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

| | | |
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| **In the Matter of the Accusation Against:** | ) | |
| **SOLEYMAN MIRAKHOR, M.D.** | ) | **Case No. 800-2015-016740** |
| **Physician's and Surgeon's Certificate No. C52017** | ) | |
| **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 January 3, 2020.**

**IT IS SO ORDERED: December 4, 2019.**

**MEDICAL BOARD OF CALIFORNIA**

**Kristina D. Lawson, J.D., Chair**
**Panel B**

XAVIER BECERRA
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E. A. JONES III
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*Attorneys for Complainant*

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

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| In the Matter of the Accusation Against:<br><br>SOLEYMAN MIRAKHOR, M.D.<br>5857 Winnetka Avenue<br>Woodland Hills, CA 91367<br><br>Physician's and Surgeon's Certificate No. C 52017,<br><br>Respondent. | Case No. 800-2015-016740<br><br>OAH No. 2019040325<br><br>**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 ("Board"). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Claudia Ramirez, Deputy Attorney General.

2. Respondent Soleyman Mirakhor, M.D. ("Respondent") is represented in this proceeding by attorneys Timothy R. Windham, Esq., and Helen H. Lee, Esq., whose address is:

Lewis, Brisbois, Bisgaard & Smith, LLP, 633 West 5th Street, Suite 4000, Los Angeles, California, 90071.

3. On or about July 27, 2005, the Board issued Physician's and Surgeon's Certificate No. C 52017 to Respondent. That Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2015-016740, and will expire on January 31, 2021, unless renewed.

## JURISDICTION

4. Accusation No. 800-2015-016740 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on September 13, 2018. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2015-016740 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. 800-2015-016740. 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. 800-2015-016740, 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 does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations contained in Accusation No. 800-2015-016740 and that he has thereby subjected his license to disciplinary action.

11. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2015-016740 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 the Disciplinary Order below, requiring the disclosure of probation pursuant to Business and Professions Code section 2228.1, serves to protect the public interest.

13. 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.

**CONTINGENCY**

14. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having

considered this matter.

15. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

**DISCIPLINARY ORDER**

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. C 52017 issued to Respondent Soleyman Mirakhor, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for seven (7) years on the following terms and conditions.

1. ACTUAL SUSPENSION. As part of probation, Respondent is suspended from the practice of medicine for 30 days beginning the sixteenth (16th) day after the effective date of this decision.

2. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act until he successfully completes a clinical competence assessment program and prescribing practices course.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that

Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

3. 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 of the following: 1) the name and address of the 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.

4. 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.

5. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider 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.

6. 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 approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider 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.

7. CLINICAL COMPETENCE ASSESSMENT PROGRAM-CONDITION PRECEDENT. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the

scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

Respondent shall not practice medicine until Respondent has successfully completed the program and has been so notified by the Board or its designee in writing.

Within 30 days after Respondent has successfully completed the clinical competence assessment program, Respondent shall participate in a professional enhancement program approved in advance by the Board or its designee, which shall include 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.

8. 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.

9. PATIENT DISCLOSURE.

Before a patient's first visit following the effective date of this order and while the Respondent is on probation, the Respondent must provide all patients, or patient's guardian or health care surrogate, with a separate disclosure that includes the Respondent's probation status, the length of the probation, the probation end date, all practice restrictions placed on the Respondent by the board, the board's telephone number, and an explanation of how the patient

can find further information on the Respondent's probation on the Respondent's profile page on the board's website. Respondent shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure. Respondent shall not be required to provide a disclosure if any of the following applies: (1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy; (2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities; (3) Respondent is not known to the patient until immediately prior to the start of the visit; (4) Respondent does not have a direct treatment relationship with the patient.

10. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

11. 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.

12. 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.

13. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

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.

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.

14. 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.

15. 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 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. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-

practice and does not relieve Respondent from complying with all the terms and conditions of probation. 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 the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment 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 for a Respondent residing outside of California 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; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

16. 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.

17. 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.

18. 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.

19. 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 attorneys, Timothy R. Windham, Esq., and Helen H. Lee, Esq. 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: 7.30.19

SOLEYMAN MIRAKHOR, M.D.
*Respondent*

I have read and fully discussed with Respondent Soleyman Mirakhor, 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: 8/13/19

TIMOTHY R. WINDHAM, ESQ.
HELEN H. LEE, ESQ.
*Attorneys for Respondent*

**ENDORSEMENT**

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

DATED: 8/19/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

CLAUDIA RAMIREZ
Deputy Attorney General
*Attorneys for Complainant*

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# Exhibit A

**Accusation No. 800-2015-016740**

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*Attorneys for Complainant*



**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
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| In the Matter of the Accusation Against:<br><br>Soleyman Mirakhor, M.D.<br>5857 Winnetka Avenue<br>Woodland Hills, CA 91367<br><br>Physician's and Surgeon's Certificate No. C 52017,<br><br>Respondent. | Case No. 800-2015-016740<br><br>**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 ("Board").

2. On or about July 27, 2005, the Board issued Physician's and Surgeon's Certificate Number C 52017 to Soleyman Mirakhor, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2019, unless renewed.

## JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following

laws. All section references are to the Business and Professions Code ("Code") unless otherwise indicated.

4. Section 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.

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 by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

7. Section 2242 of the Code states:

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

"(b) No licensee shall be found to have committed unprofessional conduct within the

meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

8. Section 2266 of the Code states:

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

**PERTINENT DRUGS**

9. **Amitriptyline** is a tricyclic antidepressant. It is used to treat depression, anxiety, migraine headaches, insomnia, and neuropathic pain. It is well documented to cause switch states in Bipolar patients, to go from depression to full mania. It is not approved for use in treating bipolar depression. Brand names include Vanatrip, Elavil, Endep. Amitriptyline is a dangerous drug as defined in Business and Professions Code section 4022.

10. **Baclofen** is a muscle relaxer and an antispastic agent. Baclofen is used to treat

muscle symptoms caused by multiple sclerosis, including spasm, pain, and stiffness. Baclofen is sometimes used to treat muscle spasms and other symptoms in people with injury or disease of the spinal cord. It is a dangerous drug as defined in Business and Professions Code section 4022.

11. **Benzodiazepines** are a class of drugs that produce Central Nervous System ("CNS") depression and are most commonly used to treat insomnia and anxiety. They include Xanax (alprazolam), Ativan (lorazepam), Valium (diazepam), Restoril (temazepam), and Klonopin (clonazepam). They are Schedule IV controlled substances as defined by 21 Code of Federal Regulations part 1308.14(c)(2), (c)(16), (c)(30), (c)(50), and (c)(11), and California Health and Safety Code section 11057, subdivisions (d)(1), (d)(7), (d)(9), (d)(16), and (d)(29). They are dangerous drugs as defined in California Business and Professions Code section 4022.

12. **BuSpar** (buspirone hydrochloride) is an anti-anxiety medicine. It is indicated for the management of anxiety disorders or the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in Business and Professions Code section 4022.

13. **Celexa** (citalopram) is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors. It is used to treat depression and anxiety. It is a dangerous drug as defined in Business and Professions Code section 4022.

14. **Depakote** (divalproex sodium) is indicated for the treatment of the manic episodes associated with bipolar disorder, seizures, and migraine headaches. It can cause hepatotoxicity. It is a dangerous drug as defined in Business and Professions Code section 4022.

15. **Doxepin** (Sinequan) is a tricyclic antidepressant. It is indicated for the treatment of depression and anxiety. It is sometimes used off label to treat insomnia. It is not approved for use in treating bipolar depression. It is a dangerous drug as defined in Business and Professions Code section 4022.

16. **Fentanyl** is an opioid pain medication. Fentanyl is used as part of anesthesia to help prevent pain after surgery or other medical procedure. Fentanyl is also used for managing severe chronic pain. Fentanyl is a Schedule II controlled substance as defined by section 1308.12, subdivision (c)(9), of Title 21 of the Code of Federal Regulations and Health and Safety Code section 11055, subdivision (c)(8). It is a dangerous drug as defined in Business and Professions

Code section 4022.

17. **Flexeril** (cyclobenzaprine) is a muscle relaxant. It is a dangerous drug as defined in Business and Professions Code section 4022.

18. **Gabapentin** is an anti-epileptic drug, also called an anticonvulsant. It is used to treat partial seizures, neuropathic pain, hot flashes, and restless legs syndrome. It causes CNS depression. Brand names include Gralise, Horizant, Neurontin, Gabarone. It is a dangerous drug as defined in Business and Professions Code section 4022.

19. **Hydrocodone/Acetaminophen** is an opioid pain medication. Brand names include Norco, Lortab, and Vicodin. It is a Schedule II controlled substance as defined by 21 Code of Federal Regulations part 1308.12(b)(1)(vi) and Health and Safety Code section 11055, subdivision (b)(1)(I). It is a dangerous drug as defined in Business and Professions Code section 4022.

