

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

In the Matter of the Accusation Against:

Ihor Anton Michael Galarnyk, M.D.

Physician's and Surgeon's
Certificate No. G 62655

Respondent.

Case No. 800-2018-042810

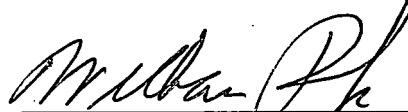
DECISION

The attached Stipulated Surrender of License and 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 June 30, 2021.

IT IS SO ORDERED June 23, 2021.

MEDICAL BOARD OF CALIFORNIA



William Prasifka
Executive Director

1 MATTHEW RODRIQUEZ
Acting Attorney General of California
2 JUDITH T. ALVARADO
Supervising Deputy Attorney General
3 EDWARD KIM
Deputy Attorney General
4 State Bar No. 195729
California Department of Justice
5 300 So. Spring Street, Suite 1702
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Facsimile: (916) 731-2117
7 *Attorneys for Complainant*

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

12 In the Matter of the Accusation Against:

Case No. 800-2018-042810

13 **IHOR ANTON MICHAEL GALARNYK, M.D.**
72440 Morningstar Road
Rancho Mirage, CA 92270

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

14 **Physician's and Surgeon's
Certificate No. G 62655,**

15 Respondent.

16
17 In the interest of a prompt and speedy settlement of this matter, consistent with the public
18 interest and the responsibility of the Medical Board of California of the Department of Consumer
19 Affairs, the parties hereby agree to the following Stipulated Surrender and Disciplinary Order
20 which will be submitted to the Board for approval and adoption as the final disposition of the
21 Accusation.

22 **PARTIES**

23 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
24 California (Board). He brought this action solely in his official capacity and is represented in this
25 matter by Matthew Rodriquez, Acting Attorney General of the State of California, by Edward
26 Kim, Deputy Attorney General.

27 2. IHOR ANTON MICHAEL GALARNYK, M.D. (Respondent) is represented in this
28 proceeding by attorney Carolyn Lindholm, whose address is: Bonne Bridges Mueller O'Keefe &

1 Nichols, 355 S. Grand Avenue, Ste. 1750, Los Angeles, CA 90071-1562.

2 3. On or about April 18, 1988, the Board issued Physician's and Surgeon's Certificate
3 No. G 62655 to Respondent. The Physician's and Surgeon's Certificate was in full force and
4 effect at all times relevant to the charges brought in Accusation No. 800-2018-042810 and will
5 expire on January 31, 2022, unless renewed.

6 **JURISDICTION**

7 4. Accusation No. 800-2018-042810 was filed before the Board, and is currently
8 pending against Respondent. The Accusation and all other statutorily required documents were
9 properly served on Respondent on April 1, 2021. Respondent timely filed his Notice of Defense
10 contesting the Accusation. A copy of Accusation No. 800-2018-042810 is attached as Exhibit A
11 and incorporated by reference.

12 **ADVISEMENT AND WAIVERS**

13 5. Respondent has carefully read, fully discussed with counsel, and understands the
14 charges and allegations in Accusation No. 800-2018-042810. Respondent also has carefully read,
15 fully discussed with counsel, and understands the effects of this Stipulated Surrender of License
16 and Order.

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

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

25 **CULPABILITY**

26 8. Respondent understands that the charges and allegations in Accusation No. 800-2018-
27 042810, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and
28 Surgeon's Certificate.

1 the Board may, without further notice or formal proceeding, issue and enter the following Order:

2 **ORDER**

3 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 62655, issued
4 to Respondent IHOR ANTON MICHAEL GALARNYK, M.D., is surrendered and accepted by
5 the Board.

6 1. The surrender of Respondent's Physician's and Surgeon's Certificate and the
7 acceptance of the surrendered license by the Board shall constitute the imposition of discipline
8 against Respondent. This stipulation constitutes a record of the discipline and shall become a part
9 of Respondent's license history with the Board.

10 2. Respondent shall lose all rights and privileges as a Physician and Surgeon in
11 California as of the effective date of the Board's Decision and Order.

12 3. Respondent shall cause to be delivered to the Board his pocket license and, if one was
13 issued, his wall certificate on or before the effective date of the Decision and Order.


14 4. If Respondent ever files an application for licensure or a petition for reinstatement in
15 the State of California, the Board shall treat it as a petition for reinstatement. Respondent must
16 comply with all the laws, regulations and procedures for reinstatement of a revoked or
17 surrendered license in effect at the time the petition is filed, and all of the charges and allegations
18 contained in Accusation No. 800-2018-042810 shall be deemed to be true, correct and admitted
19 by Respondent when the Board determines whether to grant or deny the petition.

20 5. If Respondent should ever apply or reapply for a new license or certification, or
21 petition for reinstatement of a license, by any other health care licensing agency in the State of
22 California, all of the charges and allegations contained in Accusation, No. 800-2018-042810 shall
23 be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of
24 Issues or any other proceeding seeking to deny or restrict licensure.


25 **ACCEPTANCE**

26 I have carefully read the above Stipulated Surrender of License and Order and have fully
27 discussed it with my attorney, Carolyn Lindholm. I understand the stipulation and the effect it
28 will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of

1 License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the
2 Decision and Order of the Medical Board of California.

3
4 DATED: May 7, 2021 
5 IHOR ANTON MICHAEL GALARNYK,
6 M.D.
7 Respondent

8 I have read and fully discussed with Respondent IHOR ANTON MICHAEL GALARNYK,
9 M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License
10 and Order. I approve its form and content.

11 DATED: May 7, 2021 
12 CAROLYN LINDHOLM
13 Attorney for Respondent

14 **ENDORSEMENT**

15 The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted
16 for consideration by the Medical Board of California of the Department of Consumer Affairs.

17 DATED: _____

18 Respectfully submitted,
19 MATTHEW RODRIQUEZ
20 Acting Attorney General of California
21 JUDITH T. ALVARADO
22 Supervising Deputy Attorney General

23 EDWARD KIM
24 Deputy Attorney General
25 Attorneys for Complainant

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1 License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the
2 Decision and Order of the Medical Board of California.

3
4 DATED: _____
5 IHOR ANTON MICHAEL GALARNYK,
6 M.D.
7 *Respondent*

8 I have read and fully discussed with Respondent IHOR ANTON MICHAEL GALARNYK,
9 M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License
10 and Order. I approve its form and content.


11 DATED: _____
12 CAROLYN LINDHOLM
13 *Attorney for Respondent*

14 **ENDORSEMENT**

15 The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted
16 for consideration by the Medical Board of California of the Department of Consumer Affairs.

17 DATED: 6-15-21

18 Respectfully submitted,
19 MATTHEW RODRIQUEZ
20 Acting Attorney General of California
21 JUDITH T. ALVARADO
22 Supervising Deputy Attorney General

23 
24 EDWARD KIM
25 Deputy Attorney General
26 *Attorneys for Complainant*

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Exhibit A

Accusation No. 800-2018-042810

1 XAVIER BECERRA
Attorney General of California
2 JUDITH T. ALVARADO
Supervising Deputy Attorney General
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7 *Attorneys for Complainant*

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

12 In the Matter of the Accusation Against:

Case No. 800-2018-042810

13 **IHOR ANTON MICHAEL GALARNYK, M.D.**
72440 Morningstar Rd.
Rancho Mirage, CA 92270

A C C U S A T I O N

14 **Physician's and Surgeon's**
15 **Certificate No. G 62655,**

Respondent.

16
17 **PARTIES**

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

21 2. On or about April 18, 1988, the Medical Board issued Physician's and Surgeon's
22 Certificate Number G 62655 to IHOR ANTON MICHAEL GALARNYK, M.D. (Respondent).
23 The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the
24 charges brought herein and will expire on January 31, 2022, unless renewed.

25 **JURISDICTION**

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

1 furnished, any of the following applies:

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

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

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

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

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

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

21 7. Section 725 of the Code states:

22 (a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or
23 administering of drugs or treatment, repeated acts of clearly excessive use of
24 diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or
25 treatment facilities as determined by the standard of the community of licensees is
26 unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist,
27 physical therapist, chiropractor, optometrist, speech-language pathologist, or
28 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.

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.

1 9. Health and Safety Code section 11165.4, subdivision (a) states, in pertinent part:

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

8 DEFINITIONS

9 "Acamprosate" is a medication used to treat alcoholism by reducing the desire
10 to drink alcohol. It is a dangerous drug as defined in Business and Professions code
11 section 4022.

12 "Acetaminophen" is a widely used over-the-counter analgesic (pain reliever)
13 and antipyretic (fever reducer). It is also known as paracetamol, or APAP. It is
14 typically used for mild to moderate pain relief, such as relief of headaches. It is a
15 major ingredient in numerous cold and flu remedies. In combination with opioid
16 analgesics, paracetamol can also be used in the management of more severe pain such
17 as post surgical pain and providing palliative care in advanced cancer patients. Acute
18 overdoses of paracetamol can cause potentially fatal liver damage and, in rare
19 individuals, a normal dose can do the same; the risk is heightened by alcohol
20 consumption. It is sold in varying forms, including under the brand name Tylenol®.

21 "Alprazolam" is a benzodiazepine drug used to treat anxiety disorders, panic
22 disorders, and anxiety caused by depression. Alprazolam has a central nervous
23 system depressant effect and patients should be cautioned about the simultaneous
24 ingestion of alcohol and other central nervous system depressant drugs during
25 treatment with it. Addiction prone individuals (such as drug addicts or alcoholics)
26 should be under careful surveillance when receiving alprazolam because of the
27 predisposition of such patients to habituation and dependence. The usual starting
28 dose of alprazolam is 0.25 mg to 0.5 mg, three times per day (for a maximum 1.5 mg
per day). It is also sold under various brand names including, Intensol®, Xanax®,
and Xanax XR®. It is a schedule IV controlled substance pursuant to Health and
Safety Code section 11057(d)(1), and a dangerous drug as defined in Business and
Professions code section 4022. It is also a Schedule IV controlled substance as
defined by the Code of Federal Regulations Title 21, section 1308.14 (c).

"Amitriptyline" is a drug primarily used to treat a number of mental illnesses,
including major depressive disorder and anxiety disorders, and less commonly
attention deficit hyperactivity disorder (ADHD) and bipolar disorder. Other uses
include prevention of migraines and the treatment of neuropathic pain. It belongs to a
group referred to as tricyclic antidepressants, and is believed to increase levels of a
chemical called serotonin in the brain. It is sold under the brand name, Elavil®,
among others. It is a dangerous drug as defined in Business and Professions code
section 4022.

"Amoxicillin" is a penicillin antibiotic medication used to treat infections and
stomach ulcers. It is sold under the brand name Moxatag®. It is a dangerous drug as
defined in Business and Professions code section 4022.

"Belvomra®" is a brand name for suvorexant, which is a medicine that is used
to treat insomnia. Suvorexant is in a class of medications called orexin receptor
antagonists. It works by blocking the action of a certain natural substance in the brain

1 that causes wakefulness. It is a dangerous drug as defined in Business and Professions Code section 4022.

