

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

**In the Matter of the Accusation
Against:**

John Alexander Cervantes, M.D.

**Physician's and Surgeon's
Certificate No. G 51144**

Respondent.

Case No.: 800-2019-060170

DECISION

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

This Decision shall become effective at 5:00 p.m. on August 10, 2023.

IT IS SO ORDERED: July 11, 2023.

MEDICAL BOARD OF CALIFORNIA



**Laurie Rose Lubiano, J.D., Chair
Panel A**

1 ROB BONTA
Attorney General of California
2 JUDITH T. ALVARADO
Supervising Deputy Attorney General
3 REBECCA L. SMITH
Deputy Attorney General
4 State Bar No. 179733
300 South Spring Street, Suite 1702
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Attorneys for Complainant
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 **JOHN ALEXANDER CERVANTES, M.D.**
14 **923 Olive Street, Suite 3**
Santa Barbara, CA 93101

15 **Physician's and Surgeon's Certificate**
16 **No. G 51144,**

17 Respondent.

Case No. 800-2019-060170

OAH No. 2022100484

STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER

18
19 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
20 entitled proceedings that the following matters are true:

21 **PARTIES**

22 1. Reji Varghese (Complainant) is the Interim Executive Director of the Medical Board
23 of California (Board). He brought this action solely in his official capacity and is represented in
24 this matter by Rob Bonta, Attorney General of the State of California, by Rebecca L. Smith,
25 Deputy Attorney General.

26 2. John Alexander Cervantes, M.D. (Respondent) is represented in this proceeding by
27 attorney Mark B. Connely, whose address is 444 Higuera Street, Third Floor, San Luis Obispo,
28 California 93401.

1 or its designee, be accepted towards the fulfillment of this condition if the course would have
2 been approved by the Board or its designee had the course been taken after the effective date of
3 this Decision.

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

7 3. MEDICAL RECORD KEEPING COURSE. Within sixty (60) calendar days of the
8 effective date of this Decision, Respondent shall enroll in a course in medical record keeping
9 approved in advance by the Board or its designee. Respondent shall provide the approved course
10 provider with any information and documents that the approved course provider may deem
11 pertinent. Respondent shall participate in and successfully complete the classroom component of
12 the course not later than six (6) months after Respondent's initial enrollment. Respondent shall
13 successfully complete any other component of the course within one (1) year of enrollment. The
14 medical record keeping course shall be at Respondent's expense and shall be in addition to the
15 Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

11 At the end of the evaluation, the program will submit a report to the Board or its designee
12 which unequivocally states whether Respondent has demonstrated the ability to practice safely
13 and independently. Based on Respondent's performance on the clinical competence assessment,
14 the program will advise the Board or its designee of its recommendation(s) for the scope and
15 length of any additional educational or clinical training, evaluation or treatment for any medical
16 condition or psychological condition, or anything else affecting Respondent's practice of
17 medicine. Respondent shall comply with the program's recommendations.

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

20 If Respondent fails to enroll, participate in, or successfully complete the clinical
21 competence assessment program within the designated time period, Respondent shall receive a
22 notification from the Board or its designee to cease the practice of medicine within three (3)
23 calendar days after being so notified. Respondent shall not resume the practice of medicine until
24 enrollment or participation in the outstanding portions of the clinical competence assessment
25 program have been completed. If Respondent did not successfully complete the clinical
26 competence assessment program, Respondent shall not resume the practice of medicine until a
27 final decision has been rendered on the accusation and/or a petition to revoke probation. The
28 cessation of practice shall not apply to the reduction of the probationary time period.

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

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

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

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

27 The monitor shall submit a quarterly written report to the Board or its designee which
28 includes an evaluation of Respondent's performance, indicating whether Respondent's practices

1 are within the standards of practice of medicine, and whether Respondent is practicing medicine
2 safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure
3 that the monitor submits the quarterly written reports to the Board or its designee within ten (10)
4 calendar days after the end of the preceding quarter.

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

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

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

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

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

28 ///

1 9. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby
2 ordered to reimburse the Board its costs of investigation and enforcement, in the amount of
3 \$21,659.00 (twenty-one thousand six hundred fifty-nine dollars and no cents). Costs shall be
4 payable to the Medical Board of California. Failure to pay such costs shall be considered a
5 violation of probation.

6 Payment must be made in full within thirty (30) calendar days of the effective date of the
7 Order, or by a payment plan approved by the Medical Board of California. Any and all requests
8 for a payment plan shall be submitted in writing by Respondent to the Board. Failure to comply
9 with the payment plan shall be considered a violation of probation.

10 The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility
11 to repay investigation and enforcement costs.

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

15 Respondent shall submit quarterly declarations not later than ten (10) calendar days after
16 the end of the preceding quarter.

17 11. GENERAL PROBATION REQUIREMENTS.

18 Compliance with Probation Unit

19 Respondent shall comply with the Board's probation unit.

20 Address Changes

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

26 Place of Practice

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

1 facility.

2 License Renewal

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

5 Travel or Residence Outside California

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

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

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

15 13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
16 its designee in writing within fifteen (15) calendar days of any periods of non-practice lasting
17 more than 30 calendar days and within fifteen (15) calendar days of Respondent's return to
18 practice. Non-practice is defined as any period of time Respondent is not practicing medicine as
19 defined in Business and Professions Code sections 2051 and 2052 for at least forty (40) hours in a
20 calendar month in direct patient care, clinical activity or teaching, or other activity as approved by
21 the Board. If Respondent resides in California and is considered to be in non-practice,
22 Respondent shall comply with all terms and conditions of probation. All time spent in an
23 intensive training program which has been approved by the Board or its designee shall not be
24 considered non-practice and does not relieve Respondent from complying with all the terms and
25 conditions of probation. Practicing medicine in another state of the United States or Federal
26 jurisdiction while on probation with the medical licensing authority of that state or jurisdiction
27 shall not be considered non-practice. A Board-ordered suspension of practice shall not be
28 considered as a period of non-practice.

1 In the event Respondent's period of non-practice while on probation exceeds eighteen (18)
2 calendar months, Respondent shall successfully complete the Federation of State Medical Boards'
3 Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment
4 program that meets the criteria of Condition 18 of the current version of the Board's "Manual of
5 Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of
6 medicine.

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

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

9 Periods of non-practice for a respondent residing outside of California will relieve him of
10 the responsibility to comply with the probationary terms and conditions with the exception of this
11 condition and the following terms and conditions of probation: Obey All Laws; General Probation
12 Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled
13 Substances; and Biological Fluid Testing.

14 14. COMPLETION OF PROBATION. Respondent shall comply with all financial
15 obligations (e.g., restitution, probation costs) not later than one hundred twenty (120) calendar
16 days prior to the completion of probation. This term does not include cost recovery, which is due
17 within 30 calendar days of the effective date of the Order, or by a payment plan approved by the
18 Medical Board and timely satisfied. Upon successful completion of probation, Respondent's
19 certificate shall be fully restored.