20. **Hydroxyzine** is used as a sedative to treat anxiety and tension. It is also used together with other medications given during and after general anesthesia. Hydroxyzine is also used to treat allergic skin reactions such as hives or contact dermatitis. Brand names include Vistaril, Atarax, Vistaril IM, Hyzine, Vistaject-50, Rezine, Vistacon, Vistacot, Vistazine, and Vistazine 50. Hydroxyzine is a dangerous drug as defined in Business and Professions Code section 4022.

21. **Lamictal** (lamotrigine) is an anti-epileptic medication, also called an anticonvulsant. It is used either alone or in combination with other medications to treat epileptic seizures. Lamictal is also used for the maintenance treatment of Bipolar I Disorder. It is a dangerous drug as defined in Business and Professions Code section 4022.

22. **Latuda** (lurasidone hydrochloride) is an antipsychotic medicine used to treat schizophrenia. It is also used to treat episodes of depression associated with bipolar disorder (bipolar depression). It is a dangerous drug as defined in Business and Professions Code section 4022.

23. **Lithium** is used to treat the manic episodes of bipolar disorder (manic depression). Manic symptoms include hyperactivity, rushed speech, poor judgment, reduced need for sleep,

aggression, and anger. Lithium also helps to prevent or lessen the intensity of manic episodes. It is a dangerous drug as defined in Business and Professions Code section 4022.

24. **Luvox** (fluvoxamine) is a selective serotonin reuptake inhibitor antidepressant. It is used to treat social anxiety disorder (social phobia), obsessive-compulsive disorders involving recurring thoughts or actions, and major depressive disorder. It is a dangerous drug as defined in Business and Professions Code section 4022.

25. **Oxycodone** is an opioid pain medication. Brand names include Oxaydo, Oxycontin, Oxyfast, Roxicodone, and Xtampza ER. It is a Schedule II controlled substance as defined by section 1308.12, subdivision (b)(1)(xiii), of Title 21 of the Code of Federal Regulations and Health and Safety Code section 11055, subdivision (b)(1)(M). It is a dangerous drug as defined in Business and Professions Code section 4022.

26. **Paxil** (paroxetine hydrochloride) is an antidepressant belonging to a group of drugs called selective serotonin reuptake inhibitors. It is indicated for the treatment of Major Depressive Disorder, post-traumatic stress disorder, obsessive-compulsive disorder, and other anxiety disorders. Brand names include Brisdelle, Paxil, Paxil CR, and Pexeva. It is a dangerous drug as defined in Business and Professions Code section 4022.

27. **Risperdal** (Risperidone) is an antipsychotic medicine. It is used to treat schizophrenia, symptoms of bipolar disorder (manic depression), and symptoms of irritability in autistic children. It is a dangerous drug as defined in Business and Professions Code section 4022.

28. **Seroquel** (quetiapine fumarate) is an antipsychotic medicine. It is used to treat schizophrenia, acute mania, as monotherapy for the acute treatment of depressive episodes associated with bipolar disorder, and for the maintenance treatment of Bipolar I disorder, as an adjunct to lithium or divalproex. Brand names include Seroquel and Seroquel XR. It is a dangerous drug as defined in Business and Professions Code section 4022.

29. **Tramadol** is a narcotic-like pain reliever. Brand names include Ultram and Conzip. It is a Schedule IV controlled substance as defined by 21 Code of Federal Regulations part 1308.14(b)(3). It is a dangerous drug as defined in California Business and Professions Code

section 4022.

30. **Trazadone** is an antidepressant medicine. It is often used off-label to treat insomnia. Brand names include Oleptro, Desyrel, and Desyrel Dividose. Trazodone is a dangerous drug as defined in Business and Professions Code section 4022.

31. **Trileptal** (oxcarbazepine) is an anticonvulsant or antiepileptic medicine. It is used as an anti-epileptic, analgesic for neuropathic pain, and in the treatment of affective disorders. Other brand names include Oxtellar XR. Trileptal is a dangerous drug as defined in Business and Professions Code section 4022.

32. **Effexor** (venlafaxine) is an antidepressant belonging to a group of drugs called selective serotonin and norepinephrine reuptake inhibitors. It is used to treat major depressive disorder, anxiety, and panic disorder. Brand names include Effexor and Effexor XR. It is a dangerous drug as defined in Business and Professions Code section 4022.

33. **Viibryd** (vilazodone) is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors. It is used to treat major depressive disorder and other purposes. It is a dangerous drug as defined in Business and Professions Code section 4022.

34. **Wellbutrin** (bupropion) is an antidepressant medication used to treat major depressive disorder and seasonal affective disorder. It is also used as a smoking cessation aid. Other brand names include Aplenzin, Buproban, Forfivo XL, Wellbutrin SR, Wellbutrin XL, Zyban, Zyban Advantage Pack, Budeprion XL. Wellbutrin is a dangerous drug as defined in Business and Professions Code section 4022.

35. **Ambien** (zolpidem tartrate) is a sedative, also called a hypnotic. It is indicated for the short-term treatment of insomnia characterized by difficulties with sleep initiation. Other brand names include Edluar, Intermezzo, and Zolpimist. It is a Schedule IV controlled substance as defined by 21 Code of Federal Regulations part 1308.14(c)(54) and California Health and Safety Code section 11057, subdivision (d)(32). It is a dangerous drug as defined in California Business and Professions Code section 4022.

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## FIRST CAUSE FOR DISCIPLINE

**(Gross Negligence-Patients 1, 2, 3, & 4)**

36. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he was grossly negligent in the care and treatment of Patients 1, 2, 3, and 4. The circumstances are as follows:

Patient 1

37. On or about February 4, 2015, Respondent began providing psychiatric treatment to Patient 1, a then 38-year-old female. He was aware she was receiving treatment from Dr. S.B., Patient 1's primary care physician. Respondent did not take a history of medications being prescribed or used, other than Celexa that she was receiving from Dr. S.B. for depression.

38. Patient 1 wondered to Respondent if she suffered from Bipolar Disorder, but Respondent did not take a history to document what Patient 1 may have meant by the various labels she may have given to her behaviors or symptoms, or the history of her symptoms. His brief mental state exam of Patient 1 did not reveal significant abnormalities. Respondent did not inquire into the reasons for Patient 1's reported suicide attempt in the past.

39. Respondent diagnosed Patient 1 with Bipolar Disorder, mixed. He did not list sufficient symptoms to support that diagnosis. He prescribed Latuda 20 mg per day; Lamictal 100 mg per day; Celexa 40 mg per day; and amitriptyline 50 mg per day.

40. On or about March 18, 2015, Patient 1 returned to see Respondent. She continued to have some problems with sleep. Respondent increased the Latuda to 40 mg per day; increased Lamictal to 200 mg per day; increased amitriptyline to 300 mg per day; and kept the Celexa at 40 mg per day.

41. On or about April 29, 2015, Respondent saw Patient 1, who continued to have some problems with sleep. Respondent increased the Lamictal to 300 mg per day; increased Latuda to 60 mg per day; increased Celexa to 60 mg per day; and kept amitriptyline at 300 mg per day.

42. On or about June 3, 2015, Respondent next saw Patient 1. Respondent discontinued the amitriptyline. He increased Latuda to 80 mg per day. He kept Lamictal at 300 mg per day, and Celexa at 60 mg per day. He started her on Wellbutrin XL 150 mg per day and Trazodone at

100 mg per day.

43. On or about July 8, 2015, Patient 1 returned to see Respondent. Respondent increased Wellbutrin XL to 300 mg per day, Lamictal to 400 mg per day, and Trazadone to 150 mg per day. He kept Latuda at 80 mg per day and Celexa at 60 mg per day.

44. On or about July 22, 2015, Respondent saw Patient 1. Respondent documented that Patient 1 stated that she had manicky symptoms and mood changes, but he failed to record details of her symptoms, except that Patient 1 had difficulty sleeping. Respondent stated this was due to "racing thoughts," but he did not describe her symptoms so as to distinguish what Patient 1 might have meant by "racing thoughts." Respondent increased Lamictal to 500 mg per day; increased Wellbutrin XL to 450 mg per day; increased trazodone to 200 mg per day. He prescribed Latuda 80 mg per day and Celexa 60 mg per day.

45. On or about August 19, 2015, Respondent next saw Patient 1. Respondent documented that he did not believe Patient 1 was having any side effects to medications, even though she reported having visual disturbances. Respondent assumed the visual disturbances were "psychotic" symptoms without documenting any psychotic thinking. Respondent did not conduct cognitive testing or a mental status examination. The visual disturbances were likely early signs of Serotonin syndrome.[1] Respondent prescribed Lamictal 500 mg per day; Wellbutrin XL 450 mg per day; trazadone 200 mg per day; and Celexa 60 mg per day. He increased Latuda to 120 mg per day, and added Trileptal 300 mg two times per day.

