annual testing given Patient GC's abnormal labs and the antipsychotics that he was prescribing.

39. During the period March 25, 2010 to November 7, 2013, Respondent failed to document and/or perform any "psychotherapy" that was being performed. Respondent failed to document the specific barriers that Patient GC experienced which prevented her from recovery. Respondent failed to document anything to justify medical necessity for treatment, especially for the use of antipsychotic medications. Respondent routinely used a template that read "She remains disabled from gainful employment and is to continue her psychotherapy and medication

management with us" without indicating his findings, analysis and reasoning regarding the nature of the disability and how that disability influences Patient GC's day to day living. Respondent failed to keep timely, accurate and legible medical records which include preventive services and risk screening; a detailed history of the present illness or status of chronic conditions; up-to-date medication lists; an appropriate physical examination performed which should be appropriate for the complaint and medical conditions being followed. Respondent also failed to document an adequate diagnosis and treatment plan; failed to use generally accepted abbreviations. In addition Respondent failed to provide detailed documentation providing the reasoning behind his treatment decisions. Respondent failed to clearly indicate the expected and actual outcomes of treatment, and provide subjective reports and objective findings.

40. During the period of March 25, 2010 to November 7, 2013, Respondent failed to document or adequately treat Patient GC's sleep disturbance. Respondent failed to identify issues related to sleep hygiene or provide any medical inquiry assessing the root cause, or a thorough clinical description of Patient GC's condition.

41. During the period of March 25, 2010 to November 7, 2013, Respondent failed to document and/or perform any "Medical Psychoanalysis." Respondent failed to adequately treat Patient GC's Post Traumatic Stress Disorder. Respondent also prescribed benzodiazepines to Patient GC who has Post Traumatic Stress Disorder.

42. During the period of March 25, 2010 to November 7, 2013, Respondent failed to document and/or identify dysfunctional coping strategies which impaired Patient GC's social functioning. Respondent failed to document and/or identify attempts to improve her adaptive mechanisms. Respondent failed to provide a therapeutic environment in which the clients could freely share vulnerable feelings and be open to psychotherapeutic interventions.

43. Respondent committed gross negligence in his care and treatment of Patient GC which included, but was not limited to the following:

A. Respondent failed to maintain adequate documentation and failed to document and/or perform testing when necessary.

B. Respondent failed to adequately treat and diagnose Patient GC's sleep disturbance.

C. Respondent failed to adequately treat and diagnose Patient GC's Post Traumatic Stress Disorder; Respondent failed to document the details of his "Medical Psychoanalysis"; He failed to perform any "Medical Psychoanalysis"; Respondent prescribed or recommended benzodiazepines to Patient GC, who has Post Traumatic Stress Disorder.

D. Respondent failed to adequately provide supportive psychotherapy; Respondent failed to identify and/or document barriers to Patient GC's recovery, or maladaptive coping strategies and/or dysfunctional coping strategies that allegedly impaired Patient GC; Respondent failed to specifically identify attempts to improve Patient GC's adaptive mechanisms; Respondent failed to provide a therapeutic environment in which Patient GC could freely share vulnerable feelings and be open to psychotherapeutic interventions.

E. Respondent prescribed antipsychotics to Patient GC without adequate medical indication; Respondent failed to follow prescribing guidelines in that he failed to document and monitor Patient GC's weight, body mass index, waist circumference, fasting blood glucose or lipid profile.

F. Respondent failed to adequately treat Patient GC's general anxiety. Respondent failed to document specifically what "cognitive behavioral therapy" and "supportive psychotherapy" he used on Patient GC. Respondent failed to perform any "cognitive behavioral therapy" and "supportive psychotherapy." Respondent failed to document Patient GC's specific treatment goals and objectives, methods to measure progress in such goals, and discussion about barriers if present to achieve such goals. He prescribed Xanax without any clear evidence of encouraging non-pharmacological means to cope with stress as well as relaxation techniques.

