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

In the Matter of the Accusation Against: TRAVIS KNIGHT SVENSSON, M.D. Physician's and Surgeon's Certificate No. G 80502 Respondent.	)))))))))	Case No. 03-2012-229059

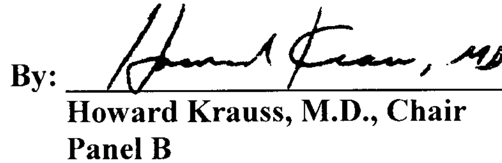
DECISION AND ORDER

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

This Decision shall become effective at 5:00 p.m. on November 4, 2016.

IT IS SO ORDERED October 5, 2016.

MEDICAL BOARD OF CALIFORNIA

By: 
Howard Krauss, M.D., Chair
Panel B

KAMALA D. HARRIS
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
EMILY L. BRINKMAN
Deputy Attorney General
State Bar No. 219400
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5742
Facsimile: (415) 703-5843
E-mail: Emily.Brinkman@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the Accusation Against: **Travis Knight Svensson, M.D.** Clinical Training & Research Institute 4104 24th Street #521 San Francisco, CA 94114 **Physician's and Surgeon's Certificate No. G80502** Respondent.	Case No. 03-2012-229059 OAH No. 2016060085 **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 Emily L. Brinkman, Deputy Attorney General.

2. Respondent Travis Knight Svensson, M.D. ("Respondent") is represented in this proceeding by attorney Gregory Abrams, whose address is: 6045 Shirley Drive, Oakland, CA 94611.

3. On or about January 4, 1995, the Medical Board of California issued Physician's and Surgeon's Certificate No. G80502 to Travis Knight Svensson, M.D. (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. 03-2012-229059, and will expire on January 31, 2017, unless renewed.

JURISDICTION

4. Accusation No. 03-2012-229059 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 October 5, 2015. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 03-2012-229059 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. 03-2012-229059. 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.

CULPABILITY

9. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations contained in Accusation

No. 03-2012-229059. and that he has thereby subjected his Physician's and Surgeon's Certificate No. G80502 to disciplinary action.

10. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 03-2012-229059. shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

CONTINGENCY

11. 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 Medical Board of California 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.

12. 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.

13. 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. G80502 issued to Respondent Travis Knight Svensson, 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. 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.

2. 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.

3. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program 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 program would have been approved by the Board or its designee had the program 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 program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. 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(s), 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/psychiatry 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.

5. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting 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. The Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, 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. The Respondent shall not resume practice until an appropriate practice setting is established.

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, NURSE PRACTITIONERS, AND MARRIAGE AND FAMILY THERAPIST INTERNS. During probation, Respondent is prohibited from supervising physician assistants, nurse practitioners, and marriage and family therapist interns.

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).

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.

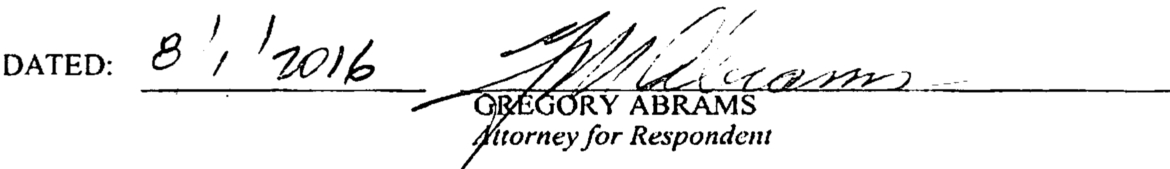
ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Gregory Abrams. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. G80502. 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: 1 August 2016

TRAVIS KNIGHT SVENSSON, M.D.
Respondent

I have read and fully discussed with Respondent Travis Knight Svensson, 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: 8/1/2016

GREGORY ABRAMS
Attorney for Respondent

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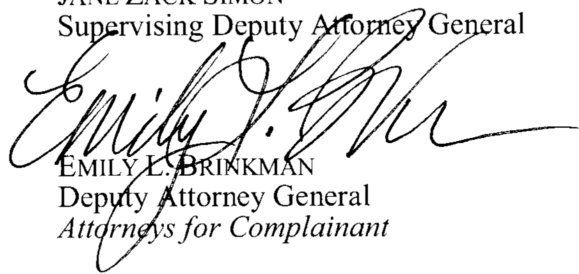
ENDORSEMENT

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

Dated: August 1, 2016

Respectfully submitted,

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



EMILY L. BRINKMAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 03-2012-229059

KAMALA D. HARRIS
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
VIVIEN H. HARA
Deputy Attorney General
State Bar No. 84589
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5513
Facsimile: (415) 703-5480
E-mail: vivien.hara@doj.ca.gov
Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO October 5 20 15
BY R. Firdaus ANALYST

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

In the Matter of the Accusation Against: **Travis Knight Svensson, M.D. Clinical Training & Research Institute 4104 24th Street #521 San Francisco, CA 94114** **Physician and Surgeon's Certificate No. G 80502,** Respondent.	Case No. 03-2012-229059 **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 (Board).

