

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

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

Philip A. Grossi, M.D.

**Physician's and Surgeon's
Certificate No. G 12389**

Respondent.

Case No. 800-2019-060792

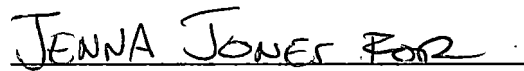
DECISION

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

This Decision shall become effective at 5:00 p.m. on January 30, 2024.

IT IS SO ORDERED January 23, 2024.

MEDICAL BOARD OF CALIFORNIA



**Reji Varghese
Executive Director**

1 ROB BONTA
Attorney General of California
2 MATTHEW M. DAVIS
Supervising Deputy Attorney General
3 LEANNA E. SHIELDS
Deputy Attorney General
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8 *Attorneys for Complainant*

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

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In the Matter of the First Amended Accusation
Against:

Case No. 800-2019-060792

14

OAH No. 2023080029

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PHILIP A. GROSSI, M.D.
3425 S. Bascom Ave., Suite C
Campbell, CA 95008-7006

**STIPULATED SURRENDER OF
LICENSE AND DISCIPLINARY ORDER**

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**Physician's and Surgeon's Certificate
No. G 12389,**

18

Respondent.

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

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PARTIES

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1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of
California (Board). He brought this action solely in his official capacity and is represented in this
matter by Rob Bonta, Attorney General of the State of California, by LeAnna E. Shields, Deputy
Attorney General.

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1 CULPABILITY

2 8. Respondent understands that the charges and allegations in the First Amended
3 Accusation No. 800-2019-060792, if proven at a hearing, constitute cause for imposing discipline
4 upon his Physician's and Surgeon's Certificate No. G 12389.

5 9. For the purpose of resolving the First Amended Accusation No. 800-2019-060792
6 without the expense and uncertainty of further proceedings, Respondent agrees that, at an
7 administrative hearing, Complainant could establish a *prima facie* case with respect to the charges
8 and allegations contained in the First Amended Accusation No. 800-2019-060792, and agrees that
9 he has thereby subjected his Physician's and Surgeon's Certificate No. G 12389 to discipline.
10 Respondent hereby surrenders his Physician's and Surgeon's Certificate No. G 12389 for the
11 Board's formal acceptance.

12 10. Respondent further agrees that if he ever petitions for reinstatement of his Physician's
13 and Surgeon's Certificate No. G 12389, all of the charges and allegations contained in the First
14 Amended Accusation No. 800-2019-060792 shall be deemed true, correct, and fully admitted by
15 Respondent for purposes of any such proceeding.

16 11. Respondent understands that by signing this stipulation he enables the Board, or the
17 Executive Director on behalf of the Board, to issue an order accepting the surrender of his
18 Physician's and Surgeon's License No. G 12389, without further notice or opportunity to be
19 heard.

20 RESERVATION

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

25 CONTINGENCY

26 13. Business and Professions Code section 2224, subdivision (b), provides, in pertinent
27 part, that the Medical Board "shall delegate to its executive director the authority to adopt a ...
28 stipulation for surrender of a license."

1 14. Respondent understands that, by signing this stipulation, he enables the Executive
2 Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his
3 Physician's and Surgeon's Certificate No. G 12389 without further notice to, or opportunity to be
4 heard by, Respondent.

5 15. This Stipulated Surrender of License and Disciplinary Order shall be subject to the
6 approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated
7 Surrender of License and Disciplinary Order shall be submitted to the Executive Director for his
8 consideration in the above-entitled matter and, further, that the Executive Director shall have a
9 reasonable period of time in which to consider and act on this Stipulated Surrender of License and
10 Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands
11 and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the
12 time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

13 16. The parties agree that this Stipulated Surrender of License and Disciplinary Order
14 shall be null and void and not binding upon the parties unless approved and adopted by the
15 Executive Director on behalf of the Board, except for this paragraph, which shall remain in full
16 force and effect. Respondent fully understands and agrees that in deciding whether or not to
17 approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive
18 Director and/or the Board may receive oral and written communications from its staff and/or the
19 Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the
20 Executive Director, the Board, any member thereof, and/or any other person from future
21 participation in this or any other matter affecting or involving respondent. In the event that the
22 Executive Director on behalf of the Board does not, in his discretion, approve and adopt this
23 Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it
24 shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied
25 upon or introduced in any disciplinary action by either party hereto. Respondent further agrees
26 that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason
27 by the Executive Director on behalf of the Board, Respondent will assert no claim that the
28 Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review,

1 discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or
2 of any matter or matters related hereto.

3 **ADDITIONAL PROVISIONS**

4 17. This Stipulated Surrender of License and Disciplinary Order is intended by the parties
5 herein to be an integrated writing representing the complete, final and exclusive embodiment of
6 the agreements of the parties in the above-entitled matter.