2 "Benzodiazepines" are a class of drugs that produce central nervous system
3 (CNS) depression. They are used therapeutically to produce sedation, induce sleep,
4 relieve anxiety and muscle spasms, and to prevent seizures. They are most
5 commonly used to treat insomnia and anxiety. In general, benzodiazepines act as
6 hypnotics in high doses, anxiolytics in moderate doses, and sedatives in low doses,
7 and are used for a limited time period. There is the potential for dependence on and
8 abuse of benzodiazepines particularly by individuals with a history of multi-substance
9 abuse. Benzodiazepines can cause dangerous deep unconsciousness. When
10 combined with other CNS depressants such as alcoholic drinks and opioids, the
11 potential for toxicity and fatal overdose increases. Benzodiazepines are commonly
12 misused and taken in combination with other drugs of abuse. Commonly prescribed
13 benzodiazepines include alprazolam (Xanax®), lorazepam (Ativan®), clonazepam
14 (Klonopin®), diazepam (Valium®), and temazepam (Restoril®). Risks associated
15 with use of benzodiazepines include 1) tolerance and dependence, 2) potential
16 interactions with alcohol and pain medications, and 3) possible impairment of
17 driving. Before initiating a course of treatment, patients should be explicitly advised
18 of the goal and duration of benzodiazepine use. Risks and side effects, including risk
19 of dependence and respiratory depression, should be discussed with patients.
20 Alternative treatment options should be discussed. Treatment providers should
21 coordinate care to avoid multiple prescriptions for this class of drugs. Low doses and
22 short durations should be utilized.

23 "Clonazepam" is a benzodiazepine-based sedative. It is generally used to
24 control seizures and panic disorder. It is also sold under the brand name Klonopin®.
25 It is a Schedule IV controlled substance pursuant to Health and Safety Code section
26 11057, subdivision (d)(7), and a dangerous drug as defined in Business and
27 Professions Code section 4022.

28 "Depakote®" is a brand name for sodium valproate or divalproex sodium
which is an anticonvulsant mood stabilizer drug that can be used to treat bipolar
disorder and seizures. It can also help prevent migraine headaches. It is a dangerous
drug as defined in Business and Professions Code section 4022.

"Diazepam" is a psychotropic drug used for the management of anxiety
disorders or for the short-term relief of the symptoms of anxiety. It can produce
psychological and physical dependence and should be prescribed with caution
particularly to addiction-prone individuals (such as drug addicts and alcoholics)
because of the predisposition of such patients to habituation and dependence. It is
sold under the brand name Valium®. It is a schedule IV controlled substance as
designated by Health and Safety Code section 11057(d)(1), and is a dangerous drug
as designated in Health and Safety Code section 4022.

"Gabapentin" is an anticonvulsant medication used to treat partial seizures,
neuropathic pain, hot flashes, and restless legs syndrome. It is recommended as one
of a number of first-line medications for the treatment of neuropathic pain caused by
diabetic neuropathy, postherpetic neuralgia, and central neuropathic pain. It is sold
under the brand name Neurontin® among others. It is a dangerous drug as defined in
Business and Professions Code section 4022.

"Hydrocodone" is a semisynthetic opioid analgesic similar to but more active
than codeine. It is used as the bitartrate salt or polistirex complex, and as an oral
analgesic and antitussive. It is marketed, in its varying forms, under a number of
brand names, including Vicodin®, Hycodan® (or generically Hydromet®), Lorcet®,

1 Lortab®, Norco®, and Hydrokon®, among others). Hydrocodone also has a high
2 potential for abuse. Hydrocodone is a Schedule II controlled substance pursuant to
Health and Safety Code section 11055, subdivision (b)(1)(I), and a dangerous drug
pursuant to Business and Professions Code section 4022.

3 “Including” or “included” means, “including, without limitation.”

4 “Ingrezza®” is a brand name for valbenazine which is a medication used to
5 treat involuntary movements of tardive dyskinesia. It acts as a vesicular monoamine
6 transporter. It is a dangerous drug pursuant to Business and Professions code section
4022.

7 “Lisinopril” is a medication used to treat high blood pressure and heart failure.
8 It can also reduce the risk of death after a heart attack. It belongs to a class of drugs
9 known as angiotensin-converting enzyme (ACE) inhibitors, which are heart
10 medications that widen, or dilate, blood vessels to increase the amount of blood
11 pumped by the heart and lower blood pressure. They work by causing relaxation of
12 blood vessels as well as a decrease in blood volume, which leads to lower blood
13 pressure and decreased oxygen demand from the heart. It is sold under the brand
14 name Qbrelis®, Zestril®, and Prinivil®. It is a dangerous drug pursuant to Business
15 and Professions Code section 4022.

16 “Lorazepam,” is a benzodiazepine medication. It is used to treat anxiety
17 disorders, trouble sleeping, active seizures including status epilepticus, alcohol
18 withdrawal, and chemotherapy induced nausea and vomiting, as well as for surgery to
19 interfere with memory formation and to sedate those who are being mechanically
20 ventilated. It is sold under the brand name Ativan® among others. It is a Schedule
21 IV controlled substance pursuant to Health and Safety Code section 11057,
22 subdivision (d)(16), and a dangerous drug pursuant to Business and Professions Code
23 section 4022.

24 “Lurasidone” is an antipsychotic medication used to treat schizophrenia and
25 bipolar disorder. It is sold under the brand name Latuda® among others. It is a
26 dangerous drug pursuant to Business and Professions Code section 4022.

27 “Maxalt®” is a brand name for rizatriptan, a medication used to treat migraine
28 headaches. It is a dangerous drug pursuant to Business and Professions Code section
4022.

“Mirtazapine” is an antidepressant primarily used to treat depression. It is often
used to treat depression complicated by anxiety or trouble sleeping. It is sold under
the brand name Remeron® among others. It is a dangerous drug pursuant to Business
and Professions Code section 4022.

“Naltrexone” is a medication primarily used to manage alcohol dependence and
opioid dependence. It is sold under the brand names, ReVia® and Vivitrol®. It is a
dangerous drug as defined in Business and Professions code section 4022.

“Norco®” is a brand name for acetaminophen and hydrocodone. This
combination of hydrocodone and acetaminophen is used to relieve pain severe
enough to require opioid treatment and when other pain medicines did not work well
enough or cannot be tolerate. Other brand names for this combination of drugs
include Hycet®, Lorcet®, Lortab®, Maxidone®, Vicodin®, Zamicet® and Zydone®.

“Olanzapine,” sold under the brand names Zyprexa Relprevv®, Zyprexa
Zydis®, and Zyprexa® and Losec®, is a medication used in the treatment of mental

1 disorders, including schizophrenia and bipolar disorder. It is a dangerous drug as
2 defined in Business and Professions code section 4022.

3 "Oxazepam" is a short-to-intermediate-acting benzodiazepine. It is used to
4 treat anxiety and insomnia and in the control of symptoms of alcohol withdrawal
5 syndrome. It is sold under the brand name Serax®. It is a Schedule IV controlled
6 substance pursuant to Health and Safety Code section 11057, subdivision (d)(23), and
7 a dangerous drug as defined in Business and Professions Code section 4022.

8 "Percocet®" is a form of "oxycodone," which is an opioid analgesic medication
9 synthesized from thebaine. It is a semi-synthetic narcotic analgesic with multiple
10 actions quantitatively similar to those of morphine. It is generally used as an
11 analgesic, but it also has a high potential for abuse. Repeated administration of
12 oxycodone may result in psychic and physical dependence. Oxycodone is commonly
13 prescribed for moderate to severe chronic pain. It is sold in its various forms under
14 several brand name, including OxyContin® (a time-release formula) and
15 Roxicodone®. Oxycodone is also available in combination with other drugs and sold
16 under brand names including, acetaminophen (Endocet®, Percocet®, Roxicet®, and
17 Tylox® among others); aspirin (Endodan®, Percodan® and Roxiprin® among
18 others); and ibuprofen (Combunox®). It is a Schedule II controlled substance
19 pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a
20 dangerous drug as defined in Business and Professions Code section 4022.

21 "Propranolol" is a medication used to treat high blood pressure, chest pain
22 (angina), and uneven heartbeat (atrial fibrillation). It can also treat tremors and
23 proliferating infantile hemangioma. In addition, it can also be used to prevent
24 migraine headaches. It belongs to a class of drugs known as beta blockers (which are
25 medications that reduce your blood pressure and work by blocking the effects of the
26 hormone epinephrine, also known as adrenaline; beta blockers cause the heart to beat
27 more slowly and with less force, which lowers blood pressure). It is sold under the
28 brand names Inderal LA®, Hemangeol® and InnoPran XL®. It is a dangerous drug
pursuant to Business and Professions Code section 4022.

"Prozac®" is a brand name for fluoxetine, a medication used to treat
depression, obsessive-compulsive disorder (OCD), bulimia nervosa, and panic
disorder. It belongs to a group of drugs called selective serotonin reuptake inhibitors
(SSRIs). It is dangerous drug as defined in Business and Professions code section
4022.

"Quetiapine" is an atypical antipsychotic drug used for the treatment of
schizophrenia, bipolar disorder, and major depressive disorder. It is sold under the
brand name Seroquel®, among others. It is a dangerous drug pursuant to Business
and Professions code section 4022.

"Risperidone" is an antipsychotic medication. It is generally used to treat
schizophrenia, bipolar disorder, and irritability in people with autism. It is sold under
the brand name "Risperdal®." It is a dangerous drug pursuant to Business and
Professions code section 4022.

"Rozerem®" is a brand name for ramelteon, a sedative medication used to treat
insomnia. It is a dangerous drug pursuant to Business and Professions code section
4022.

"Soma®" is a brand name for carisoprodol. It is a muscle-relaxant and
sedative. It is a Schedule IV controlled substance pursuant to federal Controlled
Substances Act, and a dangerous drug pursuant to Business and Professions Code

1 section 4022.

2 "Sonata®" is a brand name for zaleplon, a sedative medication used to
3 insomnia. It is a dangerous drug pursuant to Business and Professions Code section
4 4022.

5 "SSRI" means Selective Serotonin Reuptake Inhibitor. SSRI antidepressants
6 are a type of antidepressant that work by increasing levels of serotonin within the
7 brain. Serotonin is a neurotransmitter that is often referred to as the "feel good
8 hormone."

9 "TD" means tardive dyskinesia, which is a condition affecting the nervous
10 system and causes repetitive, involuntary movements, such as grimacing and eye
11 blinking. It is often caused by long-term use of some psychiatric drug, which are
12 used to treat psychiatric conditions.

13 "Tegretol®" is a brand name for carbamazepine, which is an anticonvulsant
14 medication used to treat seizure, nerve pain and bipolar disorder. It is dangerous drug
15 as defined in Business and Professions code section 4022.

16 "Temazepam" is a benzodiazepine medication. It is generally indicated for the
17 short-term treatment of insomnia. It is sold under the brand names Restoril® among
18 others. It is a Schedule IV controlled substance pursuant to Health and Safety Code
19 section 11057, subdivision (d)(29), and a dangerous drug as defined in Business and
20 Professions Code section 4022.

21 "Tramadol" is a synthetic pain medication used to treat moderate to moderately
22 severe pain. The extended-release or long-acting tablets are used for chronic ongoing
23 pain. Tramadol is sold under various brand names, including Ultram® and ConZip®.
24 It is a Schedule IV controlled substance pursuant to federal Controlled Substances
25 Act, and a dangerous drug pursuant to Business and Professions Code section 4022.

26 "Trileptal®" is a brand name for oxcarbazepine, an anticonvulsant medication
27 used to treat epileptic seizures. It is dangerous drug as defined in Business and
28 Professions code section 4022.

"Venlafaxine" is an antidepressant belonging to a group of drugs called
selective serotonin and norepinephrine reuptake inhibitors (SSNRIs). Venlafaxine
affects chemicals in the brain that may be unbalanced in people with depression.
Venlafaxine is used to treat major depressive disorder, anxiety and panic disorder. It
is sold under various brand names, including, Effexor XR®. It is a dangerous drug
pursuant to Business and Professions Code section 4022.

"Zolpidem" is a sedative drug primarily used for the treatment of trouble
sleeping. It has a short half-life. Its hypnotic effects are similar to those of the
benzodiazepine class of drugs. It is sold under the brand name Ambien®. It is a
schedule IV controlled substance and narcotic as defined by Health and Safety Code
section 11057, subdivision (d)(32) and a dangerous drug pursuant to Business and
Professions Code section 4022.

