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

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| In the Matter of the Accusation Against:<br><br>DAVID MARK GUDEMAN, M.D.<br>Physician's and Surgeon's<br>Certificate No. G 69799<br><br>Respondent. | ) | Case No. 05-2010-204739 |

## DENIAL BY OPERATION OF LAW
## PETITION FOR RECONSIDERATION

No action having been taken on the petition for reconsideration, filed by James Studer, Esq. on behalf of David Mark Gudeman, M.D., and the time for action having expired at 5 p.m. on December 6, 2013, the petition is deemed denied by operation of law.

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

| | | |
|---|---|---|
| In the Matter of the Accusation Against: | ) | |
| | ) | MBC No. 05-2010-204739 |
| DAVID MARK GUDEMAN, M.D. | ) | |
| | ) | |
| Physician's & Surgeon's | ) | **ORDER GRANTING STAY** |
| Certificate No. G 69799 | ) | |
| | ) | (Gov't Code Section 11521) |
| | ) | |
| Respondent | ) | |

James Studer on behalf of Respondent, David Mark Gudeman, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of November 27, 2013.

Execution is stayed until December 6, 2013.

This stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: November 22, 2013

A. Renee Threadgill
Chief of Enforcement
Medical Board of California

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

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|---|---|---|
| In the Matter of the Accusation Against: | ) | |
| DAVID MARK GUDEMAN, M.D. | ) | Case No. 05-2010-204739 |
| Physician's and Surgeon's Certificate No. G 69799 | ) | |
| Respondent | ) | |

## DECISION

The attached Proposed Decision 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 November 27, 2013.

IT IS SO ORDERED October 29, 2013.

MEDICAL BOARD OF CALIFORNIA

By: _____
Barbara Yaroslavsky, Chair
Panel A

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

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|---|---|
| In the Matter of the Accusation Against:<br><br>DAVID MARK GUDEMAN,<br><br>Physician and Surgeon Certificate No. 69799,<br><br>Respondent. | Agency Case No. 05-2010-204739<br><br>OAH Case No. 2012010053 |

# PROPOSED DECISION

Daniel Juárez, Administrative Law Judge, Office of Administrative Hearings, heard this matter on August 20-22, 2012, April 22-25, and 29, 2013, and July 8-11, 2013, in Los Angeles, California.

Klint James McKay, Deputy Attorney General, represented Linda K. Whitney (Complainant), then-Executive Director of the California Medical Board (Board).

James Studer, Esq., represented David Mark Gudeman, M.D. (Respondent).

The ALJ left the record open for closing and reply briefs. Both parties filed briefs timely. The parties submitted the matter for decision on September 23, 2013.

## STATEMENT OF THE CASE

Complainant contends Respondent's care and treatment of seven patients was below the standard of care. More specifically, Complainant alleges that Respondent improperly prescribed controlled substances to treat pain in patients with substance abuse problems, did not obtain consultations, and in some cases, he improperly terminated treatment. Complainant argues that Respondent's actions warrant revocation of his medical license.

Respondent contends that his care and treatment of each patient was within the standard of care. He seeks dismissal of the First Amended Accusation.

## FACTUAL FINDINGS

1. The Board issued physician and surgeon certificate number G 69799 to Respondent on September 17, 1990; it expires on April 30, 2014, unless renewed.

2. Complainant filed the Accusation on September 30, 2011, and the First Amended Accusation on February 22, 2013. Respondent filed a Notice of Defense on October 20, 2011. Respondent was deemed to have controverted the additional allegations in the First Amended Accusation, in accordance with Government Code section 11507.

Respondent's Background

3. Respondent practices psychiatry in private practice in Simi Valley, California. At the time of the allegations, Respondent also practiced addiction medicine. As noted *post*, he no longer practices addiction medicine. He received his medical degree in 1989 from the University of California, at Los Angeles (UCLA), School of Medicine. From 1989 to 1993, Respondent enrolled in and completed an internship and residency in internal medicine at the UCLA San Fernando Valley Program (UCLA/San Fernando) in Sepulveda, California. In 1996, he completed a residency in psychiatry at the UCLA Neuropsychiatric Institute (NPI) in Los Angeles, where he was Chief Resident of Substance Abuse from June 1995 to June 1996.

4. He was a Diplomate of the American Board of Psychiatry and Neurology between January 2001 and December 31, 2011. He is a Diplomate of the American Board of Internal Medicine (1993). He is certified by the American Society of Addiction Medicine (1998).

5. At the time that he began his private practice in 2002, Respondent was a physician specialist at the Olive View Medical Center (Olive View) in Sylmar, California (2002-2006). Among other earlier positions as a psychiatrist, Respondent was the Medical Director of Behavioral Medicine at Simi Valley Adventist Health (2002-2004), and the Medical Director of Ventura County Behavioral Health Services (1999-2002). His last positions in internal medicine were as an emergency room admitting physician at Olive View (1991-1997), and Kaiser Permanente in Los Angeles (1993-1996).

The Board's Guidelines for Prescribing Controlled Substances for Pain

6. As this matter involves Respondent's prescriptions of controlled substances for pain, the Board's guidelines for prescribing such medications is noteworthy, albeit on its own, not controlling.

7. The Board adopted "Guidelines for Prescribing Controlled Substances for Pain" in 1994, revised in 2007 (hereafter, "the Guidelines" or "the Board's Guidelines"). The Guidelines cite and quote Business and Professions Code section 2241.5, subdivision (c). That provision states, "No physician and surgeon shall be subject to disciplinary action

by the board for prescribing or administering controlled substances in the course of treatment of a person for intractable pain."

8. The Guidelines "are intended to improve effective pain management in California, by avoiding under treatment, over treatment, or other inappropriate treatment of a patient's pain and by clarifying the principles of professional practice that are endorsed by the Medical Board so that physicians have a higher level of comfort in using controlled substances, including opioids, in the treatment of pain."

9. The Board sets forth several standards of care in managing pain patients. First, a medical history and physical examination must be accomplished, including the assessment of the pain, physical, and psychological function, a substance abuse history, a history of prior pain treatment, an assessment of underlying or co-existing diseases or conditions, and documentation of the presence of a recognized medical indication for the use of a controlled substance. The Board notes that a referral to one or more consulting physicians may be required, and in continuing care situations for chronic pain management, the physician should have a more extensive evaluation of the history, past treatment, and diagnostic tests and physical examinations. Second, the treatment plan should state objectives by which the treatment plan can be evaluated, such as pain relief, improved physical and psychosocial function, and indicate if further diagnostic evaluations or other treatments are planned. Third, a physician should discuss the risks and benefits of controlled substances and other treatment modalities with the patient. Fourth, the physician should periodically review the course of pain treatment. Fifth, the physician should consider referring the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Complex pain problems may require consultation with a pain medicine specialist. Coordination of care in prescribing chronic analgesics is of paramount importance. In situations where there is a dual diagnosis of opioid dependence and intractable pain, both of which are being treated with controlled substances, protections apply to physicians who prescribe controlled substances for intractable pain provided the physician complies with the requirements of the general standard of care and Business and Professions Code sections 2241 and 2241.5. Sixth, physicians should keep accurate and complete records according to the standards above.

10. The Guidelines provide that, when prescribing or administering narcotic controlled substances to known addict patients, a physician must follow the same standards of care as with any other patient, including the standards set forth *ante*.

11. The Guidelines also provide that a patient in pain, who is also chemically dependent, should not be deprived of appropriate pain relief.

Respondent's Board Interviews

12. As part of its investigation of the seven patients at issue, the Board interviewed Respondent in February 2011, and July 2012. In addition to commenting on and explaining his care and treatment decisions as to these patients, Respondent also described his overall

approach to treating patients for chronic pain who also have drug or alcohol addictions or dependencies.

*Respondent's February 2011 Board Interview*

13. The Board interviewed Respondent on February 3, 2011, in Valencia, California. Respondent's comments in the interview that are germane to this matter are set forth in Factual Findings 14-16.

14. Respondent sees between 25 and 30 patients per day. Respondent sees himself primarily as a psychiatrist. He tries to "stay out" of internal medicine. He only does pain management work when other pain management options are unavailable to the patients.

15. Respondent does not perform a traditional physical examination, but he assesses each patient by observing their gait when they walk into the office or his examination room and by observing how they sit in a chair. He does not always document his observations. Respondent does not use any objective scale, like a one-to-ten numerical scale to gauge pain in his patients; he asks them directly if they are in pain and accepts their response unless he finds reason to doubt them.

16. If terminating a patient, Respondent will end his care and treatment, but give them a "bridge" prescription, to provide them medication for some time until they can find another physician. If such patients have made no effort to finding a new physician, Respondent then refers them to an emergency room.

*Respondent's July 2012 Board Interview*

17. The Board interviewed Respondent a second time on July 19, 2012, also in Valencia. Respondent's comments in the interview that are germane to this matter are set forth in Factual Findings 18-20.

18. Respondent described his therapeutic modality generally: "Prochaska and DiClemente have a model of where you assess the addict and which part of their career they're in, so you have an addiction careers concept. And in pre-contemplation phase, they're not aware they're addicted. In contemplation phase, they're . . . contemplating getting treatment . . . . Then there's the determination phase. And there's . . . [the] abstinence phase. And then there's relapse phase. And the concept of harm reduction and motivational interviewing is to assess where they are and move them up a step and keep them in treatment and reduce the harm."

19. Respondent defined "psychotherapy" as asking interval history, assessing self-awareness of behavior, compare it to other data obtained through family members and other sources, and if necessary confront the patient on inconsistent data. As part of psychotherapy, Respondent also inquires as to how much medication the patient is using and compares that

amount with his own medication use data, among other things. Respondent conceded that, in the cases of the patients at issue, he had not documented these psychotherapeutic actions.