7 18. The parties agree that copies of this Stipulated Surrender of License and Disciplinary
8 Order, including copies of the signatures of the parties, may be used in lieu of original documents
9 and signatures and, further, that such copies shall have the same force and effect as originals.

10 19. In consideration of the foregoing admissions and stipulations, the parties agree the
11 Executive Director of the Board may, without further notice to or opportunity to be heard by
12 Respondent, issue and enter the following Disciplinary Order on behalf of the Board:

13 **ORDER**

14 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 12389, issued
15 to Respondent Philip A. Grossi, M.D., is hereby surrendered and accepted by the Board.

16 1. The surrender of Respondent's Physician's and Surgeon's Certificate No. G 12389
17 and the acceptance of the surrendered license by the Board shall constitute the imposition of
18 discipline against Respondent. This stipulation constitutes a record of the discipline and shall
19 become a part of Respondent's license history with the Board.

20 2. Respondent shall lose all rights and privileges as a physician and surgeon in
21 California as of the effective date of the Board's Decision and Order, which shall be on or after
22 January 30, 2024.

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

25 4. If Respondent ever files an application for licensure or a petition for reinstatement in
26 the State of California, the Board shall treat it as a petition for reinstatement. Respondent must
27 comply with all the laws, regulations and procedures for reinstatement of a revoked or
28 surrendered license in effect at the time the petition is filed, and all of the charges and allegations

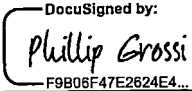
1 contained in the First Amended Accusation No. 800-2019-060792 shall be deemed to be true,
2 correct and fully admitted by Respondent when the Board determines whether to grant or deny
3 the petition.

4 5. Respondent shall pay the agency its costs of investigation and enforcement in the
5 amount of \$44,000.00 prior to issuance of a new or reinstated license.

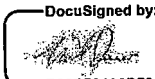
6 6. If Respondent should ever apply or reapply for a new license or certification, or
7 petition for reinstatement of a license, by any other health care licensing agency in the State of
8 California, all of the charges and allegations contained in the First Amended Accusation No. 800-
9 2019-060792 shall be deemed to be true, correct, and fully admitted by Respondent for the
10 purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

11 **ACCEPTANCE**

12 I have carefully read the above Stipulated Surrender of License and Disciplinary Order and
13 have fully discussed it with my attorneys Nicole Irmer, Esq. and Kimberly J. Elkin, Esq. I fully
14 understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate
15 No. G 12389. I enter into this Stipulated Surrender of License and Disciplinary Order
16 voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the
17 Medical Board of California.

18 DATED: 12/08/2023 
19 PHILIP A. GROSSI, M.D.
20 Respondent

21
22 I have read and fully discussed with Respondent Philip A. Grossi, M.D., the terms and
23 conditions and other matters contained in this Stipulated Surrender of License and Disciplinary
24 Order. I approve its form and content.

25 DATED: 12/08/2023 
26 NICOLE IRMER, ESQ.
27 KIMBERLY J. ELKIN, ESQ.
28 Attorneys for Respondent

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ENDORSEMENT

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

DATED: December 11, 2023

Respectfully submitted,

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General


LEANNA E. SHIELDS
Deputy Attorney General
Attorneys for Complainant

SF2022401298
84250598

Exhibit A

First Amended Accusation No. 800-2019-060792

1 ROB BONTA
Attorney General of California
2 MATTHEW M. DAVIS
Supervising Deputy Attorney General
3 LEANNA E. SHIELDS
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15

PHILIP A. GROSSI, M.D.
3425 S. Bascom Ave., Suite C
16 Campbell, CA 95008-7006

FIRST AMENDED ACCUSATION

16

[Cal. Gov. Code, § 11507.]

17

**Physician's and Surgeon's Certificate
No. G 12389,**

18

Respondent.

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PARTIES

22

1. Reji Varghese (Complainant) brings this First Amended Accusation solely in his
23 official capacity as the Executive Director of the Medical Board of California, Department of
24 Consumer Affairs (Board).

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2. On or about September 15, 1966, the Medical Board issued Physician's and
26 Surgeon's Certificate No. G 12389 to Philip A. Grossi, M.D. (Respondent). The Physician's and
27 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
28 herein and will expire on May 31, 2025, unless renewed.

JURISDICTION

1
2 3. This First Amended Accusation, which supersedes Accusation No. 800-2019-060792
3 filed on October 18, 2022, in the above-entitled matter, is brought before the Board, under the
4 authority of the following laws. All section references are to the Business and Professions Code
5 (Code) unless otherwise indicated.

