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

In the Matter of the Accusation Against:	)	
ALEXANDER GRINBERG, M.D.	)	Case No. 03-2013-230317
Physician's and Surgeon's Certificate No. A56467	)	
Respondent	)	

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 December 15, 2016.

IT IS SO ORDERED: November 15, 2016.

MEDICAL BOARD OF CALIFORNIA

Jamie Wright, J.D., Chair
Panel A

KAMALA D. HARRIS
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **ALEXANDER GRINBERG, M.D.** **2320 Sutter Street, Suite 101** **San Francisco, CA 94115** **Physician's and Surgeon's Certificate** **No. A 56467** Respondent.	Case No. 03-2013-230317 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Brenda P. Reyes, Deputy Attorney General.

2. Respondent Alexander Grinberg, M.D. ("Respondent") is represented in this proceeding by attorney Stephen M. Boreman, Esq., whose address is: Slote, Links & Boreman, LLP, One Embarcadero Center, Suite 400, San Francisco, CA 94111.

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3. On or about December 18, 1996, the Medical Board of California issued Physician's and Surgeon's Certificate No. A 56467 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 03-2013-230317, and will expire on December 31, 2016, unless renewed.

JURISDICTION

4. Accusation No. 03-2013-230317 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on January 6, 2015. Respondent timely filed his Notice of Defense contesting the Accusation. An Amended Accusation (hereinafter "Accusation") was properly served on Respondent on February 23, 2015.

5. A copy of Accusation No. 03-2013-230317 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 03-2013-230317. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 03-2013-230317, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 56467 issued to Respondent Alexander Grinberg, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES- MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

3. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the

Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

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

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

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

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

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to

Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

7. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

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

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

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

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

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Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

13. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

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

15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject

to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Stephen M. Boreman, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 09/01/16

ALEXANDER GRINBERG, M.D.
Respondent

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

DATED: 9/1/16

STEPHEN M. BOREMAN, Esq.
Attorney for Respondent

ENDORSEMENT

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

Dated: September 15, 2016

KAMALA D. HARRIS
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General

Brenda P. Reyes

BRENDA P. REYES
Deputy Attorney General
Attorneys for Complainant

SF2014409231

Exhibit A

Accusation No. 03-2013-230317

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO February 23 20 15
BY K. Voong ANALYST

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

In the Matter of the Amended Accusation Against: **ALEXANDER GRINBERG, M.D.** **2320 Sutter Street, Suite 101** **San Francisco, CA 94115** **Physician's and Surgeon's Certificate No. A 56467** Respondent.	Case No. 03-2013-230317 **AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about December 18, 1996, the Medical Board of California issued Physician's and Surgeon's Certificate Number A 56467 to Alexander Grinberg, 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 December 31, 2016, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board),[1] Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states, in relevant part:

"The board shall have the responsibility for the following:

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

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

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

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

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

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

6. Section 2234 of the Code, states in relevant part:

"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:

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

"(b) Gross negligence.

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[1] The term "board" means the Medical Board of California. "Division of Medical Quality" shall also be deemed to refer to the Medical Board. (Bus. & Prof. Code, § 2002.)

"(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) 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.

"(d) Incompetence."

7. Section 2266 of the Code states: AThe failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.@

PERTINENT DRUGS

8. The following controlled substances and/or dangerous drugs are involved in this proceeding:

A. **Adderall** is a trade name for **amphetamine** and **dextroamphetamine**, a central nervous system stimulant. Amphetamine is a dangerous drug as defined in section 4022 of the Code, a Schedule II controlled substance as defined by section 11055, subdivision (d) (1) of the Health and Safety Code, and a Schedule II controlled substance as defined by section 1308.12 (d) of Title 21 of the Code of Federal Regulations. Adderall is used in the treatment of Attention Deficit Hyperactivity Disorder (ADHD). Like all amphetamines, it has a high potential for abuse.