46. Respondent never obtained a history to support that Patient 1 ever had a Major Depressive Episode or a Manic Episode or even a hypomanic episode. Respondent never ordered

[1] Serotonin syndrome is an uncommon, but potentially life-threatening, iatrogenic toxidrome. It may occur following use or overdosage of certain proserotonergic drugs alone or in combination. Trazodone, opioids, hydrocodone, oxcarbazepine, cyclobenzaprine, selective serotonin reuptake inhibitors, serotonin and norepinephrine reuptake inhibitors, tricyclic antidepressants, and atypical antipsychotics are associated with Serotonin syndrome alone or in combination. The mental status changes seen with Serotonin syndrome include: anxiety, agitation, confusion, hypomania, visual hallucinations, restlessness, disorientation, and coma. The autonomic symptoms may include: tachycardia, labile blood pressure, dizziness, diaphoresis, flushing, and hyperthermia. Milder forms may present with anxiety, akathisia, diarrhea, and tremors, but full-blown Serotonin syndrome may present with altered mental status and myoclonus. Severe serotonin toxicity may be a life-threatening crisis with muscular rigidity more pronounced in lower extremities, hyperthermia, and coma.

any records or laboratory tests to check for hepatic or renal functioning or for pregnancy. Respondent never considered if any of Patient 1's psychiatric symptoms were medication side effects or from drug-to-drug interactions.

47. From approximately February 26, 2014, to approximately December 10, 2015, Patient 1 received Hydrocodone Bitartrate-Acetaminophen 325-10 mg from Dr. S.B. Commencing on or about February 26, 2014, Patient 1 received 60 tablets per month. Commencing on or about August 18, 2014, she received 120 tablets per month. Commencing on or about October 20, 2014, she received 180 tablets per month. In or around September 2014, she received 210 tablets. In or around October 2015, she received 236 tablets. Patient 1 was also taking estrogen, gabapentin 600 mg, and Flexeril.

48. On or about August 23, 2015, Patient 1 was hospitalized with respiratory failure and altered mental status. She nearly died from drug-to-drug interactions.

49. On or about August 27, 2015, Patient 1 received a prescription from Dr. D.L. for lorazepam, 1 mg, 10 tablets.

50. On or about November 25, 2015, Respondent met with Patient 1 and her mother. Respondent denied any issues with his treatment as causing Patient 1's mental state alterations. He acknowledged that Patient 1 was taking other medications, including pain medications. Respondent stated in his note that he was sympathetic to Patient 1.

51. Respondent committed grossly negligent acts concerning Patient 1 as follows:

52. Respondent committed an extreme departure from the standard of care when he failed to obtain Patient 1's other treatment records before prescribing a large number of CNS psychotropic medications with serious drug-to-drug interactions. He did not document any information about the somatic medications that Patient 1 was currently taking, or how they would interact with the medications that he was prescribing. Had he reviewed Patient 1's other treatment records, Respondent would have learned that Patient 1 was taking medications that had a significant and dangerous interactions with the medications that he was prescribing. Respondent

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did not run a Controlled Substance Utilization Review and Evaluation System[2] ("CURES") report on Patient 1 to learn of her opioid prescriptions, or other controlled substances that she might have been prescribed. A review of CURES would indicate that Patient 1 was physically dependent on opioids.

53. Respondent committed an extreme departure from the standard of care when he prescribed amitriptyline to Patient 1. If Respondent believed Patient 1 suffered from Bipolar Disorder, mixed, then his use of amitriptyline was risky and without justification.

54. Respondent committed an extreme departure from the standard of care when he prescribed multiple psychotropic medications in very high doses without awareness of other psychoactive medications Patient 1 was taking. Respondent started Lamictal at an unsafe high dose, and continued to increase Lamictal in dose steps higher than recommended for safe practice. Respondent also started Trileptal at a high dose, with disastrous results. Patient 1 nearly died from drug-to-drug interactions. Respondent did not have a good faith basis for believing that Patient 1 had a form of mental illness that required the extremely aggressive treatment that he was providing to her. It does not appear that Respondent considered that he was attempting to treat symptoms that reflected drug toxicities. The multitude of prescriptions are in amounts and doses that reflect excessive prescribing.

55. Respondent committed an extreme departure from the standard of care when he prescribed multiple CNS-impairing medications without any monitoring of CNS impairment, or even noting the possibility of CNS impairment. Respondent was simultaneously prescribing a relatively high dose of Celexa, a very high dose of Wellbutrin, a very high dose of Trileptal, as well as Latuda and trazodone, all of which would add to the CNS depression and psychomotor impairments of each other. Respondent failed to perform mental status examinations to attempt to detect if there was medication impairment of cognition, in a patient showing signs of toxicity with visual hallucinations. He failed to inquire about other medications from other prescribers that result in CNS depression. Dr. S.B. was prescribing gabapentin, hydrocodone, and

[2] CURES refers to the Controlled Substance Utilization Review and Evaluation System, which is a government database containing information on Schedule II through IV controlled substances dispensed in California.

cyclobenzaprine, all of which cause CNS depression.

56. Respondent committed an extreme departure from the standard of care when he failed to learn of other CNS depressants Patient 1 was taking before prescribing high doses of multiple CNS depressants.

57. Respondent committed an extreme departure from the standard of care when he failed to warn Patient 1 of the off-label dangerous combination of medications he was prescribing and failed to provide even minimal informed consent with such a dangerous combination of medications.

58. Respondent committed an extreme departure from the standard of care when he failed to have an awareness of the dangers of the combinations of high dose medications he was prescribing to Patient 1.

59. Respondent committed an extreme departure from the standard of care when he started Patient 1 on an initial dose of Lamictal 100 mg per day. Because of the danger of fatal skin rashes, Lamictal should be increased slowly, starting at 25 mg per day. Fatal skin rash is more common with rapid dose increase. A dose of 100 mg should not be reached until after four weeks. Respondent did not warn Patient 1 about the risks of skin rash. He continued to escalate the dosage of Lamictal by 100 mg at a time, until Patient 1 was taking a daily dose of 500 mg. Respondent prescribing an ultra-high dose of Lamictal is unsupported.

60. Respondent committed an extreme departure from the standard of care when he escalated the amitriptyline dose. He escalated the dose of amitriptyline from 50 mg to 300 mg. The rapid escalation could have made Patient 1 more susceptible to a manic switch. Respondent increasing the dose by a factor of six is unsupported.

61. Respondent committed an extreme departure from the standard of care when he used amitriptyline, to ultra-high doses of 300 mg per day. Amitriptyline is well documented to cause mood state switches from depressed or mixed states to florid manic states. If Respondent actually believed that Patient 1 suffered from Bipolar Disorder, the use of amitriptyline is contraindicated. If amitriptyline is used, the risks associated with the use must be disclosed to the patient. Respondent did not seem aware of the risks, and did not disclose the risks to Patient 1.

Amitriptyline posed no benefits over less toxic medications for insomnia or dysphoria, and many more risks.

62. Respondent committed an extreme departure from the standard of care when he failed to warn Patient 1 of the risks of amitriptyline.

63. Respondent committed an extreme departure from the standard of care when he failed to maintain adequate and accurate records. Respondent was prescribing high dose CNS medications to a patient already on multiple CNS psychoactive medications. The lack of outside records contributed to Respondent's failure to monitor or properly treat Patient 1. Respondent failed to document that he considered the risks of multiple high doses of psychotropic medications; that he provided Patient 1 informed consent about the risks of the individual medications or the risks of taking multiple psychotropic medications with a large number of dangerous interactions; that he inquired about her comorbid medical treatments or requested a Release of Information from Patient 1 for information from other treatment providers' records; or that he considered the possibility of drug-to-drug interactions. There is no documentation reflecting rational thought processes about prescribing high dose dangerous medications. There is no documentation about what sort of symptoms Patient 1 was actually having, other than Respondent's conclusory labeling of symptoms. There is minimal information about Patient 1's life or life struggles. There is no indication that he tried to learn about the circumstances of Patient 1's suicide attempt or why Patient 1 might be suggesting that she suffers from Bipolar Disorder.

64. Respondent committed an extreme departure from the standard of care when he failed to maintain a current medication history.

65. Respondent committed an extreme departure from the standard of care when he reached unsupportable diagnoses, without obtaining information from prior treatment providers. His prescribing excessive amounts of medications without a valid medical condition is without justification.

66. Respondent committed an extreme departure from the standard of care when he failed to provide Patient 1 informed consent for medications he prescribed to her. Respondent failed to

warn her about the signs of either Serotonin syndrome or CNS over-sedation from the combination of medications he was prescribing or from the medications he was prescribing, with the medications other physicians were prescribing; about the dangers of amitriptyline if she were actually suffering from Bipolar Disorder; about the off-label use of Trileptal; and about drug-to-drug interactions and the risks of Serotonin syndrome or respiratory failure.