6 4. Section 2227 of the Code states:

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

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
17 board.

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

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

26 5. Section 2234 of the Code, states, in pertinent part:

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

...

(b) Gross negligence.

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

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

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

6 ...

7 6. Section 2238 of the Code states, "A violation of any federal statute or federal
8 regulation or any of the statutes or regulations of this state regulating dangerous drugs or
9 controlled substances constitutes unprofessional conduct."

10 7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain
11 adequate and accurate records relating to the provision of services to their patients constitutes
12 unprofessional conduct."

13 8. From January 1, 2017, through June 30, 2021,¹ section 11165.4 of the Health and
14 Safety Code stated, in pertinent part:²

15 (a)(1)(A)(i) A health care practitioner authorized to prescribe, order, administer,
16 or furnish a controlled substance shall consult the CURES database to review a
17 patient's controlled substance history before prescribing a Schedule II, Schedule III,
18 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
patient.

19 ...

20 (e) This section is not operative until six months after the Department of Justice
21 certifies that the CURES database is ready for statewide use and that the department
22 has adequate staff, which, at a minimum, shall be consistent with the appropriation
23 authorized in Schedule (6) of Item 0820-001-0001 of the Budget Act of 2016
(Chapter 23 of the Statutes of 2016), user support, and education. The department
24 shall notify the Secretary of State and the office of the Legislative Counsel of the date
of that certification.

25 ¹ Health and Safety Code section 11165.4 was amended on January 1, 2020, however the
26 provisions of subdivisions (a)(1)(A)(i) and (e) remained unchanged until July 1, 2021.

27 ² The Controlled Substance Utilization Review and Evaluation System (CURES) was certified for
28 statewide use by the Department of Justice (DOJ) on April 2, 2018. Therefore, the mandate to consult
CURES prior to prescribing, ordering, administering, or furnishing a Schedule II-IV controlled substance
became effective October 2, 2018.

1 COST RECOVERY

2 9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
3 administrative law judge to direct a licensee found to have committed a violation or violations of
4 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
5 enforcement of the case, with failure of the licensee to comply subjecting the license to not being
6 renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be
7 included in a stipulated settlement.

8 DEFINITIONS

9 10. Adderall is a trade name for a combination drug containing four salts of
10 amphetamine, also known as mixed amphetamine salts (MAS), and is a central nervous system
11 (CNS) stimulant of the phenethylamine class. It is a Schedule II controlled substance under
12 Health and Safety Code section 11055(d) and is a dangerous drug as defined in Business and
13 Professions Code section 4022. It is used in the treatment of attention deficit disorder (ADD),
14 attention deficit hyperactivity disorder (ADHD), and narcolepsy. It may cause new or worsening
15 psychosis (unusual thoughts or behavior), especially in those with a history of depression, mental
16 illness, or bipolar disorder.

17 11. Clonazepam, known by the trade name Klonopin, is an anti-convulsant of the
18 benzodiazepine class of drugs. It is a Schedule IV controlled substance under Health and Safety
19 Code section 11057(d)(7) and is a dangerous drug as defined in Business and Professions Code
20 section 4022. It produces central nervous system (CNS) depression and should be used with
21 caution with other CNS depressant drugs. Like other benzodiazepines, it can produce
22 psychological and physical dependence. Withdrawal symptoms similar to those associated with
23 withdrawal from barbiturates and alcohol have been noted upon abrupt discontinuance of
24 Klonopin.

25 12. Dexedrine is a trade name for dextroamphetamine sulfate, a central nervous system
26 (CNS) stimulant used in the treatment of ADHD, fatigue, and narcolepsy. It is a Schedule II
27 controlled substance under Health and Safety Code Section 11055(d) and is a dangerous drug as
28 defined in Business and Professions Code Section 4022.

1 13. Diazepam, known by the trade name Valium, is a psychotropic drug used for the
2 management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a
3 Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and
4 section 1308.14 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as
5 defined in Business and Professions Code section 4022. Diazepam can produce psychological
6 and physical dependence and it should be prescribed with caution particularly to addiction-prone
7 individuals (such as drug addicts and alcoholics) because of the predisposition of such patients to
8 habituation and dependence.

9 14. Emsam transdermal patch is the trade name for selegiline (transdermal), a monoamine
10 oxidase inhibitor (MAOI) that is used to treat major depressive disorder in adults. It is a
11 dangerous drug as defined in Business and Professions Code section 4022. It should not be used
12 concomitantly with the consumption of alcohol.

13 15. Hydrocodone bitartrate, known by the trade name Zohydro, is a semisynthetic
14 narcotic analgesic of the opioid class of medications. It is used to treat symptoms of moderate to
15 severe pain. It is a Schedule II controlled substance as defined by section 11055, subdivision (e)
16 of the Health and Safety Code and is a dangerous drug as defined in Business and Professions
17 Code section 4022.