25 ///

26 ///

1 **FACTUAL ALLEGATIONS**

2 **Patient A.**¹

3 10. The Board received a complaint from Patient A, a former patient of Respondent
4 alleging that he had been her doctor for 18 years and that she initially saw him for domestic
5 violence counseling. She alleged that Respondent prescribed at least 17 different medications to
6 her during that time, not including the six medications that she was currently prescribed. She
7 further alleged that Respondent failed to adequately monitor her heart health despite a family
8 history of heart disease and diabetes. Most recently, Respondent failed to refill Patient A's
9 medications due to a balance she owed to Respondent's office. She further alleged that
10 Respondent had been prescribing Norco® and diazepam to her for over ten years, and that when
11 she confronted him with patient abandonment, he only refilled the Norco® prescription for her.
12 She stated that no doctor should "blithely" prescribe to a patient such as her for years.

13 11. On or about November 12, 2020 and January 29, 2021, an investigator and medical
14 consultant interviewed Respondent ("First Interview" and "Second Interview," respectively) on
15 behalf of the Board regarding Patient A and Patient B. At the First Interview, Respondent
16 admitted that his prescribing to Patient A was not within the standard of care for each of
17 diazepam (Valium®) and Norco®.

18 12. Respondent had treated Patient A, a woman, for 18 years until February 2018 when
19 she was 57 years old. However, due to issues, including possibly a flood and staffing changes,
20 his medical records for Patient A are only available beginning from 2014. Respondent diagnosed
21 Patient A with Axis I, post-traumatic stress disorder (PTSD) and Axis III, migraine headaches
22 (her primary complaint to Respondent). PTSD and migraine headaches are co-morbidities.
23 According to Respondent, Patient A, a Canadian citizen, did not have medical insurance and paid
24 for her visits in cash. She was a paralegal by profession.

25 13. A CURES report for the period from on or about June 29, 2011 through on or about
26 June 29, 2018 revealed that Respondent wrote regular (approximately monthly) on-going

27 _____
28 ¹ Letters are used in lieu of names to address privacy concerns.

1 prescriptions to Patient A for controlled substances, including, hydrocodone with acetaminophen
2 (7.5-325),² Vicodin ES® (7.5-750) and diazepam.³ However, many prescriptions do not have a
3 corresponding documented in-person patient visit with Respondent. During 2016 and 2017,
4 Patient A filled prescriptions from Respondent at least 13 times each year including 780 pills per
5 year of diazepam. Similarly, in 2015, Patient A filled prescriptions by Respondent 13 times for
6 1,950 pills of Norco®. When confronted with these amounts at the First Interview, Respondent
7 seemed surprised that the patient was filling so many pills. In addition, Respondent also regularly
8 prescribed Maxalt® and propranolol to Patient A.

9 14. At the Second Interview, Respondent stated that Patient A suffered from post-
10 traumatic stress and “has a major depression history in the past,” and that he was constantly
11 “reviewing those symptoms [to make] sure they don’t come back.” He also stated that she has a
12 “migraine headache daily, 40 years, since age nine -- uh -- worse with periods until . . . 2014,
13 when she got menopausal.”

14 15. Respondent’s medical records for Patient A included notes beginning in 2014 which
15 document a history of extensive childhood trauma, involving physical, sexual and emotional
16 abuse, as well as adult sexual abuse and include chart notes for the following dated patient
17 encounters: May 27, 2014, July 20, 2015, April 12, 2016, June 8, 2017⁴ and February 22, 2018.
18 Each visit includes a diagnosis of PTSD and migraine headaches. The chart notes dated July 20,
19

20 ² Including the following dates: January 26, 2015, February 25, 2015, March 26, 2015,
21 April 24, 2015, May 26, 2015, July 27, 2015, August 26, 2015, September 29, 2015, October 31,
22 2015, November 2, 2015, November 5, 2015, December 16, 2015, January 1, 2016, March 1,
23 2016, April 13, 2016, May 16, 2016, June 18, 2016, July 21, 2016, August 30, 2016, October 14,
2016, November 19, 2016, December 28, 2016, February 3, 2017, March 9, 2017, April 13, 2017,
24 May 24, 2017, July 5, 2017, August 22, 2017, October 5, 2017, November 22, 2017, January 4,
25 2018 and February 25, 2018.

26 ³ Including the following dates: December 29, 2014, January 23, 2015, February 18, 2015,
27 March 17, 2015, April 14, 2015, May 11, 2015, June 8, 2015, July 5, 2015, July 31, 2015, August
28 31, 2015, September 28, 2015, October 27, 2015, November 23, 2015, December 10, 2015,
January 8, 2016, February 3, 2016, March 3, 2016, April 1, 2016, April 30, 2016, May 30, 2016,
June 29, 2016, July 25, 2016, August 23, 2016, September 20, 2016, October 18, 2016,
November 16, 2016, December 15, 2016, January 12, 2017, February 10, 2017, March 8, 2017,
April 5, 2017, May 2, 2017, May 29, 2016, July 5, 2017, August 3, 2017, August 30, 2016,
October 1, 2017, October 31, 2016, November 27, 2017, December 27, 2017 and February 3,
2018.

⁴ At this visit, Respondent documented her use of Norco® and diazepam, but wrote that
she rarely took these drugs. He also wrote that she took a shot of Baileys® with her coffee.

1 2015, April 12, 2016, and June 8, 2017 also include a diagnosis of "MDD" (major depressive
2 disorder).

3 16. Respondent's medical records for Patient A, beginning in 2014, also included
4 prescriptions to Patient A for multiple medications, including Norco® and Maxalt®. Respondent
5 also stated at his First Interview that he prescribed drugs to Patient A after she would call him,
6 including on or about November 13, 2017. Respondent acknowledged that he considered these
7 patient encounters as practicing telemedicine. He also acknowledged that he did not take
8 temperatures of patients at patient visits and asked the patients to provide their blood pressure and
9 heart rate.

10 17. In or around December 2017 or January 2018, Patient A called Respondent's office.
11 The receptionist told her that Respondent's wife required that Patient A come into the office to
12 make a payment, before she could pick up her prescription. According to Patient A, she
13 periodically carried a balance with Respondent's office.

14 18. On or about February 21, 2018, Patient A wrote a letter to Respondent, expressing her
15 shock and sadness when she was informed on or about February 15, 2018 that Respondent was
16 requiring that she pay her outstanding balance with Respondent's office and come for an in-
17 person appointment in order to obtain a prescription for Norco®. She accused him of lying about
18 his wife and expressed concern about her risk for withdrawal symptoms without her medications.

19 19. On or about February 22, 2018 (the final patient encounter), Respondent saw
20 Patient A. According to Respondent, he told her that their patient/physician relationship would
21 be discontinued and believed that her migraine headaches were stable. However, the progress
22 note does not contain any documentation about the termination of care. According to
23 Respondent, she had an outstanding bill with him. The note also documents a prescription for
24 Norco®, a statement that the patient "needs payment plan/agrees," and the name of Dr. A. At the
25 Second Interview, Respondent identified Dr. A. as a new primary care physician that Patient A
26 had "finally found." Instead of listing the other medications she was taking, this note states, "see
27 list." Although Respondent stated at his First Interview that he believed her termination was fine
28 because she no longer had psychiatric medical problems, his progress note for this visit

1 documents the following findings, which are similar to descriptions of her PTSD symptoms in
2 other notes: "Associations: 'she can get tangential. With triggers, she can ... but she is able to
3 reorganize herself;' Insight: 'she has a tendency to have difficulty with trauma triggers;' Other
4 findings: 'Tendency to go into survival mode, as opposed to flourishing.'"

5 20. Respondent's records include a letter dated February 22, 2018 from Respondent to
6 contact the County Medical Society for the names of primary physicians to treat her. The records
7 also contain a blank "authorization for release of information." There is an undated handwritten
8 note on the letter stated, "Rev'd." However, there is no documentation about how or when this
9 letter was delivered to Patient A. The letter states that Patient A's "condition" with her headaches
10 has been "interpreted as stable enough," and that utilizing a "comprehensive medical system is
11 better." The letter does not discuss a psychiatric diagnosis, psychiatric treatment
12 recommendations, or whether Respondent recommends that Patient A seek care with another
13 psychiatrist.

14 21. A prescription request, dated March 4, 2018 from Super Rx pharmacy for diazepam,
15 5 mg # 60 is signed as not authorized by Respondent on March 8, 2018.

16 22. Respondent's records include a copy of his February 22, 2018 letter to the patient
17 with the following phrase circled, "1-3 months," and the addition of a hand written note stating
18 "Please refill the diazepam that Dr. G and I spoke about; the pharmacy informs me they have
19 notified you twice already, thank you [Patient A]."

20 23. On or about March 19, 2018, Patient A wrote another letter to Respondent stating that
21 she had not received the diazepam yet, and that on March 12, 2018, she had called the office
22 (after the pharmacy had faxed twice and she had faxed three times) and been told that she had to
23 come in person to Respondent's office to make a payment and pick-up the prescription. She said
24 she would not do that because this was "gamesmanship," because Respondent had always called-
25 in prescriptions for this medication. In this letter, she reported having missed work due to lack of
26 sleep, and gone through "withdrawal" despite having reduced her dose of diazepam as of her last
27 visit on February 22, 2018.

28 24. Respondent failed to adequately address the issues for Patient A with an abrupt

1 discontinuation of benzodiazepine medications after nearly two decades of continuous use,
2 including that it would place the patient at risk of withdrawal with severe discomfort, and
3 possible serious medical risks including seizures. Despite having treated the patient for nearly
4 two decades (often prescribing controlled substances over the phone without an in-person
5 evaluation), and his familiarity with her extensive trauma history (including regularly prescribing
6 controlled substances to her), and having recorded her “boundary problems” and problems with
7 transference early in their relationship (on or about May 27, 2014) and her continued struggles
8 with “survival versus mastery” in his last clinical visit with her on or about February 22, 2018, he
9 nevertheless failed to adequately appreciate that the manner of his termination of his treatment for
10 her could result in the possibility of significant emotional trauma from the perceived unexpected
11 and arbitrary abandonment associated with his “new office policy.” He also failed to adequately
12 inform her about why and how she could obtain psychiatric care and medication maintenance
13 (especially in light of her long-term benzodiazepine use) in the future, including emergency
14 psychiatric care, and/or document his discussion with and/or correspondence to the patient.

15 25. At his Second Interview, Respondent stated that Patient A would say “she didn’t need
16 any more psychiatric medical care” and that “she didn’t have a psychiatric medical problem any
17 longer.” He also stated that she let him know that Patient A finally had a doctor [primary care
18 doctor]. He stated that he was never her primary care doctor. However, Respondent also stated
19 that Patient A “frequently falls into or slides into symptoms” – “survival mode.” However, he
20 also stated she took three or four of the Norco he gave her per migraine incident.

21 **Patient B.**

22 26. At his First Interview, Respondent stated that he first saw Patient B, a 63-year-old
23 man, in or around February in 2004, and that Patient B was a retired school teacher from New
24 York who came to see Respondent about his “treatment-resistant depression.” Respondent also
25 stated that Patient B “always had difficulty with anxiety and sleep at night.”

26 27. Thereafter, Respondent continued to treat and prescribe drugs to Patient B, but failed
27 to adequately document an assessment and/or rationale for the prescriptions, including lorazepam,
28 alprazolam and zolpidem, among others. He also prescribed Belsomra® and Rozerem®, which

1 also cause sedation.

2 28. On or about April 5, 2016, Respondent received a letter from the pharmacy warning
3 him of the danger of prescribing quetiapine⁵ and risperidone.