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

27 16. LICENSE SURRENDER. Following the effective date of this Decision, if
28 Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy

1 the terms and conditions of probation, Respondent may request to surrender his or her license.
2 The Board reserves the right to evaluate Respondent's request and to exercise its discretion in
3 determining whether or not to grant the request, or to take any other action deemed appropriate
4 and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent
5 shall within fifteen (15) calendar days deliver Respondent's wallet and wall certificate to the
6 Board or its designee and Respondent shall no longer practice medicine. Respondent will no
7 longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical
8 license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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

14 18. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for
15 a new license or certification, or petition for reinstatement of a license, by any other health care
16 licensing action agency in the State of California, all of the charges and allegations contained in
17 Accusation No. 800-2019-060170 shall be deemed to be true, correct, and admitted by
18 Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or
19 restrict license.

20 ACCEPTANCE


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

26
27 DATED: 4-21-23


28 _____
JOHN ALEXANDER CERVANTES, M.D.
Respondent

1 I have read and fully discussed with Respondent John Alexander Cervantes, M.D. the terms
2 and conditions and other matters contained in the above Stipulated Settlement and Disciplinary
3 Order. I approve its form and content.

4 DATED: 4-21-23


5 MARK B. CONNELLY
6 Attorney for Respondent

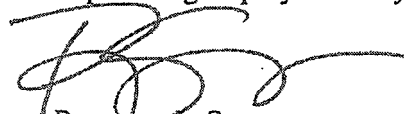
7 ENDORSEMENT

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

10 DATED: April 21, 2023

11 Respectfully submitted,

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


16 REBECCA L. SMITH
17 Deputy Attorney General
18 Attorneys for Complainant

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Exhibit A

Accusation No. 800-2019-060170

1 ROB BONTA
Attorney General of California
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Supervising Deputy Attorney General
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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. 800-2019-060170

13 **John Alexander Cervantes, M.D.**
14 **923 Olive Street, Suite 3**
Santa Barbara, CA 93101

ACCUSATION

15 **Physician's and Surgeon's Certificate**
16 **No. G 51144,**

Respondent.

17
18
19 **PARTIES**

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

23 2. On or about August 29, 1983, the Board issued Physician's and Surgeon's Certificate
24 Number G 51144 to John Alexander Cervantes, M.D. (Respondent). That license was in full
25 force and effect at all times relevant to the charges brought herein and will expire on November
26 30, 2022, unless renewed.

27 ///

28 ///

JURISDICTION

1
2 3. This Accusation is brought before the Board under the authority of the following
3 provisions of the California Business and Professions Code ("Code") unless otherwise indicated

4 4. Section 2004 of the Code states:

5 The board shall have the responsibility for the following:

6 (a) The enforcement of the disciplinary and criminal provisions of the Medical
7 Practice Act.

8 (b) The administration and hearing of disciplinary actions.

9 (c) Carrying out disciplinary actions appropriate to findings made by a panel or an
10 administrative law judge.

11 (d) Suspending, revoking, or otherwise limiting certificates after the conclusion of
12 disciplinary actions.

13 (e) Reviewing the quality of medical practice carried out by physician and
14 surgeon certificate holders under the jurisdiction of the board.

15 (f) Approving undergraduate and graduate medical education programs.

16 (g) Approving clinical clerkship and special programs and hospitals for the
17 programs in subdivision (f).

18 (h) Issuing licenses and certificates under the board's jurisdiction.

19 (i) Administering the board's continuing medical education program.

20 5. Section 2220 of the Code states:

21 Except as otherwise provided by law, the board may take action against all
22 persons guilty of violating this chapter. The board shall enforce and administer this
23 article as to physician and surgeon certificate holders, including those who hold
24 certificates that do not permit them to practice medicine, such as, but not limited to,
25 retired, inactive, or disabled status certificate holders, and the board shall have all the
26 powers granted in this chapter for these purposes including, but not limited to:

27 (a) Investigating complaints from the public, from other licensees, from health
28 care facilities, or from the board that a physician and surgeon may be guilty of
unprofessional conduct. The board shall investigate the circumstances underlying a
report received pursuant to Section 805 or 805.01 within 30 days to determine if an
interim suspension order or temporary restraining order should be issued. The board
shall otherwise provide timely disposition of the reports received pursuant to Section
805 and Section 805.01.

 (b) Investigating the circumstances of practice of any physician and surgeon
where there have been any judgments, settlements, or arbitration awards requiring the

1 physician and surgeon or his or her professional liability insurer to pay an amount in
2 damages in excess of a cumulative total of thirty thousand dollars (\$30,000) with
respect to any claim that injury or damage was proximately caused by the physician's
and surgeon's error, negligence, or omission.

3 (c) Investigating the nature and causes of injuries from cases which shall be
4 reported of a high number of judgments, settlements, or arbitration awards against a
physician and surgeon.

5 6. Section 2227 of the Code states:

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

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

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

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

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

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

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

22 STATUTORY PROVISIONS

23 7. Section 2234 of the Code, states:

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

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

1 (b) Gross negligence.

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

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

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

14 (d) Incompetence.

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

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

20 (g) The failure by a certificate holder, in the absence of good cause, to attend
21 and participate in an interview by the board. This subdivision shall only apply to a
22 certificate holder who is the subject of an investigation by the board.

23 8. Section 2228.1 of the Code states:

24 (a) On and after July 1, 2019, except as otherwise provided in subdivision (c),
25 the board shall require a licensee to provide a separate disclosure that includes the
26 licensee's probation status, the length of the probation, the probation end date, all
27 practice restrictions placed on the licensee by the board, the board's telephone
28 number, and an explanation of how the patient can find further information on the
licensee's probation on the licensee's profile page on the board's online license
information Internet Web site, to a patient or the patient's guardian or health care
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:

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

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

(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.

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

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

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

10 (b) A licensee required to provide a disclosure pursuant to subdivision (a) shall
11 obtain from the patient, or the patient's guardian or health care surrogate, a separate,
12 signed copy of that disclosure.

13 (c) A licensee shall not be required to provide a disclosure pursuant to
14 subdivision (a) if any of the following applies:

15 (1) The patient is unconscious or otherwise unable to comprehend the
16 disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a
17 guardian or health care surrogate is unavailable to comprehend the disclosure and
18 sign the copy.

19 (2) The visit occurs in an emergency room or an urgent care facility or the visit
20 is unscheduled, including consultations in inpatient facilities.

21 (3) The licensee who will be treating the patient during the visit is not known to
22 the patient until immediately prior to the start of the visit.

23 (4) The licensee does not have a direct treatment relationship with the patient.