18 16. Ketamine is a short-acting dissociative injectable anesthetic that has some
19 hallucinogenic effects. It induces a trance-like state while providing pain relief, sedation, and
20 memory loss. It is a Schedule III controlled substance, as defined by section 11056 of the Health
21 and Safety Code and is a dangerous drug as defined in Business and Professions Code section
22 4022. Although primarily used in humans as an anesthetic, it may also be used for post-operative
23 pain management or to treat major depression. In some limited cases it may be used to treat
24 complex regional pain syndrome but its use in treating non-cancer chronic pain is considered to
25 be controversial or experimental. Ketamine may increase the effects of other sedatives, such as
26 alcohol, benzodiazepines, opioids, and barbiturates. It also has a high potential for abuse and for
27 diversion.

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1 17. Lamictal, a trade name for lamotrigine, is a medication in the class known as triazine
2 anticonvulsants. It is used in the treatment of bipolar disorder, seizure prevention, schizoaffective
3 disorder, or epilepsy. It is a dangerous drug as defined in Business and Professions Code section
4 4022.

5 18. Lorazepam, known by the trade name Ativan, is a benzodiazepine and central nervous
6 system (CNS) depressant used in the management of anxiety disorder for short-term relief from
7 the symptoms of anxiety or anxiety associated with depressive symptoms. It is a Schedule IV
8 controlled substance as defined by section 11057 of the Health and Safety Code and by section
9 1308.14 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in
10 Business and Professions Code section 4022. Long-term or excessive use of Ativan can cause
11 dependency. Concomitant use of alcohol or other CNS depressants may have an additive effect.

12 19. Nardil is a trade name for phenelzine sulfate and is in the drug class of monoamine
13 oxidase inhibitors (MAOI). It is used to treat symptoms of atypical depression in adults when
14 other medicines have not been effective. It is a dangerous drug as defined in Business and
15 Professions Code section 4022.

16 20. Nuvigil is a trade name for armodafinil, a central nervous system (CNS) stimulant
17 medication that promotes wakefulness and is used to treat excessive sleepiness caused by sleep
18 apnea, narcolepsy, or shift-work sleep disorder. It is a Schedule IV controlled substance as
19 defined by section 11057 of the Health and Safety Code and is a dangerous drug as defined in
20 Business and Professions Code section 4022. It may be habit-forming, especially for someone
21 with a history of drug abuse or addiction. It should not be taken concomitantly with alcohol.

22 21. Ritalin is a trade name for methylphenidate, a central nervous system (CNS)
23 stimulant. It is used to treat attention deficit disorder (ADD), attention deficit hyperactivity
24 disorder (ADHD), and narcolepsy. It is a Schedule II controlled substance as defined by section
25 11055 of the Health and Safety Code and is a dangerous drug as defined in Business and
26 Professions Code section 4022.

27 22. Sonata is a trade name for zaleplon, a sedative hypnotic drug used for the short-term
28 treatment of insomnia. It slows activity in the brain to allow sleep. It should not be taken

1 concomitantly with alcohol. It is a Schedule IV controlled substance as defined by section 11057
2 of the Health and Safety Code and is a dangerous drug as defined in Business and Professions
3 Code section 4022.

4 23. Temazepam, known by the trade name Restoril, is in the class of medications known
5 as sedative/hypnotics. It is used in the treatment of symptoms of insomnia. It is a Schedule IV
6 controlled substance as defined by section 11057 of the Health and Safety Code and is a
7 dangerous drug as defined in Business and Professions Code section 4022.

8 24. Vicoprofen, a trade name for the combination of hydrocodone (an opioid pain
9 medication) and ibuprofen (a nonsteroidal anti-inflammatory drug, NSAID) that is used for the
10 short-term relief of severe pain. This brand name has been discontinued in the U.S.
11 Hydrocodone is a Schedule II controlled substance as defined by section 11055, subdivision (e) of
12 the Health and Safety Code, and is a dangerous drug as defined in Business and Professions Code
13 section 4022.

14 25. Xanax, a trade name for alprazolam, is a psychotropic triazolo-analogue of the
15 benzodiazepine class of central nervous system-active compounds. It is used for the management
16 of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a Schedule IV
17 controlled substance as defined by section 11057, subdivision (d) of the Health and Safety Code,
18 and by section 1308.14 (c) of Title 21 of the Code of Federal Regulations, and is a dangerous
19 drug as defined in Business and Professions Code section 4022. Xanax has a central nervous
20 system (CNS) depressant effect and patients should be cautioned about the simultaneous
21 ingestion of alcohol and other CNS depressant drugs during treatment with Xanax.

