

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

In the Matter of the Accusation Against:

Gregory L. Gorski, M.D.

**Physician's and Surgeon's
Certificate No. G 15977**

Respondent.

Case No. 800-2018-044578

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 December 30, 2021.

IT IS SO ORDERED December 23, 2021.

MEDICAL BOARD OF CALIFORNIA



**for: William Prasifka
Executive Director**

**Reji Varghese
Deputy Director**

1 ROB BONTA
Attorney General of California
2 JUDITH T. ALVARADO
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7
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:

13 **GREGORY L. GORSKI, M.D.**
14 **834 Milan Avenue**
15 **South Pasadena, CA 91030**
16 **Physician's and Surgeon's Certificate**
17 **No. G 15977,**

18 Respondent.

Case No. 800-2018-044578

OAH No. 2021070033

19 **STIPULATED SURRENDER OF**
20 **LICENSE AND ORDER**

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

23 **PARTIES**

24 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
25 California (Board). He brought this action solely in his official capacity and is represented in this
26 matter by Rob Bonta, Attorney General of the State of California, by Tan N. Tran, Deputy
27 Attorney General.

28 2. Gregory L. Gorski, M.D. (Respondent) is represented in this proceeding by attorneys
Kent T. Brandmeyer and Jeannette Van Horst, Law & Brandmeyer LLP, 2 North Lake Avenue,
Suite 820, Pasadena, California 91101.

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1 against Respondent. This stipulation constitutes a record of the discipline and shall become a part
2 of Respondent's license history with the Board.

3 2. Respondent shall lose all rights and privileges as a physician and surgeon in
4 California as of the effective date of the Board's Decision and Order.

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

7 4. If Respondent ever files an application for licensure or a petition for reinstatement in
8 the State of California, the Board shall treat it as a petition for reinstatement. Respondent must
9 comply with all the laws, regulations and procedures for reinstatement of a revoked or
10 surrendered license in effect at the time the petition is filed, and all of the charges and allegations
11 contained in Accusation No. 800-2018-044578 shall be deemed to be true, correct and admitted
12 by Respondent when the Board determines whether to grant or deny the petition.

13 5. If Respondent should ever apply or reapply for a new license or certification, or
14 petition for reinstatement of a license, by any other health care licensing agency in the State of
15 California, all of the charges and allegations contained in Accusation No. 800-2018-044578 shall
16 be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of
17 Issues or any other proceeding seeking to deny or restrict licensure.

18 ACCEPTANCE

19 I have carefully read the above Stipulated Surrender of License and Order and have fully
20 discussed it with my attorneys, Kent T. Brandmeyer and Jeannette Van Horst. I understand the
21 stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this
22 Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to
23 be bound by the Decision and Order of the Medical Board of California.

24
25 DATED: 12/17/21 _____
26 GREGORY L. GORSKI, M.D.
27 Respondent
28

1 I have read and fully discussed with Respondent Gregory L. Gorski, M.D. the terms and
2 conditions and other matters contained in this Stipulated Surrender of License and Order. I
3 approve its form and content.

4 DATED: 12/20/2021



5 KENT T. BRANDMEYER, ESQ.
6 *Attorney for Respondent*

7 **ENDORSEMENT**

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

10 DATED: 12/20/21

Respectfully submitted,

11 ROB BONTA
12 Attorney General of California
13 JUDITH T. ALVARADO
14 Supervising Deputy Attorney General



15 TAN N. TRAN
16 Deputy Attorney General
17 *Attorneys for Complainant*

Exhibit A

Accusation No. 800-2018-044578

1 ROB BONTA
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**
STATE OF CALIFORNIA

11 In the Matter of the Accusation Against:

Case No. 800-2018-044578

12 **GREGORY L. GORSKI, M.D.**
13 834 Milan Avenue
South Pasadena, CA 91030

A C C U S A T I O N

14 **Physician's and Surgeon's**
15 **Certificate No. G 15977,**

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 October 31, 1968, the Medical Board issued Physician's and Surgeon's
22 Certificate Number G 15977 to Gregory L. Gorski, M.D. (Respondent). The Physician's and
23 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
24 herein and will expire on September 30, 2021, 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 information Internet Web site, to a patient or the patient's guardian or health care
2 surrogate before the patient's first visit following the probationary order while the
licensee is on probation pursuant to a probationary order made on and after July 1,
2019, in any of the following circumstances: .

3 (1) A final adjudication by the board following an administrative hearing or
4 admitted findings or prima facie showing in a stipulated settlement establishing any
of the following:

5 (A) The commission of any act of sexual abuse, misconduct, or relations with a
6 patient or client as defined in Section 726 or 729.