4 29. On or about April 12, 2018, Respondent saw Patient B with a chief complaint
5 documented as "wonder if meds cause problems" and about light headedness. Respondent also
6 refilled Patient B's prescription for zalepion (Sonata®) as well.

7 30. On or about June 10, 2018 and May 4, 2019, Patient B filled a prescription for
8 zalepion (Sonata®).

9 31. On or about April 16, 2019 and April 23, 2019, Respondent reported that Patient B
10 had been taking lorazepam, 4 mg per day and zolpidem, 40 mg per day, in addition to Belsomra®
11 and Ingrezza®.

12 32. On or about October 31, 2019, Respondent documented that Patient B was feeling
13 lightheaded, dizzy, pressure, and a "heavy head, neurologically speaking."

14 33. Respondent wrote a prescription to Patient B dated November 14, 2019, for
15 Ambien®, 10.mg, one or two per night (120 pills), and for alprazolam (Xanax®), 1 mg, two per
16 day (180 pills). These drugs are contraindicated for Patient B, due to issues such as dizziness,
17 balance, sedation and coordination.

18 34. In a questionnaire dated December 3, 2019, Patient B listed his top three concerns as
19 dizziness, balance, and light headedness. Respondent's records also include several warning
20 letters from the pharmacy indicating the risks of the medications Respondent was prescribing to
21 Patient B.

22 35. On or about December 5, 2019, Respondent referred Patient B to a cardiologist in
23 connection with complaints of dizziness and orthostatic hypertension. At this patient encounter,
24 Respondent prescribed the following drugs to Patient B: amitriptyline,⁶ Ingrezza®, Xanax® and
25 Ambien® (up to two 10 mgs a day). Each one of these drugs can cause dizziness. At his First
26 Interview, Respondent stated that Patient B always took 10 mg of Ambien® that he prescribed to
27

28 ⁵ Common side effects include dizziness, drowsiness and tiredness.

⁶ Common side effects include drowsiness, weakness or tiredness.

1 this patient.

2 36. On or about January 20, 2020, Respondent reported that Patient B's prescriptions,
3 included amitriptyline, Ingrezza®, Xanax®, Ambien®, and Ativan®, and that his "best formula"
4 for Ambien® was "12.5 times two at bedtime"⁷ and "'Xanax' was one Ativan 1 mg at night."

5 37. On or about January 30, 2020, Patient B filled a prescription for lorazepam at 1 mg,
6 90 pills from Respondent, despite the patient's prescriptions for Ambien® and alprazolam on or
7 about November 14, 2019 and for amitriptyline on or about January 20, 2020.

8 38. On or about March 16, 2020, Respondent had a patient encounter with Patient B and
9 his wife spoke to Respondent about taking two amitriptyline per day. She wanted to know if
10 Respondent could lower his dose; he was dizzy.

11 39. On or about June 11, 2020, Respondent saw Patient B who was a 79-year-old man at
12 the time with complaints about balance, light-headedness and falling and hurting his knee. He
13 had his knee replaced in January and while he had previously used a walker, he did not want to
14 use a walker again. His wife played tennis at the time. He also had a history of seeing a physical
15 therapist in 2019.

16 **Patient C.**

17 40. During the period from in or around July 2015 until in or around April 2018,
18 Respondent treated Patient C, a male aged 60 (in July 2015) with a principal diagnosis of
19 alcoholism. During that time, Respondent's medical practice was located in Palm Desert,
20 California and Patient C lived in Arizona (from in or around July 2015 until August 2016) and
21 Montana (from in or around October 2016 through in or around April 2018). During his care for
22 the patient, Respondent diagnosed Patient C with a primary diagnosis of alcoholism, in addition
23 to PTSD, MDD, ADD (Attention Deficit Disorder), bipolar disorder and Dementia. He
24 prescribed a combination, naltrexone and acamprosate (FDA approved), as well as several non-
25 FDA approved medications, to Patient C. However, he failed to adequately document his
26 rationale for these medication choices, and failed to adequately monitor Patient C for their

27 _____
28 ⁷ Presumably, this was for 12.5 mg of Ambien CR® and the recommended dose is 12.5
mg maximum.

1 efficacy and side-effects.

2 41. This matter arose upon the Board's receipt of a complaint expressing concern about
3 Respondent's excessive prescribing of lorazepam, quetiapine and divalproex to Patient C while he
4 was continuing to consume alcohol, and without seeing Patient C in-person for patient
5 encounters. In or around April 2018, Respondent's care for Patient C ended when he terminated
6 care and referred him to another doctor and an addiction treatment counselor in Montana where
7 the patient was living. In response to the complaint, Respondent alleged that he repeatedly
8 attempted to transfer care for Patient C to a local physician during the time he provided medical
9 care for him, but that he was unsuccessful and therefore continued to treat him. However,
10 Respondent's medical records for Patient C fail to include adequate documentation of such
11 alleged repeated attempts to transfer his medical care to a local provider in either Arizona or
12 Montana until in or around March 2018. In addition, while documentation dated in 2017
13 indicates that the patient was going to see a primary physician in Montana and addiction
14 counseling at an addiction treatment center in Montana, Respondent failed to adequately attempt
15 to transfer his care of the patient to a local provider, or explain to the patient that he could not
16 continue to treat him without periodic in-person examinations, and that he could not prescribe in
17 another state, and/or he failed to adequately document the same.

18 42. In or about November 12, 2020, an investigator and medical consultant interviewed
19 Respondent on behalf of the Board about Patient C ("Third Interview"). At the Third Interview,
20 Respondent stated that he only had a California medical license, and did not have a license to
21 practice medicine in any other state.

22 43. Respondent committed unprofessional conduct (including gross negligence,
23 negligence and incompetence) for years with respect to his care of Patient C, a seriously ill
24 patient, by treating him without periodic in-person examinations and by remotely prescribing
25 medications to him in another state without a license to practice medicine in the state where the
26 prescriptions were filled. He continued to do this despite the fact that he should have known that
27 patients with significant alcohol/substance use disorders are often not adherent to treatment, not
28 reliable about their substance use patterns, and otherwise tend to hide or minimize problems

1 associated with their substance misuse.

2 44. Patient C also suffered from repeated serious complications from his continued
3 excessive alcohol consumption during the period of treatment by Respondent for that condition.
4 Severe alcoholism is an extremely serious, often lethal condition and Respondent failed to
5 adequately adjust his treatment plan despite evidence that it was not working.

6 **FIRST CAUSE FOR DISCIPLINE**

7 **(Gross Negligence)**

8 45. Respondent is subject to disciplinary action under Code section 2234, subdivision (b),
9 in that he committed gross negligence in his care and treatment of three patients. The
10 circumstances are as follows:

11 **Patient A.**

12 46. On or about May 27, 2014 and thereafter, Respondent committed the following acts,
13 individually and/or collectively, of gross negligence, in connection with his treatment and care of
14 Patient A, as follows:

15 (A) Respondent excessively prescribed medications, including controlled
16 substances to Patient A, including benzodiazepines and opioids. Respondent failed to adequately
17 assess, re-assess and/or monitor his continuous prescribing of controlled substances to Patient A.
18 He failed to adequately monitor her use of controlled substances, including through the use of
19 biological toxicology testing. He also failed to adequately obtain and/or document an informed
20 consent from the patient, including adequate documentation of his explaining all of the attendant
21 risks, benefits and alternatives. He failed to adequately consider and investigate whether Patient
22 A was actually "rarely" using opioids and benzodiazepines, i.e., 3 to 4 Norco® per migraine
23 episode. He failed to adequately assess her in person before continuing her medications. He
24 failed to recognize and/or address that opioids and diazepam could have dangerous synergistic
25 effects when combined, this was even in light of her reporting to him her past history of alcohol
26 use and that she used Baileys® in coffee throughout the day.

27 (B) Respondent inappropriately prescribed benzodiazepines to Patient A. His
28 psychiatric diagnoses for her were PTSD and MDD. He maintained Patient A on

1 benzodiazepines for years at high doses to treat PTSD⁸ and insomnia. He failed to adequately
2 obtain and/or document her informed consent to these treatments which were unorthodox. He
3 failed to adequately inform her about the benefits, risks (including of abuse, dependence tolerance
4 and withdrawal, sedation, and cognitive impairment) and alternatives to treatment. Further,
5 diazepam is a benzodiazepine with long-acting metabolites and inappropriate to address sleep
6 issues, i.e., a build-up of long acting metabolites can occur and exacerbate with age. Short term
7 use of short-acting agents is more appropriate for sleep issues. Prescribing of long-acting
8 benzodiazepines also required consistent follow up and re-assessment for effectiveness (including
9 through intermittent use) and monitoring of side effects, which Respondent failed to do for
10 Patient A. He failed to adequately perform and/or document any systemic monitoring of Patient
11 A's sleep function, attempt at behavioral treatment, and/or discussion of alternatives (including
12 trials of CBT which may have had more efficacy) to diazepam. His documentation was also
13 inconsistent, e.g., indicating 5 mg twice a day and 10 mg qHS.

14 (C) Respondent inappropriately prescribed opioids to Patient A, including on a
15 long-term basis. Opioids are not recommended as a first-line treatment for migraines, and are
16 associated with avoidable risks, including risks for abuse, tolerance and dependence. He also
17 failed to appropriately treat her migraines. Respondent failed to adequately assess, re-assess,
18 monitor and/or document details about Patient A's migraines systematically and the efficacy or
19 adverse effect from his treatment, e.g., the frequency, duration and severity (impact on
20 functionality) of migraines. He also failed to adequately recognize and/or consider that excessive
21 opioid treatment could actually increase the risk of headaches and chronic migraines. He failed to
22 adequately explain why he used opioids to treat Patient A medically and/or obtain her informed
23 consent after explaining all of the risks, benefits and treatment alternatives. He failed to
24 adequately medically treat Patient A, including by inappropriately prescribing Maxalt®.

25 (D) Respondent's medical record keeping for his treatment of Patient A represents
26 gross negligence. Respondent also committed gross negligence by failing to adequately assess
27 and/or examine the patient (including by obtaining an adequate history and symptomology from

28 ⁸ Which is not recommended to treat this condition.

1 the patient), and/or by failing to adequately document the same. At the Second Interview,
2 Respondent was asked to read his records due to their illegibility. The illegibility of
3 Respondent's records would have made it extremely difficult for another healthcare provider to
4 review them. This is further complicated by his underuse of standard medical terminology in his
5 description of findings. In addition, the organization of Respondent's progress notes did not
6 follow standard divisions of the medical assessment, despite the template for his notes. For
7 example:

8 (i) Respondent failed to adequately document Patient A's symptoms of her
9 main complaints, e.g., headache frequency, PTSD symptoms, and/or track the course of her
10 condition(s) over time and her responses to treatment.

11 (ii) Respondent's progress note dated May 27, 2014, failed to include an
12 adequate description of the patient's current PTSD Symptoms. His record for the visit failed to
13 include a diagnostic assessment (i.e., a Diagnostic and Statistical Manual of Mental Disorders,
14 "DSM" criteria for PTSD) for Patient A, who had a history of trauma. Respondent failed to
15 adequately assess Patient A for such typical symptoms as nightmares, flashbacks, avoidance,
16 physiological hyperarousal upon exposure to reminders, sleep disturbance, hypervigilance, startle
17 reactions, and altered cognitive (self-blame, other self-concept issues) or dissociative symptoms
18 in connection with his diagnosis of PTSD, and in monitoring the condition. Respondent also
19 failed to adequately address Patient's A's symptoms and responses to treatment, including to
20 medications, and how any co-morbidities such as depression would be affected. Such
21 information would affect treatment plans and possible medications, including fluoxetine,
22 paroxetine, sertraline or venlafaxine, among which only paroxetine and sertraline are indicated
23 for PTSD. He failed to adequately document whether he considered Patient A's undated list of
24 medications which she used prior to age 37/38 (1994 or 1995).