24 (d) On and after July 1, 2019, the board shall provide the following
25 information, with respect to licensees on probation and licensees practicing under
26 probationary licenses, in plain view on the licensee's profile page on the board's
27 online license information Internet Web site.

28 (1) For probation imposed pursuant to a stipulated settlement, the causes
alleged in the operative accusation along with a designation identifying those causes
by which the licensee has expressly admitted guilt and a statement that acceptance of
the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes
for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the
probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

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1 9. Section 2242 of the Code states:

2 (a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section
3 4022 without an appropriate prior examination and a medical indication, constitutes
4 unprofessional conduct. An appropriate prior examination does not require a
5 synchronous interaction between the patient and the licensee and can be achieved
6 through the use of telehealth, including, but not limited to, a self-screening tool or a
7 questionnaire, provided that the licensee complies with the appropriate standard of
8 care.

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

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

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

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

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

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

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

10. Section 725 of the Code states:

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

1 (b) Any person who engages in repeated acts of clearly excessive prescribing or
2 administering of drugs or treatment is guilty of a misdemeanor and shall be punished
3 by a fine of not less than one hundred dollars (\$100) nor more than six hundred
4 dollars (\$600), or by imprisonment for a term of not less than 60 days nor more than
5 180 days, or by both that fine and imprisonment.

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

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

11 11. Section 2266 of the Code, states:

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

15 CONTROLLED SUBSTANCES/DANGEROUS DRUGS

16 12. Code section 4021 states:

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

19 13. Code section 4022 provides:

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

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

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

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

DRUG DEFINITIONS

14. As used herein, the terms below will have the following meanings:

"Alprazolam" is a benzodiazepine drug used to treat anxiety disorders, panic
disorders, and anxiety caused by depression. Alprazolam has a central nervous
system depressant effect and patients should be cautioned about the simultaneous

1 ingestions of alcohol and other central nervous system depressant drugs during
2 treatment with it. Addiction prone individuals should be under careful surveillance
3 when receiving alprazolam because of the predisposition of such patients to
4 habituation and dependence. The usual starting dose of alprazolam is 0.25 mg to
5 0.5 mg, three times per day (for a maximum 1.5 mg per day). It is also sold under
6 various brand names including, Intensol, Xanax, and Xanax XR. It is a Schedule IV
7 controlled substance pursuant to Health and Safety Code section 11057(d)(1), and a
8 dangerous drug as defined in Code section 4022. It is also a Schedule IV controlled
9 substance as defined by the Code of Federal Regulations Title 21, section 1308.14
10 (c).

11 "Ambien" is a brand name for zolpidem. It is a central nervous system
12 depressant.

13 "Belsomra" is a brand name for suvorexant, which is a medicine that is used
14 to treat insomnia. Suvorexant is in a class of medications called orexin receptor
15 antagonists. It works by blocking the action of a certain natural substance in the
16 brain that causes wakefulness. It is a central nervous system depressant. It is
17 contraindicated with the use of other medications for insomnia. It is a dangerous
18 drug as defined in Code section 4022.

19 "Benzphetamine" is a stimulant and appetite suppressant that affects the
20 central nervous system. It is a Schedule III controlled substance pursuant to Health
21 and Safety Code section 11056, subdivision (b)(2), and a dangerous drug pursuant
22 to Code section 4022.

23 "Buspar" is a brand name for buspirone. It is an anti-anxiety medication
24 used to treat symptoms of anxiety disorders. It is a dangerous drug as defined in
25 Code section 4022.

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

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

"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.

1 "Fluoxetine" is an antidepressant and belongs to the group of medicines
2 known as selective serotonin reuptake inhibitors (SSRIs). It is a dangerous drug as
3 defined in Code section 4022.

4 "Gabapentin" is an anticonvulsant medication used to treat partial seizures,
5 neuropathic pain, hot flashes, and restless legs syndrome. It is recommended as one
6 of a number of first-line medications for the treatment of neuropathic pain caused by
7 diabetic neuropathy, postherpetic neuralgia, and central neuropathic pain. It is sold
8 under the brand name Neurontin, among others. It can have potentially harmful
9 effects when combined with opioids. It is a dangerous drug as defined in Code
10 section 4022.

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

18 "Risperdal" is a brand name for risperidone, an antipsychotic medication. It
19 is generally used to treat schizophrenia, bipolar disorder, and irritability in people
20 with autism. It is a dangerous drug pursuant to Code section 4022.

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

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

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

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

"Trazodone" is an antidepressant medication. It is used to treat major
depressive disorder, anxiety disorders, and in addition to other treatment, alcohol

1 dependence. It belongs to the serotonin receptor antagonist and reuptake inhibitors
2 (SARIs) group of medications. It is a dangerous drug as defined in Code section
3 4022.

4 “Zolpidem” is a sedative drug primarily used to treat insomnia. It has a
5 short half-life. Its hypnotic effects are similar to those of the benzodiazepine class
6 of drugs. It is sold under the brand name Ambien and Intermezzo. It is a Schedule
7 IV controlled substance and narcotic as defined by Health and Safety Code section
8 11057, subdivision (d)(32) and a dangerous drug pursuant to Code section 4022.

9 “Xanax” is a brand name for alprazolam.

10 COST RECOVERY

11 15. Section 125.3 of the Code states:

12 (a) Except as otherwise provided by law, in any order issued in resolution of a
13 disciplinary proceeding before any board within the department or before the
14 Osteopathic Medical Board, upon request of the entity bringing the proceeding, the
15 administrative law judge may direct a licensee found to have committed a violation or
16 violations of the licensing act to pay a sum not to exceed the reasonable costs of the
17 investigation and enforcement of the case.

18 (b) In the case of a disciplined licensee that is a corporation or a partnership, the
19 order may be made against the licensed corporate entity or licensed partnership.

20 (c) A certified copy of the actual costs, or a good faith estimate of costs where
21 actual costs are not available, signed by the entity bringing the proceeding or its
22 designated representative shall be prima facie evidence of reasonable costs of
23 investigation and prosecution of the case. The costs shall include the amount of
24 investigative and enforcement costs up to the date of the hearing, including, but not
25 limited to, charges imposed by the Attorney General.

26 (d) The administrative law judge shall make a proposed finding of the amount
27 of reasonable costs of investigation and prosecution of the case when requested
28 pursuant to subdivision (a). The finding of the administrative law judge with regard
to costs shall not be reviewable by the board to increase the cost award. The board
may reduce or eliminate the cost award, or remand to the administrative law judge if
the proposed decision fails to make a finding on costs requested pursuant to
subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as
directed in the board's decision, the board may enforce the order for repayment in any
appropriate court. This right of enforcement shall be in addition to any other rights
the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be
conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or
reinstate the license of any licensee who has failed to pay all of the costs ordered
under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion,
conditionally renew or reinstate for a maximum of one year the license of any
licensee who demonstrates financial hardship and who enters into a formal agreement

1 with the board to reimburse the board within that one-year period for the unpaid
2 costs.