B. **Ativan**, a trade name for **lorazepam**, is used for anxiety and sedation in the management of anxiety disorder for short-term relief from the symptoms of anxiety or anxiety associated with depressive symptoms. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code, and a Schedule IV controlled substance as defined

by Section 1308.14 of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

C. **Cymbalta**, a trade name for **duloxetine**, is a selective serotonin and norepinephrine reuptake inhibitor (SSNRI) antidepressant. Duloxetine affects chemicals in the brain that may become unbalanced and cause depression. It is used to treat major depressive disorder in adults. Duloxetine is a dangerous drug as defined in Business and Professions Code section 4022.

D. **Fentanyl** is an opioid analgesic. Fentanyl is a Schedule II controlled substance as defined by section 11055 of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Fentanyl's primary effects are anesthesia and sedation. Fentanyl is a strong opioid medication and is indicated only for treatment of chronic pain (such as that of malignancy) that cannot be managed by lesser means and requires continuous opioid administration. Fentanyl presents a risk of serious or life-threatening hypoventilation. When patients are receiving Fentanyl, the dosage of central nervous system depressant drugs should be reduced at least 50%. Use of Fentanyl together with other central nervous system depressants, including alcohol, can result in increased risk to the patient.

E. **Klonopin** is a trade name for **clonazepam**, an anticonvulsant of the benzodiazepine class of drugs. Klonopin is used to treat seizure disorders or panic disorder. It produces central nervous system depression and should be used with caution with other central nervous system depressant drugs. Like other benzodiazepines, it can produce psychological and physical dependence. Klonopin is a dangerous drug as defined in Business and Professions Code section 4022, a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code, and a Schedule IV controlled substance as defined by Section 1308.14 of Title 21 of the Code of Federal Regulations.

F. **Lexapro**, a trade name for **escitalopram**, is an antidepressant belonging to a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Lexapro affects chemicals in the brain that may become unbalanced and cause depression or anxiety. Lexapro is used to treat

anxiety in adults and major depressive disorder in adults and adolescents. Lexapro is a dangerous drug as defined in Business and Professions Code section 4022.

G. **Prozac**, a trade name for **fluoxetine hydrochloride**, is an antidepressant used to treat multiple conditions including major depressive disorder. Prozac is sometimes used together with olanzapine (Zyprexa) to treat depression caused by bipolar disorder (manic depression). Prozac is a dangerous drug as defined in Business and Professions Code section 4022.

H. **Ritalin** is a trade name for **methylphenidate hydrochloride**, a mild central nervous system stimulant. Ritalin is used to treat attention deficit disorder (ADD) and attention deficit and hyperactivity disorder (ADHD). It is a dangerous drug as defined in Business and Professions Code section 4022 and a Schedule II controlled substance as defined in Health and Safety Code section 11055.

I. **Suboxone** is a trade name for **buprenorphine HCI**, an opioid medicine similar to morphine, codeine, and heroin. It targets the same places in the brain that opioids do. It relieves drug cravings without inducing the same high as other opioid drugs. Buprenorphine can cause side effects similar to other opioids and also can cause physical dependence. Buprenorphine can help treat addiction to opioid drugs, including heroin and narcotic painkillers. It prevents or reduces withdrawal symptoms caused by quitting these drugs. Suboxone is a dangerous drug as defined in Business and Professions Code section 4022 and a Schedule V controlled substance as defined by section 11058 (d) of the Health and Safety Code.

J. **Trazadone** is an antidepressant medicine used to treat major depressive disorder. Trazadone is a dangerous drug as defined in Business and Professions Code section 4022.

K. **Valium** is a trade name for **diazepam**, a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in Business and Professions Code section 4022, and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code, and a Schedule IV controlled substance as defined by Section 1308.14 of Title 21 of the Code of Federal Regulations. Diazepam can produce psychological and physical dependence and it 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.