20. Respondent asserted that, in October 2011, he completed the record keeping course at the Physician Assessment and Clinical Evaluation program (PACE) at the University of California at San Diego, School of Medicine. He provided no documentary evidence to support his enrollment and completion of the course, but Complainant did not contest his assertion.

Respondent's Academic Support and Additional Assertions

21. In support of the theoretical approach to his care and treatment of the patients at issue in this matter, Respondent cited to a pharmacology textbook entitled, "Goodman & Gilman's Manual of Pharmacology and Therapeutics," by L. Brunton, K. Parker, D. Blumenthal, and I. Buxton, published in 2008 by the McGraw-Hill Companies, Inc.. Respondent subscribes to this publication's discussion of "drug dependence." That discussion is as follows: "Although many physicians are concerned about 'creating addicts,' relatively few individuals begin their drug addiction problems by misuse of prescription drugs. Confusion exists because the correct use of prescribed medications for pain, anxiety, and even hypertension commonly produces tolerance and physical dependence. These are *normal* physiological adaptations to repeated use of drugs from many different categories. Tolerance and physical dependence . . . *do not* imply abuse or addiction. This distinction is important because patients with pain sometimes are deprived of adequate opioid medication simply because they have shown evidence of tolerance or they exhibit withdrawal symptoms if the analgesic medication is stopped abruptly." (Original italics.)

22. This portion of Goodman and Gilman's discussion on drug dependence fails to address one of the salient questions raised in this matter. That is, not whether Respondent's prescriptions created addiction in his patients, but whether Respondent's prescriptions for addictive controlled substances promoted or exacerbated the patients' existing addictions unnecessarily.

23. Respondent is greatly concerned that his patients with pain, who are also addicted to drugs, may be under-medicated due to their addiction history. In that vein, Respondent offered the following academic textbook: "Kaplan & Sadock's Comprehensive Textbook of Psychiatry," Volume II, Ninth Edition, by B.J. Sadock, V.A. Sadock, and P. Ruiz, published by Wolters Kluwer Health and Lippincott Williams & Wilkins. The date of publication was not ascertainable. In Chapter 24, entitled, "Psychosomatic Medicine," discussing the "Undertreatment of Pain," the textbook states, "The incidence of psychiatric complications is particularly high when pain is underestimated and undermedicated by caretakers . . . . It [the undertreatment of pain] is also driven by the resistance of some patients and families who do not accept side effects and are *opioid phobic*. They may be denying the severity of the situation, using fear of addiction as a metaphor for fear of death." (Original italics.) Respondent subscribes to this view of the under-treatment of pain.

24. Respondent offered the August 2012 issue of the periodical, "Current Psychiatry." In an article by S.C. Miller, M.D, and D. Frankowski, M.D., entitled, "Prescription opioid use disorder: A complex clinical challenge," Miller and Frankowski discuss patients' aberrant medication-taking behaviors and statistical findings related to those aberrant behaviors. The authors propose, that while genuine pain should be treated, prescribers should take steps to monitor and control misuse by actions such as drug testing, establishing a therapeutic alliance, educating patients, engaging in motivational enhancement therapy, facilitating the use of 12-step programs, and referring patients to other self-help groups.

25. In his closing brief, Respondent asserted that, "[t]here is a split of authority in the medical community on the appropriate approach to a patient's pain/psychiatric/and addiction co-morbidity." Respondent cited to an article entitled, "Providers' Experiences Treating Chronic Pain Among Opioid-Dependent Drug Users," by K.M. Berg, M.D.; J.H. Arnsten, M.D.; G. Sacajiu, M.D.; and A. Karasz, Ph.D., published by the Journal of General Internal Medicine, Volume 24, Number 4, online February 3, 2009. The authors of that article described two frameworks used by physicians that treat chronic pain. In general and somewhat gross terms, one of the frameworks supports Complainant's view of how Respondent should have treated the patients at issue, and the other framework supports Respondent's view of how he believes he treated those same patients. The authors of this article do not suggest that one framework is superior or preferred to the other. Instead, they explored provider perceptions of the ambiguity in determining the efficacy of their treatments and examined strategies (the two frameworks) for making diagnostic and treatment decisions.

26. The conclusions of this article did not provide clarity regarding the particular issues requiring adjudication here; however, the article served to clarify Respondent's adherence to one of the two frameworks, an assertion he emphasized throughout the hearing by referring to his preferred paradigm as the "harm reduction model," as set forth in Factual Finding 18.

27(a). In his hearing testimony, Respondent asserted the following facts with regard to all of the patients at issue:

27(b). Respondent always engaged in psychotherapy with all of his patients; he failed to document engaging in that therapy in many cases. In most cases, he did not document the details of his psychotherapy sessions.

27(c). Respondent did not always document patient records as completely as he should have because he believed that if he did so at the time of his patient appointment, his writing would disrupt the therapeutic bond between them. Additionally, some patients did not want him to write things down for greater confidentiality. Respondent conceded that, other times, he would simply not document the patient record. As to some of the inconsistent record notes, Respondent explained that he used a record keeping software program that

automatically inserted default notations and he would occasionally forget to modify those default notations.

27(d). Respondent saw a portion of his work as helping opiate addicts manage opiate prescriptions. Most persons can, and in Respondent's opinion, the patients at issue could, be on steady doses of opiates without problems. As long as the opiates were prescribed in a steady fashion, those drugs were safe and effective. The serious danger in not prescribing the opiates to his addicted patients was a painful withdrawal that he was taking substantial efforts to avoid.

27(e). Because Respondent is trained in internal medicine, emergency room medicine, and psychiatry, he does not believe he needed to obtain second opinions or consultations with regard to his care and treatment of the patients at issue.

27(f). Respondent no longer treats addiction in his practice.

The Patients

28. At issue in this matter is Respondent's care and treatment of seven patients, identified herein by their initials to maintain their privacy: J.C., S.C., D.P., J.P., D.A., A.G., and J.S. In each patient case, Respondent provided psychotherapy, counseling, and prescriptions for other medications not identified in the Factual Findings. Only medications pertinent to this matter are discussed. With the exception of Factual Finding 19 and Respondent's generalized description of discussing psychiatric problems, complaints of chronic pain, and the overuse of prescription medication with each patient, the evidence, including Respondent's record keeping, failed to establish a more detailed description of Respondent's psychotherapy and counseling sessions with each patient. Unless indicated, the records showed reasonably regular appointment schedules with each patient.

*Patient J.C.*

29. Respondent treated J.C., a 57-year-old[1] woman, from October 2004 to August 2010. Respondent originally saw her at Simi Valley Hospital on September 25, 2004, for a consultation, where Respondent noted that she was struggling with drug and alcohol abuse and was symptomatic of drug withdrawal.

30. At his first appointment with her in October 2004, Respondent noted that J.C. had "pharmaceutical dependence" and had been "self-adjusting her medication." J.C.'s treatment goals were to deal with her anxiety and work problems. Respondent documented a history of suicide attempts, including shooting herself in the abdomen at age 20. J.C. had diagnoses of manic depression, chronic pain, and hypertension, among other things.

[1] The age of each patient is stated as of the time of the initial visit with Respondent.

31. Respondent diagnosed J.C. with bipolar I disorder, mixed. He did not diagnose her with substance abuse or dependence.

32. During the time Respondent treated her, J.C. experienced significant family problems. In approximately January 2005, J.C.'s daughter, who used methamphetamines, was murdered at age 25. Respondent did not document this event's impact on J.C. At that time, Respondent prescribed 0.5 mg. Xanax without explaining the medication or its goals. In March 2005, Respondent documented that J.C. had tried 1,000 mg. of Vicodin, without further explanation. In November 2005, J.C. told Respondent that her 14-year-old grandson had put his fingers inside his sister's vagina. In September 2005, Respondent had documented another sexual impropriety by the same boy. Respondent did not document the affects of these events on J.C., nor did he modify his psychotherapy or prescriptions based on these events.

33. In addition to her psychiatric condition, Respondent began to treat J.C.'s apparent complaints of chronic pain from scoliosis. There was no evidence objectively confirming scoliosis. He documented that his primary goal was to keep J.C. functioning and to treat her pain. Respondent did not perform any diagnostic workup for chronic pain, nor did he physically examine her or order laboratory tests. He also failed to establish whether J.C. had attempted to deal with her pain through other treatment modalities, including orthopaedics.

34. After November 4, 2005, J.C. did not return to Respondent until March 7, 2007. Respondent did not explain the gap in treatment in J.C.'s chart. He did not conduct any new evaluation of her upon her return. However, on March 7, 2007, he held a session with J.C. and her husband, focusing on the death of their daughter and obtained her husband's acknowledgement and apparent tacit agreement to prescribe Norco[2] to J.C. On March 7, 2007, Respondent prescribed 10/325 mg. Norco to J.C. On December 17, 2007, Respondent prescribed 20 mg. Oxycontin,[3] noting J.C.'s marital discord and her request for stronger pain medication. There was no documentation explaining the reason for such prescriptions in light of J.C.'s drug history and problems.

35. Over the time of treatment, as J.C.'s tolerance increased, Respondent increased the dosages of narcotics. In September 2007, Costco Pharmacy notified Respondent that J.C. was using multiple pharmacies and multiple doctors to obtain controlled substances and further notified Respondent that Costco Pharmacy would no longer fill his prescriptions for J.C. Respondent continued to treat J.C. with narcotics. He did not document the communication from Costco and did not document any conversation with J.C. about the

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[2] Norco is a schedule III controlled substance and an opioid. Norco is the brand name and hydrocodone is the generic name. For the purposes of the discussion herein, opioid, opiate, and narcotic are used interchangeably.