22 26. Zoloft, a trade name for sertraline, is in the class of antidepressants called selective
23 serotonin reuptake inhibitors (SSRIs). It works by increasing the amounts of serotonin, a natural
24 substance in the brain that helps maintain mental balance. It is used in the treatment of
25 depression, obsessive-compulsive disorder, panic attacks, post-traumatic stress disorder, and
26 social anxiety disorder. It is a dangerous drug as defined in Business and Professions Code
27 section 4022.

28 ///

1 FIRST CAUSE FOR DISCIPLINE

2 (Gross Negligence)

3 Patient A³

4 27. Respondent has subjected his Physician's and Surgeon's Certificate No. G 12389 to
5 disciplinary action under section 2234, as defined by section 2234, subdivision (b), in that he
6 committed gross negligence in his care and treatment of Patient A, as more fully described
7 hereinafter.⁴

8 28. On or about August 13, 2015, Respondent first saw Patient A, a female born in
9 February 1986, who presented with a chief complaint of attention deficit disorder (ADD).
10 Respondent noted that the patient had a history of several episodes of depression and at least ten
11 episodes of possible hypomania. At the time, Patient A was being prescribed Adderall 30 mg.
12 twice daily. It was noted that Patient A had five family members with alcohol problems.
13 Respondent, however, did not obtain and document a substance use history of Patient A.
14 Respondent diagnosed Patient A with ADD and an unspecified mood disorder. According to
15 records, Respondent planned for Patient A to continue with Adderall 30 mg. twice daily.

16 29. Patient A continued to see Respondent approximately every three to four weeks and
17 Respondent continued to prescribe Adderall in doses not exceeding 60 mg. daily.

18 30. On or about November 5, 2015, Respondent noted that he discussed with Patient A
19 that the CURES database showed that she was getting Adderall from other providers.
20 Respondent continued to prescribe to Patient A: 40 mg. of Adderall daily and Valium 10 mg. as
21 needed. Respondent also started to prescribe an Emsam 6-12 mg. patch, with the only
22 documented indication being that Patient A was "feeling more depressed."

23 ///

24 ///

25 _____
26 ³ To protect their privacy rights, the patients are referred to herein by letters. Their
identities will be provided to Respondent through discovery.

27 ⁴ Conduct occurring more than seven (7) years prior to the filing of the original
28 Accusation filed on October 18, 2022, is described for informational purposes only and not as a
basis for disciplinary action.

1 31. From in or around November 2015 through at least May 2016, Respondent continued
2 to prescribe to Patient A: Adderall 60 mg. daily; Emsam 12 mg. patch; and Valium 10 mg. as
3 needed.

4 32. In or around September 2016, Respondent began prescribing to Patient A both #30
5 Adderall 20 mg. and #30 Adderall 30 mg. (CER) to Patient A on approximately a monthly basis.

6 33. According to the CURES database, in 2016, Patient A received Adderall from other
7 providers while also getting Adderall from Respondent.

8 34. In a visit note dated September 19, 2017, Respondent noted that Patient A “remains
9 on” Adderall 30 mg. twice daily and diazepam (Valium) 5 mg. twice daily. Respondent’s prior
10 2017 progress notes for Patient A, however, do not document that he was prescribing Valium to
11 Patient A.

12 35. According to the CURES database, in or around August 2017, Respondent began to
13 prescribe monthly to Patient A: 30 mg. of Valium/diazepam daily, in addition to Adderall in
14 doses of both 20 mg. and 30 mg. tablets.

15 36. Respondent continued to see Patient A on approximately a monthly basis in 2018 and
16 2019 and continued to prescribe Adderall and Valium. Respondent’s progress notes, however,
17 are scant and do not always document details about the prescriptions being issued.

18 37. According to the CURES database, in or around October 2018, Respondent began to
19 prescribe to Patient A, on a monthly basis, clonazepam in place of diazepam. Respondent’s
20 progress notes, however, do not document his issuing prescriptions for clonazepam and do not
21 document the medical indication for the change in treatment.

22 38. There is no documentation in the medical records that Respondent reviewed the
23 CURES database while prescribing controlled substances to Patient A on a regular basis.
24 According to the CURES database in 2019, Patient A received Adderall and clonazepam from
25 Respondent while also receiving Adderall and clonazepam from other prescribers.

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1 39. According to hospital records, on or about March 6, 2019, Patient A was treated in
2 the Emergency Department for dental swelling and pain related to tooth decay and dental
3 infection and it was noted that Patient A had a history of Sjogren's syndrome.⁵

4 40. In a progress note dated April 2, 2019, Respondent saw Patient A but did not
5 document any subjective or objective findings. There was no mention in the progress notes of the
6 patient's physical condition or appearance, or of her recent hospital Emergency Department visit.