L. **Vicodin** is a trade name for a combination of **hydrocodone bitartrate and acetaminophen** and is a semisynthetic narcotic analgesic. It is a Schedule III controlled substance and narcotic as defined by section 11056, subdivision (e), of the Health and Safety Code, and a Schedule III controlled substance as defined by section 1308.13 (e) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Alcohol and other central nervous system depressants may produce an additive central nervous system depression, when taken with this combination product, and should be avoided. Patients taking other narcotic analgesics, antihistamines, antipsychotics, antianxiety agents, or other central nervous system depressants (including alcohol) concomitantly with Vicodin may exhibit an additive central nervous system depression. The dose of one or both agents should therefore be reduced.

FIRST CAUSE FOR DISCIPLINE

(Re: Patient MM)

(Unprofessional Conduct/Gross Negligence/Repeated Negligent Acts/Incompetence/Inadequate Records)

9. Patient MM,[2] a 50-year-old woman, was first seen by Respondent in 2000 as an inpatient at St. Luke's Hospital in San Francisco, where Respondent was working at the time as an attendant psychiatrist. In or about 2003, MM began seeing Respondent in his private practice in San Francisco. Patient MM remained a patient of Respondent's until approximately February 13, 2013, when Respondent terminated MM from his practice after she moved away.

10. Patient MM's chief complaints were chronic anxiety, panic attacks, and depression. Patient MM also suffered from substance abuse, which included at various times opioid, amphetamine, and/or cocaine abuse.

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[2] Patient names are kept confidential to protect their right to privacy but will be identified to Respondent in discovery.

11. On or about January 20, 2010, Respondent reported to the California Department of Social Services that MM was unable to work due to fatigue, lack of focus, anxiety, and emotional disturbance. Respondent's prescribed medications for MM at the time included Klonopin 2 mg., twice daily; Ativan 1-2 mg., 2-3 times daily, as needed; and, Prozac 20 mg. daily. Respondent saw MM on March 19, 2010, at which time MM reported increased sadness and hopelessness. MM reported that she was "clean," but that she had urges to use cocaine or "speed" to get some relief. Respondent increased Klonopin 2 mg. to three times a day and he increased Prozac to 40 mg. daily.

12. MM saw Respondent on May 13, 2010 and reported frustration at the loss of effect of Ativan and she reported using more than was prescribed. Respondent added diazepam (Valium) 10 mg. every 8 hours, as needed, to MM's prescribed medications.

13. On August 10, 2010, MM saw Respondent and reported a "few relapses of amphetamine use." Portions of Respondent's progress note for this date are illegible. It appears MM reported increased paranoia and that she took diazepam 4-5 times a day to relax and get some sleep. As a result of the increased usage of diazepam, MM reported that she was out of the medication. Respondent documented that he advised MM to get back into a rehabilitation program. Respondent's records appear to document that he added Trazadone 100 mg. at bedtime to MM's prescribed medications.

14. Respondent's records document that MM failed to appear for an appointment on December 28, 2010. Respondent documented that he spoke with MM and that she reported combining diazepam and Ativan to stop panic resulting from bad arguments with her boyfriend and to suppress her cravings for cocaine. Respondent noted that he discussed the risks of combining benzodiazepines with MM, "but as the combination works," he approved MM's request that he continue prescribing both medications. Respondent's records document that on January 18, 2011, Prozac was increased to 60 mg. daily.

15. Respondent saw MM on March 29, 2011, and noted that he had reviewed a prescription profile for MM from her insurance company. Respondent documented that the profile was consistent with MM's report of her use of benzodiazepines, i.e., that she runs out of

her medications usually 8-9 days early. MM reported that she had two one-day relapses on "MA" (methamphetamine?). Respondent documented that he renewed MM's prescriptions for Klonopin, diazepam, Ativan, Prozac, and Trazadone and that he encouraged MM to attend Narcotics Anonymous and see a therapist.

16. On May 3, 2011, Respondent documented that MM was taking Vicodin, prescribed by her primary care physician, for back pain. MM reported on this date that her boyfriend occasionally "steals" a few of her diazepam and Vicodin.