[3] Oxycontin is a schedule II controlled substance and an opioid. Oxycontin is the brand name and oxycodone is the generic name.

issue. In his interview with the Board, when asked what changes he made to J.C.'s treatment, if any, after receiving notification from Costco Pharmacy, Respondent did not recall any specifics and said he likely spoke with her about appropriate opiate use and doctor shopping. There was no documentary evidence to establish any such conversation.

36. On January 28 2008, Respondent documented his plan to discontinue Oxycontin because of "Increased frequency." Respondent did not explain that notation. Yet despite the plan to discontinue Oxycontin, on February 15, 2008, Respondent prescribed 40 mg. Oxycontin (he had previously prescribed her 20 mg. Oxycontin) for chronic pain due to scoliosis. Confusingly, on that same date, Respondent described J.C.'s condition as "tolerating the medications well" and "progressing in treatment."

37. On March 19, 2008, Respondent documented his concern that J.C. might be overusing medication even though she was denying it adamantly. At the time, Respondent was prescribing her Norco, Oxycontin, and alprazolam,[4] among other things. He continued to prescribe her opiates with no further documentation of his concern of her overuse.

38. On September 22, 2008, Respondent documented that the 10/325 mg. Norco he had been prescribing would be the "ceiling" and that if she needed more than that, he would refer her to another physician. In his interview with the Board, Respondent explained that, even in these types of situations, he would consider a patient's extenuating circumstances to not hold to a "ceiling." Without documenting any discussion with J.C. and any extenuating circumstances, Respondent continued prescribing narcotics to J.C.

39. On June 18, 2009, Respondent received an anonymous letter alleging that J.C. was abusing prescribed medications. Respondent continued to prescribe medications. There was no evidence he spoke with J.C. about the allegations in the anonymous letter.

40. On June 24, 2010, J.C.'s son committed suicide. Respondent did not document the impact of this event on J.C., nor did he document any modification to his psychotherapy or prescriptions. On July 2, 2010, with no documentation of her son's suicide, Respondent described J.C. as, "doing okay" and coping well. Respondent continued to prescribe her opiates.

41. In his interview with the Board, Respondent conceded that his documentation was inaccurate. He explained that he does not always fully document what he does in each patient's case and that another physician would be able to infer his actions or the patient's status from the medication prescriptions. While conceding that his patient notes were inaccurate, Respondent asserted at hearing that his record keeping was sufficient to meet the standard of care.

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[4] Alprazolam is a schedule IV controlled substance and a benzodiazepine. Xanax is the brand name and alprazolam is the generic name.

42. In his Board interview, Respondent was asked how he concluded in one of his notes that J.C. was "functioning in her job." J.C. was a self-employed cleaning person. Respondent explained that, on occasion, while waiting for their appointment in his office, J.C. would clean his office and she did so well. Respondent did not employ J.C. to clean his office. Instead, it appears that J.C. only took on busy tasks while waiting for Respondent in his waiting area, and Respondent based his assessment of her employment on the times she would tidy his office lobby.

43. Respondent's pertinent testimony at hearing regarding his care and treatment of J.C. is set forth in Factual Findings 44-50.

44. Respondent did not refer J.C. to detoxification because she had chronic pain and showed only mild addictive behavior. Respondent's view on J.C.'s addiction problem, however, was inconsistent. On the one hand, Respondent believed that if he did not prescribe her opiates, J.C. would turn to alcohol. On the other hand, Respondent also stated that he did not refer J.C. to Alcoholics Anonymous (AA) because he did not believe she had an alcohol problem. He conceded she would sometimes try to obtain more pills, but he believed she had genuine pain. Respondent said it was "ridiculous" to say he should not prescribe opiates to J.C. because she had genuine chronic pain.

45. Respondent did not document or take further action with J.C. with regard to her grandson's problems because he considered J.C. too removed from those incidents. Additionally, he did not believe J.C. was in pain due to the loss of her son, and therefore he did not change his treatment plan. He noted that, at times, J.C. feared that Respondent would have to report things that she would disclose to him and he remained sensitive to that fear. As to the anonymous letter alleging J.C.'s improprieties, he found the hearsay document too uncertain to act on and he would not change treatment based on such a letter. This response to the anonymous letter was reasonable.

46. Regarding the communication from Costco Pharmacy, Respondent saw it as unethical to stop treating her, based on that letter.

47. Respondent stated that it was typical of patients to have lapses in treatment, like J.C. had between November 4, 2005, and March 7, 2007. He did not see the lapse in time as a problem to document or deal with separately.

48. He does not believe he needed to order laboratory tests or contact her other care providers, as he has a background in internal and addiction medicine. He did not ever take J.C.'s blood pressure because it is outside of the scope of a psychiatrist's practice.

49. In discussing why he did not terminate treatment with J.C. and refer her to other health care providers, Respondent stated that he would not terminate J.C. for aberrant drug-taking behavior because, as an addictionologist, he saw his role as one to treat her for such an issue, not abandon her because of it.

50. Respondent believes that any other physician could follow and understand J.C.'s treatment, based on his patient records.

*Patient S.C.*

51. Respondent treated S.C., a 50-year-old woman, from March 2008 to August 2010, for anxiety. S.C. had a strong family history of drug and alcohol problems. Her mother suffered from depression. S.C.'s psychiatric problems began at age 12 and included drug and alcohol abuse. S.C. had been attending AA meetings since the 1980s. She had been addicted to heroin and alcohol; she temporarily overcame her heroin addiction with methadone treatment. S.C. had been sober from 1994 to 1997. S.C. had hepatitis C, hypothyroidism, hypertension, obesity, and sciatica. S.C. was being treated by at least two physicians (other than Respondent), and by the Aegis Center, a Methadone clinic. S.C. was addicted to heroin and alcohol.

52. On March 5, 2008, Respondent diagnosed S.C. with opioid dependence and major depression, recurrent, non-psychotic. He later diagnosed her with fibromyalgia; he made no referrals for this condition.

53. On March 26, 2008, Respondent prescribed 750/7.5 mg. Vicodin ES[5] for S.C.'s pain and 100 mg. Lamictal[6] for mood stabilization. On April 9, 2008, Respondent discontinued the Vicodin ES, but started 10/325 mg. Norco for sciatica pain and 1 mg. alprazolam for anxiety.

54. On July 7, 2008, S.C. told Respondent that, just previous to that appointment, she had had a severe suicidal episode just before her menstrual period. Respondent continued his prescription of Norco, and added 20 mg. Prozac.[7] He failed to document his therapeutic actions to address her earlier suicidal condition, other than to prescribe 20 mg. fluoxetine to be taken a week before her period. He increased the Lamictal prescription from 100 mg. to 200 mg. on August 19, 2008, without explanation, and prescribed Neurontin[8] for increasing depression and anxiety. On April 30, 2009, he prescribed 200 mg. gabapentin for depression.

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[5] Vicodin ES is a schedule III controlled substance and an opioid. Vicodin is the brand name and hydrocodone is the generic name.

[6] Lamictal is not a controlled substance.

[7] Prozac is not a controlled substance. Prozac is the brand name and fluoxetine is the generic name.

[8] Neurontin is not a controlled substance. Neurontin is the brand name and gabapentin is the generic name.

55. On April 2, 2009, Respondent changed S.C.'s prescription of 180 mg. methadone[9] to 168 mg. This was a medication prescribed by the Aegis clinic. Respondent modified the methadone prescription without contacting the Aegis clinic. Without any documented reason, he also discontinued her prescription of mirtazapine,[10] a medication she used since before she began treatment with Respondent. Respondent modified S.C.'s methadone again on July 9, 2009, from 168 mg. to 178 mg., also without any documented reason or contact with the Aegis clinic. Respondent did not discuss his medication changes with any of S.C.'s other physicians.

56. Respondent's pertinent hearing testimony regarding his care and treatment of S.C. is set forth in Factual Findings 57-61.

57. As S.C. was on methadone maintenance, she found it difficult to get care for her pain from her treating physicians. Respondent was willing to treat her because he sees himself as heavily trained in the use of Suboxone and the use of methadone for pain for patients in a methadone maintenance program. Respondent was comfortable treating such patients.

58. S.C. was afraid of detoxification and Respondent was concerned with the possibility of leaving S.C. in pain. He therefore thought it appropriate to prescribe the indicated medications to her. He believes that abstinence is not a good end if pain is left untreated. In addition to untreated pain, Respondent was also concerned with withdrawal. Furthermore, he believed that if he did not treat her pain, S.C. might self-medicate with opiates. He believed his prescriptions were warranted and appropriate because she gave him no signs she was not handling the medications well.

59. Respondent did not talk to the Aegis clinic because S.C. did not want him to do so and he respected her wishes.

60. Respondent confirmed S.C.'s back pain by reviewing imaging studies. He did not feel obligated to contact S.C.'s internist.

61. Respondent prescribed multiple anti-depressants because S.C. was treatment resistant.

*Patient D.P.*

62. Respondent treated D.P., a 20-year-old man, from June 19, 2007, to September 10, 2010. He had had a motorcycle accident in April 2007, with injuries to his clavicle, the clavicular cervical joint, his wrist, and thumb.

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[9] Methadone is a schedule II controlled substance and an opioid.

[10] Mirtazapine is not a controlled substance.

63. Respondent diagnosed D.P. with opiate abuse, major depressive disorder, recurrent, severe, without psychosis, and chronic pain due to trauma in the sternoclavicular joint.

64. On June 19, 2007, Respondent documented that D.P. was on criminal probation and that he was depressed, anxious, and overwhelmed. However, as his "chief complaint," Respondent wrote, "he is doing well."

65. On the first day of treatment, Respondent discussed Methadone with D.P. and his fear of heroin withdrawal. Respondent documented his worry that D.P. craved Oxycontin and was abusing opiates. Nevertheless, on June 27, 2007, Respondent prescribed 10/325 mg. Norco for D.P.'s pain. In his Board interview, Respondent explained that he prescribed Norco, and later, Oxycontin to address D.P.'s pain with something that would stop him from using heroin.