25 (iii) Respondent's progress note dated May 27, 2014 also failed to include
26 documentation of an assessment / history of drug use other than her denial of use of an illicit
27 substance or medical marijuana on or about April 12, 2016, and her consumption of Baileys® in
28 coffee throughout the day.

1 (iv) Respondent failed to adequately document Patient A's history of suicidal
2 thoughts/behavior, which is common in victims of extensive childhood trauma such as Patient A.

3 (v) Respondent's records included a diagnosis of MDD on or about April 12,
4 2016 and June 8, 2017. However, his records failed to adequately document any history of
5 depressive symptoms, episodes, or treatment for this condition.

6 (vi) At his Second Interview, Respondent explained in regards to Patient A's
7 visit on or about April 12, 2016, that "she does have a much more disciplined way in her affect
8 recognition management and skills strategies. . . . stronger "ARMS" . . . a much more diagnostic
9 and therapeutic way of saying things . . . a disorder has been replaced with the word diagnosis . . .
10 you want diagnosis, and you don't want disorders." This way of describing PTSD differs from
11 the standard nomenclature (e.g., DSM). Further, "stronger" ARMS seems to be a subjective
12 global judgement. How will it be determined when her ARMS is strong enough, or when
13 additional treatment is required?

14 (vii) At his Second Interview, Respondent explained in regards to Patient A's
15 visit on or about June 8, 2017, that she is not the person she stated and described big "mind F
16 experience," and F is a letter to represent one word . . . and used the acronym "AMAP" which
17 meant as much as possible. He also described her physical health and five goals (home, school,
18 work, play, jobs and self) and that there were the "third of the two rules, of basically the
19 diagnostic and therapeutic is to do the kindness, the Hippocratic. The double H test. Helping, not
20 hurting self and others." Another health care provider would have difficulty interpreting
21 Respondent's documentation of this visit.

22 (viii) At his First Interview, Respondent, in regards to Patient A's visit on or
23 about February 22, 2018, deciphered his documentation which listed information in a very
24 unsystematic way and failed to include specific symptoms of PTSD (or MDD), the psychiatric
25 medical condition(s) he treated.

26 ///

27 ///

28

1 **Patient B.**

2 47. In or around April, 2014, and thereafter, Respondent committed the following acts,
3 individually and/or collectively, of gross negligence, in connection with his treatment and care of
4 Patient B as follows:

5 (A) Respondent inappropriately prescribed medications to Patient B, including controlled
6 substances such as benzodiazepines, zolpidem and Belsonra®. Respondent excessively
7 prescribed controlled substances, and failed to adequately endeavor to prescribe medications at
8 the lowest effective dose and for short durations. He failed to adequately treat Patient B's sleep
9 difficulty. Benzodiazepines are a high risk medication for elderly patients due to their sedative
10 effects. There is a heightened risk of falls and concomitant risk of hip fracture in elderly patients
11 who are prescribed benzodiazepines. In addition, zolpidem should be prescribed at a low dose; 5
12 mg is the recommended dose for an elderly patient. Further, concurrently prescribing these
13 medications is especially dangerous in elderly patients. Although Respondent noted the risk of
14 falling, he failed to adequately assess, re-assess, and/or document his rationale for his medication
15 treatment for Patient B. He failed to adequately recognize that the drugs he provided to the
16 patient, including amitriptyline, Ingrezza®, Xanax® and Ambien® could have caused dizziness.
17 He failed to adequately provide informed consent for the treatment he provided to him as well,
18 including by explaining the risks, benefits, and treatment alternative (such as CBT) for the
19 patient, especially in light of the high doses of sedative drugs he prescribed to Patient B.⁹ Several
20 warning letters from the pharmacy are in Respondent's records about the possible adverse effects
21 from the drugs Respondent prescribed to Patient B, including quetiapine and amitriptyline. He
22 also failed to adequately recognize the dangerous side effects that could result when he prescribed
23 the dangerous drugs to the patient in high doses, including 10 mg of Ambien® and 1 mg of
24 Ativan® on an on-going basis, including balance, coordination and cognition. Respondent also
25 failed to adequately adjust his treatment of Patient B in light of these dangers.¹⁰

26 (B) In or around April 2014 and thereafter, Respondent failed to adequately evaluate, re-

27 ⁹ Such high doses could be considered "off-label" use.

28 ¹⁰ This was despite concerns raised by the patient's wife about these very risks, i.e.,
dizziness/unsteadiness and loss of balance.

1 evaluate and/or monitor his continuous prescribing of controlled substances to Patient B,
2 including for any adverse effects from the drugs he was prescribing. Respondent also failed to
3 adequately obtain and/or document an informed consent from Patient B for each of the dangerous
4 drugs he prescribed to him, after explaining all of the attendant risks, benefits and alternatives to
5 the medications he prescribed to Patient B.

6 (i) A pharmacy sent Respondent a letter dated May 15, 2017 regarding a
7 prescription for amitriptyline and stated that a prior authorization ("PA") was required. In
8 another letter dated December 20, 2017, the pharmacy warned Respondent about the dangers of
9 "high risk medication," viz., tricyclic antidepressant in older adults and the increased risk of
10 adverse side effects related to its anticholinergic properties, including impaired coordination,
11 memory dysfunction and cognitive impairment in the elderly.

12 (ii) Respondent's records fail to adequately document that he informed the patient
13 about the dangers of using the medications he prescribed, including quetiapine and olanzapine,
14 with the attendant risks for weight gain, type II diabetes mellitus and hyperlipidemia. In addition,
15 both amitriptyline and quetiapine are associated with risk of QTc prolongation and associated
16 cardiac arrhythmia, and their use requires monitoring of cardiac health. Respondent failed to
17 adequately perform and/or document an informed consent with the patient, including by
18 explaining the benefits, risks, and alternatives to treatment.¹¹ In addition, Ingrezza® and
19 amitriptyline use could increase nortriptyline levels and pose a risk for cardiac toxicity.
20 Respondent failed to obtain any relevant testing, such as an electrocardiogram or blood tests
21 showing level of amitriptyline or nortriptyline blood levels. Ingrezza® could also induce
22 somnolence and Parkinson-like symptoms and Respondent failed to adequately document that he
23 informed the patient about these risks.

24 ¹¹ There is a documented visit on or about March 16, 2020 when the patient's wife asked
25 to decrease the amitriptyline from two to one per day and Respondent engaged in a discussion
26 about the risks/benefits and lowered the dose. Similarly, a chart note dated February 26, 2020
27 does state, "safety, risk, benefit conversation" in a record that lists quetiapine, amitriptyline,
28 zolpidem, Ativan®, Xanax® and Ingrezza®. However, the same note discussed a recent
emergency room visit for a hypotensive episode with blood pressure of 50/42. An overdose from
benzodiazepine and non-benzodiazepine sedative-hypnotics can cause hypotension, and there is
no adequate documentation that Respondent informed the patient about these risks.

1 (iii) Respondent diagnosed and treated Patient B for TD. He failed to adequately
2 consider that lurasidone¹² and olanzapine may cause symptoms associated with the condition. He
3 also failed to adequately monitor the patient's progress over time (e.g., abnormal involuntary
4 movement scale or "AIMS") and response to treatment, i.e., medications.¹³ He failed to
5 adequately inform the patient that quetiapine could cause or exacerbate TD.

6 (C) In or around April 2014 and thereafter, Respondent's medical record keeping of his
7 treatment of Patient B represents gross negligence. Respondent also failed to adequately assess
8 and/or examine the patient (including by obtaining an adequate history and symptomology from
9 the patient), and/or document the same. At the Second Interview, Respondent was asked to read
10 his records due to their illegibility. The illegibility of Respondent's records would have made it
11 extremely difficult for another healthcare provider to review them. This is further complicated by
12 underuse of standard medical terminology in his description of findings. In addition, the
13 organization of Respondent's progress notes did not follow standard divisions for medical
14 assessments, despite the template for his notes. For example:

15 (i) Respondent used a series of single words, some corresponding to current
16 symptoms, past history, psychosocial history and medical terminology.

17 (ii) Respondent failed to adequately document Patient B's symptoms for his
18 diagnoses. He failed to adequately assess and/or document Patient B's PTSD symptoms and
19 progression from age five to 75. He failed to adequately document the longitudinal pattern of
20 Patient B's sleep changes (e.g., whether chronic insomnia related to the mood disorder or PTSD).
21 Further, it is unclear from his documentation whether Respondent's diagnosis of major depression
22 was related to Patient B's sleep issues or other problems, i.e., whether there were changes in
23 appetite, interests, energy level, self-worth, psychomotor activity level or suicidal thinking, in
24 patterns corresponding to diagnostic criteria for a major depressive episode. He also failed to
25 adequately assess and/or document Patient B's bipolar disorder.

26 (iii) Respondent's documentation of his patient encounters over time is

27 ¹² Which he prescribed to the patient on or about November 13, 2018.

28 ¹³ Although he did estimate the AIMS score intermittently such as on or about May 15,
2017, April 12, 2018 and October 3, 2019.

1 difficult to follow and inconsistent. For example, Respondent's progress note dated March 3,
2 2020, stated the patient tried to cut the treatment with Xanax®. But later in the same note, he
3 wrote, "Xanax sleeping good." In a questionnaire dated March 3, 2020, Respondent wrote that
4 the patient only takes Ativan and not Xanax any longer. And, in a note dated March 16, 2020,
5 Respondent wrote, "good follow up, compliance." However, this contrasts with the First
6 Interview, when Respondent stated that the patient would often change his medications.
7 Similarly, regarding the patient's TD issue, from on or about February 19, 2019 through March
8 16, 2020, the patient continued to suffer from possible issues including shortness of breath and
9 Respondent nevertheless failed to adequately assess, treat and/or document the patient's TD by
10 noting the symptoms and changes over time. He failed to adequately consider that it could have
11 been related to possible withdrawal TD when the patient was taken off olanzapine. Further, on or
12 about February 19, 2020, Respondent documented that Ingrezza® 80 mg "couldn't take it," and
13 on or about October 31, 2019, he documented that 40 mg was "best" and 80 mg made it "worse."
14 Yet, he continued to prescribe that amount to the patient for several months.

15 (iv) Respondent used medical terminology in an unusual way. On or about
16 June 11, 2020, Respondent saw Patient B and found that he had "constitutional issues – uh – he
17 felt stressed," and "his eyes and ears and heart are all that . . ." In that same chart note,
18 Respondent referred to using dialectical behavior therapy ("DBT") and cognitive behavior
19 therapy ("CBT") without qualification. Furthermore, at his Second Interview, Respondent stated,
20 "Would pay more attention, curiosity of how he thinks and feels, as opposed to reacting to it.
21 Most people I know I work with, we talk about reflective -- always reflective, never reactive.
22 And likes that, a lot." This appears to be a description of therapeutic components of mindfulness
23 which is used as a component of CBT, while DBT was developed to assist young women with
24 borderline personality disorders reduce their injurious/parasuicidal behavior. Thus, Respondent
25 failed to adequately explain in his documentation how Patient B received both CBT and DBT.
26 Additionally, at his Second Interview, Respondent stated that he used CBT, DBT and "PIOP"
27 (psychodynamic insight oriented psychotherapy) which is a long-term treatment modality
28 involving the therapist's facilitating the patient's understanding of the influence of unconscious

1 processes on emotions, thinking and behavior (based on principles usually attributed to Sigmund
2 Freud). Thus, his use of this term is inadequately documented. Further, CBT, DBT and PIOP are
3 not typically used simultaneously in a patient. Yet, Respondent stated at the Second Interview
4 that; “If I say do not think of the color red, it’s physically impossible . . . We kind of focus on
5 positive confrontation . . . its ongoing growth and development . . . that goes with sleep hygiene,
6 and “[H]is cognitive behavioral therapy, his dialectical behavioral therapy, where he can pay
7 more attention just observing and be kind of fascinated and curious with it, and then deciding
8 what it kind of means, the way he thinks, feels and says, and does; He likes that;” and “He had a
9 history of crying a lot as a child – um – when he was in the hospital, in the iron lung, and all that
10 other stuff he went through before, and the detail of that and how bad it was and what he did from
11 then until now to make it better was very helpful for him that’s the insight oriented and gives him
12 chance to be more cognitively, emotionally, and behaviorally restructuring.” In a discussion of
13 the patient’s TD, he stated at the Second Interview that he discussed “valbenazine and meclizine”
14 and that he went through a detailed treatment review, helping the patient to integrate and be more
15 diagnostic and therapeutic.”