67. Respondent committed an extreme departure from the standard of care when he failed to consider all likely causes of Patient 1's visual disturbances and accurately diagnose Patient 1's visual disturbances. The sudden appearance of visual disturbances or visual illusions in a non-psychotic patient without a history of auditory hallucinations or delusions, is often the result of an "organic" lesion, either a brain tumor, infection, or drug effects. Respondent failed to take a history of Patient 1's symptoms of visual disturbances. Respondent failed to consider the most common causes of visual disturbances in a non-psychotic patient. That failure resulted in Patient 1's continuing to take dangerous levels and dangerous combinations of drugs.

Patient 2

68. On or about May 26, 2011, Respondent began providing psychiatric treatment to Patient 2, a then 55-year-old female who was raising three grandchildren because of her daughter's drug problems. Patient 2 reported feeling overwhelmed and sad. She reported hearing noises at night and worried that her house was haunted. With little documentation of actual symptom severity or duration, Respondent diagnosed her with Major Depression with Psychotic features. Respondent started her on Lexapro 10 mg and Risperdal 0.5 mg per day. Respondent was aware of Patient 2 having comorbid medical problems.

69. On or about July 14, 2011, Respondent next saw Patient 2. Respondent misreported the dose of medications he had placed her on. He reported that she was taking Risperdal 1.5 mg per day (she was taking 0.5 mg) and Lexapro 20 mg per day (she was taking 10 mg). Respondent believed that she was actively psychotic without evidence. Respondent prescribed Depakote ER 500 mg. He "increase[d]" Risperdal to 2.5 mg per day. He prescribed Lexapro at 20 mg per day.

70. On or about December 22, 2011, Patient 2 returned to see Respondent. Respondent again misreported Patient 2's medications. He misreported that she was taking Risperdal 2.0 mg

per day (she was taking 2.5 mg) and Celexa 30 mg per day (she was taking Lexapro). Respondent prescribed the medications he misreported and continued the Depakote ER 500 mg.

71. On or about February 27, 2012, Respondent treated Patient 2. Patient 2 was doing better. Respondent increased Depakote to 1000 mg per day. He prescribed Risperdal 2 mg per day and Celexa 30 mg per day.

72. On or about May 7, 2012, Respondent saw Patient 2. Patient 2 reported no symptoms and asked to have her Risperdal decreased. Respondent decreased it to 1.0 mg per day. He prescribed Depakote 1000 mg per day and Celexa 30 mg per day.

73. On or about June 4, 2012, Respondent next saw Patient 2. Patient 2 continued to do well. She asked to be taken off all her medications. Respondent decreased the Risperdal to 0.5 mg; decreased the Depakote to 500 mg per day; and decreased Celexa to 20 mg per day.

74. On or about July 12, 2012, Patient 2 returned to see Respondent. She remained without symptoms, but was still dealing with the problems of raising her grandchildren. Respondent misreported that he had decreased the Celexa from 40 to 20 mg (he had decreased it from 30 mg to 20 mg). Respondent discontinued the Risperdal. He kept the Depakote and Celexa unchanged.

75. On or about August 20, 2012, Respondent treated Patient 2. Patient 2 was having severe back pain which caused sleep problems. Respondent started Patient 2 on doxepin 100 mg per day. He prescribed Celexa 20 mg per day and Depakote ER 500 mg per day.

76. On or about September 24, 2012, Respondent saw Patient 2. Patient 2 still had insomnia. Respondent increased the doxepin to 300 mg per day. He kept the Celexa and Depakote unchanged.

77. On or about November 1, 2012, Respondent next saw Patient 2. Respondent discontinued the Depakote. It appears that he also discontinued the doxepin, but this is not documented in his medical records for Patient 2. Respondent started Ambien 5 mg per day. He prescribed Celexa 20 mg per day.

78. On or about December 3, 2012, Patient 2 returned to see Respondent. Her problems with her grandchildren continued. He increased the Ambien to 10 mg per day. There is no

documentation about how often Patient 2 was using the Ambien, or if she was becoming tolerant to it. There is no documentation of how Respondent told Patient 2 to use the Ambien or whether he told her to use it every night. He also prescribed Celexa 20 mg per day.

79. On or about January 7, 2013, Respondent treated Patient 2. Patient 2 stated she was wrong for asking Respondent to take her off Risperdal. She reported feeling overwhelmed with anxiety. She stated she was paranoid and suspicious and believed she was being watched by others. Respondent prescribed Risperdal 1.0 mg per day; Depakote ER 500 mg per day; and Celexa 20 mg per day.

80. On or about February 4, 2013, Respondent saw Patient 2. She again reported feeling overwhelmed by her situation. Respondent prescribed Risperdal 1.0 mg per day; Depakote ER 500 mg per day; Celexa 20 mg daily; and Ambien 10 mg per day.

81. On or about March 18, 2013, Respondent next saw Patient 2. Patient 2 reported that she stopped taking Ambien, was more anxious, and was having more problems with insomnia. Respondent did not consider the possibility that Patient 2 may have been having rebound or withdrawal symptoms. He did not inquire why Patient 2 stopped taking the Ambien or document whether he counseled her about the risks of suddenly stopping the Ambien. Respondent continued the Ambien 10 mg per day. He kept the Depakote and Risperdal at the same dosage. He increased Celexa to 40 mg per day.

82. On or about July 29, 2013, Patient 2 returned to see Respondent. Patient 2 reported she was sleeping well. There is no documentation about her use of Ambien. Respondent prescribed Risperdal 1.0 mg per day; Depakote ER 500 mg per day; Celexa 40 mg daily; and Ambien 10 mg per day.

83. On or about August 22, 2013. Respondent treated Patient 2. Patient 2 reported seeing shadows and hearing her name called. Respondent saw this as further proof that Patient 2 was "psychotic." Inexplicably, Respondent placed her on Paxil 80 mg at once. His note states "[i]ncrease Paxil to 80 mg daily." He raised Risperdal to 3.0 mg per day. Respondent started her on Klonopin 1.0 mg per day. Respondent made no mention of the Ambien or Celexa he had been prescribing. It appears that Respondent was confused about what he was in fact prescribing to

Patient 2.

84. On or about October 31, 2013, Respondent saw Patient 2. Patient 2 reported no symptoms. Respondent prescribed Paxil 80 mg per day; Risperdal 3 mg per day; Klonopin 1 mg per day; and Ambien 10 mg per day. There is no mention of any concern about additive CNS effects. Respondent documented her diagnosis was Major Depressive Disorder, severe, with psychotic features.

85. On or about January 23, 2014, Respondent next saw Patient 2 and continued the same medications. Patient 2 reported no symptoms. Respondent documented her diagnosis was Major Depressive Disorder, severe, recurrent with psychotic features.

86. On or about May 29, 2014, Patient 2 returned to see Respondent. She was again without symptoms. Respondent informed Patient 2 to decrease the dose of Ambien to 5 mg, but did not prescribe Ambien 5 mg, and continued to prescribe Ambien 10 mg. Respondent also prescribed Paxil 80 mg per day; Risperdal 3 mg per day; and Klonopin 1 mg per day.

87. On November 13, 2014, February 12, 2015, June 25, 2015, September 24, 2015, Respondent saw Patient 2. There was no change in medications. Respondent prescribed Risperdal 3 mg per day; Paxil 80 mg per day; Klonopin 1 mg per day; and Ambien 10 mg per day.

88. On or about December 17, 2015, Respondent next saw Patient 2. Respondent decreased Risperdal to 2 mg. He did not change any other medications.

89. On or about February 11, 2016, Respondent treated Patient 2. There was no change in medications. Respondent prescribed Risperdal 2 mg per day; Paxil 80 mg per day; Klonopin 1 mg per day; and Ambien 10 mg per day.

90. On or about May 3, 2016, Patient 2 returned to see Respondent. It appears the diagnosis was changed to Bipolar II Disorder. There was no change in medication. However, the computer printout now showed all of Patient 2's other medications which Respondent should have been aware of earlier. Now that it was printed out in his note, he still demonstrated no concern or provided any documentation of any concern about drug-to-drug interactions. Patient 2 was taking tramadol, cyclobenzaprine, gabapentin, and hydrocodone, in addition to the

psychotropics that Respondent was prescribing.

91. Respondent committed grossly negligent acts concerning Patient 2 as follows:

92. Respondent committed an extreme departure from the standard of care when he prescribed chronic doses of sedative-hypnotics to Patient 2. There was no evidence to support that she had a panic disorder. He prescribed Ambien and/or Klonopin for nearly four years for daily use. Respondent created an addiction in Patient 2 with no meaningful benefit to her. Respondent did not inform Patient 2 about the danger of becoming addicted to Ambien and/or Klonopin. Patient 2 was also taking opioid medications, but Respondent failed to document it. Respondent did not consider that the use of benzodiazepines and opioids is particularly dangerous, or any other drug-to-drug interactions or drug-to-drug CNS depression.