3 (h) All costs recovered under this section shall be considered a reimbursement
4 for costs incurred and shall be deposited in the fund of the board recovering the costs
5 to be available upon appropriation by the Legislature.

6 (i) Nothing in this section shall preclude a board from including the recovery of
7 the costs of investigation and enforcement of a case in any stipulated settlement.

8 (j) This section does not apply to any board if a specific statutory provision in
9 that board's licensing act provides for recovery of costs in an administrative
10 disciplinary proceeding.

11 FIRST CAUSE FOR DISCIPLINE

12 (Gross Negligence)

13 16. Respondent is subject to disciplinary action under Code Section 2234, subdivision
14 (b), in that he engaged in gross negligence in his care and treatment of Patients 1, 2 and 3.¹ The
15 circumstances are as follows:

16 PATIENT 1:

17 17. Respondent started treating Patient 1, a then 38-year-old female patient, in March of
18 2007.² Respondent saw Patient 1 on a weekly to biweekly basis for medication management and
19 therapy until May of 2019.

20 18. Respondent's medical record documentation and tracking of prescriptions for Patient
21 1 are handwritten and poorly legible.

22 19. During Respondent's care and treatment of Patient 1, she had been hospitalized in
23 excess of 20 times, most following suicide attempts. She was seen by numerous psychiatrists
24 during those hospitalizations who confirmed her bipolar disorder, type 1, mixed with rapid
25 cycling. During Respondent's care and treatment of Patient 1, he prescribed over 70 different
26 medications to Patient 1. Respondent prescribed multiple controlled substances to Patient 1,
27 including benzodiazepines, opioids, and stimulants. He also prescribed anti-psychotic mood
28 stabilizers and atypical antipsychotic medications to address her bipolar disorder and anti-
depressants and anti-anxiety medications to address the mixed and rapid cycling components of

¹ For privacy purposes, the patients in this Accusation are referred to as Patients 1 through 3.

² Care rendered to the patients described herein prior to 2015 is for historical purposes or to illustrate Respondent's patterns and practices.

1 her bipolar condition. Respondent also prescribed medications to treat the patient's obsessive
2 compulsive disorders, alcohol abuse issues, sleep issues and insomnia, tremors and shaking, as
3 well as other medical conditions including diabetes, low thyroid, high blood pressure and weight
4 gain.

5 20. Respondent documented Patient 1's drinking in the context of her alcohol use
6 disorder on numerous occasions between March of 2016 and June of 2018.

7 21. Respondent documented Patient 1's non-compliance with medications and
8 medication instructions on numerous occasions between September 2015 and November 2018.

9 22. Respondent's medical records for Patient 1 set forth numerous reference to self-harm
10 and/or suicidality, including on March 17, 2016, May 12, 2016, July 8, 2016, July 27, 2017,
11 September 28, 2017, and April 23, 2018. Respondent did not document the performance of a
12 suicidal risk assessment during any of these encounters where self-harm and/or suicidality was
13 noted.

14 23. Respondent did not review Patient 1's CURES reports or order any drug screens for
15 Patient 1.

16 Inappropriate Prescribing of Benzodiazepines to Patient 1.

17 24. The standard of care requires a medical indication for a physician to prescribe
18 medications to patients. When prescribing medications, a physician must perform an appropriate
19 prior medical examination; identify a medical indication; maintain accurate and complete medical
20 records, including treatments, medications; periodic reviews of treatment plans; and provide
21 ongoing and follow-up medical care, as appropriate and necessary. Prescribing medications that
22 have a potential for causing dependence requires careful monitoring for dangerous side effects.
23 Monitoring includes review of CURES reports and obtaining periodic drug screens.

24 25. Throughout his care and treatment of Patient 1, Respondent prescribed
25 benzodiazepines to Patient 1, including Klonopin/Clonazepam, Lorazepam, and Temazepan.

26 26. Patient 1's history of alcohol use disorder was first diagnosed by Respondent at the
27 time of Patient 1's first visit with Respondent on March 1, 2007. Benzodiazepines are contra-
28 indicated in patients with alcohol use disorder. Patient 1 had a substantial history of non-

1 compliance, non-response to treatment, self-harm, and suicidality. Benzodiazepines are
2 dangerous medications that can be fatal in patients with frequent incidents of self-harm.

3 27. Respondent continued to prescribe benzodiazepines to Patient 1 despite reports of
4 ongoing drinking. Respondent documented Patient 1's ongoing drinking on April 4, 2016, May
5 4, 2017, June 22, 2017, July 13, 2017, July 20, 2017, September 7, 2017, April 23, 2018, June 7,
6 2018, and June 28, 2018. Respondent continued to prescribe benzodiazepines to Patient 1 despite
7 noting on October 6, 2016 that Patient 1 had been involved in a three vehicle accident.

8 Respondent continued to prescribe benzodiazepines to Patient 1 despite noting on January 12,
9 2017 that she was also using cannabis. Respondent continued to prescribe benzodiazepines to
10 Patient 1 despite noting on March 23, 2017 that she was altering her medications and not taking
11 them as prescribed. On multiple occasions from 2015 through 2018, Respondent continued to
12 prescribe benzodiazepines to Patient 1 despite her reports of non-compliance. Respondent failed
13 to appropriately prescribe benzodiazepines to Patient 1. This is an extreme departure from the
14 standard of care.

15 Inappropriate Prescribing of Opioids to Patient 1.

16 28. Opioids, like Tramadol, are contra-indicated in patients with an alcohol use disorder.
17 Opioids are also dangerous medications that can be fatal in patients with frequent incidents of
18 self-harm.

19 29. Respondent prescribed Tramadol to Patient 1 in April, May, July, August and
20 September of 2018. As Patient 1's psychiatrist, Respondent prescribed Tramadol for her
21 complaints of pain without appropriate justification. Respondent failed to perform an evaluation
22 of Patient 1 for the use of opioid pain medication, including a physical examination, review
23 relevant records, and ordering of diagnostic and radiologic tests. Respondent failed to formulate
24 a differential diagnosis and treatment plan for prescribing opioid pain medication. Respondent
25 prescribed Tramadol to Patient 1 despite her reports of ongoing drinking, the concomitant
26 benzodiazepine prescriptions issued by Respondent, a concomitant opioid prescription by another
27 provider, the patient's significant history of medication non-compliance, and the patient's

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1 significant history of suicidality and self-harm. This is an extreme departure from the standard of
2 care.

