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

In the Matter of the Accusation Against: **Alan Michael Krystal, M.D.** **1492 Pioneer Cir.** **Oceanside, CA 92057-1804** **Physician's and Surgeon's Certificate No. G 74558,** Respondent.	Case No. 800-2021-078050 **A C C U S A T I O N**

PARTIES

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

2. On or about July 7, 1992, the Board issued Physician's and Surgeon's Certificate No. G 74558 to Alan Michael Krystal, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2025, unless renewed.

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JURISDICTION

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

4. Section 2220 of the Code states:

> Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. . .

5. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government 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:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
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> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
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> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
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> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
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> . . .

6. Section 2234 of the Code states:

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

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

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

. . .

7. Section 2266 of the Code states:

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

COST RECOVERY

8. Section 125.3 of the Code states:

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

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

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

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested 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 with the board to reimburse the board within that one-year period for the unpaid costs.

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

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

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

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

9. Respondent has subjected his Physician's and Surgeon's Certificate No. G 74558 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A, as more particularly alleged hereinafter:[1]

10. At all times relevant to the allegations herein, Respondent was a primary care physician providing care and treatment to homebound patients as part of his mobile practice.

11. On or about June 25, 2016, Patient A's care was transferred to Respondent from another mobile practice.[2] Patient A's medical history included primary progressive multiple sclerosis diagnosed at age 31, generalized pain, chronic muscle spasms, placement of a suprapubic catheter in situ, and chronic urinary tract infections. Patient A also had a history of recurrent kidney stones, labile hypertension with intermittent high and low systemic blood pressures, depression with prior suicidal thoughts, bilateral femoral neck fractures, and chronic pain syndrome. Patient A was paralyzed from the waist down, bedbound, and living with his

[1] References to "Patient A" herein are used to protect patient privacy.

[2] Any medical care or treatment rendered by Respondent more than seven years prior to the filing of the instant Accusation is described for informational and contextual purposes only and not pleaded as a basis for disciplinary action.

parents. At the time, Patient A was 5'11" and weighed 102 pounds. Respondent reviewed the medical chart that was transferred to him, completed an intake and physical examination of Patient A, and discussed Patient A's case with his parents.

12. According to the prior progress notes from between in or about February 2016, and April 2016, Patient A's pains were localized to the quadriceps and groins, mostly involving the bilateral legs, and he had diffuse muscle atrophy resulting from his bedbound status with stage IV skin pressure ulcers. During a visit that took place on or about April 21, 2016, Patient A was described as appearing inebriated.

13. As of on or about June 25, 2016, Patient A's medications included, *inter alia*, diazepam,[3] methadone,[4] MS Contin,[5] baclofen,[6] gabapentin,[7] and tizanidine.[8] The dosage for methadone was 2.5 mg once a day, and the dosage for MS Contin was 30 mg two to three times a day. Respondent noted that Patient A's pain was mitigated to "4/5 out of 10" on methadone. In addition, Respondent noted that although Patient A experienced depression, he refused anti-depressant medication. Respondent refilled Patient A's methadone at this visit.

14. In or about July 2016, Respondent ordered x-rays for Patient A. The results confirmed bilateral femoral neck fractures due to severe osteoporosis.

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[3] Diazepam (Valium) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[4] Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

[5] MS Contin (morphine sulfate) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[6] Baclofen is a muscle relaxer used to treat muscle symptoms caused by multiple sclerosis, including spasm, pain, and stiffness.

[7] Gabapentin is an anticonvulsant and nerve pain medication.

[8] Tizanidine is used to treat muscle spasms caused by multiple sclerosis and other conditions.

15. Respondent regularly saw Patient A between on or about November 23, 2016, and May 27, 2021. The visits in 2016 and 2017 took place on or about November 23, 2016, March 25, 2017, May 25, 2017, July 26, 2017, August 23, 2017, November 25, 2017, and December 19, 2017.