66. On July 6, 2007, Respondent changed D.P.'s diagnosis to opiate dependence. Respondent did not modify D.P.'s treatment plan, other than prescribing him 350 mg. Soma.[11] On August 1, 2007, Respondent documented that D.P. had bought a gram of heroin. Respondent then prescribed 80 mg. Oxycontin and 2 mg. Xanax to D.P. while continuing the Norco and Soma.

67. On September 21, 2007, Respondent documented that D.P. was beyond Respondent's control and that he would have to refer him to a pain physician. He documented that he would not prescribe any more opioids to D.P. until D.P. consulted with a pain specialist. Respondent did not document any consultation; however, on October 12, 2007, Respondent prescribed 40 mg. Oxycontin to D.P. On October 23, 2007, in D.P.'s chart, under the subtitle, "Assessment and Medical Reasoning," Respondent described D.P. as being off pain medication and wrote, "[h]e was suicidal." Without documenting any non-prescription therapy actions to address the notation regarding suicide, Respondent prescribed 2 mg. Xanax and 150 mg. Wellbutrin.[12] On November 30, 2007, Respondent documented that D.P. had smoked a gram of tar heroin and on that same day, he prescribed 10/325 Percocet[13] while continuing the Oxycontin, among the other medications. In December 2007, D.P.'s insurance company advised Respondent that D.P. was using multiple pharmacies and multiple physicians to obtain controlled substances. Respondent did not document the contact or any conversation with D.P. regarding the same. In his interview with the Board, when asked if he would typically chart the event and alter treatment based on

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[11] Soma is a schedule IV controlled substance. The ALJ is aware that Soma only became a controlled substance in 2012. (Gov. Code, § 11425.50, subd. (c) ["The presiding officer's experience, technical competence, and specialized knowledge may be used in evaluating evidence."].)

[12] Wellbutrin is not a controlled substance.

[13] Percocet is a schedule II controlled substance and an opioid. Percocet is the brand name and oxycodone is the generic name.

such a communication (regarding the use of multiple pharmacies and physicians), Respondent answered, "Not necessarily."

68. On July 17, 2008, Respondent sent D.P. a termination letter, but on July 21, 2008, he documented a treatment plan to begin weaning him off of opioids. On November 10, 2008, he continued what he defined as a slow detoxification process. Between July 2009 and September 2010, Respondent prescribed and modified the quantities and potencies of various medications including Oxycontin, Roxicodone,[14] Xanax, and hydromorphone.[15] On September 10, 2010, Respondent documented that D.P. was attending Narcotics Anonymous (NA) meetings.

69. D.P. apparently entered a detoxification treatment center for opiates in 2010. Respondent did not document this fact. D.P. was discharged from treatment in February 2010. Thereafter, Respondent did not contact the treatment center doctors. He did not request the records of that treatment. On April 16, 2010, Respondent saw D.P. after opiate detoxification treatment, and based on what Respondent described in his interview with the Board as a relapse, Respondent prescribed 80 mg. Oxycontin AD to D.P. Respondent asserted that D.P. improved thereafter. However, later in 2010, Respondent conceded that he became concerned with D.P.'s increasing use of opiates, his suffering of a criminal arrest for driving under the influence of drugs or alcohol (DUI), and his use of heroin. Additionally, D.P. was threatening to report Respondent to the Board and was becoming demanding and threatening assault if Respondent did not meet his medication demands. Respondent considered getting a restraining order. Instead, Respondent terminated treatment. Respondent did not document these problems.

70. D.P. testified at hearing but provided inconsistent statements. For example, he testified that he had not taken opioids before meeting Respondent. However, the evidence established that that assertion was false. D.P.'s overall demeanor at hearing and his inconsistent statements made his testimony, as a whole, suspect and therefore not credible.

71. Respondent's pertinent hearing testimony regarding his care and treatment of D.P. is set forth in Factual Finding 72.

72. Respondent took on D.P.'s care, in part, because no physician would prescribe him pain medications due to his heroin use. Respondent treated D.P. to keep him safe. Due to Respondent's care and treatment, D.P.'s health improved in that he went from regularly using one-half gram of heroin, to being in NA and graduating from mechanic school. Respondent believes he clearly documented D.P.'s treatment plan.

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[14] Roxicodone is a schedule II controlled substance and an opioid. Roxicodone is the brand name and oxycodone is the generic name.

[15] Hydromorphone is a schedule II controlled substance and an opioid. Dilaudid is the brand name and hydromorphone is the generic name.

*Patient J.P.*

73. Respondent treated J.P., a 42-year-old man, from March 2008 to January 6, 2009. J.P. had depression since adolescence and had attempted suicide in high school. He had been treated for alcohol and marijuana use while in college. He suffered a neck injury in 2004 and was using Vicodin for pain.

74. Respondent diagnosed J.P. with major depressive disorder, recurrent-severe, without psychotic features and facet joint disease in the neck. Respondent was treating J.P. solely for depression. Respondent did not document a treatment plan, a fact Respondent conceded in his interview with the Board.

75. On April 24, 2008, Respondent documented that J.P. had no complaints and that he was progressing well in treatment; however, on that same day, he added the diagnosis of alcohol dependence, and made no treatment plan changes. Respondent also prescribed 6 mg. Emsam[16] for depression and 0.5 mg. Xanax for anxiety. He stated that he prescribed Emsam because other anti-depressants had failed. He reached this conclusion solely based on J.P.'s assertions.

76. On May 8, 2008, Respondent noted J.P.'s subjective report of depression and continued prescriptions of Emsam, Lamictal, and Xanax. On May 23, 2008, Respondent increased the Lamictal from 25 mg. to 100 mg. and the alprazolam from 0.5 mg. to 1 mg.

77. On June 30, 2008, Respondent documented that J.P. had "rage," had obtained a bottle of vodka, and was going to slit his wrist. In response, Respondent prescribed 250 mg. Depakote ER,[17] and continued the prescriptions of Emsam and Xanax.

78. On July 21, 2008, Respondent documented his worry about J.P.'s "low mood." He documented that J.P. had sliced his wrist in an attempt at self-mutilation and prescribed Kadian.[18]

79. On January 6, 2009, Respondent documented that J.P. had no suicidal ideation, low ambition, fatigue, and a depressed mood, among other things. He discontinued the Emsam prescription.

80. On January 12, 2009, J.P. died of morphine, oxycodone, and oxymorphone[19] intoxication. The county coroner ruled his death an accident.

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[16] Emsam is not a controlled substance.

[17] Depakote ER is not a controlled substance.

[18] Kadian is a schedule II controlled substance and an opioid.

[19] Oxymorphone is a schedule II controlled substance and an opioid.

81. Pursuant to a physician prescription, J.P. had purchased 60 tablets of Kadian and 90 tablets of oxycodone on January 7, 2009; however, those prescriptions were issued by another physician, not Respondent. The last Respondent-issued prescription J.P. obtained prior to his death was on January 5, 2009, for 60 tablets of alprazolam.

82. Respondent's pertinent hearing testimony regarding his care and treatment of J.P. is set forth in Factual Findings 83-85.

83. J.P. did not have a drug problem and showed no evidence that he was misusing medications. For this reason, Respondent believed his prescriptions were appropriate. He saw no need to order laboratory tests or an electrocardiogram. His treatment of J.P. met the standard of care, which he described as frequent monitoring, prescribing antidepressants, finding a proper combination of medications, creating a therapeutic bond, referring to alcohol programs, and to hospitalize as and if necessary. He referred J.P. to AA. His prescriptions of Kadian and Emsam were reasonable.

84. Respondent does not believe the standard of care required him to contact J.P.'s primary care physician regarding his previous medications and pain conditions. Respondent contested Complainant's opinion that opiates and benzodiazepines are absolutely contraindicated; he further contested the opinion that Emsam and Xanax are a lethal combination.

85. At every visit, Respondent assessed J.P. for the risk of suicide. He saw J.P. as a high-risk patient for suicide, as he was a Caucasian male, with no support network, who did not like his job, and whose children rejected him. Respondent talked with him before and after he cut his wrists. Respondent opined that J.P.'s depression was treatment resistant, but he does not believe J.P. committed suicide. He believes J.P. used cough medicine while on opiates and that his death was a "mistake." Respondent asserted that J.P.'s death was not foreseeable to him and noted that at each visit, J.P. did not meet the criteria for an involuntary psychiatric hold.

*Patient D.A.*

86. Respondent treated D.A., a 44-year-old male, from February 27, 2007, to August 2, 2010. D.A. had chronic pain, ADHD, bipolar depression, anxiety, and hypothyroidism. He had been treated with methadone and psychotropic medications. D.A. had a history of emotional breakdowns, addiction, and allegations that he molested his own child.

87. Respondent diagnosed D.A. with depression, bipolar II, and chronic pain.

88. At the initial evaluation in February 2007, Respondent charted D.A.'s addiction problems with pain medication, a history of drug treatment at the Schick Center and through NA, and the fact that D.A. could take between 10 and 12 Percocet tablets. D.A. was already taking 5 mg. methadone.

89. Respondent prescribed 10 mg. methadone to D.A. On June 5, 2007, Respondent increased the methadone, from 10 mg. to 15 mg. with no explanation.

90. Respondent did not contact D.A.'s referring physician to obtain a medical history. In his interview with the Board, Respondent asserted that he evaluated D.A.'s lower back and obtained reports from D.A.'s physicians. There was no evidence, other than Respondent's testimony, to support Respondent's assertion.