2. On or about January 4, 1995, the Medical Board issued Physician and Surgeon's Certificate Number G 47741 to Travis Knight Svensson, M.D. (Respondent). The Physician and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2017, 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 unless otherwise indicated.

4. 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..

5. Section 2052 of the Code states:

> "(a) Notwithstanding Section 146, any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter [Chapter 5, the Medical Practice Act], or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law, is guilty of a public offense, punishable by a fine not exceeding ten thousand dollars ($10,000), by imprisonment in the state prison, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment.
>
> "(b) Any person who conspires with or aids or abets another to commit any act described in subdivision (a) is guilty of a public offense, subject to the punishment described in that subdivision.
>
> "(c) The remedy provided in this section shall not preclude any other remedy provided by law."

6. Section 2234 of the Code, states, in pertinent 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.
>
> "(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.

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

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

" . . . ."

7. Section 2242(a) of the Code states: "Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct."

8. Section 2264 of the Code provides that that employing, directly or indirectly, the aiding, or the abetting of any unlicensed person to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.

9. 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.

DRUGS INVOLVED

10. Adderall, a trade name for mixed salts of a single-entity amphetamine product (dextroamphetamine sulfate, dextroamphetamine saccharate, amphetamine sulfate, amphetamine aspartate), is a dangerous drug as defined in section 4022 and a schedule II controlled substance as defined by section 11055 of the Health and Safety Code. Adderall is indicated for Attention Deficit Hyperactivity Disorder (ADHD) and narcolepsy. It is contraindicated for patients with advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, glaucoma, agitated states, a history of drug abuse, and patients who have taken monoamine oxidase inhibitors during or within 14 days or administration. Administration of amphetamine to

psychotic children may exacerbate symptoms of behavior disturbance and thought disorder. Caution is to be exercised in prescribing amphetamines for patients with even mild hypertension. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Amphetamines have been extensively abused. Tolerance, extreme psychological dependence, and severe social disability have occurred. There are reports of patients who have increased the dosage to many times that which is recommended. For ADHD, only in rare cases will it be necessary to exceed a total of 40 mg per day. For Narcolepsy, the usual dose is 5 mg to 60 mg per day in divided doses depending on individual patient response.

11. Ambien, a trade name for zolpidem tartrate, is a non-benzodiazepine hypnotic of the imidazopyridine class. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It is indicated for the short-term treatment of insomnia. It is a central nervous system (CNS) depressant and should be used cautiously in combination with other CNS depressants. Any central nervous system depressant could potentially enhance the CNS depressive effects of Ambien. It should be administered cautiously to patients exhibiting signs or symptoms of depression because of the risk of suicide. Because of the risk of habituation and dependence, individuals with a history of addiction to or abuse of drugs or alcohol should be carefully monitored while receiving Ambien. The recommended dosage for adults is 10 mg. immediately before bedtime.

12. Depakote, a trade name for divalproex sodium, is a dangerous drug as defined in section 4022. Divalproex sodium dissociates to the valproate ion in the gastrointestinal tract. It is used to treat migraine headache, epilepsy, and the manic episodes associated with bipolar disorder. It is contraindicated in patients with compromised liver function, as hepatic failure resulting in fatality has occurred. Its CNS depressant effects require caution in prescribing in combination with other CNS depressants or in patients who concurrently drink alcohol. Clearance of this drug is affected by many factors, including the taking of aspirin, rifampin, or felbamate. Depakote can also affect the pharmacokinetics or pharmacodynamics of such drugs as carbamazepine, clonazepam, diazepam, and warfarin. The dosage varies depending on the condition it is being used to treat.

13. Klonopin is a trade name for clonazepam, an anticonvulsant of the benzodiazepine class of drugs. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It produces CNS depression and should be used with caution with other CNS depressant drugs. Like other benzodiazepines, it can produce psychological and physical dependence. Withdrawal symptoms similar to those noted with barbiturates and alcohol have been noted upon abrupt discontinuance of Klonopin. The initial dosage for adults should not exceed 1.5 mg. per day divided in three doses.