7 (B) Drug or alcohol abuse directly resulting in harm to patients or the extent
that such use impairs the ability of the licensee to practice safely.

8 (C) Criminal conviction directly involving harm to patient health.

9 (D) Inappropriate prescribing resulting in harm to patients and a probationary
10 period of five years or more.

11 (2) An accusation or statement of issues alleged that the licensee committed
12 any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and
13 a stipulated settlement based upon a nolo contendere or other similar compromise that
does not include any prima facie showing or admission of guilt or fact but does
include an express acknowledgment that the disclosure requirements of this section
would serve to protect the public interest.

14 7. Section 2242 of the Code states:

15 (a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section
16 4022 without an appropriate prior examination and a medical indication, constitutes
unprofessional conduct. An appropriate prior examination does not require a
17 synchronous interaction between the patient and the licensee and can be achieved
through the use of telehealth, including, but not limited to, a self-screening tool or a
18 questionnaire, provided that the licensee complies with the appropriate standard of
care.

19 (b) No licensee shall be found to have committed unprofessional conduct within
20 the meaning of this section if, at the time the drugs were prescribed, dispensed, or
furnished, any of the following applies:

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

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

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

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

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

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

8 8. Section 2266 of the Code states:

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

12 9. Section 725 of the Code states:

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

20 (b) Any person who engages in repeated acts of clearly excessive prescribing or
21 administering of drugs or treatment is guilty of a misdemeanor and shall be punished
22 by a fine of not less than one hundred dollars (\$100) nor more than six hundred
23 dollars (\$600), or by imprisonment for a term of not less than 60 days nor more than
24 180 days, or by both that fine and imprisonment.

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

28 (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.

10. Health and Safety Code section 11165.1, subdivision (a) states, in pertinent part:

(a)(1)(A)(i) A health care practitioner authorized to prescribe, order, administer,
furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances
pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug
Enforcement Administration (DEA) registration, whichever occurs later, submit an
application developed by the department to obtain approval to electronically access
information regarding the controlled substance history of a patient that is maintained
by the department. Upon approval, the department shall release to that practitioner
the electronic history of controlled substances dispensed to an individual under the
practitioner's care based on data contained in the CURES Prescription Drug
Monitoring Program (PDMP).

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

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

1 patient.

2 **DEFINITIONS**

3 "Abilify" is a brand name for aripiprazole, which is an atypical antipsychotic
4 medication. It is primarily used in the treatment of schizophrenia and bipolar
5 disorder. Other uses include as an add-on treatment in major depressive disorder, tic
6 disorders and irritability associated with autism. It is a dangerous drug as defined in
7 Business and Professions code section 4022.

8 "Adderall®" is a brand name of a combination of two stimulant drugs,
9 amphetamine and dextroamphetamine. It is generally used to treat attention deficit
10 hyperactivity disorder, but also has a high potential for abuse. It is a Schedule II
11 controlled substance pursuant to Health and Safety Code section 11055, subdivision
12 (d)(1), and a dangerous drug as defined in Business and Professions Code section
13 4022.

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

27 "Ambien®" see zolpidem.

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

"Carisoprodol" is a muscle-relaxant and sedative. It is sold under the brand

1 name "Soma®." It is a Schedule IV controlled substance pursuant to federal
2 Controlled Substances Act, and a dangerous drug pursuant to Business and
3 Professions Code section 4022.

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

9 "CURES" means the Department of Justice, Bureau of Narcotics
10 Enforcement's California Utilization, Review and Evaluation System (CURES) for
11 the electronic monitoring of the prescribing and dispensing of Schedule II, III and IV
12 controlled substances dispensed to patients in California pursuant to Health and
13 Safety Code section 11165. The CURES database captures data from all Schedule II,
14 III and IV controlled substance prescriptions filled as submitted by pharmacies,
15 hospitals, and dispensing physicians. Law enforcement and regulatory agencies use
16 the data to assist in their efforts to control the diversion and resultant abuse of
17 Schedule II, III and IV drugs. Prescribers and pharmacists may request a patient's
18 history of controlled substances dispensed in accordance with guidelines developed
19 by the Department of Justice.

20 "Hydrocodone" is a semisynthetic opioid analgesic similar to but more potent
21 than codeine. It is used as the bitartrate salt or polistirex complex, and as an oral
22 analgesic and antitussive. It is marketed, in its varying forms, under a number of
23 brand names, including Vicodin®, Hycodan® (or generically Hydromet®), Lorcet®,
24 Lortab®, Norco®, and Hydrokon®, among others). Hydrocodone also has a high
25 potential for abuse. Hydrocodone is a Schedule II controlled substance pursuant to
26 Health and Safety Code section 11055, subdivision (b)(1)(I), and a dangerous drug
27 pursuant to Business and Professions Code section 4022.