Patient JC

44. Patient JC is a 59-year-old male who experienced a work related injury May 31, 1989.

45. Respondent saw Patient JC for insight oriented behavior modifying and/or supportive adjustment on the following dates:

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March 8, 2010	August 31 2010	March 14, 2013
April 26, 2010	October 12, 2010	March 19, 2013
June 1, 2010	November 19, 2010	May 1, 2013
July 13, 2010	December 28, 2010	

46. Respondent supervised other clinic staff in his clinic such as physician assistants and nurses. Respondent's records indicate that he reviewed and cosigned patient's charts for services provided by these staff on the following cases:

February 8, 2011	March 19, 2013
March 22, 2011	March 21, 2013
May 3, 2011	March 28, 2013
June 14, 2011	April 4, 2013
July 26, 2011,	April 11, 2013
September 6, 2011	April 18, 2013
October 25, 2011	April 25, 2013
December 19, 2011	May 2, 2013
January 30, 2011	May 16, 2013
March 6, 2012	May 23, 2013
April 3, 2012	June 5, 2013
May 16, 2012	June 12, 2013
June 26, 2012	June 19, 2013
August 9, 2012	June 26, 2013
September 18, 2012	July 10, 2013
October 24, 2012	July 17, 2013
November 28, 2012	August 23, 2013
January 23, 2013	August 30, 2013
February 14, 2013	September 16, 2013
February 21, 2013	September 27, 2013
March 7, 2013	October 4, 2013
March 14, 2013	October 11, 2013
	November 1, 2013
	November 15, 2013

47. Respondent prescribed the following medication to Patient JC for the entire time of treatment[3]:

- Wellbutrin XL 300mg daily from March 8, 2010 until November 5, 2013.
- Zyprexa 15mg "p.o." at night from March 8, 2010 until August 9, 2012.
- Abilify 10mg daily from September 18, 2012 until November 5, 2013.

[3] Abbreviation list: "po"- by mouth; "bid" -twice a day; "prn"- as needed; "hs" – at bedtime

- Latuda 40mg "p.o. h.s" from 40mg October 24, 2012, until November 5, 2013.
- Provigil 200mg "p.o." am from March 22, 2011 until July 26, 2011, then restarted May 1, 2013 until November 5, 2013.
- Niravam 1mg "p.o. bid prn" anxiety from March 8, 2010 until September 4, 2013.
- Xanax 1mg "p.o. bid prn" anxiety from September 4, 2013 until November 5, 2013.
- Restoril 22.5mg "p.o. pm prn" insomnia from March 22, 2011 until March 8, 2013, when the dose was increased to 30mg "p.o. pm prn" insomnia until March 19, 2013.

48. On March 8, 2010, Respondent saw Patient JC for a follow up visit. Patient JC reported having an occasional nightmare related to his industrial injury. Respondent recorded Patient JC's medications as Wellbutrin, Zyprexa, Provigil, Niravam and Restoril. Respondent documented that Patient JC is permanent and stationary disabled and remains unable to engage in gainful employment. Respondent failed to document any description of behavior that supports his finding that Patient JC is unable to perform any type of work due to his work related injury. Respondent failed to clarify if Patient JC had night terrors or if he had any related autonomic symptoms. Respondent failed to document how the presence of nightmares affected Patient JC's day to day experiences. Respondent failed to document the target symptoms, indications for why medications were chosen, or description on the clinical progress of Patient JC.

49. On April 26, 2010, Patient JC was seen for a follow up visit. Respondent documented "mild" depression, "controlled" anxiety, and significantly decreased post traumatic stress disorder (PTSD) flashbacks. Respondent documented that Patient JC had not been seen for sleep apnea. Respondent prescribed Wellbutin and Niravam. Respondent failed to indicate the reasoning and medical indication behind prescribing Wellbutrin and Niravam. Respondent failed to appropriately treat Patient JC's anxiety when he prescribed Wellbutrin. Respondent failed to address and/or treat Patient JC's sleep apnea.

50. During the period of June 1 to December 28, 2010, Respondent or his Nurse Practitioner saw Patient JC. Patient JC's medications remain unchanged.

51. On or about February 8, 2011, Patient JC was seen at Respondent's clinic for a follow up visit. Patient JC reported that he "was doing fairly well, and wanted no med changes.

Patient JC is continuing to see a therapist for PTSD." Respondent prescribed Zyprexa for PTSD. Respondent failed to indicate why he was increasing Restoril and he failed to discuss its chronic use with Patient JC. Respondent failed to indicate his reasoning and describe patient JC's impairment and/or disability .