91. On October 19, 2009, Respondent documented his concern with D.A.'s misuse of prescribed medications. He provided D.A. with education regarding "pain killer use" and continued to prescribe methadone (10 mg.) for pain and 20 mg. Ritalin[20] for ADHD. He did not formally evaluate D.A. for ADHD.

92. On January 12, 2010, Respondent prescribed 150 tablets of 10 mg. methadone to D.A. without evaluating him. January 12, 2010, was the last documented day of treatment for D.A. However, Respondent continued to prescribe medication to D.A. thereafter. From February to August 2010, Respondent prescribed 150 tablets of 10 mg. methadone at least monthly. In his interview with the Board, Respondent explained that D.A. had insufficient money to pay for Respondent's services, but Respondent felt a need to continue to help him. Respondent admitted that, from approximately February to August 2010, D.A. would come to Respondent's office and pick up prescriptions, without full evaluations. Respondent said, "I would frequently . . . talk to him in the hall and see how things were going, but I wouldn't have him come into the room."

93. On August 2, 2010, Respondent prescribed 150 tablets of 10 mg. methadone without evaluating him. D.A came to Respondent's office, and after a short verbal exchange through the window between the lobby and Respondent's office, Respondent handed D.A. the methadone prescription.

94. On August 3, 2010, D.A. died from methadone intoxication. The county coroner ruled it an accident.

95. Respondent's pertinent hearing testimony regarding his care and treatment of D.A. is set forth in Factual Findings 96-98.

96. Respondent saw his prescriptions as a way to keep D.A. from experiencing heroin withdrawal. D.A. did not show addict behavior and therefore believes his prescriptions were appropriate. Respondent explained that even when D.A. could no longer pay for treatment, Respondent continued to treat and prescribe to D.A. to help him. He saw his continued prescriptions as "risk reduction." He did not feel the need to talk to D.A.'s physician regarding methadone.

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[20] Ritalin is a schedule II controlled substance.

97. As to physical examinations, he does not believe it is helpful to do physical examinations in his practice of psychiatry. Regarding his prescriptions without evaluation, Respondent explained that his prescriptions without evaluations were not departures from the standard of care because he had a previous treatment plan, had previously evaluated him, and interacted with him. Additionally, he saw these last prescriptions as medication refills.

98. Respondent argued that D.A. did not commit suicide, but died of a heart attack.

*Patient A.G.*

99. Respondent treated A.G., a 31-year-old male, from June 17, 2011, to October 13, 2011. Several years earlier, A.G. had gone through an in-patient, drug treatment program. A.G. had used heroin four months before Respondent's first evaluation; he had been using opiates since age 16. A.G.'s previous physician terminated his medications (alprazolam, Soma, and Suboxone[21]). Respondent did not contact A.G.'s previous physician to uncover the reason for terminating A.G.'s treatment; however, in his interview with the Board, Respondent asserted that A.G. informed him that the previous termination was due to his overuse of medications. Respondent did not document this data. A.G. was on formal criminal probation for drug-related charges. Due to his probation, he was having his urine tested every two weeks. Respondent never obtained the urine test results. A.G.'s history included sexual molestation at age six. He was depressed and had significant concern about opioid withdrawal.

100. Respondent diagnosed A.G. with opioid dependence, major depressive disorder, recurrent, severe without psychosis, and chronic pain. He planned to, and did, continue the previous physician's medication regimen: 2 mg. alprazolam, 200 mg. Seroquel XR,[22] 350 mg. Soma, and 8/2 mg. Suboxone.

101. In his interview with the Board, when discussing how he assessed A.G.'s pain, Respondent explained that he observed A.G., whether he grimaced, how he moved, how he sat in a chair, and how he walked. He asserted that he would not touch the patient because that is not appropriate for a psychiatrist.

102. On July 26, 2011, Respondent went over concerns about drug overuse and sudden withdrawal from alprazolam and documented that A.G. understood his comments. Eventually, Respondent recommended that A.G. attend NA.

103. On August 25, 2011, Respondent noted problems dealing with A.G.'s family that included A.G.'s mother threatening Respondent. Among other things, Respondent documented that A.G.'s mother threatened to "turn him into" the Board due to her concerns

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[21] Suboxone is a schedule III controlled substance and an opioid.

[22] Seroquel XR is not a controlled substance.

about A.G.'s overuse of controlled substances. Respondent found this threatening behavior too taxing and distracting from the patient's actual treatment. He decided to terminate treatment later that same year.

104. On October 13, 2011, Respondent provided A.G. with a 30-day termination letter "due to repeated threatening phone calls from family members." Respondent documented referring A.G. to "the county or resources of his choice." However, he thereafter refilled A.G.'s prescriptions for thirty days.

105. Respondent wrote a lengthy discharge note, dated February 26, 2012. In that note, he documented his contact with a county drug treatment entity. He also described the overall treatment as follows: "This was a brief and difficult treatment episode. . . . he was having difficulty in staying clean however he was well aware that he had drug dependence issues." Respondent noted that although he recommended NA meetings, A.G. refused them.

106. Although Respondent ended his treatment of A.G. on October 13, 2011, Respondent continued to prescribe him medication beyond a 30-day period: 20 tablets of Suboxone on November 14, 2011, 15 tablets of Suboxone on December 1, 2011, 5 tablets of Suboxone on December 16, 2011, 120 tablets of alprazolam and 10 tablets of Suboxone on December 20, 2011, and 5 tablets of Suboxone on January 2, 2012.

107. Respondent's pertinent hearing testimony regarding his care and treatment of A.G. is set forth in Factual Findings 108-112.

108. In light of A.G.'s disclosure to Respondent that his previous physician had terminated his treatment due to overuse of medication, Respondent saw A.G. as an honest patient. His plan was to continue A.G.'s last physician's treatment because it appeared successful and he wanted to keep A.G. off of heroin and prevent withdrawal.

109. On prescribing alprazolam, Respondent explained that A.G. had stated that he did not want to take a less addictive medication like a selective serotonin reuptake inhibitor (SSRI), but would take alprazolam. As Respondent considered A.G. an honest patient, he accepted A.G.'s preference for alprazolam.

110. Respondent did not feel the need to obtain A.G.'s previous medical records; he believed he had enough information to manage A.G.'s treatment without reviewing previous doctor records. Respondent explained that, many times, other physician records are not legible and therefore it is not a good use of time to acquire them. He does not usually require urine testing because patients find it offensive. In his opinion, drug testing impedes the development of the therapeutic alliance, it is time consuming, and expensive.

111. Respondent could not think to have done anything differently in his care and treatment of A.G.

112. Respondent believes his documentation of A.G.'s treatment was self-evident to any physician reading his notes.

*Patient J.S.*

113. Respondent treated J.S., a 22-year-old-woman, between January 10, 2011, and September 16, 2011. J.S. had anxiety, scoliosis, a strong family history of addiction, and her own history of drug addiction. J.S. told Respondent she had been previously using heroin. She was seeing Respondent for chronic pain. J.S. was taking 30 mg. Roxicodone, 5 mg. diazepam,[23] and 350 mg. Soma, all prescribed by another physician.

114. Respondent wrote in J.S.'s record, "she is here for Roxicodones and is not too interested in any other treatment at this time. . . . For risk reduction it is better to treat her scoliosis pain with Roxicodones as she has been on this in a stable amount and it controls her pain and continue building a therapeutic bond." Respondent noted that J.S. was at high risk for bipolar, bipolar II, and cluster B personality disorder. He reviewed an x-ray of J.S.'s back and found severe scoliosis.

115. J.S. disclosed to Respondent that she was a heroin addict and told Respondent that she needed Oxycontin or she would return to using heroin. However, J.S. asserted at her deposition, dated June 5, 2013, that she lied and had not used heroin before seeing Respondent. According to J.S.'s deposition testimony, she first used heroin in January 2012, after her treatment with Respondent had completed. J.S. stated at her deposition that she lied to get Respondent to prescribe her Roxicodone.

116. Respondent provided evidence that, on March 22, 2012, J.S. disclosed to a drug treatment agency that she had used heroin since the age of 15, and was using one gram of heroin per day. This assertion is similar to J.S.'s initial disclosure to Respondent in January 2011, but contrary to her deposition testimony in 2013.

117. J.S. lied regarding her heroin use. The evidence, however, could not establish the truth—whether she used heroin before Respondent's treatment. The evidence did not establish whether J.S. was addicted to heroin before or after Respondent's care and treatment. J.S.'s assertions in the record were all suspect and not credible.

118. Respondent diagnosed J.S. with generalized anxiety disorder, opioid dependence, in remission, cluster B, and scoliosis. Respondent noted J.S.'s short-term goal was "pain management with minimal opioids" and "no relapse to heroin."

119. At J.S.'s first appointment with Respondent, Respondent prescribed 75 tablets of 30 mg. Roxicodone and 60 tablets of 5 mg. diazepam. Respondent prescribed Oxycontin regularly, approximately every 15 days, from August 6, 2009, to August 6, 2012.

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[23] Diazepam is a schedule IV controlled substance and a benzodiazepine.

120. On January 26, 2011, Respondent prescribed 5 mg. diazepam, 30 mg. Roxicodone, and 350 mg. Soma.

121. On February 10, 2011, Respondent prescribed 2 mg. alprazolam for insomnia. On February 23, 2011, Respondent documented that J.S. had difficulty concentrating, based on the patient's assertions, and prescribed 10 mg. Adderall[24] for ADHD. He did not perform any formal testing to confirm the presence of ADHD. He noted that he provided substance abuse counseling. On April 18, 2011, Respondent recommended detoxification, noting, "counseling provided concerning her opioid use and the danger of escalation of dosing."

122. On July 14, 2011, Respondent increased the Adderall from 10 mg. to 20 mg. Respondent explained in his interview with the Board that J.S. requested a higher dose. He did not document her request or his reasoning for obliging it.