28 "Hydroxyzine" is an antihistamine medication, used to treat anxiety, nausea,
vomiting, allergies, skin rash, hives, and itching. It can also be used with anesthesia
before medical procedures. It is a dangerous drug pursuant to Business and
Professions Code section 4022.

"Klonopin®" see clonazepam.

"Lisdexamfetamine" is a stimulant used as part of a treatment program to
control symptoms of attention deficit hyperactivity disorder (ADHD; more difficulty
focusing, controlling actions, and remaining still or quiet than other people who are
the same age) in adults and children. It is a psychostimulant prodrug of the
phenethylamine and amphetamine chemical classes. It is sold under the brand name
Vyvanse®. It is a dangerous drug as defined in Business and Professions Code
section 4022.

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

"Methylphenidate" is a central nervous system stimulant medication primarily

1 used to treat symptoms of attention deficit hyperactivity disorder (ADHD). It may
2 also be used to treat narcolepsy. It is sold in its various forms under the following
brand names: Concerta®, Ritalin®, Daytrana®, Aptensio XR®, Metadate CD®,
3 Methylin®, Quillivant XR®, Jornay PM®, Adhansia XR and Cotelpla®. It is a
dangerous drug pursuant to Business and Professions Code section 4022.

4 “Restoril®” is a brand name for temazepam, which is a benzodiazepine
medication. It is generally indicated for the short-term treatment of insomnia. It is a
5 Schedule IV controlled substance pursuant to Health and Safety Code section 11057,
subdivision (d)(29), and a dangerous drug as defined in Business and Professions
Code section 4022.

6
7 “SOAP” is an acronym for Subjective, Objective, Assessment and Plan, which
is a method of organizing medical records commonly used by healthcare providers.
Each component is defined below:

8
9 Subjective. This section documents the patient’s “subjective” experiences
and information. It includes the chief complaint (CC) or presenting problem and
10 history of present illness reported by the patient. It may include symptoms,
conditions, previous diagnoses or other statements that describes why the patient
11 is presenting. Helpful information also includes, onset, location, duration,
characterization, alleviating and aggravating factors and severity of the CC.
12 Relevant history (medical, surgical, family, social, medications, etc.) of the
patient should also be discussed. A review of systems (inventory of body
13 systems, i.e., questions arranged by organ system, designed to uncover
dysfunction and disease) should be included.

14 Objective. This section documents the objective data from the patient visit.
15 This includes: vital signs; physical exam findings; laboratory, imaging, or other
diagnostic data; and review of records by other clinicians.

16 Assessment. This section documents the synthesis of “subjective” and
17 “objective” evidence to arrive at a diagnosis. A differential diagnosis may list
different possible diagnoses, from most to least likely, and include the
18 practitioner’s rationale.

19 Plan. This section includes the plan for how the doctor will treat the
20 patient’s illness after taking into account all subjective and objective
information.

21 “Strattera®” is a brand name for atomoxetine, which is a cognition-enhancing
medication used to treat ADHD. It is a dangerous drug pursuant to Business and
22 Professions Code section 4022.

23 “SNRI” and “SSNRI” means selective serotonin and norepinephrine reuptake
inhibitors, which are a class of medications that are effective in treating depression.
24 SNRIs are also sometimes used to treat other conditions, such as anxiety disorders
and long-term (chronic) pain, especially nerve pain. SNRIs work by ultimately
25 effecting changes in brain chemistry and communication in brain nerve cell circuitry
known to regulate mood, to help relieve depression. SNRIs block the reabsorption
26 (reuptake) of the neurotransmitters serotonin and norepinephrine in the brain. They
are sold in several formulations, including desvenlafaxine (Pristiq®), duloxetine
27 (Cymbalta®), levomilnacipran (Fetzima®), and venlafaxine (Effexor XR®). They
are dangerous drug as defined in Business and Professions Code section 4022.

28 “SSRI” means Selective Serotonin Reuptake Inhibitor. SSRI antidepressants

1 are a type of antidepressant that work by increasing levels of serotonin within the
2 brain. Serotonin is a neurotransmitter that is often referred to as the "feel good
3 hormone."

4 "Suboxone®" is a brand name for a formulation of buprenorphine that contains
5 naloxone and a drug used to treat opiate addiction. Buprenorphine is an opioid
6 medication that is similar to other opioids such as morphine, codeine, and heroin,
7 however, it produces less euphoric effects and therefore may be easier to stop taking.
8 Naloxone blocks the effects of opioids such as morphine, codeine, and heroin.