52. On or about May 3, 2011, Patient JC was seen in Respondent's clinic for a follow up visit. Patient JC reported that "he is doing fairly well. He is sleeping at night. His mood is consistent. He denied suicidal or homicidal ideation." Respondent documented that Patient JC spends some time with his granddaughter and was involved in her care at times. Respondent noted that Patient JC is unable to engage in gainful employment, and was permanent and stationary. Respondent failed to adequately document his reasoning on why Patient JC was found to be unable to engage in gainful employment, and was considered permanent and stationary.

53. On or about June 14, 2011, Respondent saw Patient JC for a follow up visit for "insight oriented behavior modifying and/or supportive adjustment." Respondent documented that Patient JC was doing fairly well; sleeping at night; mood was stable and consistent; denied suicidal ideation. Respondent noted that Patient JC enjoyed spending time with his granddaughter and is recently divorced. Respondent noted that Patient JC was permanent and stationary and unable to engage in gainful employment. Respondent failed to document what targeted behaviors were modified, as well as what type of treatment was provided.

54. On or about September 6, 2011, Patient JC was seen for a follow up visit. The progress note was the same as prior notes except that a prescription for Zyprexa was given for prevention of auditory and visual hallucinations.

55. On or about October 25, 2011, Patient JC was seen for a follow up visit. The progress note was the same as prior notes except that "Provigil was denied by the State Compensation Insurance Fund. (SCIF)" Respondent failed to document the risks or benefit of the changes and impact the denial of Provigil has on treatment. Respondent failed to document the diagnosed condition. Respondent's documentation only identified the symptom of being "more sleepy" had recurred.

56. During the period of December 19, 2011 to August 9, 2012, Patient JC was seen in

Respondent's office. Respondent failed to document and/or explain to Patient JC the specific details regarding the risks, benefits, adverse effects, side effects, and therapeutic effects of the drugs he prescribed. Respondent failed to document and explain to Patient JC why Provigil was denied by SCIF. Respondent failed to discuss the risks and benefits of the prescribed medication and alternative treatments.

57. On September 18, 2012, Patient JC was seen in Respondent's office. Patient JC informed Respondent's nurse practitioner that he had "prediabetes." Respondent discontinued Zyprexa. Respondent failed to document and/or discuss with Patient JC that diabetes is a well known complication to Zyprexa. Respondent failed to monitor Patient JC for diabetes.

58. On October 24, 2012, Respondent saw Patient JC for a follow up visit. Patient JC reported insomnia and auditory hallucinations. Respondent failed to make a clinical diagnosis and what treatment was being provided for that diagnosis. Respondent failed to document the reasoning behind using two antipsychotics, namely Latuda which is a dopamine antagonist, and Abilify which is a dopamine agonist.

59. On or about May 1, 2013, Respondent saw Patient JC for a psychiatric follow-up visit. Respondent documented that Patient JC is on "a very complex medication regimen; very isolative; withdrawn; periodically very paranoid and agitated." Patient JC's mood is profoundly depressed. Respondent also noted that for the first time, Patient JC has "paranoid ideation" He also highlighted the severity of a psychiatric symptom, "agitation", which was never identified previously as disabling or present to require a change in medication adjustment. Respondent failed to document his reasoning for resuming Provigil. Respondent failed to document his reasoning for prescribing Niravam. Respondent failed to document his reasoning in prescribing two atypical antipsychotics, Abilify, a partial D-2 agonist, and Latuda, a D-2 selective antagonist.

60. On or about July 23, 2013, Patient JC was seen for a follow up visit at Respondent's clinic. Respondent documented that Patient JC continues to "suffer from nightmares; he stays up most of the time and wakes up nightly at 3:00 a.m.; Intermezzo in (sic) no longer effective; He is able to sleep three to four hours on a good night; He feels depressed in the early afternoon or at noon." Respondent failed to document and/or address Patient JC's chronic and persistent

complaints of insomnia. Respondent failed to discuss and/or document clear recommendations assessing sleep hygiene, and providing constructive behavioral interventions.

61. On or about July 24, 2013, Patient JC was seen in Respondent's clinic. Patient JC stated: "My depression is coming from not having something to do."

62. On or about July 21, 2013, Patient JC was seen in Respondent's clinic. Respondent documented that Patient JC's depression is a "5" and his anxiety is a "5". Respondent failed to document and/or discuss his analysis assessing change in status from the previous session.