93. Respondent committed an extreme departure from the standard of care when he erratically switched medications and used them as though they were the same medications. On or about December 22, 2011, Respondent switched Lexapro to Celexa, which are distinct medications. On or about August 22, 2013, he switched Celexa to Paxil, which are also distinct medications. Respondent did not provide a rational for the switches in his notes. Patient 2, an older patient, was exposed to Paxil suddenly at 80 mg per day.

94. Respondent committed an extreme departure from the standard of care when he initiated Paxil at 80 mg per day.

95. Respondent committed an extreme departure from the standard of care when he prescribed multiple CNS impairing medications without any monitoring of CNS impairment, or even noting the possibility. Respondent simultaneously prescribed Klonopin 1.0 mg and Ambien 10 mg per day on a chronic basis. It appears that Patient 2 reported symptoms of withdrawal or rebound. Respondent continued to prescribe a high dose of Ambien even after the U.S. Food & Drug Administration ("FDA") issued warnings about the risks of consuming Ambien, on top of the Klonopin dose. Respondent should have addressed this issue and initiated a gradual withdrawal plan.

96. In addition to the Klonopin and Ambien, Respondent also prescribed an extremely high dose of Paxil and Risperdal, all of which would add to the CNS depression and psychomotor

impairment. It also appears that Patient 2 was simultaneously taking hydrocodone, cyclobenzaprine, gabapentin and tramadol, all of which would add to the CNS depression and psychomotor impairment from the medications Respondent was prescribing. Respondent did not make any notes demonstrating his awareness of the risks of CNS impairment in an older female who may have been driving and was responsible for child care. Respondent did not perform mental status examinations to attempt to quantify any CNS impairments.

97. Respondent committed an extreme departure from the standard of care when he treated Patient 2 with multiple proserotonergic medications, in addition to those prescribed by other providers, without any monitoring. Risperdal, cyclobenzaprine, hydrocodone, tramadol, Celexa, and Paxil all can contribute in an additive manner to Serotonin syndrome. Respondent did not mention any concern about the drug-to-drug interactions in his records for Patient 2.

Patient 3

98. On or about August 5, 2014, Respondent began providing psychiatric treatment to Patient 3, a then twenty-three-year-old male. Patient 3 reported prior psychiatric treatment at age sixteen. He reported symptoms to Respondent of anxiety and obsessive-compulsive disorder ("OCD") behaviors. Respondent documented that he believed Patient 3 had OCD, but also symptoms of bipolarity. Respondent started Patient 3 on Depakote ER 500 mg; Klonopin 1.0 mg; and Zoloft 100 mg per day.

99. On or about September 2, 2014, Respondent saw Patient 3. Patient 3 reported his anxiety was worse, and blamed it on Depakote. It appears Depakote was stopped. Respondent then started Patient 3 on Lamictal 100 mg per day; Latuda 40 mg per day; and Luvox 100 mg per day. He increased Klonopin to 1.5 mg per day. There is no indication whether Respondent continued the Zoloft or stopped it.

100. On or about October 7, 2014, Respondent next saw Patient 3. Respondent felt there were increased hypomanic symptoms. Respondent increased the Lamictal to 200 mg per day; the Latuda to 60 mg per day; and the Luvox to 100 mg two times per day. The Klonopin dose remained at 1.5 mg per day.

101. On or about November 4, 2014, Respondent treated Patient 3. Patient 3 complained

of muscle weakness and attributed it to the Latuda. Respondent decreased the Latuda to 40 mg per day, and increased the Lamictal to 200 mg two times a day. The doses of Luvox and Klonopin were not changed. Luvox remained at 100 mg two times per day. Klonpin remained at 1.5 mg per day.

102. On or about December 2, 2014, Patient 3 returned to see Respondent and continued to complain of muscle weakness from Latuda. Respondent increased Lamictal to 500 mg per day. Respondent appears to have restarted Depakote ER at 1000 mg per day. The doses of Luvox and Klonopin were not changed. Luvox remained at 100 mg two times per day. Klonopin remained at 1.5 mg per day.

103. On or about January 6, 2015, Respondent saw Patient 3. Respondent wrote that he believed Patient 3 continued to have "racing thoughts and mood changes." He increased Depakote ER to 1500 mg per day and Klonopin to 2.0 mg per day. He did not change the doses of Luvox and Lamictal. Luvox remained at 100 mg two times per day. Lamictal remained at 500 mg per day.

104. On or about February 3, 2015, Respondent next saw Patient 3. Patient 3 complained of not sleeping and feeling angry. Respondent stopped the Depakote. He started Patient 3 on lithium 300 mg two times per day. He did not order baseline laboratory studies. He increased Luvox to 300 mg per day. He did not change the doses of Lamictal and Klonopin.

105. On or about March 3, 2015, Patient 3 returned to see Respondent. Respondent changed Patient 3's diagnosis to Bipolar Disorder mixed with psychotic features, without any explanation. Patient 3 reported that he lost his job, and his wife moved out of the house. Respondent stopped Lithium. He started Patient 3 on Seroquel XR 150 mg per day. He did not change the doses of Klonopin, Luvox, and Lamictal. Klonopin remained at 2.0 mg per day, Luvox remained at 300 mg per day, and Lamictal remained at 500 mg per day.

106. On or about March 31, 2015, Respondent treated Patient 3. Patient 3 reported an improvement in his symptoms. Respondent increased Seroquel XR to 200 mg per day. He did not change the doses of Klonopin, Luvox, and Lamictal. Klonopin remained at 2.0 mg per day. Luvox remained at 300 mg per day. Lamictal remained at 500 mg per day.

107. On or about April 28, 2015, Respondent saw Patient 3. Patient 3 reported that he was robbed at gunpoint at work, he experienced a home invasion robbery, and his wife was in her third trimester of pregnancy. Respondent added the diagnosis of Post-Traumatic Stress Disorder. He increased Seroquel XR to 400 mg per day. He did not change the doses of Klonopin, Luvox, and Lamictal.

108. On or about June 24, 2015, Respondent next saw Patient 3. Patient 3 believed that Lamictal was upsetting his stomach. Respondent discontinued Lamictal. He started Patient 3 on BuSpar 10 mg three times a day and Trileptal 300 mg two times a day. He did not change the doses of Klonopin, Luvox, and Seroquel XR. Klonopin remained at 2.0 mg per day. Luvox remained at 300 mg per day. Seroquel XR remained at 400 mg per day.

109. On or about July 22, 2015, Patient 3 returned to see Respondent. Patient 3's two-year-old son suffered a head injury. Patient 3 reported severe anxiety. Respondent increased Trileptal to 600 mg two times per day and increased BuSpar to 15 mg three times per day. Respondent continued Klonopin 2 mg, Luvox 300 mg, and Seroquel XR 400 mg daily.

110. On or about August 19, 2015, Respondent treated Patient 3. He described Patient 3 as extremely anxious. Respondent reported that Patient 3's hands were wet with sweat. He increased Trileptal to 1800 mg per day. He increased Klonopin to 2.5 mg daily. He did not mention BuSpar. Respondent continued Luvox 300 mg and Seroquel XR 400 mg daily.

111. On or about September 30, 2015, Respondent saw Patient 3. Patient 3 reported arguing with his wife. Respondent continued Seroquel XR 400 mg, Klonopin 2.5 mg, Luvox 300 mg, and Trileptal 1800 mg daily. Respondent advised Patient 3 to see a therapist with his wife.

112. On or about October 28, 2015, Respondent next saw Patient 3. Patient 3 reported that his wife was having an affair with her boss and was pregnant. There was no change in medications.

113. On November 10, 2015, Patient 3 returned to see Respondent. He remained upset about his marriage. Respondent increased Seroquel XR to 600 mg per day. He continued Klonopin 2.5 mg, Luvox 300 mg, and Trileptal 1800 mg daily.

114. On or about December 8, 2015, Respondent treated Patient 3. Patient 3 continued to

be upset about his marriage. He continued to have sweaty hands and anxiety. Respondent increased Seroquel XR to 800 mg per day. He continued Klonopin 2.5 mg, Luvox 300 mg, and Trileptal 1800 mg daily.

115. On or about January 5, 2016, February 2, 2016, March 23, 2016, April 27, 2016, and May 25, 2016, Respondent saw Patient 3. Respondent continued Seroquel XR 800 mg, Klonopin 2.5 mg, Luvox 300 mg, and Trileptal 1800 mg daily.

116. On or about June 9, 2016, Respondent next saw Patient 3. It appears that Respondent added Venlafaxine HCI ER 75 mg per day to Seroquel XR to 800 mg, Klonopin 2.5 mg, Luvox 300 mg, and Trileptal 1800 mg daily. There is no explanation for this prescription in the encounter note.

117. On or about August 3, 2016, Respondent treated Patient 3. Respondent increased Klonopin to 3.0 mg. He discontinued Venlafaxine.