14. Lamictal, a trade name for lamotrigine, is an antiepileptic drug (AED) and is indicated as adjunctive therapy for certain types of seizures and in the maintenance treatment of bipolar disorder to delay the time to occurrence of mood episodes (depression, mania, hypomania, mixed episodes) in adults treated for acute mood episodes with standard therapy. It is a dangerous drug within the meaning of section 4022 of the Code. As with other AED's, lamotrigine may increase the risk of suicidal thoughts and behavior. Lamotrigine may cause dizziness, somnolence, and other signs of central nervous system depression. Lamotrigine has been associated with allergic reactions manifested by a severe rash. Abrupt discontinuation of lamotrigine may result in withdrawal seizures.

15. Neurontin, a trade name for gabapentin, is an AED and is indicated as adjunctive therapy in the treatment of partial seizures with and without secondary generalization in adults with epilepsy. Gabapentin is sometimes used to treat the manic stages of bipolar disorder, but its efficacy in this circumstance is not proven. It is a dangerous drug within the meaning of Business and Professions Code section 4022. The most commonly observed adverse events associated with the use of Neurontin, especially in combination with other AED's, were somnolence, dizziness, ataxia, fatigue, and nystagmus.

16. Prozac, a trade name for fluoxetine hydrochloride, an antidepressant, is a dangerous drug within the meaning of Business and Professions code section 4022. Prozac is an antidepressant agent chemically unrelated to tricyclic, tetracyclic, or other available antidepressant agents. A significant percentage (12% to 16%) of patients on fluoxetine

experienced anxiety, nervousness, or insomnia. It should be used with caution in patients with bipolar disorder since it may cause mania or hypomania.

17. Ritalin, a trade name for methylphenidate hydrochloride, is a CNS stimulant. It is a dangerous drug as defined in section 4022 and a schedule II controlled substance as defined in Health and Safety Code section 11055. It is indicated for the treatment of attention deficit hyperactivity disorder (ADHD) and narcolepsy. It should be used with extreme caution in persons with bipolar disorder since it may cause mania or hypomania. Methylphenidate may produce anxiety, nervousness, insomnia, or rapid heart beat. Methylphenidate has a high potential for abuse, since, when taken in high doses or crushed and taken intravenously or intranasally, it produces a euphoric effect similar to that of cocaine or amphetamines. Therapeutic doses for adults should not exceed 60 mg. daily.

18. Trazodone hydrochloride (trade name Desyrel) is an antidepressant medication indicated for the treatment of major depressive disorder (MDD) in patients with and without prominent anxiety and insomnia. Trazodone may enhance the response to alcohol and other CNS depressants. Patients with depression on antidepressant medications should be observed for clinical worsening and suicidality. Trazodone is not approved for use in treating bipolar depression, as the medication may cause a dangerous manic episode. Trazodone is a dangerous drug as defined in section 4022 of the Code.

19. Valium is a trade name for diazepam, a psychotropic drug 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 section 4022 and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. 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.

20. Xanax is a trade name for alprazolam tablets. Alprazolam is a psychotropic triazolo analogue of the 1,4 benzodiazepine class of central nervous system-active compounds. Xanax is 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 section 4022 and a schedule IV controlled substance and narcotic as defined by section 11057, subdivision (d) of the Health and Safety Code. Xanax has a CNS depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other CNS depressant drugs during treatment with Xanax. Addiction-prone individuals (such as drug addicts or alcoholics) should be under careful surveillance when receiving alprazolam because of the predisposition of such patients to habituation and dependence.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Negligence/Incompetence - Patient J.J[1].)

21. Respondent first saw patient J.J., a 21 year old male college student, on or about January 12, 2011 for a psychiatric evaluation. J.J. had previously been the patient of Respondent's nurse practitioner (NP), C.M., while she was employed by another physician, and when she came to work for Respondent, J.J. transferred his care to Respondent's office. Chief complaint was listed as "therapy session, new visit." Medical history indicated "none acute." The information taken on J.J. at this first visit indicated under "Social History" that J.J. had stopped "street drugs since starting medications for ADHD." The medical concerns checked on the first visit were medication management, mood and thought instability, anxiety, and sleep disorder. Mental Status examination indicated J.J. was anxious but no longer depressed. The Master Problem list included five (5) disorders: Drug Abuse NOS (Active), Sleep Disturbance, NOS (Active), Generalized Anxiety Disorder (Active), Major Depressive Disorder (MDD) severe, recurrent (Active), ADHD (Active). Respondent made no active effort to confirm or rule out these diagnoses. In J.J.'s medical records, it was indicated that Respondent continued J.J.'s regular medications, which were Adderall 20 mg 2, *tid.* Xanax 2 mg. *tid.*, and Valium 10 mg. *hs.* The actual prescription for Adderall dated January 12, 2011, however, was for 60 mg. *tid.* Follow up plan was seeing J.J. in four (4) weeks. J.J. was encouraged to enter a 12-step program, such as NA, but J.J. declined, indicating that he no longer had cravings since being placed on Adderall.