3 30. When prescribing controlled medications, the standard of care requires that the
4 physician monitor the patient for risks of abuse. Monitoring includes periodically reviewing
5 CURES reports and performing drug screens. Reviewing Patient 1's CURES report would have
6 alerted Respondent that Patient 1 was obtaining a prescription for opioids from another provider
7 at the same time Respondent was prescribing opioids on July 19, 2018. Obtaining a CURES
8 report would have also alerted Respondent that Patient 1 filled two prescriptions for
9 benzodiazepines within a day of each other on October 8, 2018 and October 9, 2018, despite
10 Respondent's medical records for Patient 1 reflecting that one prescription was issued. Obtaining
11 drug screens, such as biological fluid testing, would have better informed Respondent of Patient
12 1's use of other substances of abuse. Respondent's failure to review Patient 1's CURES reports
13 and obtain drug screens is an extreme departure from the standard of care.

14 Failure to Maintain Adequate and Accurate Medical Records as to Patient 1.

15 31. The standard of care requires that the physician document a patient's reported
16 symptoms as well as the physician's assessment, evaluation, diagnosis, and treatment plan. The
17 assessment and evaluation must include a mental status exam for psychiatric encounters. The
18 documentation must also include explanations and justifications to support the diagnosis and
19 treatment plan. The physician must also maintain an accurate medication list in the patient's
20 medical records.

21 32. Patient 1 had a complex treatment and medication regimen. Respondent's medical
22 records for Patient 1 were frequently illegible and lack the necessary examinations, assessments,
23 and indications for the care and treatment provided. Respondent did not clearly track the
24 patient's ongoing medications. Respondent's failure to maintain adequate and accurate medical
25 records of his care and treatment of Patient 1 is an extreme departure from the standard of care.

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1 **PATIENT 2:**

2 33. In 2013, Respondent was providing psychiatric care and treatment of Patient 2, a then
3 69-year-old female patient.³ Respondent's medical records and tracking of prescriptions for
4 Patient 2 are handwritten, poorly legible, and difficult to follow.

5 34. During his course of treatment of Patient 2, Respondent mainly prescribed monthly
6 refills of Lorazepam, Buspar, and Stelazine.

7 35. Of significance in 2013, Respondent prescribed two benzodiazepines (Lorazepam and
8 diazepam) to Patient 2. He did not document any discussions with Patient 2 regarding the
9 dangers of patients over the age of 65 taking benzodiazepines. Respondent documented an early
10 refill of medications on one occasion in 2013. Respondent also documented that the patient was
11 taking more Lorazepam than prescribed and that Respondent recommended that she not take
12 more than 4 mg of Lorazepam per day. Respondent noted that he reviewed Patient 2's medical,
13 non-psychiatric record wherein it was noted that her car was damaged. There was no explanation
14 as to why the car was damaged or any inquiry by Respondent to Patient 2 as to the cause of the
15 damage. In November 2013, Patient 2 told Respondent that she had transient ischemic attacks
16 (TIAs) in the past which has caused dribbling from her mouth.

17 36. From March 2014 through May 2015, Respondent repeatedly prescribed Patient 2
18 two prescriptions for Lorazepam per month, one prescription for 130 tablets of Lorazepam 1 mg
19 and another prescription for 10 tablets of Lorazepam 1 mg. Respondent noted that he did this
20 because the patient "had problems with the pharmacy getting the extra ten 1 mg tablets of
21 Lorazepam."

22 37. On June 7, 2015, Respondent prescribed an early refill of Lorazepam, Buspar, and
23 Stelazine. The next day, June 8, 2015, Respondent noted in his progress notes that the patient
24 was taking more medication than prescribed. He did not make any recommendations to address
25 medication compliance.

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28 ³ At the time of his interview with the Board, Respondent stated that he began treating Patient 2 in 1989, and that she was diagnosed with schizophrenia, agoraphobia, and multiple phobias.

1 38. In July 2016, Patient 2 told Respondent that she had TIAs months ago and was taking
2 aspirin and propranolol instead of Lisinopril, as well as Prilosec. Respondent recommended that
3 she see her neurologist for the TIAs and he recommended that she take Buspar, Lorazepam, and
4 Stelazine as prescribed.

5 39. In 2016 and 2017, Respondent documented that the patient had a tired appearance. In
6 2018, Respondent documented that the patient stated being tired, and on April 23, 2018, possibly
7 dizzy.

8 40. Respondent permitted additional early refills of Patient 2's Lorazepam on multiple
9 occasions, including September 26, 2016, November 21, 2016, January 16, 2017, February 18,
10 2019,⁴ and September 4, 2019. Respondent failed to address that Patient 2 received Lorazepam
11 from other providers in 2017, 2018, and 2019. Respondent also failed to address that Patient 2
12 received opioids from other providers while he concurrently prescribed benzodiazepines in 2016,
13 2017, and 2018. Respondent repeatedly documented that the patient claimed that her medications
14 had been lost or stolen, including October 29, 2018, February 18, 2019, March 6, 2019, and April
15 10, 2019.

16 41. Respondent reviewed Patient 2's CURES Report on one occasion in 2018 and on one
17 occasion in 2020.⁵

18 42. On October 18, 2019, Respondent documented a phone visit with Patient 2. He noted
19 that the patient was being evaluated by Ventura Ambulatory Care for the purpose of tapering
20 Lorazepam. The neurologist that the patient was seeing recommended citalopram and tapering
21 Lorazepam by ¼ tablet every two weeks. In addition, she stopped taking Buspar and had an
22 addiction counselor. The patient also stated that she was filing for bankruptcy and moving to her
23 brother's apartment. Respondent noted that the patient's mood was anxious, she had tardive

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26 ⁴ On February 18, 2019, Respondent documented that the patient called stating that she lost 55
27 tablets of Lorazepam and that it is the patient's 12th request for early refill in the past few years, that there
is concern for abuse, and that he will not give refill.

28 ⁵ Respondent did not document any reference to checking Patient 2's CURES Reports in 2015
through 2017, and 2019.

1 dyskinesia but an appropriate thought process and thought content. Respondent's plan included
2 continuing to prescribe Lorazepam.

3 Failure to Recognize or Act on Patient 2's Signs of Abuse.

4 43. Respondent failed to recognize Patient 2's misuse of scheduled medications. Factors
5 that Respondent should have considered included Patient 2's requests for early refills, her reports
6 of lost prescriptions, her reports of taking more prescriptions than prescribed, Respondent's
7 documentation of Patient 2's poor medication compliance, and being prescribed benzodiazepines
8 by other providers. On October 18, 2019, another provider recommended that Patient 2 taper
9 Lorazepam and she obtained an addiction counselor.

10 44. Respondent documented references to Patient 2's risk of abuse from being prescribed
11 central nervous system depressants, including the reference to her car being damaged, her reports
12 of being tired and dizzy, having poor concentration, and Respondent's description of the patient
13 being frail on August 15, 2018. Respondent noted Patient 2's history of cerebrovascular
14 incidents. Given Patient 2's age, being older than 65, she was more vulnerable to the risks of
15 central nervous system depressants.