63. On or about September 4, 2013, Patient JC was seen in Respondent's clinic for a follow up visit. Respondent documented his concern about Patient JC's chronic use of benzodiazepines. Respondent failed to take action and did not change his prescribing pattern.

64. On or about September 16, 2013, Patient JC was seen in Respondent's clinic for a follow up visit. Respondent documented that Patient JC is doing "good ; able to articulate his thoughts and maintained good conversation; thought process and speech was coherent."

65. In a letter dated April 8, 2013, the US Department of Labor sent a letter inquiring about Patient JC's eligibility to receive benefits under the Federal Employees Compensation Act.

66. In his reply letter dated September 3, 2013, Respondent described Patient JC's condition as permanently disabled and is not likely to improve with reasonable medical psychiatric care and treatment, which will be needed for the rest of his life.

67. Respondent was informed about Patient JC's chronic use of sleep aids on December 29, 2010, March 7, 2012, and October 10, 2013.

68. During the period of March 8, 2010 to November 15, 2013, Respondent failed to document how he arrived at his diagnoses, and how his diagnoses were obtained based upon clinical examination, review of records and/or pertinent data. Respondent failed to identify treatment goals as well as target symptoms so that the progress of treatment could be objectively evaluated. Respondent failed to document clinical reasons when there was a change in treatment, including change of medication and dose. Respondent failed to record weight and lab results. Respondent failed to perform laboratory testing on a quarterly basis. Respondent failed to

adequately treat Patient JC's "metabolic syndrome" and "prediabetes" which may have been directly related to chronic exposure to Zyprexa

69. During the period of March 8, 2010 to November 15, 2013, Respondent failed to adequately treat Patient JC's sleep disturbance. Respondent failed to document a thorough history describing Patient JC's sleeping patterns which should have included a diary of the times when the patient is asleep, when he woke up, if he took a nap, as well as what activity is done prior to and during the time they are in bed. Respondent failed to initiate behavioral therapy which generally is the first line of treatment. Respondent failed to discuss and/or document patient education on sleep hygiene, restrict certain activities prior to and during the time when patients are in the bed. Respondent used sedative hypnotics for longer than 60 days. Respondent failed to discuss and or document the etiology of Patient JC's sleep disturbance and instead prescribed medication for symptomatic relief rather than addressing the clinical issue.

70. During the period of March 8, 2010 to November 15, 2013, Respondent failed to adequately treat Patient JC's Post Traumatic Stress Disorder. Respondent prescribed Wellbutrin which has been noted to increase complaints of anxiety. Patient JC has been provided long term "supportive psychotherapy" which is not recommended for the treatment for Posttraumatic Stress disorder. Respondent prescribed benzodiazapines chronically which is also not recommended for treatment. Respondent prescribed Zyprexa, which had provided no clear benefit, but put Patient JC at risk for weight gain and disturbance of his sugar metabolism.

71. During the period of March 8, 2010 to November 15, 2013, Respondent failed to adequately provide for supportive psychotherapy. Respondent and his office staff all billed sessions for office facility, insight oriented behavior modifying and/or supportive adjustment. Respondent co-signed and supervised his office staff and thus is responsible for the standard of care provided. Respondent failed to document and/or identify precisely what type of "insight oriented behavioral modifying and/or supportive therapeutic benefit" occurred. Respondent failed to adequately treat Patient JC's post traumatic stress disorder since treatment for PTSD should not be oriented to "supportive therapy" but rather should focus on exposure therapy and to improve coping skills.

72. During the period of March 8, 2010 to November 15, 2013, Respondent failed to adequately treat Patient JC's major depression. Respondent failed to adequately document the major goal of treatment and an analysis of the progress of treatment. Respondent prescribed Wellbutrin, an antidepressant for the entire course of treatment without modification, despite Patient JC's continued and persistent complaints of depression.

73. During the period of March 8, 2010 to November 15, 2013, Respondent failed to monitor weight, check blood pressure, and fasting blood glucose while he prescribed atypical antipsychotics. Respondent missed the "prediabetes" of Patient JC and it was Patient JC that told Respondent about his "prediabetes." Respondent failed to document his reasoning behind prescribing atypical antipsychotic drugs.