[1] Initials are used to protect patient privacy. Respondent will be given the full names of the patients involved in response to any request for discovery.

Notes on this first visit were entered by C.M., N.P. and signed by Respondent. J.J. was also attended by LC, Marriage and Family Therapist (MFT) Intern, at this visit.

22. J.J. was seen monthly at Respondent's clinic until April 18, 2014. From February 9, 2011 through December 6, 2012, Respondent saw J.J., along with others of his staff, including C.M., NP; L.C., MFT Intern; and T.G.P., M.Psych. After this time, J.J. was attended solely by C.M., N.P., through his last visit. Respondent discontinued nightly Valium, but daily high dosage Adderall and Xanax were continued. J.J. was also receiving opioid analgesics from his primary care clinic. On December 1, 2011, there was a discussion concerning reducing the dosage of medications, and J.J. declined, indicating he was getting ready for his final examinations. Respondent accepted the diagnoses for J.J. which had come from his previous psychiatrist and complied with J.J.'s desires concerning his continuing to take Adderall and Xanax at high dosages.

23. On August 13, 2013, J.J. reported that his medications were stolen. He was asked to produce a police report, at which time he was given additional Adderall. No urine or blood drug screen was ordered at any time during J.J.'s treatment. At the March 14, 2014 visit, J.J. asked about a letter which his father had sent to Respondent asking him to review J.J.'s drug intake, and J.J. indicated that Respondent and his staff could not share information with his father, that his father was out of his life, and he was on his own. J.J. attended one more visit and thereafter discontinued his treatment with Respondent's clinic.

24. Respondent is subject to discipline pursuant to sections 2234(b) and/or (c) and/or (d) of the Code in that Respondent's care and treatment of patient J.J. constitutes gross negligence and/or negligence and/or incompetence by reason of the following acts or omissions:

A. Respondent's initial psychiatric evaluation lacks sufficient past and present medical and psychiatric history of J.J.'s behavior and symptoms to establish a differential diagnosis or to confirm his present diagnoses. There is no mention of a childhood or adolescent history of inattention, distractibility, disorganization, or hyperactivity to support the present diagnosis of ADHD and support the continued use of high dose amphetamine/dextroamphetamine medication. There is no clinical information in the medical record of J.J.'s diagnosis of MDD, generalized

anxiety disorder, and sleep disorder except that they have been checked off. There is no mention of exceptional circumstances justifying high-dose, long term use of amphetamines and benzodiazepines. Respondent accepted the diagnoses that J.J. carried with him from his previous treatment and complied with the patient's wishes to continue his Adderall and Xanax at the current high dosages.

B. Respondent failed to contact or obtain records from J.J.'s previous treating psychiatrist or his present health care providers, and he failed to contact other collateral sources to obtain pertinent clinical information such as drug use, past psychiatric history, compliance with treatment recommendations, past treatment with non-addicting substances and attempts at tapering controlled substances. Even when contacted by J.J.'s father and his concerns over J.J.'s drug use, no attempt was made to obtain more information.

C. Respondent's supervision and coordination of care with his non-M.D. co-therapists in the evaluation and treatment of patient J.J was insufficient.

D. Respondent did not properly monitor J.J.'s medications during the course of his treatment. There was no conscientious treatment plan that provided for follow-up monitoring of drug use, efficacy, side effects, or that provided for possible tapering or alteration of treatment regimen upon ongoing evaluation of J.J.'s response to treatment and other factors such as addiction. There was no questioning concerning J.J.'s ongoing subjective complaints, his insistence on continuing high doses, and on one occasion, loss of medication. Respondent did not at any time order a drug test on J.J. High-dose, long-term psychostimulant or benzodiazepine use is not recommended due to the development of tolerance, dependence, withdrawal, and rebound. These medications have high potential for abuse, including diversion, and side effects include cognitive impairment. Combining stimulants, sedatives, and opioids is contraindicated, as drug-drug interaction can result in respiratory depression.

SECOND CAUSE FOR DISCIPLINE

(Prescribing Without Appropriate Examination/Medical Indication - Patient J.J.)

25. The allegations of paragraphs 21 through 23, above, are incorporated herein by reference as if fully set forth.

26. Respondent failed to conduct an appropriate initial psychiatric examination with proper diagnostic techniques to establish medical indication for the treatment administered and failed to perform appropriate follow up examinations before continuing to prescribe high-dose amphetamine/dextroamphetamines and benzodiazepines, and therefore, Respondent is subject to discipline pursuant to sections 2242(a) and 2234 of the Code.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence/Negligence/Incompetence - Patient A.J.)