7 41. According to hospital records, on or about April 3, 2019, Patient A was seen in the
8 Emergency Department for possible alcohol withdrawal, a likely seizure, and anxiety. It was
9 reported that Patient A stated that she "does not drink every day" and that her last drink had been
10 three days prior.

11 42. Respondent's progress notes of visits with Patient A on May 2, 2019 and on July 11,
12 2019, do not document objective or subjective physical findings and do not mention Patient A's
13 prior hospital visits. Respondent continued to prescribe Adderall, both immediate release and
14 extended release tablets, to Patient A.

15 43. According to hospital records, on or about July 30, 2019, Patient A presented to the
16 Emergency Department in an altered mental status with symptoms of possible alcohol withdrawal
17 and convulsions, after sustaining a possible seizure, falling and hitting her head. Patient A
18 reported that she had trouble managing her Adderall dosing and sometimes used alcohol to help
19 bridge the lack of medication. She stated that she had not had any alcohol for about two weeks.
20 It was noted that Patient A's mother called the hospital to request treatment of her daughter for a
21 substance use disorder.

22 44. Respondent saw Patient A for visits in October, November, and December 2019.
23 There was no mention in the progress notes of Patient A's prior hospital visits or substance use
24 disorder concerns, and there was no documented physical exam or other findings regarding the
25 patient's mental and physical status. Respondent continued to prescribe Adderall and clonazepam
26 to Patient A.

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28 ⁵ The main symptoms of Sjogren's syndrome are dry mouth and dry eyes.

1 45. In 2020, Respondent saw Patient A approximately every three months and continued
2 to prescribe Adderall and clonazepam. On or about May 18, 2020, Respondent saw Patient A and
3 increased the prescription of Adderall, only noting that “she needs slightly better focus.” There
4 was no documentation of an exam or objective/subjective findings to support the increased
5 prescription.

6 46. According to hospital records, on or about August 24, 2020, Patient A arrived at the
7 Emergency Department “in custody for public intoxication.” Patient A reported drinking vodka
8 and taking four Adderall tablets. She said that she had been hit in the head by an unidentified
9 person and lost consciousness.

10 47. On or about September 1, 2020, Respondent saw Patient A. His progress notes are
11 scant and inadequate. Respondent noted that the patient took clonazepam “rarely” and that she
12 was getting both Adderall 30 mg. ER and 30 mg. Adderall immediate release tablets.

13 48. For the remainder of 2020 through at least September 2021, Respondent continued to
14 regularly prescribe Adderall to Patient A.

15 49. According to hospital records, on or about August 23, 2021, Patient A arrived at the
16 Emergency Department via ambulance for acute alcohol intoxication. Patient A was found, with
17 a bottle of vodka, by a bystander while on the ground outside her apartment complex.

18 50. According to hospital records, on or about August 25, 2021, Patient A was
19 hospitalized and treated for a seizure related to “chronic episodic alcohol dependence” after
20 witnessed seizure activity and associated confusion. She reported that she had been drinking
21 heavily recently, about 1.5 liters of vodka per day. The Emergency Department physician
22 recommended that Patient A abstain from Adderall. Patient A left the hospital the next day,
23 against medical advice.

24 51. On or about August 26, 2021, the Board received an email from Patient A’s sister
25 who complained that Respondent was overprescribing addictive benzodiazepines and
26 amphetamines to her sister, for an excessively long period of time. She alleged that Patient A was
27 suffering major medical emergencies because of the medications prescribed by Respondent.

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1 that he committed repeated negligent acts in his care and treatment of Patients A, B, C, and D, as
2 more fully described hereinafter.

3 **Patient A**

4 57. Paragraphs 27 through 55, above, are hereby incorporated by reference and realleged
5 as if fully set forth herein.

6 58. From in or around November 2015, through in or around September 2021,
7 Respondent committed repeated negligent acts in his care and treatment of Patient A in that he
8 failed to obtain an adequate substance use history of Patient A before prescribing controlled
9 substances on a chronic basis and throughout the course of treatment over many years.

10 **Patient B**

11 59. On or about October 18, 2018, Respondent saw Patient B, a female born in June
12 1976, who complained of symptoms that included a lack of motivation, anxiety, obsessive
13 thoughts, and deep sadness. Respondent noted that Patient B had a medical history of pancreatitis
14 and that her current medications included: Xanax, Celexa (citalopram), and Tylenol PM. It was
15 also noted that Patient B consumed alcohol "to cope", which had caused acute pancreatitis for
16 which she had been hospitalized. Her past psychiatric history was significant for depression,
17 three separate episodes while in her early 20's. Respondent documented a history of depressive
18 symptoms and of panic attacks. Respondent diagnosed Patient B with major depressive disorder
19 and panic disorder. Respondent's treatment plan for Patient B was to discontinue Celexa and
20 Xanax, and to start Prozac 40 mg. in the morning, olanzapine 10 mg. at night, and clonazepam 1
21 mg. twice daily.