123. On September 9, 2011, Respondent noted J.S.'s "turbulent" family life, that J.S.'s father was threatening Respondent, and that J.S. did not want him in her treatment.

124. On September 16, 2011, Respondent documented that J.S. was overusing medication and described her father as "menacing." Respondent further documented that he prescribed her one week's worth of medication, referred her to another physician, and recommended detoxification. He decided to terminate treatment. Upon termination, Respondent prescribed 49 tablets of Roxicodone and 60 tablets of alprazolam to J.S. Respondent explained at hearing that this was a "bridge" prescription to address her medication needs until she found another physician.

125. Respondent's pertinent hearing testimony regarding his care and treatment of J.S. is set forth in Factual Finding 126.

126. Respondent does not believe J.S. was lying about her pain. He does not believe J.S. was using prescription medication to get "high." He does not believe he caused her opioid dependence because J.S. did not use heroin while he treated her, nor did she display addictive behavior. He recommended detoxification, but J.S. refused.

The Opinions of M.T. Lymberis, M.D.

127. Maria T. Lymberis, M.D., practices adult and child psychiatry (since 1970), psychoanalysis (since 1972), forensic psychiatry (since 1982), and combined psychopharmacology and psychotherapy (since 1998) in private practice in Santa Monica, California. She is also a Clinical Professor of Psychiatry at the UCLA School of Medicine (since 1996).

128. Lymberis received her medical degree in 1964 from the University of Southern California (USC) School of Medicine in Los Angeles. She completed a straight

[24] Adderall is a schedule II controlled substance.

medical internship at Mount Sinai Hospital in New York, New York in 1965, and residencies in neurology at Mount Sinai Hospital in 1966 and psychiatry at the Albert Einstein Bronx Municipal Hospital in New York, New York, in 1968. She completed a fellowship in child psychiatry at UCLA NPI in 1970. Lymberis graduated from the Los Angeles Psychoanalytic Institute in Los Angeles in Adult and Child Psychoanalysis in 1978. She is a Diplomate of the American Board of Psychiatry and Neurology. Lymberis was an examiner in Adult and Child Psychiatry for the American Board of Psychiatry and Neurology from 1984-2005.

129. She has been an expert consultant for the Board since 1978.

130. Lymberis reviewed Respondent's treatment of patients J.C., S.C., D.P., J.P., and D.A. She was critical of Respondent's treatment of all five patients. Overall, Lymberis opined that psychiatrists must undertake due diligence when treating persons with drug addictions or drug dependencies. Specifically, psychiatrists must evaluate each patient on each visit, avoid risky prescriptions, and seek consultations and second opinions as to treatment plans and medication choices. To treat persons with drug addiction for pain, physicians take on a special burden to make sure the patient is safe. A physician cannot treat such a patient routinely. The physician must follow the patient meticulously and document the patient chart similarly. Additionally, Lymberis stated that, contrary to Respondent's actions, a psychiatrist cannot solely treat a patient's physical pain, but she or he must treat the whole person. In her opinion, Respondent isolated the pain problem to the detriment of each patient's psychiatric health, namely their addictions to controlled substances. She criticized Respondent's assertion that the goal of his treatment for each patient was to avoid withdrawal symptoms, opining that a focus solely on avoiding withdrawal was improper.

131. The opinions of Lymberis regarding J.C., S.C., D.P., J.P., and D.A. are set forth in Factual Findings 132-168.

*Lymberis Regarding Patient J.C.*

132. Overall, Respondent's care and treatment of J.C. constituted an extreme departure from the standard of care.

133. There was insufficient evidence in the patient record to support Respondent's diagnosis of bipolar disorder in J.C. If J.C. were truly bipolar, Respondent failed to properly assess her risk of suicide, since persons with bipolar are known to abuse drugs and alcohol and have a high suicide rate.

134. Respondent never focused his treatment on J.C.'s family issues, including the instances of J.C.'s grandson's sexual touching of his sibling. Respondent should have considered family therapy.

135. Respondent did not diagnose J.C.'s substance dependence or abuse. He did not document a treatment plan for his prescribed medications.

136. In her report, Lymberis wrote that J.C., "somatized her pain and focused it on her scoliosis defect as a defense against her psychic pain over her defects as an addict, a parent and the death of her daughter." She opined that the March 7, 2007 joint session with J.C.'s husband was unethical and an extreme departure from the standard of care because he was largely obtaining J.C.'s and her husband's consent to use medication to deal with her psychiatric problems instead of focusing on non-medication therapy options. Lymberis opined that, in effect, Respondent was modeling addict behavior and failing to treat J.C.'s psychiatric disease appropriately.

137. From March 2007 to August 2010, Respondent prescribed opiates in violation of the Board's Guidelines for treating chronic pain with opiates. That is, Respondent treated a known addict with opiates and continued to prescribe higher doses as J.C.'s tolerance developed, with no evaluation or review before increasing the doses. Respondent did not conduct a proper evaluation, physical examination, or laboratory studies; he did not obtain past records, or contact J.C.'s other physicians to determine the medical basis of her pain. After being informed by Costco Pharmacy as to J.C.'s multiple pharmacy and doctor contacts, Respondent failed to take any action. Respondent should have evaluated J.C. and referred her to an in-patient treatment program for drug dependence when she was initially discharged from the hospital in 2004, and after the deaths of her adult son and daughter. Respondent should have referred J.C. to AA or other 12-step programs. Respondent should never have prescribed opiates to J.C., and if she had demanded them, he should have terminated his treatment.

138. Respondent should have sought supervision or consultations as his concerns grew regarding J.C.'s increasing dosages.

139. Respondent's documentation of J.C.'s patient record was inadequate.

*Lymberis Regarding Patient S.C.*

140. Overall, Respondent's care and treatment of S.C. constituted an extreme departure from the standard of care.

141. Respondent should have focused his treatment on S.C.'s psychiatric problems, not her pain management with opiates.

142. Respondent prescribed opiates to a known addict, and by his prescriptions, Respondent undermined the methadone clinic program. His prescriptions put S.C. at risk for overdosing or committing suicide. Specifically, his prescriptions of Vicodin, Norco, and increasing dosages of Xanax were dangerous due to her addiction history. S.C. was also at risk for death from drug interactions and from the risk of overdose.

143. Fibromyalgia is not treated with opiates.

144. Opiates and benzodiazepines, for pain management, are contraindicated. The standard of care requires Respondent to seek out a specific consultation from specialists in opiate addiction and chronic pain before using opiates and benzodiazepines together.

145. As to the Lamictal, Respondent prescribed too great a dose that could have led to severe skin rashes (a simple departure from the standard of care). At least one of S.C.'s treatment goals should have been sobriety. Respondent should have worked closely with the methadone clinic and used problem solving and behavior modification techniques to deal with her drug urges and drug-use triggers. Lymberis clarified that Respondent's failure to communicate with the methadone clinic before prescribing to S.C. was a simple departure from the standard of care.

146. Respondent never assessed the medical status of S.C.'s pain.

147. Respondent's records did not reflect S.C.'s clinical reality, or Respondent's clinical reasoning for his treatment. Respondent's records do not meet the requirements of the Board's Guidelines for the treatment of chronic pain with opiates and with other controlled substances.

*Lymberis Regarding D.P.*

148. Overall, Respondent's care and treatment of D.P. constituted an extreme departure from the standard of care.

149. The standard of care required Respondent to treat D.P.'s drug and alcohol abuse by referring him for detoxification treatment and involving his parents to reach a treatment alliance with goals of drug treatment and sobriety. Although Respondent argued that involving D.P.'s parents would impede the development of his treatment alliance with D.P., Lymberis opined that patient confidentiality should not be used to prevent effective care in patients like D.P. whose life could be in jeopardy.

150. Respondent chose to treat D.P.'s pain with opiates and take all efforts to avoid withdrawal, but in doing so, Respondent supported D.P.'s addiction. The presence of a current addiction is an absolute contraindication to the use of opiates for pain. Respondent should have used opiate substitutes followed by gradual tapering. Respondent could have used other medications like Clonidine to suppress withdrawal symptoms.

151. Respondent should have sought consultations with other physicians to deal with D.P.'s DUI and threats.

152. Respondent's documentation was inadequate. Respondent failed to document a detailed drug history or a proper treatment plan. He failed to document any details about D.P.'s accident or the drugs he used. He did not evaluate D.P.'s suicide risk or his mood disorder. He did not document D.P.'s developmental history regarding his use of drugs and alcohol or his depression. He did not document D.P.'s school history, sexual history,

childhood abuse, or neglect. He failed to document D.P.'s probation status. Respondent's mental status documentation is superficial and incomplete.

*Lymberis Regarding J.P.*

153. Overall, Respondent's care and treatment of J.P. constituted an extreme departure from the standard of care.

154. Respondent failed to evaluate and diagnose J.P.'s substance abuse and failed to evaluate his suicide risk. He did not diagnosis J.P. with opiate dependence and multiple substance abuse. Respondent's use of opiates and benzodiazepines in the presence of active drug and alcohol abuse with severe depression and a high suicide risk was inappropriate.

155. Respondent should not have prescribed Xanax as first choice for anxiety without assessing J.P.'s alcohol and substance use. Respondent's prescriptions for Xanax and Emsam, without requiring treatment for alcohol and substance abuse, is a possibly lethal drug combination in a patient, like J.P., who cannot be trusted to self-monitor. Kadian and Emsam affect blood pressure and should not be prescribed together because they can cause death.

156. The standard of care requires patients like J.P. to be in an in-patient drug and alcohol rehabilitation treatment program, to have baseline laboratory tests, including a liver function test, before prescribing Depakote, careful monitoring of Emsam, and substitute other anti-depressant medication such as Cymbalta. To prescribe Emsam, Respondent should have referred J.P. to his internist to have him or her evaluate and monitor him. Respondent should have also conducted a physical examination to obtain a baseline blood pressure.