27. Patient A.J., a 26 year-old female, was referred to Respondent by N.L., L.C.S.W. for a psychiatric evaluation and treatment for possible ADHD. A.J. had a history of ADHD and had had treatment with Ritalin at age 7, but N.L. requested a reassessment of the condition so many years after A.J.'s initial diagnosis.

28. A.J.'s first appointment with Respondent's clinic was on November 20, 2013. A medical assistant took vital signs, and thereafter, A.J. was seen by L.C., M.F.T. Intern. On her New Patient Intake sheet, A.J. indicated that she drank alcohol several times weekly and used marijuana infrequently. L.C., M.F.T. Intern, did not enter any information following up on the revelation of alcohol and marijuana intake and their possible interaction with stimulant medications for ADHD. A.J. indicated to LC that she was there to be re-tested for ADHD, but L.C. proceeded on the assumption that A.J. did suffer from ADHD and went on to discuss medications. L.C. indicated in A.J.'s medical record that the chief complaint was, "I was diagnosed with ADHD . . . and I would like to try medication." The only testing required of A.J. by L.C. was a Public Health Questionnaire 9 (PHQ-9), a brief questionnaire which is designed to aid in screening, diagnosing, monitoring, and measuring the severity of depression in patients who indicate they are depressed; A.J.'s results were high, indicating depression and possible suicidality, but L.C. did not follow up on the results of this test. After this, L.C. asked A.J. whether she preferred to go back on Ritalin or to try Adderall. A.J. chose Ritalin, which she had taken before when she was a child, and L.C. filled out the prescription for 10 mg. Ritalin *qd*, left the room, and returned with the prescription signed by Respondent. Respondent did not speak

with, take any medical information from, or examine A.J. before signing the prescription prepared by his marriage and family therapist intern, L.C.

29. On A.J.'s second visit to Respondent's clinic on December 13, 2013, A.J. again saw L.C., M.F.T. Intern. A.J. indicated that she was still lacking focus, so L.C. increased the dosage of Ritalin to 20 mg. *qd.* L.C. filled out the prescription, left the room, and returned with the prescription signed by Respondent. Respondent did not speak with, take any medical information from, or examine A.J. before signing the prescription prepared by L.C. At this visit, L.C. asked A.J. if she had any other problems, and A.J. indicated that she had trouble sleeping, and L.C. indicated that marijuana would help A.J. sleep, but A.J. declined.

30. At the increased dose of Ritalin, A.J. began to have bouts of sweatiness and flank pain, and she consulted her family physician, who discovered that A.J. had an elevated heart rate and recommended that she discontinue the Ritalin. A.J. did not return to Respondent's clinic.

31. Respondent is subject to discipline pursuant to sections 2234(b) and/or (c) and/or (d) of the Code in that

Respondent's care and treatment of patient A.J. constitutes gross negligence and/or negligence and/or incompetence by reason of the follow acts or omissions:

A. Respondent failed to conduct an adequate initial psychiatric evaluation either by himself or through his unlicensed M.F.T. Intern. He failed to establish whether a mental disorder existed; failed to collect data to support a differential diagnosis and clinical formulation; failed to collaborate with the patient to develop an initial plan, with particular consideration for the patient's safety; and failed to identify longer term issues for follow-up care. A.J. was referred to Respondent for an evaluation of her diagnosis of ADHD and treatment for the disorder once diagnosed. She had no face-to-face contact with Respondent, and important issues were not addressed, such as her complaints about sleep problems, her statement concerning her alcohol intake and marijuana use, and her possible concomitant depression indicated by her answers on the PHQ-9. Specific details about A.J.'s alcohol intake were especially important to obtain, as the combination of excessive alcohol and psychostimulant medication is contraindicated. A.J.

reported a history of a suicide attempt, so pursuing the extent of her depression and suicidality was particularly important.

B. Respondent allowed his M.F.T. Intern, who had no medical training and no license to practice medicine, to determine the diagnosis and the drug regimen for A.J., in that it was she who spoke to the patient about the available treatments and assumed based only on the information that the patient was diagnosed when a child, that A.J. had ADHD as an adult. L.C. took limited

historical information from A.J., offered her the choice of one of two psychostimulant medications in high dosages, filled out the prescription for Ritalin and took it into Respondent who signed it without seeing the patient or confirming the diagnosis or medical indication for the drug himself.