22 60. On or about December 7, 2018, Respondent saw Patient B who reported that she was
23 doing "really well" but that she was still "anxious." Respondent increased the prescription for
24 clonazepam to 1 mg. three times daily.

25 61. On or about March 15, 2019, Respondent saw Patient B who reported that she had
26 moved to Sacramento. Patient B complained of immediate memory loss, possibly due to the
27 clonazepam. Respondent noted that Patient B should taper off the clonazepam and use Xanax 1-2

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1 mg. daily, as needed. According to the CURES database, Respondent issued a prescription to
2 Patient B for #60 Xanax 1 mg. tablets.

3 62. According to the CURES database, from in or around March 2019 through in or
4 around October 2019, Respondent continued to issue prescriptions for Xanax to Patient B while
5 the patient also filled prescriptions for opioids that were issued by other prescribers.

6 63. From in or around October 2018, through in or around October 2019, Respondent
7 committed repeated negligent acts in his prescribing of benzodiazepines to Patient B in that he did
8 not obtain an appropriate substance use history before prescribing controlled substances despite
9 Patient B having a history of alcohol use disorder, he did not consider using an alternative
10 antidepressant/antianxiety medication before prescribing benzodiazepines, and he did not monitor
11 for compliance or review the CURES database, particularly after October 2018 as required by
12 section 11165.4 of the Health and Safety Code.

13 **Patient C**

14 64. On or about September 15, 2013, Respondent first saw Patient C, a male born in July
15 1969, who presented with a long history of mood swings, obsessive behavior, and hypomania. It
16 was noted that there was a family history of alcohol problems for both Patient C's father and
17 paternal uncle. Patient C reported that he was being prescribed Lamictal 100 mg. twice daily,
18 lorazepam 2 mg. twice daily, Buspar 15 mg. twice daily, and Dexedrine 15 mg. four times daily.
19 It was noted that Patient C had a liver function test with an increased level that was possibly
20 related to the Lamictal. Respondent diagnosed Patient C with Bipolar II Disorder. Respondent
21 continued Patient C's prescriptions and increased the dosage of Lamictal.

22 65. Respondent continued to see Patient C on a somewhat regular basis from October
23 2013 through at least July 2020 and to issue prescriptions for controlled substances.

24 66. On or about April 17, 2017, Respondent saw Patient C who reported taking more
25 Dexedrine than what was prescribed and who asked for an early refill, which was denied by
26 Respondent.

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1 67. According to the CURES database, in April 2017, Patient C filled the following
2 prescriptions for controlled substances issued by Respondent: #60 lorazepam 2 mg.; #60
3 clonazepam 2 mg.; #180 Dexedrine 10 mg.; and #240 Dexedrine (CER) 15 mg.

4 68. On or about June 6, 2017, Patient C saw Respondent who noted "concerns" about the
5 use of Dexedrine. Respondent issued a prescription for a two weeks' supply of Dexedrine (#130
6 tablets) and issued a prescription for #30 Nuvigil 250 mg., along with prescriptions for
7 clonazepam and lorazepam.

8 69. On or about October 14, 2019, Respondent saw Patient C and noted that Patient C
9 was taking Dexedrine 40 mg. (extended release tablets) four times daily and Dexedrine IR
10 (immediate release) 20 mg. tablets three times daily. There is no documentation in Respondent's
11 records of the medical indication for the increase in medications.

12 70. According to the CURES database, in October 2019, Patient C filled the following
13 monthly prescriptions for controlled substances issued by Respondent: #60 lorazepam 2 mg.; #60
14 clonazepam 2 mg.; #180 Dexedrine 10 mg.; #240 Dexedrine (CER) 15 mg.; and #30 Nuvigil 250
15 mg. Respondent continued to prescribe this monthly regimen of controlled substances for Patient
16 C through at least July 2020.

17 71. From in or around November 2015, through in or around July 2020, Respondent
18 committed repeated negligent acts in his prescribing controlled substances to Patient C in that he
19 failed to document his rationale for prescribing high doses of Dexedrine and/or clonazepam above
20 prescribed limits or his rationale for sudden escalations of Dexedrine and/or clonazepam.