157. Respondent should have recommended voluntary in-patient care after J.P. lost his job. Had J.P. refused such care, Respondent should have terminated treatment and referred J.P. to another physician or a county clinic.

158. By June 30, 2008, and again on July 21, 2008, after being aware that J.P. had abused drugs and alcohol and attempted suicide by slitting his wrist, Respondent should have deemed J.P. a high suicide risk and involved at least one family member to discuss involuntary commitment. By July 21, 2008, the standard of care required termination of treatment and action to involuntarily commit J.P.

159. J.P.'s death was a foreseeable risk given his chronic depression, past suicide attempts, and Respondent's prescriptions in the face of J.P.'s chronic drug and alcohol abuse.

*Lymberis Regarding D.A.*

160. The standard of care for D.A.'s treatment required Respondent to diagnose him with drug abuse, inform D.A. and his wife about the risk of death, terminate his care,

and arrange for involuntary in-patient treatment in a county facility for acute detoxification and drug treatment.

161. D.A.'s risk of suicide was high. Respondent should have seen the risk and realized that D.A. needed to be hospitalized. The suspicion of methadone abuse was high; there was a clear risk of death.

162. Respondent had no evidence to support the ADHD and bipolar diagnoses. He performed no specific evaluation. He did not contact D.A.'s referring physician.

163. Respondent did not consult with another physician to support his prescription of methadone. Respondent should not have treated D.A. for chronic pain with methadone because he was addicted to opiates. He did not adhere to the Board's Guidelines for treatment with controlled substances and chronic pain. He performed no physical examination, he did not obtain past treatment records, and he did not coordinate his care with D.A.'s other physicians. He did not refer D.A. to a county medical center after documenting D.A.'s struggle with withdrawal.

164. Prescribing methadone as needed contravenes the Board's Guidelines for the use of opiates to address pain, given its high risk of abuse and the possibility of respiratory depression.

165. Respondent started Lamictal at 100 mg.; he should have started D.A. at 25 mg., with weekly increases, to avoid the risk of serious skin rashes.

166. Respondent prescribed Depakote without a proper physical evaluation and without blood tests, including the monitoring of D.A.'s liver function.

167. Respondent should have obtained supervision and consultation once Respondent was willing to prescribe methadone for D.A.'s pain.

168. Respondent's record keeping was incomplete; his records for D.A. contain gross inconsistencies and contradictions. D.A.'s psychiatric, medical, behavioral, and social problems required further explanation, clarification, and documented follow-up. He documented no hospitalization history, no addiction history, no school history, no family history, and no job history.

The Opinions of N.E. Lavid, M.D.

169. Nathan E. Lavid, M.D., practices clinical and forensic psychiatry in a private practice in Long Beach, California (since 2002). Lavid received his medical degree from the University of Kansas, School of Medicine in Kansas City, Kansas in 1997. He completed an internship in neurology, pediatrics, psychiatry, and human behavior in 1998 and a residency in psychiatry and human behavior in 2001, both at the University of California, at Irvine, in Orange, California. He completed a forensic fellowship at the USC Institute of Psychiatry,

Law & Behavioral Science in 2002. Lavid is board certified by the American Board of Psychiatry and Neurology (2003).

170. Lavid has been an expert reviewer for the Board since 2007. He is also a psychiatric consultant for the Judicial Council of California's Psychotropic Medication Consultation Pilot Project (since 2007). Since March 2011, he has been a review editor for the publication, "Frontiers in Forensic Psychiatry."

171. Lavid's opinions regarding Patients A.G. and J.S. are set forth in Factual Findings 172-182.

*Lavid Regarding Patient A.G.*

172. Lavid opined that it was an extreme departure from the standard of care for Respondent to continue prescribing controlled substances to A.G. after terminating treatment.

173. SSRIs for anxiety would have been an appropriate choice. Respondent should not have prescribed alprazolam solely on the basis of A.G.'s stated preference. This was a simple departure from the standard of care.

174. Oxycodone for a person with a heroin addiction is never appropriate. Respondent has no duty to give opiates to a person addicted to heroin. Respondent should have limited himself to treating A.G.'s psychiatric pain but not his physical pain.

175. Respondent committed a simple departure from the standard of care when he prescribed Soma for a patient with drug addiction. Although Soma had been prescribed to A.G. earlier, Soma has potential for abuse and he should not have prescribed it. Lavid clarified that he could not comment on the use of Soma for medical purposes, as he was only assessing Respondent's actions as a psychiatrist. He thus did not comment on Respondent's medical evaluation and treatment of A.G.'s pain.

176. When asked about Respondent's proffered publication, "Current Psychiatry" (Factual Finding 24), Lavid opined that the publication is a "throw-away" publication, not well known, and not a reliable source.

*Lavid Regarding Patient J.S.*

177. Respondent's care and treatment of J.S. overall constituted an extreme departure from the standard of care.

178. Respondent improperly relied on J.S.'s assertions in treating her. He did not obtain collateral information from family members, review previous medical records, or obtain diagnostic tests. Respondent's diagnostic impressions did not change where he found that J.S. had opioid dependence anxiety, cluster B personality traits, and scoliosis. He did

not investigate whether J.S.'s anxiety had medical causes. He did not inquire whether her asserted symptoms of ADHD were present before age seven, as diagnostically required. Instead, Respondent made the diagnosis of ADHD based solely on J.S.'s assertions.

179. Respondent prescribed psychotropic medications to J.S. that she could abuse. Respondent should not have treated her with opioids. Respondent's prescriptions for oxycodone and Soma for scoliosis and chronic pain are outside the scope Respondent's psychiatric assessment and treatment.

180. Respondent documented that he was intending to decrease opioids, but he increased Roxicodone on April 18, 2011. Such a prescription sends a confusing message to the patient. This was an example of how Respondent's medical treatment for scoliosis and chronic pain with oxycodone impeded his psychiatric treatment for addiction.

181. Respondent should have recommended in-patient substance abuse treatment.

182. Respondent's prescriptions at and after terminating treatment were extreme departures from the standard of care. He should have referred J.S. to detoxification. "Bridge" medication is not safe and sends patients a mixed message that is inappropriate.

The Opinions of A.A. Abrams, M.D.

183. Alan A. Abrams, M.D, practices psychiatry in private practice in San Diego, California (since 1979). He received his medical degree from the University of California, at San Diego (UCSD), in 1974. He completed an internship in psychiatry at the UCLA-Harbor General Hospital, in Torrance, California in 1975, and a residency in psychiatry at the UCSD School of Medicine in 1976. Abrams completed a post-doctoral fellowship in psychopharmacology in 1977, and a second residency in psychiatry in 1978, both at the UCSD School of Medicine. Abrams also received a juris doctorate from Boalt Hall School of Law (U.C. Berkeley) in 1992. He is a Diplomate of the American Board of Psychiatry and Neurology (1981), and a Diplomate of the American Board of Forensic Medicine (1996). Abrams has a board subspecialty certification in addiction psychiatry from the American Board of Psychiatry and Neurology.

184. Abrams has been an expert consultant for the Board since 2003.

185. Abrams testified and wrote a report dated December 26, 2012. The report was admitted into the record. The ALJ allowed Abrams to testify over Respondent's objection that Abrams constituted a second, cumulative expert (cumulative as to Lavid).

186. Post-hearing, the ALJ considered the substance of the testimony and determined that Abrams was sufficiently similar to Lavid's testimony and was, consequently, cumulative. Contrary to Complainant's counsel's assertions, the pre-hearing questions posed to Abrams by Complainant in order for him to write his report, while worded distinctly, were undoubtedly intended to elicit the same information as the pre-hearing questions

Complainant posed to Lavid. Therefore, Abrams' testimony and reports, while part of the record, are not discussed herein, as his opinions were cumulative.

187. Abrams was a reliable witness. However, given the similar questions posed by Complainant, where Abrams found violations of the standard of care that Lavid did not, Abrams' opinions were discounted, since Lavid, also found to be a reasonable and reliable expert witness, found otherwise.

188. In this case, the fact that two experts opined similarly, in contrast to the sole expert opinion in Respondent's favor, was not dispositive in finding whether Respondent departed from the standard of care.

The Opinions of K. de Brito, M.D.

189. Dirk de Brito, M.D., practices psychiatry in Pasadena, California. He received his medical degree from the Columbia College of Physicians and Surgeons, in New York, New York in 1997. He completed a general surgery internship at Huntington Memorial Hospital 1998, and an emergency medicine residency at the Los Angeles County-USC Emergency Room program in 2001. He practiced emergency medicine in Texas and California from 2001-2005. De Brito enrolled in a psychiatry residency at UCLA/San Fernando in Northridge, California (2005-2007), and completed the psychiatry residency at the University of New Mexico, in Albuquerque, New Mexico in June 2010. The evidence failed to explain the split in location.

190. De Brito is board certified by the American Board of Psychiatry and Neurology and the American Board of Emergency Medicine. The evidence failed to establish the dates of certification.

191. De Brito disputed the assertions that Respondent departed from the standard of care as to his care and treatment of all seven patients, including his record keeping.

192. De Brito's opinions are set forth in Factual Findings 193-223.

*De Brito Regarding Patient J.C.*

193. The diagnoses and overall care and treatment of J.C. were appropriate and within the standard of care. Respondent provided appropriate psychotherapy and only adjusted her pain medications after clear signals from the patient about her pain.

194. The prescription for gabapentin was evidence that Respondent tried other medications to get J.C. off of narcotics.

195. Respondent did not need to review past medical records, because it was appropriate for Respondent to trust J.C.'s assertions regarding her treatment history. It is not usual for psychiatrists to obtain previous records.