16 **Patient C.**

17 48. In or around April, 2014, and thereafter, Respondent committed the following acts,
18 individually and/or collectively, of gross negligence, in connection with his treatment and care of
19 Patient C as follows:

20 (A) In or around July 2015, and thereafter, Respondent committed gross negligence
21 when he practiced medicine in a state where he did not have a valid and effective medical license.
22 Respondent possessed a valid medical license only in California during the time he treated
23 Patient C (who resided in other states), including by prescribing controlled substances to him. In
24 addition to violating the law, Respondent failed to recognized that he would not be able to
25 effectively handle psychiatric emergencies, arrange for emergency assessment and
26 hospitalizations, and coordinate care from California, especially in light of his unfamiliarity with
27 applicable standards of care and local laws. Once realizing that Patient C would remain in
28 another state, he should have transferred care for the patient to a licensed physician in the other

1 state, where the other physician could conduct regular in-person examinations of the patient.
2 Respondent had multiple opportunities to transfer his care for the patient to another local
3 provider. Yet, he continued to treat the patient.

4 (i) In or around July 2016, when the patient resided in Arizona, he had
5 reportedly been seeing a new doctor. However, Respondent failed to adequately follow up about
6 this doctor with the patient, including about his specialty and/or whether he could take over care
7 for the patient, including in respect of his medications.

8 (ii) On or about January 30, 2017, Respondent identified that Patient C had
9 scheduled an appointment in one week with a new primary care physician in Big Fork, Montana.
10 Respondent should have informed the patient that coordination of care was necessary, and asked
11 for the patient's authorization to share records with and to communicate his medical history to the
12 new primary care physician. He should have informed the patient that he was going to transfer
13 his care and could not continue to treat Patient C out of state. However, Respondent failed to
14 attempt to coordinate care for Patient C. At the time of this visit, Patient C was consuming 15
15 alcoholic beverages per day.

16 (iii) On or about May 26, 2017, Respondent failed to follow-up with Patient C
17 and/or document about whether the patient had seen the primary care doctor in Montana, or what
18 she recommended.

19 (iv) On or about June 25, 2017, Respondent noted that Patient C was doing
20 well, and tapering off of the medications Respondent had prescribed to him. However, he failed
21 to follow up and/or document about the patient's prior scheduled local primary care doctor visit,
22 and failed to transfer his care and end his remote treatment of the patient.

23 (B) In or around July 2015, and thereafter, Respondent committed gross negligence
24 when he continued to treat Patient C without in-person examinations, including to perform
25 adequate mental status examinations. At his Third Interview, Respondent stated that he continued
26 to treat Patient C via telephonic conference calls. However, his documentation for his patient
27 encounters fails to indicate that his visits were via telephone.

28 (C) In or around July 2015, and thereafter, Respondent committed gross negligence

1 when he inappropriately prescribed medications to Patient C, including benzodiazepines.
2 Respondent excessively prescribed benzodiazepines for years on a monthly basis to Patient C
3 who had alcohol use disorder and documented harm and evidence of misuse. Benzodiazepines
4 should be prescribed in low doses for the shortest time possible in patients with alcohol use
5 disorder because of the risks of tolerance, dependence and additive CNS depression when
6 combined with alcohol. A patient's denial of misuse is not a reliable method of assessing the
7 patient's potential harm. Respondent continued to prescribe large quantities of 2 mg lorazepam to
8 Patient C, who had alcohol use disorder and suffered from (i) harmful drinking behavior,
9 including DUIs, medical problems such as "brain damage," hepatitis and hip fracture, and (ii)
10 misuse and overdose from lorazepam as discussed at the Third Interview (when he first learned
11 about the patient's anxiolytic use disorder diagnosis and discharge summary from a treatment
12 program in Florida).¹⁴

13 (i) On or about February 19, 2016, Patient C was admitted to a hospital for
14 benzodiazepine intoxication.

15 (ii) On or about October 3, 2016, Respondent documented his first patient
16 encounter after Patient C moved to Montana. He also prescribed both lorazepam and oxazepam
17 to the patient, when the patient informed him he had difficulty with opioid withdrawal.

18 (iii) On or about January 10, 2017, Respondent prescribed a high dose of
19 lorazepam (2 milligrams twice a day).

20 (iv) On or about January 30, 2017, Patient C reported to Respondent that he
21 had suffered an alcohol related driving under the influence (DUI) incident two weeks earlier.
22 However, Respondent failed to investigate whether his lorazepam prescription contributed to the
23 DUI. He also failed to warn the patient that he would recommend suspending those prescriptions
24 for safety. The patient also reported to Respondent that he was binge drinking 15 vodkas a day.

25 (v) On or about February 20, 2017, Patient C was transported to a hospital
26 with an altered medical status. He had possibly overdosed on benzodiazepines and paramedics
27 noticed that he was missing a substantial quantity of his Ativan®, prescribed from this doctor in

28 ¹⁴ Respondent continued to prescribe lorazepam to Patient C on or about March 14, 2018.

1 Palm Desert.

2 (vi) On or about May 26, 2017, Respondent prescribed lorazepam (2 mg BID
3 as directed, 60 tablets with one refill) to Patient C. This was despite the patient having told
4 Respondent that he was drinking 15 alcoholic beverages per day at the last documented patient
5 encounter in January. Respondent failed to document any assessment of the patient or the
6 medication's effects or safety. The patient also reportedly completed a rehab program and was
7 taken off of the lorazepam in that program (Watershed).

8 (vii) On or about September 28, 2017, Patient C "confessed" to Respondent
9 that he had "violated the script" and was taking five lorazepam pills per day instead of three. He
10 wrote, "not toxic until" exceeds 8 mg. Patient C's friend was invited to participate in the meeting
11 and stated that the patient functions "funky" when he has "too many benzo." In his plan,
12 Respondent increased the patient's dose to lorazepam, 2 mg four times a day (#90). He also
13 included a statement "Lorazepam 2 mg if he takes more, good to go" and "4 DUIs, caught and
14 prosecuted." However, Respondent failed to counsel the patient about the danger of taking these
15 large doses of lorazepam; nor about the inadvisability of taking more than prescribed, nor about
16 the risks of using this medication in conjunction with alcohol, nor about the risk of
17 benzodiazepine use contributing to hazardous driving.

18 (viii) On or about November 15, 2017, Respondent wrote in a progress note
19 that the patient, while undergoing court mandated alcohol counseling, was taking "no benzos,"
20 and "Sometimes I get mad to myself if I take too many pills." He then prescribed lorazepam, 2
21 mg, bid, 30 pills to the patient.

22 (ix) On or about December 6, 2017, Respondent documented that the patient
23 reported having a DUI problem and that his hands were shaking. The patient also stated that he
24 gets "completely confused regarding medications." Respondent also prescribed lorazepam, 2 mg,
25 tid, 90 pills to the patient, without instructions or an attempt to coordinate care.

26 (x) On or about March 13, 2018, a pharmacist informed Respondent that the
27 patient came to the pharmacy on or about March 12 intoxicated and wanted more lorazepam.
28 However, the pharmacist only provided "2 pills" (of lorazepam) because the patient had already

1 received 30 pills on March 7, 2018.

2 (xi) On or about March 14, 2018, Respondent prescribed lorazepam (2 mg
3 TID, 90 pills) to Patient C. This was despite the patient reporting that he was in five days of
4 "pure hell" and felt like "dying," and his employee was going to get him alcohol. Respondent
5 placed the patient at risk of serious harm by prescribing a month's supply of a large dose (6 mg
6 per day) of a sedative-hypnotic drug when he knew the patient had relapsed. There was no
7 documentation in the note of his rationale for this decision. When asked about this at his Third
8 Interview, Respondent acknowledged that this was not a safe prescription and that the patient
9 should be in a hospital. On or about April 3, 2018, Respondent prescribed 90 pills of lorazepam
10 with refills to the patient.

11 (D) In or around July 2015, and thereafter, Respondent committed gross negligence
12 when he prescribed benzodiazepines to Patient C without medical indication. Benzodiazepines
13 are not recommended for the treatment of alcoholism because of the risk of harm, including
14 dependence, tolerance, abuse and withdrawal, except in limited situations such as acute alcohol
15 withdrawal or where co-occurring disorders may indicate use in light of the other
16 circumstances.¹⁵ However, Respondent's records for this patient do not include any symptomatic
17 or diagnostic basis for his continuous treatment of benzodiazepines for Patient C. Repeating a
18 month's supply of benzodiazepines over a multi-year period is not standard treatment for alcohol
19 withdrawal or sleep issues. Moreover, use of benzodiazepines in the setting of alcohol
20 intoxication entails risks of harmful effects, including additive sedation, respiratory depression,
21 and even death. Respondent failed to adequately assess, re-assess, and monitor Patient C for any
22 benefits and harms or misuse, despite repeated instances where the withdrawal strategy clearly
23 failed, and instances of misuse or overuse occurred.

24 (E) In or around July 2015, and thereafter, Respondent committed gross negligence
25 and incompetence when he prescribed many dangerous drugs to Patient C without indication.
26 Respondent prescribed medications to Patient C for years, including for citalopram (CelexaR®)

27 ¹⁵ When used to treat a co-morbid anxiety disorder, it should only be used after
28 psychotherapy or antidepressants have failed, and then, only in limited quantities and at the
lowest possible dose.

1 40 mg/day, divalproex (Depakote ERR®) 500 mg BID and quetiapine (SeroquelR®) 150-300
2 mg/d and other doses as needed for "severe agitation," without adequate documentation of any
3 diagnostic indication(s) for these medications. Alcohol use disorder was not an indication for use
4 of these medications during the treatment periods in question. In addition, use of acamprosate,
5 naltrexone and the combination of these two is not indicated for alcohol use disorder.
6 Furthermore, while gabapentin and topiramate may have some efficacy for individuals trying to
7 achieve abstinence or reduce drinking severity, the abuse potential for gabapentin requires
8 attentive monitoring. Antidepressants have minimal benefits, no benefit or even worsening of
9 alcohol use outcomes when prescribed for this indication. In addition, use of antidepressants in
10 patients with differential diagnoses of alcohol use related mood disturbance and independent co-
11 morbidities must be carefully discerned and documented. Respondent treated Patient C for
12 alcohol dependence, and intermittently for alcohol withdrawal. He failed to document an
13 adequate rationale for Depakote® as well. Respondent also diagnosed Patient C with "MDD,"
14 "PTSD," and "ADHD." Quetiapine was not indicated for MDD. Neither citalopram nor
15 quetiapine were indicated for the treatment of PTSD or ADD (assuming Respondent means
16 attention deficit (hyperactivity) disorder). Respondent failed to adequately document any "off-
17 label" rationale for use of his prescribing in those instances where Respondent presumably used
18 citalopram, divalproex and quetiapine, nor any documentation that he informed Patient C that he
19 used such medications in an "off-label" manner, or that he explained the risks, benefits, or
20 alternatives to any of his medications. Finally, on or about September 28, 2017, Respondent
21 prescribed lithium, 300 mg #60 with 3 refills, to Patient C, without a diagnosis of bipolar
22 disorder, or without an explanation of the purpose, directions or potential risks and benefits, or
23 without a recommendation for monitoring levels and other laboratory test results, including renal
24 and thyroid functions and calcium metabolism. Respondent also prescribed lisinopril to the
25 patient at this visit, but failed to adequately monitor the patient's lithium level which is important
26 due to the risk of drug interactions.