21 **Patient D**

22 72. On or about July 21, 2017, Patient D, a male born in June 1980, first saw Respondent
23 and presented with complaints of anxiety, OCD, and panic attacks. Patient D reported being
24 diagnosed in 2012 with generalized anxiety disorder by a psychologist at Kaiser. It was noted
25 that Patient D was taking medications of Zoloft 50 mg. daily, along with Zyrtec and Flonase. It
26 was noted that Patient D's family history included a mother who suffered with depression and
27 anxiety, and a father and a maternal grandmother with alcohol problems. No substance use
28 history of Patient D was documented. Respondent diagnosed Patient D with generalized anxiety

1 disorder. Respondent noted that he issued a prescription for clonazepam 1 mg, three times daily.
2 Respondent also noted that he discontinued the Zoloft and that he discussed with Patient D the
3 risks/benefits associated with MAOI (Monoamine Oxidase Inhibitor) antidepressants.

4 73. On or about November 9, 2017, Patient D reported being hospitalized for suicidal
5 ideation. It was noted that Patient D had continued to take Zoloft 150 mg. daily along with
6 clonazepam. Respondent's records for Patient D include a hospital summary dated November 9,
7 2017 that indicates Patient D was diagnosed with an alcohol use disorder, cocaine use disorder,
8 cannabis use disorder, and hepatomegaly (abnormal enlargement of the liver). The hospital noted
9 a recommendation against the use of clonazepam. A urine drug screen was positive for
10 benzodiazepines, cannabis, and cocaine. At the hospital, Patient D received a Valium taper for
11 alcohol withdrawal.

12 74. On or about November 16, 2017, Respondent saw Patient D and noted that they
13 discussed switching medications to an MAOI. Respondent issued prescriptions for: Zoloft 150
14 mg.; #60 clonazepam 1 mg.; and Nardil (an MAOI).

15 75. Respondent continued to see Patient D on an irregular basis, about every two to four
16 months, and continued to issue prescriptions.

17 76. On or about September 4, 2018, Respondent saw Patient D and noted that he met the
18 criteria for ADHD. Respondent increased the dose of Nardil to 90 mg. daily and issued
19 prescriptions for temazepam 30 mg. and Dexedrine. In October 2018, Respondent increased the
20 monthly dose of Dexedrine to 60 mg. daily, along with clonazepam 3 mg. daily and temazepam
21 30 mg. daily.

22 77. On or about December 21, 2018, Respondent added Ketamine nasal spray to the
23 monthly prescription regimen for Patient D.

24 78. On or about May 26, 2020, Patient D complained of insomnia. Respondent
25 discontinued the Dexedrine and prescribed #90 Ritalin 10 mg., along with Nardil 60 mg. daily
26 and temazepam 60 mg. daily.

27 79. On or about June 10, 2020, Respondent saw Patient D who reported that the Ritalin
28 was ineffective. Respondent issued a prescription for Dexedrine. Respondent also noted that

1 Patient D reported that he had a hypertensive episode that required hospitalization, which
2 Respondent described as “an independent phenomena.”

3 80. Respondent continued to issue similar monthly prescriptions to Patient D while
4 seeing him infrequently through at least December 15, 2021.

5 81. From in or around July 2017, through in or around December 2021, Respondent
6 committed repeated negligent acts in his care and treatment of Patient D in that he failed to obtain
7 an adequate substance use history of Patient D, who had a history of multiple substance use
8 disorder, before prescribing controlled substances to Patient D on a chronic basis and throughout
9 the course of treatment over many years.

10 **THIRD CAUSE FOR DISCIPLINE**

11 **(Violation of State Statutes Regulating Controlled Substances)**

12 82. Respondent has further subjected his Physician’s and Surgeon’s Certificate No. G
13 12389 to disciplinary action under sections 2227 and 2234, as defined by section 2238, of the
14 Code, in that he violated state statutes regulating controlled substances, including, but not limited
15 to, section 11165.4 of the Health and Safety Code, by not reviewing the CURES database, as
16 more particularly alleged in paragraphs 27 through 81, above, which are hereby incorporated by
17 reference and realleged as if fully set forth herein.

18 **FOURTH CAUSE FOR DISCIPLINE**

19 **(Failure to Maintain Adequate and/or Accurate Records)**

20 83. Respondent has further subjected his Physician’s and Surgeon’s Certificate No. G
21 12389 to disciplinary action under sections 2227 and 2266, of the Code, for failing to maintain
22 adequate and/or accurate medical records with regard to his care and treatment of Patients A, B,
23 C, and D, as more particularly alleged in paragraphs 27 through 81, above, which are hereby
24 incorporated by reference and realleged as if fully set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 12389, issued to Respondent Philip A. Grossi, M.D.;
2. Revoking, suspending or denying approval of Respondent Philip A. Grossi, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering Respondent Philip A. Grossi, 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; and
4. Taking such other and further action as deemed necessary and proper.

DATED: NOV 07 2023

JENNA JONES FOR
REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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