118. Respondent committed grossly negligent acts concerning Patient 3 as follows:

119. Respondent committed an extreme departure from the standard of care when he started Patient 3 on an initial dose of Lamictal 100 mg per day. He did not warn Patient 3 of the risks of skin rash.

120. Respondent committed an extreme departure from the standard of care when he started Patient 3 on lithium without baseline chemistries. Lithium is toxic to the kidneys and the thyroid gland. Necessary baseline studies before initiating lithium therapy involve tests of complete blood count, electrolytes, thyroid function, and renal function. Patients being started on Lithium need to be made aware of the many common medications or activities that can increase lithium levels to toxicity. Respondent did not provide any of this information to Patient 3.

121. Respondent committed an extreme departure from the standard of care when he prescribed multiple CNS impairing medications without any monitoring of CNS impairment, or even noting the possibility. Respondent was simultaneously prescribing a relatively high dose of Klonopin which by itself can cause paradoxical aggressive behaviors, due to its disinhibiting effects. Patient 3 was showing signs of increased verbal aggression. Respondent should have addressed this issue. In addition to the Klonopin, Respondent was also prescribing Trileptal,

Seroquel and Luvox, all of which would add to the CNS depression and psychomotor impairment. Respondent did not perform mental status examinations to attempt to detect if there was medication impairment of cognition, in a patient showing signs of aggression.

122. Respondent committed an extreme departure from the standard of care when he treated Patient 3 with multiple proserotonergic medications without any monitoring or comment when Patient 3 began to show signs associated with Serotonin syndrome. Seroquel, Luvox, Trileptal and BuSpar all can contribute in an additive manner to Serotonin syndrome. Patient 3 was complaining of muscle problems which may have been early signs of Serotonin syndrome. Respondent noticed extreme sweating which is also a sign of Serotonin syndrome. Respondent did not make any notation that he considered these effects as possibly due to Serotonin syndrome even though he was prescribing four medications that could combine to create Serotonin syndrome.

Patient 4

123. On or about October 4, 2014, Respondent treated Patient 4, a then thirty-four-year-old male. He diagnosed Patient 4 with Panic disorder with agoraphobia and Major depressive disorder, severe, recurrent. He prescribed Viibryd 40 mg daily; Risperdal 3.0 mg every day; Wellbutrin XL 450 mg daily; and Ativan 0.5 mg daily.

124. On or about February 25, 2015, Respondent treated Patient 4. Respondent diagnosed Patient 4 with Panic Disorder without agoraphobia; and Major Depressive Disorder, severe, recurrent. There are nearly no descriptions of symptoms. Respondent prescribed Risperdal 3.0 mg every day; Viibryd 40 mg daily; Wellbutrin XL 450 mg daily; and Ativan 0.5 mg daily. There is no indication in Patient 4's psychiatric records why Patient 4 required the doses or combination of medications.

125. Respondent's medical records for Patient 4 show that he did not obtain any history of current medication treatments for Patient 4, or indicate that he requested a Release of Information from Patient 4 to learn of any current treatments or comorbid medical conditions. There is no description of how frequently Patient 4 was having panic episodes, prior mental health treatment, or any history of substance misuse.

126. On or about February 23, 2016, Respondent saw Patient 4. He did not mention any overall clinical status for Patient 4, or any information about adverse medication effects. There is no detail about any of the identified symptoms. He did not change Patient 4's medications, other than the substitution of Klonopin 0.5 mg per day for Ativan.

127. The only clinical information that Respondent provided about Patient 4 is: "Associated symptoms include insomnia, tingling, nausea, racing thoughts, depression, about recurrent panic attacks. Associated symptoms include depressed mood, fatigue, poor sleep, headaches and irritability."

128. On or about March 29, 2016, Respondent saw Patient 4. The only clinical information that Respondent provided about Patient 4 is: "Associated symptoms include fatigue, weight gain, irritability and social difficulties." He continued Viibryd 40 mg daily; Risperdal 3.0 per day; Wellbutrin XL 450 mg daily; and Klonopin 0.5 mg daily.

129. On or about May 31, 2016, Respondent saw Patient 4. Respondent changed Patient 4's diagnosis to Bipolar II Disorder, without any explanation for the change. He described Patient 4 as asymptomatic. Respondent did not change Patient 4's medications. He did not consider that Patient 4 may have had a "switch" state from the Viibryd.

130. Respondent described Patient 4's clinical condition as follows: "The patient is being seen for a routine clinic follow-up of a bipolar disorder. The patient has a type II bipolar disorder. The patient is currently asymptomatic. The rate of mood cycling is slow. He describes this as mild. Exacerbating factors: emotional stress, fatigue and family stressors. Relieving factors: bipolar medications and psychotherapy. Associated symptoms: anxiety symptoms. Suicidal risk: no suicidal thoughts and no suicidal intention. Homicidal risk: no homicidal thoughts and no homicidal intention. Current treatment includes atypical antipsychotics, mood stabilizers and benzodiazepines. There are no medication side effects."

131. On or about June 28, 2016, Respondent saw Patient 4. Respondent described Patient 4 as improving from being described as asymptomatic. Despite improving from being asymptomatic, Respondent diagnosed Patient 4 with "Generalized anxiety disorder (300.02) (F41.1); and Bipolar II, mixed, severe with psychotic behavior (296.89) (F31.81)." He did not

mention any psychotic symptoms in the mental status exam section of Patient 4's psychiatric records. Respondent did not change any medications. He continued Viibryd 40 mg daily; Risperdal 3.0 per day; Wellbutrin XL 450 mg daily; and Klonopin 0.5 mg daily.

132. Respondent described Patient 4's clinical condition as follows: "The patient is being seen for a routine clinic follow-up of a bipolar disorder. The patient has a type II bipolar disorder. The patient is currently asymptomatic. There is no known event that preceded symptom onset. The rate of mood cycling is slow. He describes this as mild and improving. Exacerbating factors: emotional stress and fatigue. Relieving factors: bipolar medications and psychotherapy. Associated symptoms: anxiety symptoms. Suicidal risk: no suicidal thoughts and no suicidal intention. Homicidal risk: no homicidal thoughts and no homicidal intention. Current treatment includes selective serotonin reuptake inhibitors, atypical antipsychotics, mood stabilizers and benzodiazepines. There are no medication side effects."

133. On or about August 2, 2016, Respondent saw Patient 4. Respondent changed Patient 4's diagnoses to "Depression." He continued Viibryd 40 mg daily; Risperdal 3.0 per day; Wellbutrin XL 450 mg daily; and Klonopin 0.5 mg daily.

134. Respondent described Patient 4's clinical condition as follows: "Associated symptoms include insomnia, tingling, nausea, racing thoughts, depression, about recurrent panic attacks. Associated symptoms include depressed mood, fatigue, poor sleep, headaches, irritability, social difficulties and financial difficulties, but no suicidal ideation, no suicide attempt, no sense of failure, no poor concentration, no indecisiveness, no psychomotor retardation, no hypersomnia, no racing thoughts, no periods of excess energy, no periods of euphoria, no employment difficulties, no difficulty with activities of daily living, no delusions, no auditory hallucinations and no visual hallucinations."

135. On or about September 6, 2016, Respondent's treated Patient 4. He changed Patient 4's diagnosis back to only Bipolar II, mixed, severe with psychotic behavior, without any explanation. He continued Viibryd 40 mg daily; Risperdal 3.0 per day; Wellbutrin XL 450 mg daily; and Klonopin 0.5 mg daily.

136. Respondent described Patient 4's clinical condition as follows: "The patient is being

seen for a routine clinic follow-up of a bipolar disorder. The patient has a type II bipolar disorder. The patient is currently asymptomatic. Onset followed work problems and family problems. The rate of mood cycling is slow. He describes this as mild and improving. Exacerbating factors: emotional stress and job stressors. No associated symptoms are reported. Suicidal risk: no suicidal thoughts, no suicidal intention, no suicide attempt(s) and no organized plans. Homicidal risk: no homicidal thoughts, no homicidal intention, no homicide attempt(s) and no organized plan. Current treatment includes selective serotonin reuptake inhibitors, atypical antipsychotics, mood stabilizers and benzodiazepines. There are no medication side effects."

137. Patient 4's psychiatric records, dated September 6, 2016, include the following list of diagnoses: Bipolar II, mixed, severe with psychotic behavior (296.89) (F31.81); Chronic pain syndrome (338.4) (G89.4); Depression (311) (F32.9); Drug addiction in remission (304.93) (F19.21); Generalized anxiety disorder (300.02) (F41.1); Major depressive disorder, recurrent, severe w/o psychotic behavior (296.33) (F33.2); Morbid obesity (278.01) (E66.01); Nicotine dependence (305.1) (F17.200); Panic disorder with agoraphobia (300.21) (F40.01); and Sleep apnea (780.57) (G47.30). Respondent did not make all the diagnoses. He did not correct any of the diagnoses that he believed were inaccurate in the list.