74. During the period of March 8, 2010 to November 15, 2013, Respondent failed to adequately treat Patient JC's anxiety. Despite fluctuations of symptoms and complaints of anxiety, Respondent failed to adjust dose and/or medications. Respondent failed to document his reasoning behind prescribing antipsychotics for anxiety. Respondent failed to document and/or discuss coping skills with Patient JC.

75. Respondent committed gross negligence in his care and treatment of Patient JC which includes, but is not limited to the following:

A. Respondent failed to maintain adequate documentation and failed to document and/or perform testing when necessary.

B. Respondent failed to adequately treat and diagnose Patient JC's sleep disturbance.

C. Respondent failed to adequately treat and diagnose Patient JC's Post Traumatic Stress Disorder; Respondent prescribed or recommended benzodiazepines to Patient JC, who has Post Traumatic Stress Disorder.

D. Respondent failed to adequately provide supportive psychotherapy

E. Respondent prescribed antipsychotics to Patient JC without adequate medical indication

F. Respondent failed to adequately treat Patient JC's general anxiety.

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Patient RW

76. Patient RW is a 48-year-old, male who was seriously injured during the course of his employment while on his way to a service call. He sustained a serious head injury and has been totally and permanently disabled ever since. He has had multiple surgical interventions and has been in and out of medical and psychiatric hospitals. He has had a series of outbursts of anger, irritability and agitation. He has become increasingly more depressed and suicidal. He has made several suicide attempts.

77. Respondent supervised other clinic staff in his clinic such as physician assistants and nurses. Respondent's records indicate that he reviewed and cosigned patient's charts for services provided by these staff on the following cases:

March 4, 2010	August 10, 2011
May 17, 2010	October 4, 2011
July 1, 2010	January 4, 2012
August 24, 2010	March 2, 2012
October 18, 2010	April 10, 2012
November 17, 2010	June 20, 2012
December 17, 2010	August 20, 2012
January 25, 2011	October 24, 2012
January 31, 2011	January 2, 2013
March 2, 2011	March 4, 2013
June 15, 2011	July 31, 201
August 10, 2011	August 14, 2013
October 4, 2010	September 24, 2013
January 4, 2011	November 18, 2013
March 2, 2011	
May 10, 2011	
June 15, 2011	

78. Respondent prescribed the following medication: Klonopin 2mg tablets #90 with one refill on July 6, 2010, and on August 1, 2010 with 2 refills.

79. Respondent prescribed Diazepam 5mg tab #30 with no refill on July 15 2010, the dose was then tripled to 5mg p.o. t.i.d[4]. #90 on August 24, 2010 with no refill, 5mg p.o. t.i.d. #90 on September 18, 2010 with one refill, 5mg p.o. t.i.d. #90 on October 18, 2010, with no refill,

[4] Abbreviation list "tid" – three times a day

5mg p.o. t.i.d. #90 on December 1, 2010, with no refill, 5mg p.o. t.i.d. #90 on December 21, 2010, with no refill, 5mg p.o. t.i.d. #90 on February 7, 2011, with one refill, 5mg p.o. t.i.d. #90 on March 16, 2011, 5mg p.o. t.i.d. on May 10, 2011, with no refill, 5mg p.o. t.i.d. #90 on June 15, 2011, with no refill, 5 mg p.o. t.i.d. #90 August 10, 2011, with no refill, 5mg p.o. t.i.d. #90 on September 9, 2011, with one refill, 5 mg p.o. t.i.d. #90 on October 4, 2011, with no refill, 5 mg p.o. t.i.d. #90 on December 7, 2011, with one refill. The dose was doubled to 10mg p.o. t.i.d. #90 on March 6, 2012, with no refill, 10 mg p.o. t.i.d. #90 on April 11, 2011 with no refill, 10 mg p.o. t.i.d. #90 on May 8, 2011 with one refill, 10 mg p.o. t.i.d. #90 on June 8, 2011, with no refill, 10 mg p.o. t.i.d. #90 on July 5, 2011 with no refill, 10 mg p.o. t.i.d. #90 on August 1, 2011 with one refill, 10 mg p.o. t.i.d. #90 on 10 mg p.o. t.i.d. #90 on August 25, 2011 with no refill, 10 mg p.o. t.i.d. #90 on October 22, 2012 with one refill, 10 mg p.o. t.i.d. #90 on January 2, 2012 January 28, 10 mg p.o. t.i.d. #90 on March 5, April 2, 2013.