17. On July 1, 2011, MM reported that she needed more Klonopin because of legal problems. Respondent noted that MM was detained for shoplifting. MM also reported that she was stressed by her boyfriend's behavior, which was not described in the record. Respondent documented that he renewed MM's prescriptions.

18. Respondent's records document that on September 20, 2011, MM called to report that she could not make her appointment because she was being hospitalized at U.C. San Francisco Medical Center after having a stroke. MM reported that she had used cocaine for a few days prior to the stroke. On October 13, 2011, Respondent noted that MM had been discharged from the hospital two weeks prior and that she had mild to moderate left side residual weakness.

19. On November 26, 2011, MM was admitted to U.C. San Francisco Medical Center due to somnolence following over-ingestion of psychiatric medications. MM's hospital course included discovery of bilateral pulmonary emboli. During MM's hospitalization all psychiatric medications were discontinued with the exception of Klonopin, which was reduced to 0.5 mg. twice a day, and Prozac, which was reduced to 10 mg. daily. MM was discharged from the hospital on December 2, 2011. The hospital record documents that at the time of discharge MM was not requiring additional PRN doses. The Discharge Summary notes that MM was to continue on Klonopin 0.5 mg. twice daily either until long-term maintenance became effective for anxiety symptoms or until MM could be weaned off of benzodiazepines completely. The Discharge Summary documents that the importance of a lock-box to secure MM's prescribed medications was discussed with MM and her daughters and that MM's daughters agreed to administer MM's

prescribed medications to her. MM's daughters were also advised to accompany MM to her appointment with Respondent to set new goals and expectations.

20. Respondent's records document that on December 27, 2011, MM called and complained that Klonopin 0.5 mg. was inadequate and that she was experiencing increased anxiety. MM also reported that she could not be dependent on her daughter to dispense her medications when she needs them because her daughter is busy and unavailable. Respondent increased Klonopin to 1 mg. twice a day and Prozac to 20 mg. daily. On January 13, 2012, Respondent saw MM and prescribed Klonopin, Prozac, and Ativan 2 mg. every 8 hours, as needed. On March 3, 2012, Respondent increased MM's Prozac dose to 40 mg. daily.

21. Respondent's records document that on April 17, 2012, he was notified that MM was being discharged from San Francisco General Hospital to Shrader House, a short-term crisis residential program for treatment of acute symptoms of mental illness. Respondent noted that MM's prescribed medications at this time included Trazadone 50-100 mg. at bedtime, as needed.

22. Respondent's records document that on September 14, 2012, MM called and requested that Respondent fax a prescription for her medications to a new pharmacy because she had moved to Antioch, CA. Patient MM reported that the move was temporary. Respondent documented that he faxed a prescription to the pharmacy for Klonopin 2 mg., twice daily; Prozac 40 mg. daily; and, Trazadone 50-100 mg. at bedtime.

23. Respondent's records document that on October 9, 2012, MM called and reported increased anxiety and frequency of panic attacks. Respondent prescribed diazepam 10 mg. every 12 hours, as needed.

24. Respondent's records document that on October 25, 2012, MM failed to appear for her scheduled appointment. Respondent spoke by telephone with MM later that day. MM reported that she was thinking of staying in Antioch for good. Respondent agreed to provide MM with two more refills of her medications to continue her treatment until she could arrange care with another provider. Respondent's records document that he continued to get telephone calls from the patient over the next several months requesting that he refill her medications. On February 13, 2013, Respondent documented that he terminated the physician-patient relationship.

25. Respondent's records document that MM repeatedly failed to appear for scheduled appointments. Respondent's records and pharmacy prescribing records document that Respondent routinely provided MM with early refills of her prescribed medications. Respondent's records routinely fail to document the quantity of the medications prescribed. Respondent's progress notes are handwritten. Several of the notes contain handwriting that is illegible.

26. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234 (b), and/or 2234 (c), and/or 2234 (d) of the Code in that Respondent was grossly negligent, and/or committed repeated negligent acts, and/or was incompetent in the practice of medicine in his care and treatment of Patient MM, including but not limited to the following:

A. Patient MM was not an appropriate candidate for long-term use of benzodiazepine medications or for "as needed" dosing because of her known active substance abuse. The standard of care in treating a dual diagnosis patient in the office setting is to treat the substance abuse first and taper and discontinue addicting medications. Respondent simultaneously prescribed two or three benzodiazepine medications, in high doses, and he ordered some of the medications to be taken on an "as needed" basis so that MM could use her own judgment about when to use the medications for symptom relief.

B. Respondent failed to manage, and/or failed to document management of Patient MM's psychiatric conditions and medication use, including but not limited to, laboratory testing to monitor compliance with prescribed medications; response to treatment; side effects to medications; sustained trials off benzodiazepine medications; and, medical necessity for the continued prescribing of medications.

C. Respondent failed to monitor the patient's medication use for early refills.

D. Respondent failed to refer Patient MM to a substance abuse specialist.

27. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234 and/or 2266 of the Code in that he failed to keep adequate and accurate

records related to his care and treatment of Patient MM, including but not limited to the following:

A. Respondent failed to document periodic review of the patient's treatment plan and medications, such as the patient's compliance with prescribed medications; response to treatment; and, any side effects to medications.

B. Respondent failed to document in the patient record the quantity of prescribed medications.

C. Significant portions of Respondent's progress notes are illegible.

SECOND CAUSE FOR DISCIPLINE

(Re: Patient MT)

(Unprofessional Conduct/Gross Negligence/Repeated Negligent Acts/ Incompetence/Inadequate Records)

28. Patient MT, a 52-year-old woman, was a patient of Respondent's from 1999 to approximately 2006. Patient MT returned to see Respondent on April 4, 2011. In an Initial Psychiatric Evaluation of the same date, Respondent noted that MT has a history of depression, anxiety disorder with panic attacks, and attention deficit disorder (ADD). She had been treated in the past with antidepressants from the SSRI group, and with Wellbutrin and Effexor; with mood stabilizers such as gabapentin and Topamax; and, with anti-anxiety medications, such as clonazepam and lorazepam. Respondent noted that MT achieved the best results treating her ADD with Adderall. MT's history also included morbid obesity and bariatric surgery which was done in 2004. The surgery helped MT lose a significant amount of weight, but left her with many gastroenterological complications, including severe abdominal pain.

29. On April 4, 2011, Respondent performed a mental status examination of MT and noted that her mood was moderately depressed and that she demonstrated moderate-to-severe deficits of attention and concentration. Respondent's diagnoses were depressive disorder, generalized anxiety disorder, and ADD. Respondent prescribed Lexapro 10 mg. daily, Klonopin 0.5 mg. once a day, Topamax (an anticonvulsant) 25 mg. twice daily, and Adderall 10 mg. twice daily.

30. Respondent's care of Patient MT was reviewed for the time period April 2011 through approximately April 2014. Respondent's records contain 26 progress notes for this time period documenting doctor-patient interactions. Portions of Respondent's progress notes are illegible. The records, nevertheless, document that in at least twelve of the documented interactions Patient MT did not physically appear for an appointment.

31. Respondent's records and pharmacy prescribing records for Patient MT indicate that Respondent regularly prescribed MT clonazepam 0.5 mg. three times daily for treatment of her anxiety and panic attacks, and Adderall 20-60 mg. daily to treat her ADD and lack of energy. Pharmacy prescribing records for Patient MT indicate that during the period Respondent's care was reviewed, MT received monthly prescriptions for lorazepam 1 mg., #60, prescribed by another physician. Beginning in at least December 2011, through April 2014, MT also received monthly prescriptions for liquid Vicodin 7.5-325/15 ml, #2365 ml., also prescribed by another physician. At his Medical Board interview on May 13, 2014, Respondent reported that he was aware that MT was receiving prescriptions for lorazepam and Vicodin from another physician.

32. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234 (b), and/or 2234 (c), and/or 2234 (d) of the Code in that Respondent was grossly negligent, and/or committed repeated negligent acts, and/or was incompetent in the practice of medicine in his care and treatment of Patient MT, including but not limited to the following:

A. Respondent prescribed clonazepam and Adderall to Patient MT, while knowing she was receiving prescriptions for lorazepam and Vicodin from another physician, thereby placing Patient MT at higher risk of toxicity, respiratory depression, addiction, and possibly other complications.

B. Respondent failed to consult with and/or failed to coordinate care of Patient MT with her other prescribing physicians in order to avoid duplication and/or adverse drug interactions.

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C. Respondent failed to have regular face-to-face follow up visits with Patient MT and he failed to document periodic review of the patient's treatment plan and medications in order to rectify the poly-pharmacy and multiple prescriber issues.

33. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234 and/or 2266 of the Code in that he failed to keep adequate and accurate records related to his care and treatment of Patient MT, including but not limited to the following:

A. Respondent failed to document in the patient record the quantity of prescribed medications.

B. Significant portions of Respondent's progress notes are illegible.

THIRD CAUSE FOR DISCIPLINE

(Re: Patient AV)

(Unprofessional Conduct/Gross Negligence/Inadequate Records)

34. Patient AV, a 46-year-old man, was first seen by Respondent as an outpatient during the time Respondent worked at St. Luke's Hospital. Patient AV served time in jail for domestic violence and returned to see Respondent on February 18, 2007. In an Initial Psychiatric Evaluation Report of the same date, Respondent noted that AV suffers from generalized anxiety disorder and panic attacks. AV's medical history includes morbid obesity and borderline hypertension. AV reported a history of experimenting with amphetamine and cocaine, but discontinuing them due to panic attacks and severe anxiety.

35. Patient AV reported that while in jail he was involved in gang activity. He reported that now that he was out of jail he was afraid to leave his home, even for doctor visits, for fear of being attacked or killed by gang members. AV reported SSRI antidepressants and Buspar were ineffective in treating his anxiety and panic attacks. He reported being treated in the past with clonazepam 2 mg., three times daily, and Valium 10 mg., every 8 hours, as needed, for panic attacks. Respondent noted that AV had a high tolerance to benzodiazepines due to his morbid obesity.

36. Patient AV's complaints included panic attacks up to four times a day, extreme anxiousness, fearfulness, and fear of eminent death. The patient reported eating to comfort

himself. AV reported that he could not go to therapy because he could not be out on the street for fear of being killed and because of the difficulty ambulating due to his significant weight. Respondent documented a mental status examination and he diagnosed generalized anxiety disorder with panic attacks and possible post traumatic stress disorder. Respondent prescribed Klonopin 2 mg., 3 times daily, and Valium 10 mg., every 8 hours, as needed, for panic. Respondent noted that AV consented to communicate with Respondent by telephone every 2-3 months and to see Respondent "when he can," i.e., "when transportation is available and [AV] does not have to use public transportation."

37. Respondent's care of Patient AV was reviewed for the time period October 2010 through approximately April 2014. Respondent's records contain 13 progress notes for this time period documenting doctor-patient interactions, at least six of which were telephone calls with the patient. The records indicate that Respondent saw Patient AV one time during 2011, as many as three times during 2012, and one time during 2013. Respondent's records and pharmacy prescribing records for Patient AV indicate that from August 2012 through January 2014, Patient AV received monthly prescriptions from Respondent for Klonopin 2 mg., #120, and Valium 10 mg., #120.

38. On February 22, 2014, Patient AV saw Respondent and reported that for at least the last two months he had filled his prescriptions at different pharmacies in order to stock up. AV explained that because he was living alone and with his anxiety increasing he was afraid he would not be able to get out to get his medications when he needed them. AV asked Respondent to provide him with prescriptions for two months worth of medications to avoid this problem. Respondent agreed to provide AV with prescriptions for two months of medications "to minimize his need to go out." Pharmacy prescribing records indicate that on February 22, 2014, Respondent prescribed Klonopin 2 mg., #240, and Valium 10 mg., #240.

39. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234 (b) of the Code in that Respondent was grossly negligent in the practice of medicine in his care and treatment of Patient AV, including but not limited to the following:

A. Respondent prescribed two benzodiazepine medications, long term, and in high doses without documentation of medical indication for the ongoing prescribing.

B. Over the course of his treatment with Respondent, Patient AV essentially became housebound due to fear and he developed a tolerance for and dependency on the temporary relief from benzodiazepine medications. When his psychiatric condition did not show improvement, Respondent failed to consider alternative treatments and/or medication adjustments.

40. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234 and/or 2266 of the Code in that he failed to keep adequate and accurate records related to his care and treatment of Patient AV, including but not limited to the following:

A. Respondent failed to document in the patient record the quantity of prescribed medications.

B. Portions of Respondent's progress notes are illegible.

FOURTH CAUSE FOR DISCIPLINE

(Re: Patient DK)

(Unprofessional Conduct/Gross Negligence/Repeated Negligent Acts/ Incompetence/Inadequate Records)

41. Respondent first saw Patient DK, a 54-year-old man, on January 20, 2007, upon referral after the patient was hospitalized for 72-hours because of "SI" (suicidal ideation?). Most of Respondent's initial progress note is illegible. It appears that the patient had a history of mood disorder, depressive disorder, generalized anxiety with panic attacks, and ADD. DK appears to have reported a history of self-medicating with cocaine. At his Medical Board interview on May 13, 2014, Respondent reported that DK also had multiple medical comorbidities and orthopedic problems. Respondent started DK on Cymbalta 40 mg. (frequency illegible). On October 19, 2007, Respondent saw Patient DK and prescribed Ritalin 10 mg., three times daily.

42. Respondent's progress notes for Patient DK are frequently very brief in detail and illegible. Respondent's progress notes and pharmacy prescribing records indicate that at least by January 2011, through February 2014, Patient DK received monthly prescriptions from

Respondent for Ritalin 20 mg., 3-4 times a day; Ativan 1-2 mg., 2-3 times a day; Valium 10 mg., up to 8 tablets a day; and, Klonopin 2 mg., up to 4 times a day. Pharmacy prescribing records indicate that from January 2011 through at least July 2012, Patient DK received prescriptions for Fentanyl 50-75 mcg./hr., one patch every 48 hrs., from another physician. Patient DK also received from February 2013 through March 2014, prescriptions for Suboxone 8 mg./2 mg. prescribed by another physician. At his Medical Board interview, Respondent stated that he was aware that Patient DK received prescriptions for Fentanyl and Suboxone from another physician. Respondent's records do not document that he consulted with nor coordinated care and medication prescribing with Patient DK's other physicians.

43. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234 (b), and/or 2234 (c), and/or 2234 (d) of the Code in that Respondent was grossly negligent, and/or committed repeated negligent acts, and/or was incompetent in the practice of medicine in his care and treatment of Patient DK, including but not limited to the following:

A. Respondent prescribed Ritalin, Ativan, Valium, and Klonopin to Patient DK, while knowing he was receiving prescriptions for Fentanyl and Suboxone from another physician, thereby placing Patient DK at higher risk of toxicity, respiratory depression, addiction, and possibly other complications.

B. Respondent failed to consult with and/or failed to coordinate care and medication prescribing with Patient DK's other prescribing physicians.

44. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234 and/or 2266 of the Code in that he failed to keep adequate and accurate records related to his care and treatment of Patient DK, including but not limited to the following:

A. Respondent failed to document in the patient record the quantity of prescribed medications.

B. Significant portions of Respondent's progress notes are illegible.

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FIFTH CAUSE FOR DISCIPLINE

(Re: Patient SG)

(Unprofessional Conduct/Gross Negligence/Inadequate Records)

45. Respondent first began treating Patient SG, an elderly woman and family member of Respondent's, in 1998. Although not documented in the patient record, Respondent reported at his Medical Board interview on November 4, 2014, that SG's diagnoses include major depressive disorder, generalized anxiety disorder, sleep disorder (insomnia), arthritis, osteoporosis, gastritis, colitis, cholecystitis with gall stones, chronic sinusitis, and hypothyroidism. Respondent also reported that SG's medical history includes uterine cancer and hysterectomy in 1992, spinal surgery for spinal stenosis in 1993, and bilateral carpel tunnel syndrome for which she had surgery on the right hand in either 2013 or 2014.

46. Respondent's records document that during 2008 through September 2014, he saw Patient SG monthly or every other month. Respondent reported that he sees SG both in his office and at her apartment. Respondent reported that he shares an office with the physician who has been SG's primary care physician (PCP) for the last nine years.

47. Respondent's records document that during 2008 to 2014, medications he prescribed to SG included Prozac, temazepam, clonazepam, Seroquel, and at times, Ativan, Vicodin, Adderall, and Compazine. Respondent routinely failed to document the medication strength, dosage, and/or quantity of the prescribed medications. Numerous progress notes simply note that medications were refilled without listing the particular medications that were refilled. Respondent's records for Patient SG do not include a medication list. Pharmacy prescribing records for Patient SG indicate that she received prescriptions approximately every other month for Wellbutrin 150 mg., #30 or #60, prescribed by Respondent. Respondent's medical records do not document the ongoing prescribing of Wellbutrin to SG.

48. Pharmacy prescribing records for SG indicate that from September 2008 to March 2014, Respondent prescribed antibiotic medications, such as azithromycin, amoxicillin, ciprofloxacin, and sulfamethoxazole, to SG approximately 37 times. Respondent's records do not document that he prescribed any antibiotic medications to SG, the medical indication for such

prescribing, nor SG's response to the prescribed medications. Pharmacy prescribing records also indicate that Respondent prescribed nitroglycerin[3] on January 3, 2009 and December 10, 2013; and, VESIcare[4] on June 15, 2013, and January 6 and July 7, 2014 to SG. Respondent's records do not document that he prescribed either of these two medications to SG, the medical indications for such prescribing, nor SG's response to these medications.

49. At his Medical Board interview, Respondent reported that he consulted with SG's other treating physicians, such as her PCP and ENT physicians, regarding the prescribing of non-psychiatric medications. Respondent's records for SG fail to document consultation with any of SG's other treating physicians.

50. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234 (b), and/or 2266 of the Code in that Respondent was grossly negligent in his care and treatment of Patient SG and he failed to keep adequate and accurate records related to his care and treatment of SG, including but not limited to the following:

A. Respondent failed to document medical indication for the repeated prescribing of antibiotic medications, and the prescribing of nitroglycerin and VESIcare.

B. Respondent failed to document a treatment plan and periodic review of the patient's treatment plan and medications, including response to treatment.

C. Respondent failed to document in the patient record all medications prescribed to SG, and/or, the strength, dosage, and/or quantity of the prescribed medications.

D. Respondent failed to document in the patient record consultations with SG's other treating physicians.

E. Respondent failed to limit his care and treatment of SG, a family member, to medical emergencies and/or care on a short-term basis.

F. Significant portions of Respondent's progress notes are illegible.

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[3] Nitroglycerin is used to treat, among other things, chest pain.
[4] VESIcare is used to treat symptoms of overactive bladder and incontinence.

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 A 56467, issued to Alexander Grinberg, M.D.;

2. Prohibiting Alexander Grinberg, M.D. from supervising physician assistants pursuant to section 3527 of the Code;

3. Ordering Alexander Grinberg, M.D., if placed on probation, to pay the Medical Board of California the costs of probation monitoring; and,

4. Taking such other and further action as deemed necessary and proper.

DATED: February 23, 2015

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SF2014409231