138. Patient 4's psychiatric records, dated September 6, 2016, include the following list of psychoactive medications: baclofen 10 mg oral tablet (one to two tablets by mouth three times daily); bupropion hcl ER (XL) 150 mg oral tablet extended release 24 hour (3 tablets daily); clonazepam 0.5 mg oral tablet (1 tablet at bedtime); fentanyl 50 mcg/hr transdermal patch 72 hour (1 patch every 2 days); hydroxyzine hcl- 25 mg oral tablet (1-2 tabs every 6 hours as needed for itching); oxycodone hcl-10 mg oral tablet (take 1/2 to 1 tablet every 4-6 hours, as needed, pain levels 8, 9 or 10); risperidone 3 mg oral tablet (1 tablet at bedtime); tramadol hcl- 50 mg oral tablet (1 to 2 tablets every 6 hours, as needed for pain); and viibryd 40 mg oral tablet (1 tablet daily).

139. Respondent committed grossly negligent acts concerning Patient 4 as follows:

140. Respondent committed an extreme departure from the standard of care when he failed

to obtain Patient 4's other treatment records before prescribing a large number of CNS psychotropic medications with serious drug-to-drug interactions. Despite the patient's electronic medical records listing all the concurrent medications and the many drug-to-drug interactions, Respondent neither warned the other prescribers about the dangers nor took any steps to adjust Patient 4's treatment to minimize drug-to-drug interactions. Respondent did not consider the other medications that Patient 4 was taking, or how they would interact with the medications that he was prescribing.

141. Respondent committed an extreme departure from the standard of care when he prescribed Viibryd in this patient already on a high dose of Wellbutrin, and with minimal symptoms. The judgment that Patient 4 was not at risk for a Bipolar switch, reflected the lack of the sort of screening recommended in FDA monographs.[3] If Respondent actually believed that Patient 4 suffered from Bipolar II Disorder, severe, his use of Viibryd was risky and without justification.

142. Respondent committed an extreme departure from the standard of care when he added benzodiazepines Ativan and Klonopin to the host of CNS depressants being taken simultaneously by Patient 4. The addition of Ativan and Klonopin to a patient on a very substantial amount of GABA agonists[4] (including baclofen), and other CNS sedating medications, in a person with substance misuse problems, was highly risky and unlikely to have any benefit.

143. Respondent committed an extreme departure from the standard of care when he prescribed multiple CNS impairing medications without any monitoring of CNS impairment. Respondent was simultaneously prescribing a relatively high dose of Viibryd, a very high dose of Wellbutrin, a moderately high dose of Risperdal for a non-psychotic patient, as well as clonazepam, all of which would add to the CNS depression and psychomotor impairments of each other. Respondent failed to inquire about other medications from other prescribers that result in CNS depression. He should have known that Patient 4 was taking multiple potent

[3] FDA recommendations in drug monographs reflect the standard of care.

[4] A GABA receptor agonist is a drug that is an agonist for one or more of the GABA receptors, producing typically sedative effects, and may also cause other effects such as anxiolytic, anticonvulsant, and muscle relaxant effects.

opiates, tramadol, baclofen and hydroxyzine, all of which cause CNS depression at the same time. Respondent did not perform mental status examinations to attempt to detect if there was medication impairment of cognition, or motor performance.

144. Respondent committed an extreme departure from the standard of care when he failed to learn of the other CNS depressants that Patient 4 was taking before his prescribing doses of multiple CNS depressants.

145. Respondent committed an extreme departure from the standard of care when he failed to have an awareness of the dangers of the combinations of high dose medications he was prescribing on top of multiple other CNS depressants.

146. Respondent committed an extreme departure from the standard of care when he failed to consider the danger of the combined use of benzodiazepines and opioids, any other drug-to-drug interactions, or drug-to-drug CNS depression, and created an iatrogenic[5] sedative addiction in Patient 4. He prescribed Ativan and/or Klonopin to Patient 4 for nearly two years for daily use. Respondent should have been concerned that Patient 4 was at very high risk of becoming addicted to benzodiazepines. Respondent does not appear to have ever considered the dangers to Patient 4 of becoming addicted to Klonopin and/or Ativan, or that he ever informed Patient 4 about this danger. Patient 4 was also taking opioid medications, but Respondent failed to document this. The use of benzodiazepines and opioids is particularly dangerous. The FDA strongly warns about the combined use of opioids and benzodiazepines. There is no evidence that Respondent considered this or any other drug-to-drug interactions or drug-to-drug CNS depression.

147. Respondent's acts and/or omissions as set forth in paragraphs 37 through 146, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to Code section 2234, subdivision (b). Therefore, cause for discipline exists.

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[5] Iatrogenic means an unfavorable response to medical or surgical treatment induced by the treatment itself.

## SECOND CAUSE FOR DISCIPLINE

**(Repeated Negligent Acts-Patients 1, 2, 3, & 4)**

148. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he engaged in repeated negligent acts in the care and treatment of patients 1, 2, 3, and 4. The circumstances are as follows:

Patient 1

149. Paragraphs 37 through 67 are incorporated by reference as if fully set forth herein.

150. Respondent departed from the standard of care when he failed to take a minimally adequate history to support his diagnoses and misinformed Patient 1 of her actual psychiatric problems. The diagnosis of Bipolar I Disorder is unsupported by the data. Respondent did not take a meaningful medical, substance use information, or psychiatric history. He did not consider the possibility of an iatrogenic opioid use disorder or chronic opioid use causing her mood problems. An adequate history would have likely confirmed Diagnostic and Statistical Manual of Mental Disorders criteria for opioid misuse.

Patient 2

151. Paragraphs 68 through 97 are incorporated by reference as if fully set forth herein.

152. Respondent's diagnosis of Patient 2 was a departure from the standard of care. It does not appear that he diagnosed the issues of family relationship problems or the Adjustment Disorder of Patient 2. Instead, without reasonable documentation or sufficient data, Respondent inaccurately diagnosed her with severe mental illness (Major Depressive Disorder, severe, recurrent with psychotic features). There is no evidence for a Bipolar II Disorder.

Patient 3

153. Paragraphs 98 through 122 are incorporated by reference as if fully set forth herein.

154. Respondent's diagnoses of Patient 3 were departure from the standard of care. Patient 3 clearly suffered from OCD and anxiety. He may have also suffered from acute stress disorder, not clearly from Post-Traumatic Stress Disorder. It is much more unclear if Patient 3 ever had symptoms for hypomania, major depressive episode, or manic episode. Respondent's description of racing thoughts is not further described and more likely represents another

symptom of anxiety rather than separate "bipolarity." Similarly, insomnia and irritability are common symptoms of both anxiety and OCD. Respondent reached a very hasty conclusion that Patient 3 suffered from "bipolarity" without any history taking of actual mood states lasting at least one week. Respondent then began a very aggressive, and dangerous course of treatment for Patient 3's alleged "bipolarity." Patient 3 was never psychotic despite Respondent diagnosing him as having psychotic features.

Patient 4

155. Paragraphs 123 through 146 are incorporated by reference as if fully set forth herein.

156. Respondent departed from the standard of care when he failed to take a minimally adequate history to support his diagnoses. Respondent did not take any meaningful medical, substance use information or psychiatric history, and make appropriate medication adjustments. Respondent did not consider the possibility of an iatrogenic opioid use disorder, even though another provider had indicated an issue with substance abuse. Respondent did not consider the possibility of chronic opioid use causing Patient 4's mood problems or anxiety or his problematic relationships or homelessness. Respondent did not describe enough symptoms to remotely suggest that Patient 4 suffered from any form of Bipolar Disorder. Respondent did not suggest sufficient symptoms to meet criteria for Major Depressive Disorder, particularly in a person taking regular opioids. Respondent's description of Patient 4's depression is of minimal symptoms, that could have been addressed by discussing lowering the opioid doses with Patient 4's other providers, and referring him for substance rehabilitation. An adequate history would likely have confirmed Diagnostic and Statistical Manual of Mental Disorders criteria for opioid misuse. A treating psychiatrist would be expected to address a patient's substance use problems even if iatrogenic. Respondent did not suggest sufficient symptoms to meet criteria for Panic Disorder. This may have been a pretext diagnosis to explain the use of benzodiazepines.

157. Respondent's acts and/or omissions as set forth in paragraphs 149 through 156, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts pursuant to Code section 2234, subdivision (c). Therefore, cause for discipline exists.

## THIRD CAUSE FOR DISCIPLINE

**(Incompetence-Patients 1, 2, 3, & 4)**

158. Respondent is subject to disciplinary action under Code section 2234, subdivision (d), for incompetence with respect to Patients 1, 2, 3, and 4. The circumstances are as follows:

Patient 1

159. Paragraphs 37 through 67 and 149 through 150 are incorporated by reference as if fully set forth herein.

160. Respondent showed a lack of basic knowledge about psychopharmacology and drug-to-drug interactions when he prescribed multiple psychotropic medications in very high doses without awareness of other psychoactive medications Patient 1 was taking.