27 (F) In or around July 2015, and thereafter, Respondent committed gross negligence
28 when he failed to adequately monitor Patient C for potential adverse effects from the medications

1 he prescribed to him, and/or adequately obtain an informed consent from the patient regarding
2 those prescriptions and/or document his interactions with the patient. Respondent failed to
3 adequately consider and/or inform the patient about the potential adverse effects pertinent to
4 medications he prescribed to Patient C.

5 (i) During his treatment of Patient C, Respondent prescribed citalopram
6 (CelexaR®) 40 mg/day, divalproex (Depakote ERR®) 500 mg BID and quetiapine (SeroquelR®)
7 150-300 mg/day and other doses. However, Respondent failed to adequately monitor and/or
8 document any monitoring for potential side-effects of these medications, including ECG
9 monitoring for possible QTc prolongation (which increases the risk of serious cardiac
10 arrhythmia¹⁶). Quetiapine is associated with risk of QTc prolongation, and Respondent
11 prescribed this medication at substantial doses without documenting its indications, the
12 monitoring for potential risks, or his having advised the patient of these risks.

13 (ii) Respondent prescribed quetiapine (indicated for schizophrenia and
14 bipolar disorder and often used “off-label” for treating insomnia or other non-specific psychiatric
15 symptoms such as “agitation”) to the patient, but failed to adequately inform the patient about,
16 and monitor periodically for, the risk of metabolic syndrome, including weight gain,
17 hyperlipidemia, and type II diabetes.

18 (iii) Respondent also prescribed DepakoteR® (divalproex) for years to
19 Patient C without documenting indications or adverse effects, including warning about, and
20 monitoring for, serious risks of this medication such as pancreatitis, liver damage, hematotoxicity,
21 including lowering of white blood cell counts or platelets, and hyperammonemic encephalopathy;
22 nor monitoring the serum level of the medication (valproic acid level). Moreover, patients with
23 chronic alcoholism are at risk of liver damage, and Respondent documented a diagnosis of
24 hepatitis for Patient C. Yet, he failed to document any adequate concern about the possibility of
25 valproate hepatotoxicity in a patient maintained on that medication who had hepatitis.

26
27
28 ¹⁶ The combination of two or more drugs with QTc prolongation potential increases the
risk of serious arrhythmias.

1 (iv) On or about March 18, 2018, Patient C struggled with both alcohol and
2 lorazepam overuse, and Respondent prescribed gabapentin to the patient to assist with withdrawal
3 symptoms. However, his dosing was twice the manufacturer's maximum recommended daily
4 dosage of 3,600 mg per day. He also documented findings of "ataxia and vertigo," which placed
5 the patient at substantial risk of harm due to the high dosing. He failed to document any other
6 possible alternatives to treatment for the patient, including referring the patient to the emergency
7 room or collaboration in the care of the patient with the patient's local primary care physician.

8 (G) In or around July 2015, and thereafter, Respondent committed gross negligence
9 when he failed to adjust/change his treatment plan in light of Patient C's deteriorating condition.
10 Respondent maintained Patient C on a combination of naltrexone, acamprosate, divalproex,
11 citalopram and gabapentin for years. However, divalproex, citalopram, quetiapine and
12 gabapentin are not indicated to treat alcoholism. Further, Respondent failed to change his
13 treatment regimen over time (e.g., replacing divalproex and/or gabapentin to topiramate, another
14 anticonvulsant medication with better evidence for efficacy, as an adjunctive medication for
15 helping patients achieve or maintain alcohol abstinence).

16 (i) Respondent also repeatedly prescribed gabapentin for preventing seizures
17 during Patient C's tapering off of alcohol. However, Respondent failed to change this treatment
18 even after the evidence indicated its inefficacy, including occasions in or around 2018 when doses
19 of up to 7,200 mg gabapentin were prescribed.

20 (ii) During the period from in or around December 2015 to on or about
21 February 1, 2016, Respondent described Patient C as making progress in terms of his alcoholism.
22 However, Patient C missed appointments on or about February 5, 2016 and February 8, 2016.
23 Further, on or about February 22, 2016, Respondent noted that Patient C returned to drinking and
24 had a seizure 3-4 days prior, with hypotension and psychotic symptoms. Yet, Respondent failed
25 to change his treatment plan, and there is no documentation of any effort by Respondent to obtain
26 records of the patient's emergency room visit for the seizure. Also, Patient C missed the next
27 appointment calendared for February 29, 2016. On or about March 7, 2016, Respondent reported
28 that the patient had suffered a DUI "a month ago," and was intoxicated during the appointment,

1 and “tangential” on his mental status exam. Respondent also documented that another “specialist
2 doctor” recommended a neuropsychological assessment, and that his attorney said he needed an
3 MRI and neuropsychological assessment. Respondent also added a new diagnosis of “alcoholic
4 dementia (wet brain syndrome)” on this date. However, there was no documentation in this note
5 of an effort to communicate with this other specialist doctor, or the attorney, and no
6 documentation of any cognitive assessment by Respondent, nor a referral for neuropsychological
7 assessment to another practitioner. Further, Respondent failed to adjust his treatment plan for the
8 patient; the same medications were continued, and he also prescribed a one month supply of
9 lorazepam to aid in alcohol discontinuation, but without specific instructions on a tapering
10 regimen.

11 (iii) Respondent also failed to recommend and/or document any
12 recommendation for a higher level of care for safe detoxification followed by structured
13 psychosocial rehabilitation. On or about March 14, 2015, Patient C cancelled an appointment
14 because he overslept. Yet, Respondent still failed to document any assessment of any
15 neuropsychological impairment issue.

16 (iv) On or about March 16, 2015, Patient C’s assistant called Respondent and
17 reported dangerous changes in the patient’s status, including medication overdose, and
18 Respondent recommended an emergency department assessment.

19 (v) On or about March 21, 2016 and March 28, 2016, Patient C failed to keep
20 his scheduled appointments with Respondent. At the next appointment, on or about April 11,
21 2016, Respondent failed to follow up with the patient about his emergency department
22 recommendation, or follow-up to obtain any emergency department records. Instead, Respondent
23 merely continued the same medications as before, including lorazepam with no directions.

24 (H) In or around July 2015, and thereafter, Respondent’s medical record keeping of
25 his treatment of Patient C represents gross negligence. Respondent also committed gross
26 negligence by failing to adequately assess and/or examine the patient (including by obtaining an
27 adequate history and symptomology from the patient), and/or by failing to adequately document
28 the same. The illegibility of Respondent’s records would have made it extremely difficult for

1 another healthcare provider to review them. This is further complicated by his underuse of
2 standard medical terminology in description of findings. In addition, the organization of
3 Respondent's progress notes did not follow standard divisions of the medical assessment, despite
4 the template for his notes. Respondent's documentation of care for Patient C involved the use of
5 words, phrases and incomplete sentences. The information was also haphazardly organized in
6 terms of its placement in the categories of the history, mental status examination, diagnosis and
7 treatment Respondent included in his progress note template. For the principal diagnosis of
8 alcohol use disorder/alcohol dependence, Respondent failed to adequately document any relevant
9 changes in alcohol use patterns in the patient related to the prescribed interventions for the
10 condition. Respondent also failed to adequately document his use of benzodiazepines in the
11 patient. He failed to adequately document the patient's alcohol withdrawal symptoms. He also
12 failed to adequately document his thought processes and evidence (symptoms) in support of any
13 of his diagnoses, including for PTSD, bipolar disorder, MDD, dementia, and ADHD. He also
14 failed to adequately document the patient's response to medical interventions.

15 **SECOND CAUSE FOR DISCIPLINE**

16 **(Repeated Negligent Acts)**

17 49. Respondent is subject to disciplinary action under Code section 2234, subdivision (c),
18 in that Respondent committed repeated negligent acts in the care and treatment of three patients.

19 The circumstances are as follows:

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

22 51. Each of the alleged acts of gross negligence set forth above in the First Cause for
23 Discipline is also a negligent act. In addition, Respondent committed the following acts of
24 negligence:

25 **Patient A.**

26 52. In or around December 2017 and thereafter, Respondent negligently failed to
27 adequately manage his termination of his medical care for Patient A. He placed her at risk for
28 benzodiazepine withdrawal by terminating his care for her and/or exacerbation of her illness,

1 including PTSD by not adequately providing recommendations for continuation of her medication
2 and/or psychiatric treatment. Respondent had been prescribing benzodiazepines to the patient for
3 years, and he should have realized that she would experience withdrawal symptoms by
4 terminating her care in the manner he did.

5 53. In or around May 2014 and thereafter, Respondent negligently and incompetently
6 continued his nonstandard treatment of Patient A for a condition outside his area of expertise (i.e.,
7 migraines), including through the use of prescription medications, despite his own repeated
8 recommendation for consultation with, or transfer of care to, a neurologist. The records indicate
9 several opportunities to assist the patient in obtaining this transfer/consultation. According to
10 Patient A, Respondent told her that he was a medical doctor first and a psychiatrist second. Many
11 of her prescriptions from Respondent were to treat her medical problem, viz., migraines. On or
12 about September 21, 2015, Respondent prescribed propranolol (40 mg BID) to the patient for
13 migraines or hypertension. In addition, his repeated prescriptions for Maxalt (a triptan used only
14 for migraines) to her also indicates he was treating her as a primary care physician. He also
15 repeatedly documented the prescription of Norco® to her for her migraines. At his First
16 Interview, Respondent alleged that he repeatedly told her to get a primary care doctor or
17 neurologist for her migraines from the beginning. Yet, he continued to treat her with
18 medications. Further, he stated at his First Interview in connection with his mediation refill dated
19 November 13, 2017, that Patient A would not come in person and that this was telemedicine
20 because of her limited resources. He also failed to consider the possibility that her avoidance of a
21 primary care doctor was maintained by his continuing to prescribe medication for her migraines.
22 Respondent also failed to recognize that his care for Patient A exhibited a classic negative
23 reinforcement paradigm,¹⁷ viz., a tendency for avoidance in patients with PTSD that could be
24 maintained, i.e., negatively reinforced, by his actions.

25 **Patient B.**

26 54. In or around April 2014 and thereafter, Respondent negligently prescribed drugs
27 without indication and/or improperly managed Patient B's psychiatric conditions. He failed to

28 ¹⁷ Which is relevant to treatment of her PTSD because of the passive/mastery dynamic.

1 adequately assess and/or prescribe drugs to Patient B and/or document his rationales for his
2 treatment of the patient.

3 (A) Respondent diagnosed Patient B, a 63-year-old man with "Major Depression
4 with Anxiety" on or about February 9, 2004. However, his records fail to adequately document
5 any description of any history of depressive episodes (although there is a notation that there was
6 no history of suicide attempts or mania). Respondent noted that Patient B had a lifetime history
7 of anxiety, related to a childhood episode of polio, and that he was "usually depressed and
8 anxious." However, he failed to adequately document any current symptoms of any major
9 depressive episodes.