16 45. Respondent failed to adequately mitigate Patient 2's risk of abuse by failing to
17 regularly review her CURES report and obtain drug screens. Patient 2 was prescribed
18 benzodiazepines by other providers despite her history of already getting early refills of
19 Lorazepam from Respondent. Further, Respondent failed to address Patient 2 being prescribed
20 opioids by other providers while he was prescribing benzodiazepines. This created an additional
21 risk of overdose. Respondent did not obtain drug screens despite the significant quantities of
22 benzodiazepines that he prescribed, the patient's claims of lost and stolen medications, and the
23 patient's requests for early medication refills.

24 46. Respondent's failure to recognize signs of abuse of benzodiazepines, failure to
25 recognize the risk of abuse, and failure to mitigate the risk of abuse in Patient 2 is an extreme
26 departure from the standard of care.

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1 Failure to Maintain Adequate and Accurate Medical Records for Patient 2.

2 47. Patient 2 had a complicated treatment regimen, including significant doses of
3 benzodiazepines in a patient who was older than 65 years of age, had prior cerebrovascular
4 incidents, and required an addiction counselor. Respondent had incomplete notes of his care and
5 treatment. Further, his notes were frequently illegible. Respondent failed to adequately and
6 accurately track Patient 2's ongoing prescriptions. Respondent's failure to maintain an adequate
7 and accurate record of Patient 2's care and treatment is an extreme departure from the standard of
8 care.

9 PATIENT 3:

10 48. Respondent provided psychiatric care and treatment to Patient 3 during the timeframe
11 of 2010 through 2021. Respondent's medical records and tracking of prescriptions for Patient 3
12 are handwritten and poorly legible.

13 49. On October 4, 2010, Patient 3, a then 57-year-old female, presented to Respondent
14 for treatment of anxiety and depression. Respondent reviewed the patient's stressors, social
15 history, childhood history, occupational history, surgeries, medical history, family psychiatric
16 history, trauma history, relationship history, substance history, and medication trial history. The
17 patient was taking Xanax, 0.5 mg two to three times a day, Pristiq 50 mg, and Ambien 10 mg,
18 which was noted to be ineffective. Respondent noted that Patient 3 had gone to a rehabilitation
19 program for her use of opiates. Respondent's diagnosis was major depressive disorder. He
20 increased her Pristiq dose to 100 mg and added Gabapentin.

21 50. Patient 3 continued to see Respondent on a near monthly basis through 2011 at which
22 time Respondent continued to assess her and adjust her medications. In 2012, Respondent saw
23 Patient 3 on three occasions, in February, May and September. At each of the those visits,
24 Respondent noted his examination of the patient and prescribed Trazodone 100 mg, Risperdal 1
25 mg, and Pristiq 100 mg. Respondent saw Patient 3 from January 2013 to June 2013 at which time
26 he examined her and adjusted her medications.

27 51. Patient 3 returned to see Respondent on January 15, 2015, at which time she reported
28 marital stressor, anxiety, being separated, and taking Ambien. Respondent examined the patient

1 and prescribed Ambien 10 mg as well as Lorazepam 1 mg three times a day. On January 20,
2 2015, Respondent stopped the Lorazepam due to the patient feeling “fuzzy” and prescribed
3 Klonopin 0.5 mg, three times a day.

4 52. On February 2, 2015, Respondent noted that the patient was coping. He increased the
5 patient’s Klonopin to 1 mg, three times a day and noted that she “should only take one
6 benzodiazepine.”

7 53. Despite the recommendation that Patient 3 only take one benzodiazepine, she
8 continued to be prescribed Xanax by another provider, including February 2, 2015, February 3,
9 2015, February 13, 2015, March 4, 2015, April 6, 2015, May 4, 2015, and June 5, 2015. She was
10 also prescribed another central nervous system depressant, Ambien, by another provider, on
11 February 11, 2015, February 17, 2015, March 11, 2015, and March 20, 2015. Patient 3’s medical
12 records from Respondent’s office do not address the prescriptions by other providers.

13 54. On February 13, 2015, Patient 3 had an emergency phone session with Respondent.
14 She reported insomnia. Respondent assessed her as having insomnia and being at risk for
15 depression. His plan included starting trazodone 50 mg to 150 mg. Respondent also noted that
16 the patient could start taking fluoxetine 10 mg if she is depressed.⁶

17 55. Respondent continued to see Patient 3 on an approximate monthly basis throughout
18 2015, adjusting her medications based upon the patient’s reports as to how she was doing and
19 Respondent’s assessments.

20 56. Of significance, on September 19, 2015, Patient 3 reported feeling numb and good,
21 and having family stressors. Respondent noted that she had an appropriate appearance, behavior,
22 thought process, thought content, but a numb mood. Respondent assessed the patient as coping
23 well. He prescribed Klonopin .05 mg three times a day, and one in the evening, as well as
24 Belsomra 20 mg, Ambien 10 mg, Trazodone 50 mg, Fluoxetine 20 mg.⁷

25 ⁶ It is inappropriate to delegate to the patient the determination as to when to start an
26 antidepressant.

27 ⁷ Respondent prescribed Patient 3 three scheduled central nervous system depressants for
28 insomnia: Clonazepam, Belsomra, and Ambien, as well as a non-scheduled central nervous system
depressant, Trazodone. In addition, Belsomra is contraindicated with the use of other medications for
insomnia.

1 57. On January 21, 2016, Patient 3 reported a marital argument wherein she slapped her
2 husband; she was arrested but that the charges were dropped. Respondent noted that the patient
3 had an appropriate appearance, thought process, and thought content but was in a stressed mood.
4 He noted that she was coping well. Respondent's progress note does not include a violence risk
5 assessment despite the report of an act of violence and arrest.

6 58. Throughout 2016, Respondent continued to prescribe Ambien, Belsomra and
7 clonazepam to Patient 3. On a monthly basis from May 2016 through December 2016, Patient 3
8 was also being prescribed benzphetamine by another provider. Respondent did not address the
9 additional scheduled medication being prescribed by another provider.

10 59. Patient 3's CURES report reflects that she filled the monthly prescriptions for
11 Ambien, Belsomra, and Clonazepam prescribed by Respondent, at Rite Aid pharmacy. Patient
12 3's CURES report also reflects that Patient 3 filled an additional monthly prescription for
13 Clonazepam, prescribed by Respondent, at CVS Pharmacy in September, October, November,
14 and December of 2016. Respondent noted one Clonazepam prescription per month in Patient 3's
15 medical records, but he did not address the additional monthly prescription for clonazepam that
16 Patient 3 was filling at a second pharmacy.

17 60. In 2017, Respondent continued to see Patient 3 and adjust her medications. In 2017,
18 Patient 3's CURES report reflected that she simultaneously received opioid prescriptions from
19 other providers while Respondent prescribed central nervous system depressants.⁸ In addition,
20 Patient 3 filled benzphetamine prescriptions in July, August, September, and October of 2017.
21 Respondent did not address the risks of taking benzphetamine concurrently with the central
22 nervous system depressants he prescribed.