80. Respondent prescribed Restoril 30mg #30 on September 3, October 26, December 1, December 21, 2010, February 1, February 20, July 15, August 15, September 6, October 4, November 5, December 7, December 22, 2011, January 6, February 3, March 2, March 27, April 17, May 9, June 8, July 5, August 1, October 24, and November 27, 2012.

81. Respondent prescribed Temazepam 30mg capsule #30 0 refills on January 2, January 28, March 5, April 2, April 27, and May 24, 2013.

82. Respondent prescribed Lorazepam 1mg tab #90 0 refills on April 27 and May 10, 2013.

83. Respondent prescribed Zaleplon 10gm capsule #30 with one refill on September 23, 2012.

84. Respondent prescribed Provigil 200mg tablet #30 with 2 refills on July 23, 2010, then August 24 with no refill, September 21 with one refill, October 18 with no refill, December 1, December 29, 2010 with no refill, February 7, 2011 with one refill, March 6 with no refill, April 18 with one refill, May 10 with no refill, June 13 with one refill, July 14 with no refill, August 10 with one refill, September 8 with no refill, October 4 with no refill, November 3, 2011 with one refill, January 6, 2012 with no refill, February 3 with one refill, April 11 with no refill, May 8

with one refill, June 8 with no refill, July 5 with no refill, August 1 with one refill, August 25 with no refill, September 23, 2012 with one refill.

85. Respondent prescribed Nuvigil March 6, 2012 250mg #30 with no refill, March 27 with one refill, 150mg #30 on October 30, 2012 with no refill, November 27, 2012 with one refill, January 18, 2013 with no refill, February 12 with one refill, March 8 with no refill, April 2 with one refill, April 29 with no refill and May 24, 2013 with no refill.

86. On or about July 1, 2010, Respondent saw Patient RW for a follow up visit. Respondent documented that Patient RW "continues to have anxiety problem, but now there are also memory changes. He reports being very forgetful with daily tasks."

87. Respondent prescribed Imipramine 150mg at night from March 4, 2010 until October 18, 2010.

88. On or about September 7, 2010, Respondent received a letter from the State Compensation Insurance Fund requesting provider to provide documentation including current history, physician, and medical reasoning to determine the medical appropriateness for the prescription of Zyprexa, Diazepam and Restoril.

89. On or about June 20, 2012, Respondent prescribed Wellbutrin to augment Provigil.

90. On or about December 29, 2010, March 7, 2012, and October 10, 2013, Respondent was informed by the State Compensation Fund about the chronic use of sleep aids by Patient RW.

91. During the period of March 4, 2010 to November 18, 2013, Respondent failed to document how he obtained his diagnoses and how his diagnoses were obtained based upon clinical exam, review of records and pertinent laboratory data; Respondent failed to document treatment goals and target symptoms so that the progress of treatment could be objectively evaluated. Respondent failed to document clinical reasons when there is a change in treatment, including change of medication as well as the dose

92. During the period of March 4, 2010 to November 18, 2013, Respondent failed to adequately treat Patient RW's sleep disturbance. Respondent failed to perform and/or document a through history describing the sleeping patterns which include a diary of the times when the patient is asleep, when they wake up, if they nap, as well as what activity is done prior to and

during the time they are in bed. Respondent failed to discuss and/or document behavioral therapy with Patient RW. Respondent failed to discuss and/or document patient education on sleep hygiene, which includes restricting certain activities, prior to and during the time when patients are in the bed. Respondent used sedative hypnotics for longer than 60 days.

93. During the period of March 4, 2010 to November 18, 2013, Respondent failed to adequately treat Patient RW's organic brain disorder secondary to traumatic brain injury. Respondent prescribed high doses of Klonopin, a benzodiazepene to Patient RW, who had experienced memory disturbance related to injury. Respondent also prescribed Imipramine which has anticholinergic effects. Respondent failed to perform or document thorough neuropsychiatric testing tailored to Patient RW. Respondent prescribed Zyprexa and Abilify which has a negative impact on pharmalogic treatment for traumatic brain injury.