16. The visits in 2018 and 2019 took place on or about January 15, 2018, April 3, 2018, June 1, 2018, June 28, 2018, July 30, 2018, August 28, 2018, September 29, 2018, October 29, 2018, November 28, 2018, December 29, 2018, January 28, 2019, February 20, 2019, March 21, 2019, April 21, 2019, May 26, 2019, June 2, 2019, June 18, 2019, July 13, 2019, August 21, 2019, September 20, 2019, October 18, 2019, November 18, 2019, and December 17, 2019.

17. The visits in 2020 and 2021 took place on or about January 18, 2020, February 16, 2020, March 19, 2020, April 17, 2020, September 12, 2020, November 13, 2020, December 10, 2020, December 14, 2020, December 18, 2020, February 14, 2021, March 25, 2021, April 26, 2021, and May 27, 2021.

18. During the March 25, 2017, visit, Respondent saw Patient A to refill his pain medications. He noted that Patient A's pain was generalized and not adequately controlled. Respondent assessed that Patient A's chronic pain was related to his multiple sclerosis, and he noted that Patient A and his family desired an increase in his morphine dosage. Respondent refilled Patient A's MS Contin and methadone medications. The methadone dosage continued to be 2.5 mg once per day, and the MS Contin dosage was increased to 45 mg three times a day.

19. At the next visit, which took place on or about May 25, 2017, visit, Respondent refilled Patient A's MS Contin medication, which had an increased dosage of 60 mg three times a day. He also continued methadone 2.5 mg once per day. Respondent noted that Patient A's pain was adequately controlled on this pain medication regimen. Respondent continued Patient A on the same MS Contin and methadone regimen for the next 18 months until on or about January 18, 2019.

20. During the January 15, 2018, visit, Respondent noted that Patient A was experiencing anxiety and depression, along with poor appetite resulting in significant weight loss. Respondent noted that Patient A had lost 30 pounds in the past year and weighed 70 pounds. Respondent

prescribed Remeron, an anti-depressant, to Patient A in an effort to stimulate his appetite and aid his depression.

21. According to the Controlled Substance Utilization Review and Evaluation System (CURES) report for Patient A, between in or about July 2018, and January 2019, Patient A also regularly filled prescriptions of diazepam 5 mg, which Respondent prescribed for muscle relaxation and anxiety management. The diazepam prescriptions were in addition to the recurring MS Contin and methadone prescriptions.

22. During this timeframe, between in or about July 2018, and January 2019, Respondent also prescribed non-controlled medications to Patient A for pain and muscle relaxation, including gabapentin, tizanidine, and baclofen. In or about April 2019, due to Patient A's continuing weight loss, Respondent also prescribed dronabinol for appetite stimulation.

23. Beginning in or about July 2018, Respondent noted that Patient A's blood pressure was elevated during the previous two visits. Respondent discussed adding a low dose anti-hypertensive medication with Patient A and his father, and they agreed. Respondent prescribed lisinopril 5 mg to Patient A.

24. During the September 29, 2018, visit, Respondent increased the dosage of lisinopril to 10 mg.

25. At the next visit, which took place on or about October 29, 2018, Respondent noted that in addition to lisinopril, Patient A was also taking metoprolol and that the combination of both medications resulted in good control of Patient A's hypertension.

26. During the February 20, 2019, visit, Respondent also noted that Patient A's was experiencing tachycardia without symptoms.

27. During the March 21, 2019, visit, Respondent refilled Patient A's methadone at an increased dosage of 10 mg per day. Respondent had stopped MS Contin in or about January 2019. During this visit, Respondent noted that Patient A's blood pressure was "81/61."

28. During the April 21, 2019, visit, Respondent noted Patient A's low blood pressure and tachycardia. He further noted that both conditions were well-maintained with medication.

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29. On or about June 2, 2019, Respondent added Percocet[9] to Patient A's medication regimen to address the onset of severe breakthrough pain of the lower back. The dosage for Percocet was 5 mg one to two tablets every four to six hours per day.

30. At the next visit, which took place on or about June 18, 2019, Respondent noted that Patient A was experiencing increased pain due to bladder and kidney stones. As a result, Respondent increased Patient A's methadone to 10 mg twice per day. In addition, he prescribed Percocet 5 mg one to two tablets every six hours. Respondent noted Patient A's low blood pressure, which was well-maintained with medication. Respondent further noted that Patient A was receiving palliative care at home.