9 "Vyvanse®" see Lisdexamfetamine.

10 "Trazodone" is an antidepressant medication. It is used to treat major
11 depressive disorder, anxiety disorders, and in addition to other treatment, alcohol
12 dependence. It is a dangerous drug as defined in Business and Professions code
13 section 4022.

14 "Xanax®" see alprazolam.

15 "Zoloft®" is the brand name for sertraline, which is a drug used to treat
16 depression, obsessive-compulsive disorder (OCD), posttraumatic stress disorder
17 (PTSD), premenstrual dysphoric disorder (PMDD), social anxiety disorder, and panic
18 disorder. It is a Selective Serotonin Reuptake Inhibitor (SSRI). It is a dangerous
19 drug pursuant to Business and Professions Code section 4022.

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

26 FACTUAL ALLEGATIONS

27 Interview

28 12. On or about March 30, 2021, an investigator and medical consultant interviewed
Respondent ("Interview") on behalf of the Board regarding the patients in this matter. During the
Interview, Respondent stated that he worked at a clinic ("Clinic") staffed by other health care
providers, including a psychologist who would provide therapy to patients and where he provided
medical care (i.e., medication management with prescriptions drugs) to the patients. He stated
that he would evaluate them before prescribing to them. During the Interview, Respondent also
made several statements that evinced a lack of knowledge, including:

- 29 A. He had not applied for access to the CURES program as required by law.¹
- 30 B. He could not remember the psychiatric diagnostic criteria for anxiety.

¹ At the Interview, Respondent blamed his secretary for failing to apply for the CURES
program and alleged that he knew about the program's requirements.

1 C. He stated that he had looked at the Diagnostic and Statistical Manual of Mental
2 Disorders, 5th Edition (“DSM-V”) the day before the interview and knew Axis 1, 2, 3, 4, and 5
3 and “what each axis does.” However, the DSM-V no longer uses a five axis (multiaxial) system
4 to describe patients.

5 D. He could not adequately outline the components of a mental status examination of a
6 patient.

7 **Patient A**²

8 13. The Board received a complaint from Patient A alleging that Respondent had
9 excessively prescribed drugs to him, including Klonopin® and Xanax®, which he alleged caused
10 negative effects on his personal relationships. He wrote that his last visit with Respondent was on
11 or about March 18, 2017. Patient A was referred to Respondent by a psychologist at the clinic
12 where Respondent worked for an evaluation for medication treatment of his anxiety.

13 14. A CURES report for the period from on or about July 9, 2015 through on or about
14 July 9, 2018 revealed that Patient A filled prescriptions by Respondent from May 9, 2016 through
15 January 30, 2017 and then after an interregnum from November 27, 2017 through January 29,
16 2018.

17 15. On or about April 24, 2016, Patient A, an 18-year-old man was seen by a
18 psychologist at the Clinic. At that time, the patient had a history of taking Xanax® and
19 complained of anxiety and difficulty sleeping. The psychologist referred the patient for a
20 medication management.

21 16. On or about May 9, 2016, Respondent saw Patient A for the first time. In a four-
22 page initial evaluation preprinted form, Respondent’s notes were very minimal, including,
23 “transfer from Dr. H.” under a section entitled, “Purpose of Evaluation,” and “see Dr. K’s w/u”
24 under “History of Present Illness.” The history of present illness, current symptoms, past social,
25 psychiatric, substance abuse history, family psychiatric history, and mental status exam are all
26 blank. Under “diagnosis,” Respondent wrote, “GAD” [generalized anxiety disorder], and the
27 section under “treatment plan and medications,” was blank. Patient A was taking very high doses

28 ² Letters are used in lieu of names to address privacy concerns.

1 of controlled substances, including a maximum dosage of Adderall, 60 mg per day. However,
2 Respondent failed to document Patient A's history of ADHD and anxiety symptoms, his past
3 medication history, or previous medication trials. He also failed to document whether Patient A
4 had tried SSRIs as an alternative to benzodiazepines for anxiety.

5 17. Thereafter, Respondent continued to see Patient A through 2017. However,
6 Respondent's notes almost invariably consist of a current symptom checklist and a list of
7 medications.³ The rest of the notes, including mental status, assessment, and plan, are generally
8 blank or lacking in information.