C. Respondent failed to attend A.J.'s follow-up visit on December 13, 2013 and therefore did not personally ascertain and evaluate her progress or lack thereof on the medication prescribed. When A.J. reported lack of focus on 10 mg. Ritalin, he allowed his M.F.T. Intern to increase the dosage to 20 mg. without examining or interviewing the patient himself to ascertain possible causes for the lack of focus or inform the patient of the possible effects of increasing the dosage. Again, he was not present to discuss the issues of sleep, alcohol intake, and depression. Again, L.C. filled out the prescription for Ritalin and Respondent signed it without examining, interviewing or evaluating the patient himself.

D. Respondent failed to contact A.J.'s other treating mental health practitioners to coordinate care. Information from the treating therapist and past medical records concerning the initial diagnosis of ADHD would have assisted in formulating A.J.'s course of treatment. A.J. was referred to Respondent for a determination as to whether A.J.'s childhood ADHD diagnosis continued on into her adulthood, and if confirmed, appropriate treatment be administered. No process of diagnosis was done and possible co-morbid conditions causing reactions to psychostimulant medications were not explored. There was no coordination of care with A.J.'s treating therapist, and therefore, the patient and the referring therapist were ignorant concerning Respondent's treatment plan, or lack thereof.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Without Appropriate Examination/Medical Indication - Patient A.J.)

32. The allegations of paragraphs 27 through 30, above, are incorporated herein by reference as if fully set forth.

33. Respondent failed to conduct an appropriate initial psychiatric examination with proper diagnostic techniques to establish medical indication for the treatment administered and failed to perform an appropriate follow-up examination before doubling the dosage of Ritalin for Patient A.J. Therefore, Respondent is subject to discipline pursuant to sections 2242(a) and 2234 of the Code.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence/Negligence/Incompetence - Patient P.S.)

34. On or about November 26, 2008, Respondent undertook to care for and treat patient P.S., a 30 year-old male, who was previously diagnosed with Bipolar I Disorder (manic and depressed episodes) and Generalized Anxiety Disorder.[2] P.S. had been hospitalized at California Pacific Medical Center (CPMC) in September of 2008 under Welfare and Institutions Code section 5150 after going off of his psychotropic medications, and previously, until April 2008, he had been treated at Kaiser Permanente Medical Center. There is no indication in Respondent's records that he obtained P.S.' records from the CPMC hospitalization or from Kaiser or consulted any previous psychiatrist or mental health professional about P.S.' diagnosis, medications, or treatment. Respondent accepted P.S.' diagnoses and medication history through information obtained from P.S. P.S. was referred to Respondent through the San Francisco Mental Health Plan, for which Respondent's clinic at that time, was a provider.

35. During the first two years of treatment, P.S. saw Respondent for medication management and medication refills, and psychotherapy was provided by J.K., M.F.T. Respondent was informed that P.S. had been involuntarily committed due to a severe manic episode triggered by non-compliance with medication two months before he was referred to

[2] Although P.S. indicated that he was also being treated for Obsessive-Compulsive Disorder (OCD), this diagnosis is not mentioned in Respondent's records for P.S.

Respondent's clinic for medication management and psychotherapy. When P.S. first consulted Respondent, his medications were listed on the electronic intake record as Depakote, 500 mg. *qd.*, Klonopin 0.5 mg *bid*, Lamictal 25 mg. *bid*, and gabapentin 400 mg. *qhs.* Respondent's handwritten notes indicate that he was not taking Lamictal but was taking trazodone 50 mg. *qhs.* Respondent noted that P.S.' mental status was low mood, passive. P.S.' medical record indicates that Respondent decreased Depakote to 250 mg., discontinued trazodone and replaced it with Ambien, 10 mg. *qhs*, and continued Lamictal and Depakote at the same dosage. Up to five (5) refills were approved for all medications except for Lamictal. No reason is stated in the record for the continuance, discontinuance, change in medication, or alteration in dosage. There is no record of consultation with P.S.' previous mental health professionals or any past psychiatric records or other treatment records concerning P.S.' hospitalization in September 2008. On P.S.' second visit with Respondent on December 3, 2008, Respondent added a prescription for trazodone 50 mg. 1-2 *qhs.* with five (5) refills. There is no stated reason for this addition.