31. As of on or about August 21, 2019, until on or about March 19, 2020, Patient A's pain medication regimen included methadone 10 mg twice per day and Percocet 10 mg three times per day.

32. During the October 18, 2019, visit, Respondent noted that Patient A had low blood pressure without symptoms, which was well-maintained with medication. During this visit, Respondent noted that Patient A's blood pressure was "89/61."

33. As of on or about April 17, 2020, Respondent decreased Patient A's methadone to 10 mg total per day and he continued Percocet 10 mg at three times per day. Respondent maintained this pain medication regimen until on or about June 20, 2021. Respondent noted on multiple occasions that "[t]here is no evidence of misuse as his parents provide the pain medication to the patient as prescribed."

34. During the February 14, 2021, visit, Respondent again noted Patient A's history of low blood pressure and tachycardia, both of which continued to be treated with medication.

35. According to the CURES report for Patient A, between in or about January 2019, and June 2021, Respondent also continued to regularly prescribe diazepam 5 mg to Patient A, alongside methadone and Percocet.

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[9] Percocet (oxycodone and acetaminophen) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

36. Between in or about May 2017, and June 2021, Respondent did not prescribe and try safer alternative pain medications in an effort to reduce Patient A's opiate dependency, including topical therapies, NSAID medications, SSRI/SNRI medications, and other anticonvulsant medications.

37. Between in or about May 2017, and June 2021, Respondent did not perform any opiate risk assessment to determine Patient A's addiction and dependency risks.

38. Between in or about May 2017, and June 2021, Respondent did not perform regular urine drug screening.

39. Between in or about May 2017, and June 2021, Respondent did not review the CURES database.

40. Between in or about May 2017, and June 2021, Respondent did not properly monitor cardiac side effects from the use of methadone, including through EKG monitoring.

41. Between in or about May 2017, and June 2021, Respondent did not reduce the dosage of Patient A's opiate medications in an effort to minimize the risk of adverse cardiac side effects, particularly in light of Patient A's recurrent hypotension episodes.

42. Between in or about May 2017, and June 2021, Respondent concurrently prescribed benzodiazepine and opiate medications to Patient A on a prolonged basis without any informed consent discussion and/or documentation thereof.

43. Between in or about May 2017, and June 2021, Respondent did not actively taper Patient A off of benzodiazepine and/or opiate medications in an effort to reduce the risks of accidental overdose and respiratory failure.

44. Respondent committed repeated negligent acts in his care and treatment of Patient A between in or about May 2017, and June 2021, which included, but was not limited to, the following:

A. Respondent failed to prescribe and try safer alternative pain medications in an effort to reduce Patient A's opiate dependency, including topical therapies, NSAID medications, SSRI/SNRI medications, and other anticonvulsant medications;

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B. Respondent failed to perform any opiate risk assessment to determine Patient A's addiction and dependency risks;

C. Respondent failed to perform regular urine drug screening;

D. Respondent failed to review the CURES database;

E. Respondent continued Patient A on two long-acting opiate medications, methadone and MS Contin, which he prescribed concurrently until in or about January 2019;

F. Respondent failed to properly monitor cardiac side effects from the use of methadone, including through EKG monitoring;

G. Respondent failed to reduce the dosage of Patient A's opiate medications in an effort to minimize the risk of adverse cardiac side effects, particularly in light of Patient A's recurrent hypotension episodes;

H. Respondent concurrently prescribed benzodiazepine and opiate medications to Patient A on a prolonged basis without any informed consent discussion and/or documentation thereof; and

I. Respondent failed to actively taper Patient A off of benzodiazepine and/or opiate medications in an effort to reduce the risks of accidental overdose and respiratory failure.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

45. Respondent has subjected his Physician's and Surgeon's Certificate No. G 74558 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records regarding his care and treatment of Patient A, as more particularly alleged in paragraphs 9 through 44, above, which are hereby incorporated by reference and re-alleged 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 74558, issued to Respondent Alan Michael Krystal, M.D.;

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

3. Ordering Respondent Alan Michael Krystal, 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: MAY 10 2024

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

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