9 18. On or about May 10, 2016, Dr. K. saw Patient A and listed his medication as
10 gabapentin, Abilify® and trazodone. He also documented that the patient saw Dr. "H." for two
11 years, was on Klonopin® 4 mg "didn't work⁴ but Xanax does (2 mg bid works) [and]
12 wants...Adderall but doesn't want to take possible alternatives like Strattera." The record also
13 indicated that the patient smokes marijuana 8 times a day.⁵

14 19. On or about May 18, 2016, Respondent documented that Patient A was suffering
15 from poor sleep, anxiety and panic attacks. He prescribed alprazolam, clonazepam and
16 Adderall® to Patient A (filled on or about May 26, 2016). However, Respondent failed to
17 document why he prescribed two benzodiazepines simultaneously to the patient; each at high
18 dosages.⁶

19 20. On or about June 5, 2016, Respondent saw Patient A and documented that the patient
20 had "tons of anxiety" and was on Adderall® 20 mg tid, Xanax® 4 mg per day, and clonazepam 8
21 mg per day. He also planned to "Raise Xanax"... "another med for ADHD" "or "find another

22 ³ The form requests that the patient "please check any of the following you are
23 experiencing" and lists items; it also asks the patient to "list any medications you are taking."

24 ⁴ However, Respondent prescribed this drug to the patient and did not explain why he
25 prescribed the drug to the patient.

26 ⁵ The possibility of a cannabis use disorder and its impact on treatment are not addressed
27 by Respondent in his records.

28 ⁶ According to a summary of treatment, dated November 19, 2018, provided by
Respondent, Patient A informed Respondent that he had lost his prescriptions and Respondent
wrote him a new prescription for Xanax®, Klonopin®, trazodone, and Adderall®. However,
Respondent's medical records for Patient A fail to mention any lost prescriptions. Moreover, the
maximum dose of Adderall® is 60 mg/day, and Patient A received a 30 day supply of this from
another provider on or about May 7, 2016 and another 30 day supply from Respondent on or
about May 26, 2016, suggesting he was using 90 mg per day.

1 one that's better than Xanax." Although there are non-controlled substance alternative
2 medications to treat anxiety including SSRIs, SNRIs, atypical antipsychotics, and anti-seizure
3 drugs, Respondent did not explore these options with the patient. In addition, high dose
4 prescriptions for Adderall® can worsen anxiety symptoms in a patient.

5 21. On or about June 8, 2016, Patient A filled a prescription for alprazolam 2 mg (# 60),
6 after his previous refill for alprazolam on or about May 26, 2016.

7 22. On or about June 22, 2016, Patient A filled Respondent's prescriptions for
8 clonazepam 2 mg # 120 and amphetamine salt combo (Adderall®) 20 mg (# 90). Patient A also
9 exhibited symptoms of psychosis.

10 23. On or about June 27, 2016, Patient A filled Respondent's prescription for
11 clonazepam 2 mg, # 60. This was approximately five days after filling a 30 day supply of the drug
12 at 8 mg per day.

13 24. On or about August 3, 2016, Respondent saw Patient A and increased his
14 prescription dose of alprazolam to 2 mg (# 90); and in addition his prescription for clonazepam
15 was 2 mg (#90). Respondent's note for this visit consisted of only a list of three of the patient's
16 medications, and three items on the checklist.

17 25. On or about June 29, 2016 through August 21, 2016, Patient A filled prescriptions
18 for controlled substances from four other prescribers including, carisoprodol (Soma®), codeine
19 (opioid), hydrocodone (opioid), Vyvanse 30 mg (a stimulant), lorazepam 1 mg # 60
20 (benzodiazepine), and zolpidem (a sedative). Opioids and benzodiazepines are dangerous when
21 combined as they create is a higher risk for overdose.

22 26. On or about August 31, 2016, Patient A filled a prescriptions for clonazepam,
23 alprazolam, and Adderall®. However, clonazepam was also refilled on or about October 24,
24 2016; December 12, 2016; and January 23, 2017. Respondent's chart notes dated August 31,
25 2016; September 21, 2016; October 17, 2016 and December 12, 2016 contained very limited
26 information mostly from the preprinted checklists.

27 27. On or about January 30, 2017, Respondent saw Patient A and his progress note for
28 that visit contains a comment written on or about February 1, 2017 stating that, "on next visit he

1 should taper Xanax and Klonopin” without any rationale. The prescriptions include Adderall®
2 (same dose), Xanax® (dose increased to 2 mg 5 times per day), and Klonopin® (increased to 2
3 mg 3 times per day), without any further explanation. Patient A refilled his prescription for
4 alprazolam on or about each of the following days, October 16, 2016, October 26, 2016,
5 December 12, 2016, and January 23, 2017; and refilled his prescription for Adderall® on or about
6 September 28, 2016, and January 30, 2017.