10 (B) Patient B had a chronic history of depression. Respondent's records include
11 repeated notes indicating that Respondent prescribed quetiapine as the "best" treatment for
12 depression and insomnia. However, the patient discontinued quetiapine because it may have
13 caused pancreatitis. Further, while quetiapine is indicated for bipolar depression, it is not
14 indicated to treat unipolar depression. Moreover, Respondent's diagnosis of bipolar disorder in
15 the patient changed over time. Respondent inconsistently included bipolar in his list of diagnoses
16 (on or about October 14, 2016, November 1, 2018, December 4, 2018, February 12, 2019 and
17 October 3, 2019). He also concluded on occasion that Patient B had no history of mania on or
18 about October 31, 2019, March 3, 2020 [clearly never any mania] and June 11, 2020. This is
19 important because lurasidon and Trileptal^{®18} may have efficacy in some aspects of bipolar
20 disorder, but none have a role in unipolar depression. Further, amitriptyline is contraindicated in
21 bipolar depression because tricyclic antidepressants like amitriptyline have the greatest risk of
22 antidepressant associated manic switch among antidepressant classes. Yet, Respondent failed to
23 adequately perform an adequate diagnostic assessment for Patient B. Without a proper diagnosis,
24 Respondent failed to engage Patient B in an adequate discussion about the optimal short and long-
25 term medical treatment. If the patient did not have bipolar disorder, then Respondent should have
26 informed the patient that his prescription for quetiapine was off-label, even if it helped with sleep
27 and depression, particularly since TD can be caused or exacerbated by quetiapine.

28 ¹⁸ Which Respondent prescribed to the patient on or about April 3, 2019.

1 (C) Respondent documented Patient B's childhood experience with polio treatment
2 and PTSD and used the terms CBT, DBT and PIOP to address that PTSD. However, he failed to
3 adequately perform and/or document any of these treatments for the patient and/or whether or not
4 any of these PTSD symptoms responded to these treatments. Respondent's records fail to
5 elucidate whether the patient's sleep disturbance was a symptom of PTSD. Further, there was no
6 documentation of either CBT specifically addressing that, nor consideration of evidence-based
7 medications (fluoxetine, paroxetine, sertraline or venlafaxine, VA/DoD 2017) in lieu of the sleep
8 medications and antipsychotic medications.

9 (D) At a patient encounter on or about August 4, 2016, Respondent noted that the
10 patient was sick and on lithium. He diagnosed him with "Manic Depression." The patient had a
11 history of prior treatment with trazodone, mirtazapine, and ElavilR® (amitriptyline).
12 Prescriptions for Ambien® and Sonata® were documented. The patient had also received
13 dissolvable tablets of Zydys® (olanzapine) during a time in the hospital which had occurred an
14 unspecified time before. His plan was to consider Tegretol, Trileptal® (oxcarbazepine) and
15 Depakote®, and the patient was continued on mirtazapine, Ativan®, rozerem and "gabapentin
16 100 mg/d for mood disorder," while lithium was discontinued. However, gabapentin is not
17 indicated for the treatment of bipolar disorder, and an abrupt discontinuation of lithium increases
18 the risk of an emergent new mood episode, and of suicide. Thus, the patient was placed on
19 antidepressant monotherapy (mirtazapine) which would have placed him at risk of mania or mood
20 destabilization.

21 **Patient C**

22 55. In or around July 2015, and thereafter, Respondent committed negligence by failing
23 to adequately assess, re-assess and manage Patient's C's health issues and treatment, including his
24 dangerousness to himself and others. Respondent failed to address the information before him
25 about Patient C's dangerousness and/or analyze his risk level and/or refer him to intervention
26 such as emergency services and/or hospitalization. In or around April 2016, Respondent received
27 information that Patient C had been in three car accidents, was still driving, and had been buying
28 "stupid things" and playing with guns after receiving a \$500,000.00 settlement. The patient's

1 brother and his son feared for the life of the patient. The patient's son said that they had "locked
2 up the guns."

3 56. On or about July 2015, and thereafter, Respondent negligently and incompetently
4 diagnosed co-morbid conditions in Patient C, without performing adequate medical assessments
5 and re-assessments, and/or documenting his findings.

6 (A) Respondent repeatedly diagnosed Patient C with PTSD, but failed to adequately
7 document any trauma history, or symptoms from this diagnosis, including nightmares and
8 flashbacks, trauma-related avoidance behavior, alterations in thinking and feelings related to the
9 trauma or hyperarousal symptoms such as increased startle reaction or hypervigilance.

10 (B) Respondent also repeatedly diagnosed Patient C with ADD, but failed to
11 adequately document a developmental history of symptoms or current symptomatology for that
12 diagnosis in any detail or in a way that corresponds to standard terminology. Further, on or about
13 July 25, 2016 when he prescribed Strattera® (atomoxetine, a noradrenaline-selective reuptake
14 inhibitor antidepressant like agent, FDA indicated for ADHD in adults) to the patient, Respondent
15 failed to adequately consider the likely possibility that Patient C's alcohol misuse could explain
16 his impairments in concentration.

17 (C) On or about March 7, 2016, Respondent diagnosed Patient C with dementia,
18 specifically alcohol dementia, "wet brain," without recording any specific examination of
19 cognitive functioning, which is required for a diagnosis of dementia.

20 (D) On or about January 3, 2018, Respondent diagnosed Patient C with bipolar I
21 disorder, and discontinued the patient's prescription for fluoxetine because of this diagnosis.
22 However, he failed to document any current or past episode of mania or hypomania, which is
23 required for the diagnosis. He also failed to discuss and/or document his discussion with the
24 patient regarding the diagnosis, and acute and long-term treatment and options. Respondent also
25 prescribed a very high dose of Seroquel (presumably to address mania). If Respondent was
26 treating an acute full-blown manic episode, specific aspects of safety (poor decision making such
27 as impulsive spending) and their management (asking for the patient's permission to involve
28 family members to limit patient's access to large sums of money; limit impulsive engagement in

1 potentially dangerous behavior, etc.) should have been discussed with the patient and
2 documented. He also failed to adequately monitor for medication effects, including adverse
3 effects such as sedation (in combination with lorazepam and gabapentin and divalproex) and
4 metabolic syndrome and cardiac rhythm disturbances in the patient.

5 (E) On or about February 5, 2018, Respondent failed to document any specific
6 discussion regarding the apparent manic episode documented in the January 3, 2018 progress note
7 or its resolution. He resumed the patient's prescription for Prozac®.

8 57. On or about July 2015, and thereafter, Respondent negligently prescribed dangerous
9 drugs to Patient C without adequately documenting information regarding the diagnosis and/or
10 the condition being treated. Respondent failed to adequately document which specific diagnoses
11 he was treating with specific medications, and/or failed to adequately monitor and/or document
12 the effects of his treatment on the symptoms of each diagnosis through his continuous prescribing
13 of medications.

14 (A) On or about January 30, 2017, Respondent prescribed Strattera® (atomoxetine)
15 to the patient "to start for attention," without adequate documentation of any symptoms or history
16 of ADHD for which this medication was indicated.

17 (B) On or about December 15, 2015, Respondent prescribed lisinopril, an
18 antihypertensive medication, to Patient C and continued prescribing this through in or around
19 2018. However, Respondent failed to document a diagnosis of hypertension. Further, he only
20 documented the patient's blood pressure on or about February 22, 2016.

21 (C) Respondent prescribed atorvastatin, a cholesterol/lipid lowering medication,
22 multiple times without documenting a diagnosis or any laboratory findings.

23 58. On or about July 2015, and thereafter, Respondent negligently released private health
24 information about Patient C without authorization.

25 (A) On or about November 13, 2017, Respondent wrote a letter to Patient C and
26 S.M., LCSW, LAC Counselor (sic) Kalispel, Montana, in which he described the patient's
27 completion of courses at Flathead Valley Clinic. The letter discussed a description of the
28 patient's alcoholism diagnosis.

1 (B) On or about April 18, 2018, Respondent wrote a five-page letter discussing the
2 patient's treatment for alcoholism and electronically transmitted the letter to the patient as well as
3 to his primary care physician and alcohol abuse counselor. A request for authorization was also
4 transmitted to the patient, who did not sign it.

5 59. On or about July 2015, and thereafter, Respondent negligently failed to attempt to
6 obtain and/or review pertinent information about other treatments that Patient C received from
7 other medical providers/institutions. Respondent failed to adequately follow up and attempt to
8 obtain records from the "specialist doctor" that the patient saw after his DUI in or around
9 February 2016 and from the emergency department in connection with his emergency room visit
10 recommendation due to the deterioration in the patient's clinical status. On or about February 5,
11 2018, Patient C had a patient encounter with Respondent after completion of the "Watershed"
12 alcoholism residential treatment program in Del Ray Beach, Florida. However, Respondent
13 failed to adequately follow up or attempt to obtain copies of records from that treatment program.
14 Additionally, Respondent resumed prior medications for the patient, despite the patient having
15 told him there had been changes made in his medications during his treatment program at
16 "Watershed." In or about July 2016, the patient suffered from a severe relapse in his alcoholism.
17 He had been drinking all day and vomiting all night and went to the emergency room. He
18 reportedly had a new medical doctor at this time. However, Respondent failed to adequately
19 follow up with the patient and request more information about and from this doctor, including his
20 specialty. He failed to pursue whether this new doctor could take over care of the patient.

21 60. On or about July 2015, and thereafter, Respondent negligently failed to adequately
22 perform and/or document an informed consent with Patient C, which should have included
23 information about benefits and risks of his proposed treatments and alternatives (including any
24 off-label treatments, e.g., based on high dosage or non-indicated uses of medications).
25 Respondent repeatedly prescribed to Patient C, gabapentin, quetiapine and divalproex without
26 documented FDA indications. In addition, he prescribed other medications (e.g., Strattera® and
27 lithium) to the patient at times, with no documentation about informing the patient about potential
28 side-effects.

1 prior treatments for depression, family history of mood disorder, and, in particular about how the
2 Major Depressive Disorder condition had been distinguished from depressive symptoms that are
3 associated with symptoms of severe alcohol use disorder. ECT is indicated for treatment-
4 refractory severe major depression, or urgently life-threatening major depression, and some other
5 specific conditions not present.

6 (ii) Under a category in the chart entitled "TREATMENT/ COUNSELING
7 GOALS," most categories of treatment are checked in the majority of Respondent's notes. These
8 include the two categories of "Cognitive Em Behavioral Psychotherapy (trauma focused)" and
9 "Psychodynamic Insight Oriented Psychotherapy." These are two types of psychotherapy with
10 specific indications, training requirements and systematic, dedicated treatment approaches. They
11 can be used in the same patient for different indications, but not simultaneously. There is no
12 evidence in the record that Respondent conducted either type of psychotherapy with Patient C.
13 There were several notes where conducting either of these types of psychotherapy would be
14 contraindicated, such as on or about March 29, 2018 when the patient was actively drinking
15 during the session.

16 (iii) On or about November 21, 2016, Respondent documented "Parnate"
17 (tranylcypromine) without explanation. This Monoamine oxidase inhibitor antidepressant
18 (MAOI) is used today, but only in very selected cases of major depression because it requires
19 careful systematic assessment and management of a complex array of potential side-effects and
20 risks--including the fact that it is absolutely contraindicated in conjunction with either Strattera®
21 or citalopram, both of which Respondent was currently prescribing to Patient C. Similarly, on or
22 about March 10, 2017, Respondent documented "Consider MAOI" with no discussion about this
23 treatment.

24 **FOURTH CAUSE FOR DISCIPLINE**

25 **(Failure to Maintain Adequate and Accurate Medical Records)**

26 66. Respondent is subject to disciplinary action under section 2266 of the Code in that
27 Respondent failed to maintain adequate and accurate records related to the provision of medical
28 services to a patient. The circumstances are as follows:


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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 62655, issued to IHOR ANTON MICHAEL GALARNYK, M.D.;
2. Revoking, suspending or denying approval of IHOR ANTON MICHAEL GALARNYK, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering IHOR ANTON MICHAEL GALARNYK, 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: MAR 17 2021



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

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