36. Respondent personally attended P.S. for medication management on January 7, 2009, (medications listed as Ambien, Klonopin, Depakote 250 mg., and Lamictal; no prescriptions noted; patient noted as depressed), June 30, 2009 (Klonopin 0.5 mg. and Lamictal 25 mg. prescribed, each with five (5) refills; Respondent's notes say four (4) refills); November 5, 2009 (Klonopin 0.5 mg. and Lamictal 25 mg. prescribed; number of refills not designated); January 26, 2010 (refill request only for Lamictal 25 mg. with six (6) refills, no visit; March 3, 2010 (trazodone 50 mg. and Klonopin 0.5 mg. prescribed, each with five (5) refills. (For the first time, it is checked off that side effects, dosing and compliance were discussed with P.S.); May 3, 2010 (trazodone 50 mg. and Klonopin 0.5 mg. prescribed, each with five (5) refills); and July 2, 2010 (Lamictal 25 mg, Klonopin 0.5 mg., and trazodone. No refills indicated. No indication for addition of trazodone). On September 2, 2010, there was an approved refill request from Walgreen's for lamotrigine (Lamictal) 25 mg. with five (5) refills, and on September 22, 2010, there was an approved refill request from Walgreen's for clonazepam (Klonopin) 50 mg. with no refills and a note to call for an appointment.

37. In or about September 2010, L.C., M.F.T. Intern, took over Respondent's face-to-face visits with P.S. for medication management. L.C. discussed changes in medication and recommended certain new drugs for management of P.S.' Bipolar I and anxiety disorders. P.S. no longer consulted directly with Respondent concerning the effectiveness of his medications or any changes in medication. L.C. would consult Respondent after meeting with P.S. and emerge with a prescription, and also on several occasions, she filled out P.S.' prescriptions, left the room, and returned to the patient with the signed prescription. Progress notes for each of these visits were stamped with Respondent's signature.

38. L.C., M.F.T. Intern, also assumed responsibility in large part for major clinical decisions for P.S. She placed P.S. on Prozac (P.S. was bipolar; antidepressants such as Prozac may trigger a manic episode.) She increased Lamictal due to depression. (P.S. had both manic and depressive episodes and was simultaneously on three anti-convulsants and a benzodiazepine for mood stabilization.) When P.S. complained of insomnia, LC recommended that he stay up all night to "re-set his Circadian rhythm." (Erratic sleep in a bipolar patient can lead to a manic episode.) When P.S. presented a form from the California Department of Social Services requesting a Mental Status Evaluation in March 2011, L.C. filled out the multi-page form and Respondent's signature was stamped on the form. P.S. was still seeing J.K., M.F.T. for psychotherapy at this time.

39. At his last visit with Respondent's clinic, P.S. did see Respondent and asked for a referral, since Respondent was no longer a provider for San Francisco Mental Health Plan, and Respondent provided prescription refills but no referral.

40. Respondent is subject to discipline under sections 2234(b) and/or (c) and/or (d) of the Code by reason of the following acts or omissions:

A. Respondent failed to consult with or obtain pertinent records from P.S. from his hospitalization at CPMC in order to confirm or modify P.S.' diagnoses and ascertain the effectiveness of the medications used for P.S.' mental disorders. Similarly, medication management progress notes by Respondent thereafter contained no specific basis for any changes

in medication or any notes on the patient's progress on the medications or lack thereof, side effects, or other pertinent follow-up treatment information.

B. Respondent was absent and insufficiently involved in the patient's treatment decisions in the last two years of the patient's psychiatric care. P.S. was a complicated patient with major psychiatric disorders who had been hospitalized for a major manic episode, and Respondent failed to maintain his therapeutic alliance with him through monitoring his status, providing education, and monitoring treatment compliance by following up on the effectiveness of the drugs prescribed for the disorders. When Respondent was no longer providing services for San Francisco Mental Health Plan, Respondent failed to provide a referral for P.S. when requested at his last visit.

SIXTH CAUSE FOR DISCIPLINE

(Prescribing Without Appropriate Examination/Medical Indication - Patient P.S.)

41. The allegations of paragraphs 34 through 39, above, are incorporated herein by reference as if fully set forth.

42. Particularly in the last two years of P.S.' treatment, Respondent rarely personally assessed or met with P.S., and he usually prepared prescriptions pursuant to L.C.'s recommendations or signed prescriptions written out by L.C. Respondent failed to follow up on the efficacy of the drug treatments given, failed to personally examine and question the patient before adding, decreasing, or eliminating drugs, doing so on the strength of the recommendation and non-M.D. examination of L.C. M.F.T. Intern, who in fact saw P.S. There is no indication in the record that the risks and benefits of medications taken or any change in medication was discussed with P.S. One entry in March 2010 had "side effects" and "compliance" checked off, not detailed, but "risks and benefits" again was not. Therefore, Respondent is subject to discipline pursuant to sections 2242(a) and 2234 of the Code.

SEVENTH CAUSE FOR DISCIPLINE

(Aiding and Abetting Unlicensed Practice of Medicine – Patients A.J. and P.S.)

43. The allegations of paragraphs 27 through 30 (Patient A.J.) and paragraphs 34 through 39 (Patient P.S.), above, are incorporated herein by reference as if fully set forth.