7 28. Thereafter, an interruption in Respondent’s treatment of Patient A occurred until in or
8 around November 2017. During this period, Patient A appeared to have received medication
9 treatment from different providers who prescribed the following opioid partial agonist (used in
10 the treatment of opioid use disorder) drugs to the patient on or about the following dates:
11 Suboxone®, June 8, 2017; buprenorphine, July 31, 2017; buprenorphine, October 12, 2017;
12 buprenorphine, October 16, 2017.

13 29. On or about November 27, 2017, Respondent saw Patient A again, but failed to
14 document the patient’s interruption in treatment with Respondent. Respondent failed to
15 adequately document why Patient A was absent for approximately 10 months and what treatment
16 he received during that time, if any. Instead, his standard form progress note checklist merely
17 indicated that nine items on the possible symptom list were checked and the list of the patient’s
18 current medications included: Adderall® 20 mg (3 times per day), Klonopin® 2 mg (3 times per
19 day), and Xanax® 2 mg (5 times per day). Respondent discontinued the prescription for
20 Klonopin®, but failed to include his rationale for such cessation. He also reduced the patient’s
21 prescription for Xanax® to twice per day, without an adequate explanation. Respondent
22 prescribed Ambien® to the patient, by “calling” it in with a note dated either November 27 or 29,
23 2017. A note indicated that Restoril® “worked before,” but Trazadone® “does not work.”

24 30. From on or about November 27, 2017 through January 29, 2018, Respondent
25 prescribed Adderall® 20 mg (#60 once, and # 90 twice); alprazolam (1 mg # 120 twice, and 2 mg
26 #60 once), and zolpidem 10 mg (# 30 three times).

27 31. On or about December 5, 2017, Patient A failed to show for his therapy appointment.⁷

28 ⁷ A September 29, 2016 psychologist note stated Patient A was not interested in therapy.

1 32. Progress notes dated December 18, 2017 and January 29, 2018 indicated that the
2 patient was prescribed Xanax®, Adderall®, and Ambien®. However, no rationale for any
3 modifications to the patient's prescription was documented.

4 33. On or about May 2, 2018, Respondent saw Patient A for the final time with
5 complaints of depression, anxiety, racing heart, shaky hands, worrying and an inability to relax.
6 Respondent prescribed the following drugs to Patient A at that visit: Xanax® (4 mg per day),
7 Zoloft® (100 mg per day), Strattera® (50 mg per day), and Ambien® 10 mg.

8 34. On or about October 3, 2018, Patient A came to the Clinic, demanded to see
9 Respondent and became upset.

10 **Patient B**

11 35. A CURES report for the period from on or about May 29, 2016 through on or about
12 May 29, 2019, revealed that Patient B filled prescriptions by Respondent on a monthly basis
13 (approximately) for Adderall® and clonazepam.

14 36. On or about January 18, 2016, Respondent first saw Patient B, a 33-year-old man.
15 Respondent's records for Patient B were also written on a preprinted form with a check-the-box
16 list of symptoms. For this visit, the boxes for anxiety and poor attention span were checked and
17 the patient's current medications included Adderall®, clonazepam and sertraline (Zoloft®).
18 Respondent's plan at this visit included: "psychotherapy / medication." Respondent continued to
19 see Patient B on a monthly basis (approximately) through on or about August 13, 2020 (although
20 there is an interruption in visits from on or about March 17, 2020, until on or about July 17,
21 2020). Respondent's records for Patient B are very sparse and generally consist of checklists,
22 short sentences such as, "effectively dealing with anxiety," and a plan for "psychotherapy /
23 medication." Nevertheless, Respondent continued to prescribe dangerous drugs to the patient, but
24 failed to adequately document his rationale for his prescribing.

25 37. On or about June 1, 2020, Respondent prescribed Klonopin®, but there is no
26 corresponding office visit for this prescription.

27 38. During the Interview, Respondent stated that Patient B's presentation at his visit on or
28 about April 9, 2018 included symptoms of indecisiveness, lack of interest, and depression and

1 anxiety. However, his form did not show any mark for depression or anxiety. When asked by the
2 Board's medical consultant why depression was not marked as a symptom, Respondent stated
3 that he did not know why "it's not there." Although Respondent allegedly could remember that
4 the patient had depression, despite the lack of documentation of that symptom in the patient's
5 chart, at that same visit, when asked about what he prescribed to the patient at that visit,
6 Respondent stated that he would have to refer to the patient's previous visit to answer the
7 question.

8 39. During the Interview, in response to an inquiry into the meaning of Respondent's note
9 stating, "appropriate development" under the heading, "Assessment," in his progress noted dated
10 February 6, 2019, Respondent after reflecting on the phrase stated, it was "'justification for
11 continued treatment' [reading from what is printed on the form], appropriate development - it
12 means that he - in his life, he was developing," When asked to elaborate further, Respondent
13 stated, "he ended up - getting married - he ended up having a - getting jobs." However, these
14 details are not in Respondent's medical records for this visit. Respondent also stated that he did
15 not check the patient's records in CURES because he did not have access to CURES.