23 61. On January 9, 2017, Respondent prescribed clonazepam 0.5 mg three times a day and
24 one in the evening, trazodone 50 mg, and fluoxetine 40 mg. On January 10, 2017, Patient 3 filled
25 a prescription prescribed by Respondent for 150 tablets (one-month supply) of clonazepam 0.5
26 mg at CVS Pharmacy. On January 11, 2017, Patient 3 filled a prescription prescribed by

27 ⁸ Patient 3 filled opioid prescriptions from other providers on January 7, 2017, January 22, 2017,
28 January 23, 2017, January 26, 2017, February 13, 2017, August 14, 2017, August 22, 2017, September 1,
2017, October 30, 2017, and December 28, 2017.

1 Respondent for 300 tablets (two-month supply) of clonazepam 0.5 mg at Express Scripts
2 pharmacy. Respondent noted a single one-month prescription for clonazepam in Patient 3's
3 medical records and did not address the second two-month supply of clonazepam that Patient 3
4 obtained from a second pharmacy the following day.

5 62. On April 5, 2017, Respondent noted that Patient 3 was receiving prednisone for
6 polymyalgia rheumatica and had poor sleep and anxiety. She stated that she was taking 8 mg of
7 clonazepam. Respondent noted that she had an anxious mood, anhedonia, low energy, poor
8 concentration, and guilt but an appropriate speech and thought process. Respondent's assessment
9 was that the patient had developed a tolerance to clonazepam and the prednisone was contributing
10 to her anxiety and insomnia. His plan included increasing trazodone to 50-150 mg. Respondent
11 did not address that the patient was being prescribed 2.5 mg of clonazepam per day while taking 8
12 mg. Respondent did not address that Patient 3 met the criteria for a benzodiazepine disorder by
13 taking more clonazepam than prescribed and having developed a drug tolerance. Respondent also
14 failed to address that the maximum recommended dose of clonazepam is 4 mg per day, unless it
15 is being used for the treatment of a seizure disorder.

16 63. On April 17, 2017, Respondent noted that the patient was taking more than twice her
17 prescribed amount of clonazepam.

18 64. On May 15, 2017, Respondent noted that the patient was taking clonazepam 0.5 mg
19 three times a day and once in the evening. This is inconsistent with Patient 3's CURES report,
20 which reflects that she filled prescriptions prescribed by Respondent for 150 tablets of
21 clonazepam 1 mg, on May 16, 2017 and 150 tablets of clonazepam 0.5 mg on May 29, 2017.

22 65. On August 2, 2017, Patient 3 reported taking more medications than prescribed, and
23 not filling a prescription for clonazepam 4 mg. Respondent's plan was to re-order clonazepam 4
24 mg. Patient 3's CURES report reflects that she filled a prescription of 150 tablets of clonazepam
25 0.5 mg on August 3, 2017, and 120 tablets of clonazepam 1 mg on August 4, 2017. Respondent
26 did not address this discrepancy.

27 66. For the five-month period of August to December 2017, Patient 3 repeatedly obtained
28 early refills of her one month supply of clonazepam 1 mg from Respondent, ultimately obtaining

1 six months' supply in a five month period.⁹ During that same time period, Respondent
2 prescribed an additional 150 tablets of clonazepam 0.5 mg on August 3, 2017, and an additional
3 12 tablets of clonazepam 0.5 mg on November 6, 2017.

4 67. In 2018, Patient 3 continued to be seen by Respondent approximately once a month.
5 He continued to adjust and manage her central nervous system depressants, prescribing a two-
6 month supply of clonazepam 4 mg at a time. Patient 3 continued to receive early refills and
7 received 7 prescriptions rather than 6 in 2018. Patient 3 filled prescriptions prescribed by
8 Respondent for 240 tablets of clonazepam 1 mg on January 4, 2018, February 18, 2018, April 16,
9 2018, June 4, 2018, July 31, 2018, September 25, 2018 and November 15, 2018.

10 68. In April, May, August, September, and October of 2018, Patient 3 filled
11 benzphetamine prescriptions prescribed by others while also being prescribed central nervous
12 system depressants by Respondent. Respondent did not address the additional prescriptions with
13 the patient.

14 69. In July 2018, Patient 3 reached the age of 65. Respondent did not adjust Patient 3's
15 medications according to her age nor did he document any discussions with Patient 3 regarding
16 medication risks in the ambulatory elderly.

17 70. In 2019, Respondent continued to see Patient 3 on a monthly basis and prescribe
18 central nervous system depressants. The patient filled benzphetamine prescriptions in June,
19 August, September, and October of 2019.

20 71. In 2020, Respondent continued to see Patient 3 on a monthly basis and prescribed
21 central nervous system depressants.

22 Failure to Recognize or Act on Patient 3's Signs of Abuse.

23 72. At the time of Patient 3's first visit with Respondent, she was noted to have gone to a
24 rehabilitation program for her opiate use. Throughout his care and treatment of Patient 3,
25 Respondent documented many instances of medication non-compliance. On January 21, 2016,
26 Patient 3 was involved in a violent incident with her husband and was arrested. From 2015

27 ⁹ Patient 3 filled one-month prescriptions for clonazepam 1 mg, prescribed by Respondent, on
28 August 4, 2017, August 29, 2017, September 20, 2017, October 12, 2017, November 12, 2017, and
December 10, 2017.

1 through 2020, Patient 3 was intermittently receiving prescriptions from other providers for
2 scheduled stimulants and opioids, which are also medications of abuse, while continuing to
3 receive scheduled medications from Respondent. In September, October, November, and
4 December 2016, Patient 3 filled prescriptions of clonazepam, at times from multiple pharmacies,
5 within days of each other. Likewise in January, February, and August 2017, Patient 3 filled
6 prescriptions of clonazepam, at times from multiple pharmacies, within days of each other.
7 Patient 3 obtained early refills of clonazepam in 2017 through 2020 and obtained early refills of
8 Ambien in 2018. In 2017, Respondent noted that Patient 3 was taking more than the prescribed
9 amount of clonazepam. At times, the doses were higher than the maximum recommended dose.
10 Respondent also noted that Patient 3 was taking more clonazepam than intended and developed a
11 tolerance to clonazepam, all of which indicates a possible benzodiazepine use disorder. On June
12 28, 2017, Respondent noted that Patient 3 was using cannabis despite being prescribed three
13 scheduled medications and was intermittently receiving stimulants and opioids from other
14 providers.

15 73. Respondent failed to recognize or act on signs of substance abuse. He failed to
16 review Patient 3's CURES reports and failed to obtain drug screens. This is an extreme departure
17 from the standard of care.