94. During the period of March 4, 2010 to November 18, 2013, Respondent failed to provide adequate supportive psychotherapy. Respondent failed to identify a specific type of therapy; failed to identify goals of treatment; and failed to focus treatment on symptom relief and overt behavior change through support of Patient RW's adaptive mechanisms and environmental resources.

95. During the period of March 4, 2010 to November 18, 2013, Respondent failed to adequately treat Patient RW's major depression. Respondent failed to arrive at a diagnosis through clinical interview, review of medical records, and pertinent laboratory data. Respondent failed to identify specific target symptoms that characterize the diagnosis. Respondent failed to assess symptoms with respect as to how such symptoms adversely affect the patient's quality of life and social functioning. Respondent failed to monitor the treatment's efficacy using objective and measurable goals. Respondent prescribed Wellbutrin and Cymbalta for "added waking effect" and not for any valid clinical reason. Respondent failed to document and/or provide behavioral treatment interventions consistent with psychoanalysis.

96. During the period of March 4, 2010 to November 18, 2013, Respondent prescribed atypical antipsychotics to Patient RW without documenting the risks of metabolic syndrome associated with chronic administration of Zyprexa. Respondent failed to document weight, blood

pressure, fasting glucose quarterly. Respondent failed to document and/or identify medical necessity for use of antipsychotics.

97. During the period of March 4, 2010 to November 18, 2013, Respondent failed to adequately treat Patient RW's generalized anxiety. Respondent failed to arrive at a diagnosis through clinical interview, review of medical records, and pertinent laboratory data. Respondent failed to identify specific target symptoms that characterize the diagnosis. Respondent failed to assess and identify symptoms with respect as to how such symptoms adversely affect the patient's quality of life and social functioning. Respondent failed to monitor the treatment's efficacy using objective and measurable goals. Respondent failed to employ psychotherapies for anxiety that validate the patients emotional experience, adjust the negative self-assessment engendered by emotional overload, and help the patient find the path of support and positive developmental change. Respondent failed to change the class of medication despite Patient RW's fluctuations of complaints of anxiety.

98. During the period of March 4, 2010 to November 18, 2013, Respondent prescribed medication such as Provigil and other benzodiazepines to an individual with a chronic mental condition and history of alcohol abuse without close monitoring of the dispensing of such medication.

99. Respondent committed gross negligence in his care and treatment of patient RW which includes, but is not limited to the following:

A. Respondent failed to maintain adequate documentation and failed to document and/or perform testing when necessary.

B. Respondent failed to adequately treat and diagnose Patient RW's sleep disturbance.

C. Respondent failed to adequately treat and diagnose Patient RW's organic brain disorder secondary to traumatic brain injury.

D. Respondent failed to adequately provide supportive psychotherapy

E. Respondent failed to adequately treat and diagnose major depression

F. Respondent prescribed antipsychotics to Patient RW without adequate medical indication

G. Respondent failed to adequately treat Patient RW's general anxiety.

H. Respondent failed to adequately treat Patient RW's substance abuse disorder

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

100. Respondent is further subject to disciplinary action under section under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients GC, JC, and RW as more particularly alleged hereinafter: Paragraphs 7 through 97, above, are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE
(Prescribing Dangerous Drugs without Appropriate Examination or Medical Indication)

101. Respondent is further subject to disciplinary action under sections 2227 and 2334, as defined by section 2242, of the Code, in that he prescribed controlled substances and dangerous drugs to Patients GC, JC, and RW without an appropriate medical examination or medical indication, as more particularly alleged hereinafter: Paragraphs 7 through 97, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Medical Records)

102. Respondent is further subject to discipline under sections 2227 and 2334, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate medical records in the care and treatment of Patient GC, JC, and RW, as more particularly alleged hereinafter: Paragraphs 7 through 97, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE
(General Unprofessional Conduct)

103. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good

standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged hereinafter: Paragraphs 7 through 97, above, are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 32632, issued to Janak K. Mehtani, M.D.;

Revoking, suspending or denying approval of Janak K. Mehtani, M.D.'s authority to supervise physician's assistant, pursuant to section 3527 of the Code;

2. Ordering Janak K. Mehtani, M.D. to pay the Medical Board of California, if placed on probation, the costs of probation monitoring;

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

DATED: January 13, 2015

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

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