16 **Patient C**

17 40. A CURES report for the period from on or about May 29, 2016 through on or about
18 May 29, 2019 revealed that Patient C filled prescriptions by Respondent on a monthly basis
19 (approximately) for medications, including zolpidem and alprazolam.

20 41. On or about April 17, 2018, Respondent saw Patient C, an 89-year-old woman who
21 he diagnosed with mood disorder and depression. During the Interview, Respondent stated that
22 Patient C's depression was based upon her disagreement with her daughter who was living with
23 her and they were arguing with each other, and that she felt that her daughter was "trying to
24 control her." However, these details were not present in his medical record for the patient.
25 Respondent also stated that he had been regularly treating Patient C for anxiety with Xanax®.

26 **Patient D**

27 42. A CURES report for the period from on or about May 29, 2016 through on or about
28 May 29, 2019 revealed that Respondent prescribed medications to Patient D, including on or

1 about August 7, 2016 for methylphenidate 20 mg, # 180 (120 mg/day),⁸ lorazepam 1 mg, # 90
2 and zolpidem 5 mg, # 30.

3 43. On or about August 7, 2017, Respondent first saw Patient D, a 56-year-old man.
4 Respondent documented that the patient "wants to d/c Ritalin." Respondent also diagnosed the
5 patient with ADD and prescribed Adderall® to the patient, without documenting any details
6 about why the patient wanted to stop Ritalin, why he desired Adderall®, or what evidence
7 supported Respondent's diagnosis.

8 44. On or about February 12, 2018, Respondent saw Patient D and diagnosed him with
9 ADHD; however, he failed again to list any symptoms of the patient.

10 45. Thereafter, Respondent continued to treat Patient D and prescribed controlled
11 substances to him, including through in or around May 2019.

12 **FIRST CAUSE FOR DISCIPLINE**

13 **(Failure to Apply for Access to and Monitor under CURES)**

14 46. Respondent is subject to disciplinary action under sections 11165.1 and 11165.4 of
15 the Health and Safety Code in that he failed to apply for electronic access to information in the
16 CURES system by the required deadline and failed to utilize the system to periodically monitor
17 his patients before and while prescribing controlled substances to them. The circumstances are as
18 follows:

19 47. During the Interview, Respondent admitted that he never applied for access to the
20 CURES system and therefore he did not access the CURES database during the time he treated
21 Patients A, B, C and D. Furthermore, Respondent was not aware that he was legally required to
22 apply for CURES access by October 2, 2018 and/or negligently failed to comply with his
23 prescribing requirements under the CURES system as set forth below.

24 **SECOND CAUSE FOR DISCIPLINE**

25 **(Repeated Negligent Acts)**

26 48. Respondent is subject to disciplinary action under Code section 2234, subdivision (c),
27 in that Respondent committed repeated negligent acts in the care and treatment of patients. The

28 ⁸ The normal maximum dosage of methylphenidate is 60 mg per day.

1 circumstances are as follows:

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

4 50. Each of the alleged acts set forth above in the First Cause for Discipline is also a
5 negligent act. In addition, Respondent committed the following acts of negligence:

6 A. During all relevant time periods herein, including when Respondent treated
7 Patients A, B, C and D, including through March 30, 2021 (the date of his Interview), Respondent
8 failed to apply for access to CURES and failed to monitor CURES while he was prescribing to
9 the patients.

10 B. During all relevant time periods herein, Respondent failed to adequately
11 document an adequate medical history for his patients. His documentation for his patients
12 conveys very little information about his patients and fails to contain an adequate amount of
13 information normally found in the records of a psychiatrist.⁹

14 C. During all relevant time periods herein, Respondent failed to adequately
15 document relevant medical information related to medications prescribed for each of Patients A,
16 B, C and D, including his rationale for any medication changes, high dosages or combinations of
17 drugs (including two benzodiazepines at the same time). He failed to adequately document the
18 symptoms of each patient, including their emergence and state of improvement or worsening. His
19 records for these patients only included a checklist of symptoms and a list of medications.