44. Section 4980.02 of the Code defines the practice of marriage and family therapy as follows:

> ". . . [T]he practice of marriage and family therapy shall mean that service performed with individuals, couples, or groups wherein interpersonal relationships are examined for the purpose of achieving more adequate, satisfying, and productive marriage and family adjustments. This practice includes relationship and premarriage counseling.
>
> "The application of marriage and family therapy principles and methods includes, but is not limited to, the use of applied psychotherapeutic techniques to enable individuals to mature and grow within marriage and the family, the provision of explanations and interpretations of the psychosexual and psychosocial aspects of relationships, and the use, application, and integration of the coursework and training required by Sections 4980.36, 4980.37, and 4980.41, as applicable."

45. Section 4980.43 provides for the supervised experience necessary for licensure as a Marriage and Family Therapist. The supervised experience described includes direct supervisor contact, professional enrichment activities in marriage and family therapy, and client-centered advocacy, group therapy, psychological testing, diagnosing and treating couples, family, and children, personal psychotherapy. Section 4980.45(h) describes the responsibilities of the supervisor of a marriage and family therapist intern or trainee. Among those duties are assuring that the extent, kind and quality of counseling performed is consistent with the intern's training and experience, being responsible for assuring compliance with all laws, rules and regulations governing the practice of marriage and family therapy, and at least one to two hours of direct supervisor contact per week. All experience gained by a trainee must be monitored by the supervisor.

46. L.C. was a M.F.T. Intern at the time that patients A.J. and P.S. were treated at Respondent's clinic, and Respondent, as the owner of the clinic and a psychiatrist, was L.C.'s M.F.T. supervisor. Respondent used L.C. as a "case manager" to meet with patients A.J. and P.S. for medication management appointments and allowed her to assess the patient and provide medical treatment in the form of specifically recommending certain drugs, and even writing out prescriptions for Respondent to sign. Respondent was not supervising L.C. as a M.F.T. Intern. He allowed L.C., who was not yet licensed as a M.F.T. and did not hold a physician and

surgeon's certificate, to diagnose, treat, and prescribe for his patients in violation of section 2052(b) of the Code in that he aided and abetted the unlicensed practice of medicine.

47. Respondent, through his violation of sections 2052(b) and/or 2264 of the Code, is guilty of unprofessional conduct, and therefore, cause for discipline exists under section 2234 of the Code.

EIGHTH CAUSE FOR DISCIPLINE

(Inaccurate/Inadequate Record Keeping – All Patients)

48. The allegations of paragraphs 21 through 23 (Patient J.J.), 27 through 30 (Patient A.J.) and 34 through 39 (Patient P.S.) are incorporated herein by reference as if fully set forth.

49. Respondent's electronic medical records for each patient visit listed the same diagnoses and general complaints as recorded at the first patient visit, even though circumstances had obviously changed. The records lacked a history and physical examination that earned the diagnoses listed, except for patient P.S., where Respondent did create a handwritten full evaluation. The progress notes for each patient did not indicate any detailed discussion as to the indication, risks, and benefits of the medications prescribed, change of dosage, or change or addition of other psychotropic medications. Respondent stamped his signature on electronic records when they were printed out even when he did not see the patient himself. No detailed or goal-oriented treatment plan was set forth in the records. Follow-up medication appointment records failed to set forth the patient's progress or lack thereof on the medication regimen prescribed and any detailed medical indication for a change in dosage or medications. Concomitant drug prescriptions from other practitioners are not listed or listed as considered when changing dosage of medications or discontinuing or adding medications. Medications and dosages set forth in the records did not comport on some occasions with the actual prescriptions given to the patient.

50. Therefore, Respondent has exhibited a pattern of keeping inadequate and inaccurate medical records with respect to these patients, and cause exists for disciplinary action pursuant to sections 2266 and 2234 of the Code.

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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:

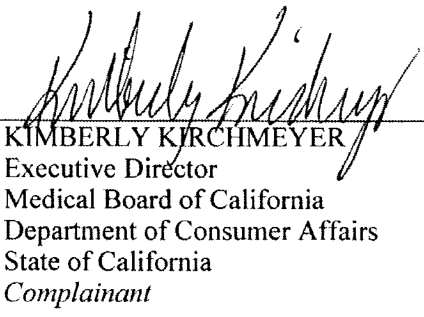
1. Revoking or suspending Physician and Surgeon's Certificate Number G 80502, issued to Travis Knight Svensson, M.D.;

2. Revoking, suspending or denying approval of Travis Knight Svensson, M.D.'s authority to supervise physician assistants pursuant to section 3527 of the Code;

3. Ordering Travis Knight Svensson, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: October 5, 2015



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

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