18 Inappropriate Prescribing of Central Nervous System Depressants to Patient 3.

19 74. Respondent engaged in excessive prescribing of central nervous system depressants,
20 including benzodiazepines, despite Patient 3's significant risk factors. Patient 3 became an older
21 adult during Respondent's care and treatment. This risk was compounded by her history of TIAs.
22 In addition, Respondent at times prescribed three scheduled central nervous system depressants
23 (clonazepam, Ambien, and Belsomra) to Patient 3, despite her age, that she had previously been
24 in a rehabilitation program, that she had chronic non-compliance, was taking more scheduled
25 medications than prescribed, and was obtaining prescriptions from more than one provider.
26 Respondent's prescribing of central nervous system depressants to Patient 3 is an extreme
27 departure from the standard of care.

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1 Failure to Maintain Adequate and Accurate Medical Records as to Patient 3.

2 75. Patient 3 had a complicated treatment regimen which included several scheduled
3 medications prescribed by Respondent as well as stimulants and opioids prescribed by other
4 providers. Respondent failed to properly track Patient 3's ongoing prescriptions. Respondent's
5 documentation of prescribing controlled medications to Patient 3 was not consistent with Patient
6 3's CURES reports. Further, Respondent failed to note reviewing Patient 3's CURES reports
7 until 2020. Respondent's documentation was often illegible and he failed to consistently
8 document necessary examinations, evaluations, and assessments. Respondent's failure to
9 maintain an adequate and accurate record of Patient 3's care and treatment is an extreme
10 departure from the standard of care.

11 **SECOND CAUSE FOR DISCIPLINE**

12 **(Repeated Negligent Acts)**

13 76. Respondent is subject to disciplinary action under section 2234, subdivision (c), of
14 the Code, in that he engaged in repeated acts of negligence in the care and treatment of Patients 1,
15 2, and 3. The circumstances are as follows:

16 77. Each of the alleged acts of gross negligence set forth above in the First Cause for
17 Discipline is also a negligent act.

18 78. Respondent committed the following additional repeated acts of negligence:

19 **PATIENT 1:**

20 Inappropriate Prescribing of Phentermine to Patient 1.

21 79. Respondent restarted Patient 1 on phentermine on August 8, 2016, after last
22 prescribing it on March 19, 2015. Respondent failed to document a physical examination, review
23 of relevant records, order appropriate tests and evaluations, and formulate an adequate differential
24 diagnosis and treatment plan to justify the use of phentermine. Respondent's prescribing of
25 phentermine for Patient 1 is a simple departure from the standard of care.

26 Failure to Perform Suicidal Risk Assessment of Patient 1.

27 80. The standard of care requires physicians to perform a suicidal risk assessment when
28 providing treatment to patients with depression, suicidality, engagement in self-harm, and those

1 who are prescribed medications that are often used in overdoses, such as benzodiazepines.
2 Respondent failed to perform suicide risk assessments despite reports of self-harm and suicidality
3 by Patient 1 on March 17, 2016, May 12, 2016, July 8, 2016, July 27, 2017, September 28, 2017,
4 and April 23, 2018. This is a simple departure from the standard of care.

5 **PATIENT 3:**

6 Treatment of Patient 3's Psychiatric Conditions.

7 81. The standard of care requires that the physician make a good faith effort to obtain
8 information necessary to establish whether a patient suffers from an illness or disorder. While
9 treating medical conditions, the physician must perform risk assessments and monitor for side
10 effects of treatment.

11 82. Respondent treated Patient 3's low mood with antidepressants over a ten-year period
12 without periodically performing and documenting a risk assessment, despite her multiple risk
13 factors, including her episode of marital violence resulting in arrest, her history of depression,
14 medication non-compliance, using more than the recommended dose of medication, chronic
15 prescriptions of opioids, benzodiazepines and other central nervous system depressants, her older
16 age starting in 2018, and insomnia.

17 Respondent failed to periodically perform and document a risk assessment of Patient 3.
18 This is a simple departure from the standard of care.

19 **THIRD CAUSE FOR DISCIPLINE**

20 **(Unprofessional Conduct - Furnishing Dangerous Drugs Without Examination)**

21 83. Respondent is subject to disciplinary action under Code section 2242, subdivision (a),
22 in that he committed unprofessional conduct when he prescribed dangerous drugs to Patients 1, 2,
23 and 3, without an appropriate prior examination or medical indication therefor. The
24 circumstances are as follows:

25 84. The allegations in the First and Second Causes for Discipline above, are incorporated
26 herein by reference as if fully set forth.

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1 **FOURTH CAUSE FOR DISCIPLINE**

2 **(Excessive Prescribing)**

3 85. Respondent is subject to disciplinary action under Code section 725, in that he
4 excessively prescribed dangerous drugs to Patients 1, 2, and 3. The circumstances are as follows:

5 86. The allegations in the First, Second, and Third Causes for Discipline above, are
6 incorporated herein by reference as if fully set forth.

7 **FIFTH CAUSE FOR DISCIPLINE**

8 **(General Unprofessional Conduct – Patients 1 and 2)**

9 87. Respondent is subject to disciplinary action under Code sections 2234 and 2228.1, in
10 that his action and/or actions represent unprofessional conduct and patient harm occurred as a
11 result as to Patients 1 and 2. The circumstances are as follows:

12 88. As more fully discussed above, Respondent's excessive prescribing of controlled
13 substances, including opioids, benzodiazepines, and other drugs caused specific harm to Patients
14 1 and 2 for purposes of Code section 2228.1 as further described below:

15 89. Patient 1 incurred harm as a result of Respondent's care and treatment. Patient 1
16 suffered numerous overdoses on scheduled medications prescribed by Respondent. In addition,
17 Patient 1, who had an alcohol use disorder, had difficulty reaching and maintaining sobriety as a
18 result of Respondent's overprescribing of benzodiazepines to her.

19 90. Patient 2 incurred harm as a result of Respondent's care and treatment. Respondent
20 inappropriately and excessively prescribed benzodiazepines to Patient 2 without recognizing the
21 risk of harm to her. Patient 2 suffered an overdose on benzodiazepines.

22 **SIXTH CAUSE FOR DISCIPLINE**

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

24 91. Respondent is subject to disciplinary action under section 2266 of the Code for failing
25 to maintain adequate and accurate records relating to his care and treatment of Patients 1, 2, and
26 3.


27 92. The allegations in the First and Second Causes for Discipline above, are incorporated
28 herein by reference as if fully set forth.

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 51144, issued to John Alexander Cervantes, M.D.;
2. Revoking, suspending or denying approval of John Alexander Cervantes, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering John Alexander Cervantes, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;
4. If disciplined, ordering John Alexander Cervantes, M.D., to disclose his discipline to patients as required by section 2228.1 of the Code; and
5. Taking such other and further action as deemed necessary and proper.

DATED: SEP 27 2022



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

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