20 D. During all relevant time periods herein, Respondent prescribed stimulant
21 medications to patients without documenting his monitoring of the patient's heart rate, blood
22 pressure or weight. Stimulant medications such as Adderall® can raise a patient's blood

23 ⁹ Generally speaking, a psychiatric history should include the patient's presenting
24 symptoms (or chief complaint), history of present illness, past psychiatric history, including a
25 history of past medication trials, substance abuse history, medical history, family history, mental
26 status examination, diagnostic formulation, and treatment plan. With respect to any prescribed
27 medication, its dosage, duration, efficacy and side effects should be documented; and if unusual
28 combinations of medications are prescribed (e.g., medications in the same class), it is important to
document the rationale for this combination. Further, if the patient is taking an unusually high
dosage of a medication, its rationale should be documented. Finally, if the patient is taking
controlled substances, the patient's history of substance abuse should be documented.

1 pressure, pulse rate, and cause weight loss. Thus, a patient's blood pressure, pulse, and weight
2 before the start of treatment and during the treatment must be monitored for potential
3 hypertension or tachycardia (which could put them at risk of adverse events). Respondent
4 prescribed amphetamine salts to Patients A and B, and methylphenidate to Patient D; and failed to
5 adequately document his monitoring of their heart rate, blood pressure or weight.

6 **THIRD CAUSE FOR DISCIPLINE**

7 **(Incompetence)**

8 51. Respondent is subject to disciplinary action under Code section 2234, subdivision (d),
9 in that Respondent was incompetent in the care and treatment of patients. The circumstances are
10 as follows:

11 52. The allegations of the First and Second Causes for Discipline, inclusive, are
12 incorporated herein by reference as if fully set forth.

13 53. During all relevant time periods herein, including during his Interview, Respondent
14 failed to possess adequate knowledge about the components of a mental status examination, the
15 criteria for generalized anxiety disorder and/or mistakenly applied the five axis multiaxial system
16 to the DSM-5. Knowledge of the components of the mental status exam is a fundamental part of
17 practicing psychiatry. Further, knowledge of the basic diagnostic criteria for the psychiatric
18 conditions that a practitioner most frequently encounters (such as anxiety) is necessary to practice
19 psychiatry. During his Interview, Respondent could not state (A) the components of a mental
20 status exam, or (B) the criteria for generalized anxiety disorder. He also conflated the use of the
21 five axis multiaxial system with the DSM-5 despite the fact that it was discarded when the DSM-
22 5 was introduced.

23 **FOURTH CAUSE FOR DISCIPLINE**

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

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

28 55. The allegations of the First, Second and Third Causes for Discipline, inclusive, are

1 incorporated herein by reference as if fully set forth.

2 **FIFTH CAUSE FOR DISCIPLINE**

3 **(Prescribing Without Appropriate Examination and Excessive Prescribing)**

4 56. Respondent is subject to disciplinary action under sections 2242 and 725 of the Code,
5 in that Respondent prescribed drugs to the three patients above, without appropriate prior
6 examinations and/or medical indications and/or excessively prescribed medications. The
7 circumstances are as follows:

8 57. The allegations of the First, Second, Third and Fourth Causes for Discipline,
9 inclusive, are incorporated herein by reference as if fully set forth.

10 58. Respondent failed to provide adequate rationales for the dangerous drugs, including
11 controlled substances he was prescribing to his patients, including high doses of alprazolam (10
12 mg per day) and clonazepam (6 mg per day) to Patient A.

13 59. In addition, Respondent prescribed drugs to his patients, without a corresponding
14 chart note of a patient encounter documented in his records. In or around 2017, Respondent
15 prescribed zolpidem to Patient C on multiple occasions, but failed to adequately document his
16 rationale for the medication.

17 **SIXTH CAUSE FOR DISCIPLINE**

18 **(General Unprofessional Conduct)**

19 60. Respondent is subject to disciplinary action under Code section 2234, in that his
20 action and/or actions represent unprofessional conduct, generally and patient harm occurred as a
21 result. The circumstances are as follows:

22 61. The allegations of the First, Second, Third, Fourth and Fifth Causes for Discipline,
23 inclusive, are incorporated herein by reference as if fully set forth.

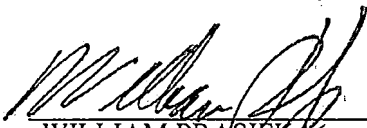
24 **PRAYER**

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

27 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 15977,
28 issued to Gregory L. Gorski, M.D.;

- 1 2. Revoking, suspending or denying approval of Gregory L. Gorski, M.D.'s authority to
- 2 supervise physician assistants and advanced practice nurses;
- 3 3. Ordering Gregory L. Gorski, M.D., if placed on probation, to pay the Board the costs
- 4 of probation monitoring;
- 5 4. If disciplined and applicable, ordering Gregory L. Gorski, M.D., to disclose his
- 6 discipline to patients as required by section 2228.1 of the Code; and
- 7 5. Taking such other and further action as deemed necessary and proper.

8
9 DATED: **MAY 11 2021**



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

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