161. Respondent showed a lack of basic knowledge about prescribing practices and basic psychopharmacology when he prescribed multiple CNS-impairing medications without any monitoring of CNS impairment, or even noting the possibility of CNS impairment. He failed to have an adequate understanding of the risks to Patient 1.

162. Respondent showed a lack of basic knowledge of prescribing practices and psychopharmacology when he started Patient 1 on an initial dose of Lamictal 100 mg per day.

163. Respondent showed a lack of basic knowledge of how to safely prescribe psychotropic medications. Respondent should have considered that a patient with fibromyalgia or chronic rheumatoid arthritis would be taking CNS active chronic medications. Respondent had a duty to investigate the totality of the medications that Patient 1 was taking simultaneously with the ones he was adding to her treatment. He had a duty to know the risks of each drug alone or in combination, and convey that information to Patient 1.

164. Respondent had a duty to investigate whether the symptoms that Patient 1 reported were medication side effects or the result of environmental or endogenous disease, unrelated to medication treatment. Respondent failed to consider exogenous causes of Patient 1's symptoms from the medications that she was taking. Respondent failed to consider that Dr. S.B.'s treatment with Celexa, Flexeril, and high dose hydrocodone could have been the cause of Patient 1's insomnia and "racing thoughts." Respondent did not inquire whether Patient 1 discontinued the

Celexa or was still taking it. Her symptoms could have reflected discontinuation or adverse effects. Because he failed to take an adequate history, Respondent could not know whether Patient 1's symptoms were medication induced. Respondent's approach to diagnosis and differential diagnosis reflects a fundamental lack of knowledge of psychiatry and psychopharmacology.

165. Respondent's lack of awareness of and failure to monitor for Serotonin syndrome demonstrates a basic lack of knowledge about psychopharmacology. He was prescribing many medications associated with Serotonin syndrome to Patient 1 who was already taking medications associated with Serotonin syndrome. Respondent failed to monitor Patient 1's mental status, attributed visual disturbances to "psychosis" in the absence of psychosis, and continued to increase dosages of proserotonergic medications.

166. Respondent's lack of awareness of and failure to monitor for CNS depression demonstrates a basic lack of knowledge about psychopharmacology. He was prescribing many medications associated with CNS and respiratory depression to Patient 1 who was already taking medications associated with CNS and respiratory depression. He failed to monitor her mental status, and continued to increase dosages of multiple CNS depressant medications.

167. Respondent's failure to consider all likely causes and accurately diagnose Patient 1's visual disturbance reflects a lack of basic knowledge of psychiatry.

Patient 2

168. Paragraphs 68 through 97 and 151 through 152 are incorporated by reference as if fully set forth herein.

169. Respondent demonstrated a basic lack of knowledge about psychopharmacology when he prescribed chronic doses of sedative-hypnotics to Patient 2. There was no evidence to support that she had a panic disorder. He prescribed Ambien and Klonopin for nearly four years for daily use. Respondent created an addiction in Patient 2 with no meaningful benefit to her. Respondent did not inform Patient 2 about the danger of becoming addicted to Ambien and Klonopin. Patient 2 was also taking opioid medications, but Respondent failed to document it. Respondent did not consider that the use of benzodiazepines and opioids is particularly

dangerous, or any other drug-to-drug interactions or drug-to-drug CNS depression.

170. Respondent demonstrated a lack of basic knowledge of psychopharmacology when he initiated Paxil at 80 mg per day.

171. Respondent demonstrated a lack of basic knowledge of prescribing practices and of psychopharmacology when he prescribed multiple CNS impairing medications without any monitoring of CNS impairment, or even noting the possibility.

172. Respondent demonstrated a lack of basic knowledge of prescribing practices and of psychopharmacology when he treated Patient 2 with multiple proserotonergic medications, in addition to those prescribe by other providers, without any monitoring. Risperdal, cyclobenzaprine, hydrocodone, tramadol, Celexa, and Paxil all can contribute in an additive manner to Serotonin syndrome. Respondent did not mention any concern about the drug-to-drug interactions in his records for Patient 2.

Patient 3

173. Paragraphs 98 through 122 and 153 through 154 are incorporated by reference as if fully set forth herein.

174. Respondent demonstrated a lack of basic knowledge of prescribing practices and psychopharmacology when he started Patient 3 on an initial dose of Lamictal 100 mg per day.

175. Respondent demonstrated a lack of basic knowledge of prescribing practices and psychopharmacology when he started Patient 3 on lithium without baseline chemistries.

176. Respondent demonstrated a lack of basic knowledge of prescribing practices and psychopharmacology when he prescribed multiple CNS impairing medications without any monitoring of CNS impairment, or evening noting the possibility.

177. Respondent demonstrated a lack of basic knowledge of prescribing practices and psychopharmacology when he treated Patient 3 with multiple proserotonergic medications without any monitoring or comment when Patient 3 began to show signs associated with Serotonin syndrome.

Patient 4

178. Paragraphs 123 through 146 and 155 through 156 are incorporated by reference as if

fully set forth herein.

179. Respondent demonstrated a lack of basic knowledge of prescribing practices and basic psychopharmacology when he prescribed multiple CNS impairing medications without any monitoring of CNS impairment.

180. Respondent demonstrated a lack of basic knowledge of prescribing practices and basic psychopharmacology when he failed to have an awareness of, and failed to monitor for, CNS depression. Respondent was prescribing many medications associated with CNS and respiratory depression to Patient 4 who was already taking medications associated with CNS and respiratory depression. Respondent failed to monitor Patient 4's mental status, and never adjusted Patient 4's medications to lower doses or discontinued them, when Patient 4 was in remission.

181. Respondent demonstrated a lack of basic knowledge of prescribing practices and basic psychopharmacology. There is very little evidence that Patient 4 had panic disorder, such that a daily at bedtime dosing was appropriate. There was no basis for Respondent prescribing chronic doses of sedative-hypnotics to Patient 4. Patient 4 was already troubled by opioid drug addiction. Respondent created an addiction in Patient 4 with no meaningful benefit to him, and with very high risks of adverse effects.

182. Respondent's acts and/or omissions as set forth in paragraph 159 through 181, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute incompetence pursuant to Code section 2234, subdivision (d). Therefore, cause for discipline exists.

## FOURTH CAUSE FOR DISCIPLINE

**(Excessive Prescribing-Patients 1, 2, 3, & 4)**

183. Respondent is subject to disciplinary action under Code section 725 for repeated acts of clearly excessive prescribing of controlled substances with respect to Patients 1, 2, 3, and 4. The circumstances are as follows:

184. Paragraphs 36 through 182 are incorporated by reference as if fully set forth herein.

185. Respondent's acts and/or omissions as set forth in paragraphs 36 through 182,

inclusive above, whether proven individually, jointly, or in any combination thereof, constitute repeated acts of clearly excessive prescribing pursuant to Code section 725. Therefore, cause for discipline exists.

**FIFTH CAUSE FOR DISCIPLINE**

**(Prescribing without Medical Indication-Patients 1, 2, 3, & 4)**

186. Respondent is subject to disciplinary action under Code section 2242, subdivision (a), in that he prescribed dangerous drugs without an appropriate prior examination and/or medical indication to Patients 1, 2, 3, and 4. The circumstances are as follows:

187. Paragraphs 36 through 182 are incorporated by reference as if fully set forth herein.

188. Respondent's acts and/or omissions as set forth in paragraphs 36 through 182, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute prescribing dangerous drugs without an appropriate prior examination and/or medical indication pursuant to Code section 2242, subdivision (a). Therefore, cause for discipline exists.

**SIXTH CAUSE FOR DISCIPLINE**

**(Inadequate and Inaccurate Record Keeping-Patients 1, 2, 3, & 4)**

189. Respondent is subject to disciplinary action under Code section 2266 for inadequate and inaccurate record keeping with respect to Patients 1, 2, 3, and 4. The circumstances are as follows:

190. Paragraphs 36 through 182 are incorporated by reference as if fully set forth herein.

191. Respondent's acts and/or omissions as set forth in paragraphs 36 through 182, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute inadequate and inaccurate record keeping pursuant to Code section 2266. Therefore, cause for discipline exists.

**SEVENTH CAUSE FOR DISCIPLINE**

**(Unprofessional Conduct-Patients 1, 2, 3, & 4)**

192. Respondent is subject to disciplinary action under Code section 2234 for unprofessional conduct with respect to Patients 1, 2, 3, and 4. The circumstances are as follows:

193. Paragraphs 36 through 191 are incorporated by reference as if fully set forth herein.

194. Respondent's acts and/or omissions as set forth in paragraphs 36 through 191, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute unprofessional conduct pursuant to Code section 2234. Therefore, cause for discipline exists.

**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 C 52017, issued to Respondent Soleyman Mirakhor, M.D.;

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

3. Ordering Respondent Soleyman Mirakhor, 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: September 13, 2018

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

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