196. De Brito was unaware of any other treatments Respondent could have attempted in treating J.C.

197. Respondent's documentation of J.C.'s records was complete and "excellent."

*De Brito Regarding Patient S.C.*

198. Had Respondent not prescribed the medications that he did, S.C. would have risked cardiovascular problems, mood problems, narcotic withdrawal, suicide, and opioid relapse. His care and treatment of S.C., including his prescribed medications, were within the standard of care.

199. Respondent considered S.C. was addicted to opiates when prescribing Vicodin and his prescription was reasonable.

200. Accepting S.C.'s assertion that she had fibromyalgia was appropriate.

*De Brito Regarding Patient D.P.*

201. Respondent properly considered that the danger in not prescribing pain medications to D.P. would be his return to opiate use. Prescribing opiates was a better risk and the best alternative for D.P. Respondent's prescriptions to D.P. were appropriate. Respondent was within the standard of care by treating D.P.'s addiction, pain, and psychiatric issues all together. Respondent's background made him capable of doing so. Evidence in the record that D.P. was "functional" at work showed that Respondent's care and treatment was effective and appropriate.

*De Brito Regarding Patient J.P.*

202. The standard of care did not require Respondent to contact J.P.'s other doctors during the time of Respondent's treatment.

203. Respondent's prescription of Emsam was appropriate. The standard of care did not require an electrocardiogram to prescribe Emsam.

204. Respondent could not force J.P. into detoxification because insisting on such treatment impedes patient autonomy. Respondent was correct to respect J.P.'s autonomy.

205. There was no evidence during J.P.'s visits to Respondent that J.P. was a danger to himself. Based on the record, J.P. did not demonstrate suicidal tendencies while in Respondent's presence. There was no reason for Respondent to consider an involuntary psychiatric hold on any day that he saw him.

206. As to J.P.'s death, there was no indication of patient suicide. J.P. was clearly at risk for suicide, but his death was not foreseeable and was not due to Respondent's care and treatment, including his prescriptions.

207. Respondent documented J.P.'s chart well.

*De Brito Regarding Patient D.A.*

208. Respondent's care and treatment of D.A. was within the standard of care.

209. The risk of not prescribing methadone to D.A., that is, the risk of untreated pain, and the risk of withdrawal symptoms was significant. If D.A. experienced opiate withdrawal, he would likely feel pain more intensely. Furthermore, D.A.'s consistent pattern of medication use did not raise any red flags for abuse. Respondent considered these factors, and concluded the risk of prescribing methadone was worth the risk of furthering D.A.'s addiction; the methadone prescriptions were within the standard of care.

210. It is not within the standard of care to obtain the full records from other psychiatrists. Due to Respondent's background in internal medicine, the standard of care did not require Respondent to obtain D.A.'s internal medicine records to treat him psychiatrically.

211. Although de Brito conceded that "ideally" a physician should bring a patient into his examination room before issuing the patient a prescription for controlled substances, Respondent's post-termination prescriptions to D.A. in Respondent's office, without evaluation, were not below the standard of care because Respondent knew D.A. well through his previous treatment. Further, a physician is able to observe a patient's movement, speech, and affect while in the waiting room.

212. D.A.'s death was not predictable.

213. Respondent's documentation of D.A.'s chart was within the standard of care.

*De Brito Regarding Patient A.G.*

214. Respondent's prescription for alprazolam was responsive to A.G.'s needs. A.G. stayed off of heroin during the time of Respondent's treatment. A.G. returned to heroin after ending Respondent's treatment. These facts establish that Respondent's treatment was effective.

215. A.G. risked severe withdrawal, seizure, or death if Respondent did not prescribe alprazolam and Suboxone. Withdrawal is a severe event that Respondent properly sought to avoid.

216. It was appropriate to listen to A.G.'s preferences with regard to an SSRI versus alprazolam. Given A.G.'s asserted preferences, Respondent could not prescribe an SSRI to A.G.

217. Respondent did not commit an extreme departure from the standard of care because A.G. was not harmed.

218. Respondent did not need to obtain previous medical records for all of the reasons stated previously. Furthermore, many times the previous medical records are simply illegible and therefore not worth the effort.

*De Brito Regarding Patient J.S.*

219. Patients might lie to their physicians; however, a physician should believe his or her patient, even if it means you might prescribe them a medication they do not need because it will further the patient's trust in the physician. In this case, it was appropriate for Respondent to believe J.S. and act according to her assertions.

220. While many persons with scoliosis do not feel pain, some do. It was believable that J.S. experienced pain from scoliosis. Therefore, Respondent's prescriptions of Oxycontin were not below the standard of care. Respondent did not cause J.S.'s addiction to opioids because while under his care, J.S. did not have an addiction problem.

221. It is not true that a physician cannot prescribe addictive controlled substances to patients with a drug addiction. It is not below the standard of care for a physician to prescribe opiates to a drug addict for pain as long as you "hold the line of propriety." De Brito failed to define that line of propriety.

222. Adderall is the first choice medication for the treatment of ADHD; its prescription was within the standard of care.

223. Respondent's documentation of J.S.'s patient record "could have been better," but it was not an extreme departure from the standard of care.

Assessing the Experts

224. When the background of de Brito is compared to that of Lymberis, Lavid, or Abrams, de Brito's background is less substantial. Notably, de Brito has had less than three years of psychiatry practice beyond his residency, whereas Lymberis has practiced psychiatry for 45 years since completing her residency. Lavid has practiced psychiatry for 12 years since completing his residency. Abrams has practiced psychiatry for 34 years beyond his residency. Their years of practice was not a largely determinative factor in assessing the experts, but those years, when compared, exposed a significant difference in experience that added to the analysis *post*.

225. When the substance of each expert's opinion was assessed, de Brito's opinions were less substantive and based largely on his belief that patients are to be trusted, a notion he emphasized in his testimony at hearing. Believing a patient is a valid starting framework. However, adhering to that belief in light of each patient's addiction history and the addictive nature of the prescribed medications at issue appears naive and fraught with the risk of patient deception and a less-than-vigorous assessment of the safety, propriety, and efficacy of prescriptions for controlled substances. Furthermore, de Brito saw no significant problem with Respondent's simultaneous practice of internal medicine, addiction medicine, and psychiatry, where Respondent treated pain like a internist might, but failed to perform all necessary testing, evaluations, and assessments; and where Respondent's treatment as a psychiatrist resulted in competing interests and contradictory results, namely the furtherance of each patient's addictions and dependencies. De Brito not only did not find these circumstances troubling, but he touted Respondent's training in all three areas as worthy of deference in each patient's case. On this point, De Brito appeared less neutral in his assessment of Respondent's actions.

226. While Lymberis took a very critical, seemingly one-sided stance in her assessment of Respondent, she based her opinions on a persuasive knowledge of the standards of care that she was able to articulate with certainty and detail. She was able to support her criticisms with objective reasoning.

227. Lavid was even-handed in his assessments, finding in many instances relating to A.G., for example, no departure from the standard of care, where Abrams did find such departures. Where Lavid and Abrams found departures from the standard of care, they were able to base their opinions on objective data and clearly articulated standards in the medical community, like Lymberis.

228. Overall, Lymberis, Lavid, and Abrams, were more persuasive than de Brito.

## LEGAL CONCLUSIONS

The Standard of Proof

1. Complainant must prove her case by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) Clear and convincing evidence means the evidence is "so clear as to leave no substantial doubt" and is "sufficiently strong to command the unhesitating assent of every reasonable mind." (*Mathieu v. Norrell Corporation* (2004) 115 Cal.App.4th 1174, 1190 [citing *Mock v. Michigan Millers Mutual Ins. Co.* (1992) 4 Cal.App.4th 306, 332-333].)

Substantial Relationship

2. Respondent's actions with regard to the seven patients at issue were substantially related to a licensed physician's qualifications, functions, and duties. (Cal. Code Regs., tit. 16, § 1360.)

Discipline Authorization

3. The Legislature authorizes the Board to take disciplinary action against Respondent that is deemed appropriate to the circumstances, including the revocation or suspension of his medical license, being placed on probation, or publicly reprimanded. (Bus. & Prof Code, § 2227.)

4. Business and Professions Code section 2234 provides that the Board must take action against any licensee who is charged with unprofessional conduct. The same provision defines unprofessional conduct as,

> (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.

Expert Testimony

5. "The standard of care against which the acts of a physician are to be measured is a matter peculiarly within the knowledge of experts . . . and can only be proved by their testimony [citations], unless the conduct required by the particular circumstances is within the common knowledge of the layman." (*Landeros v. Flood* (1976) 17 Cal.3d 399, 410.)

6. The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke, Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a

witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected available material." (*Id.* at 67-68 [citing *Nevarov v. Caldwell* (1958) 161 Cal.App.2d 762, 767].) Further, the fact finder may reject the testimony of any witness, even an expert, although uncontradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.)

7. The fact that a trier of fact "may disbelieve the testimony of a witness who testifies to the negative of an issue does not of itself furnish any evidence in support of the affirmative of that issue and does not warrant a finding in the affirmative thereof unless there is other [supportive evidence]." (*Hutchinson v. Contractors' State License Board* (1956) 143 Cal.App. 2d 628, 632 [citing *Marovich v. Central California Traction Co.* (1923) 191 Cal. 295, 304].)

Gross Negligence

8. Gross negligence is defined as "the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Eastburn v. Regional Fire Protection Authority* (2003) 31 Cal.4th 1175, 1185-1186.)

9. Despite his assertion in his interview with the Board, that he tries to stay out of internal medicine, and that he sees himself primarily as a psychiatrist, Respondent acted as more than a psychiatrist. Respondent directly treated all seven patients for chronic pain with the knowledge that they had drug addictions or dependencies and knowing that his prescriptions for controlled substances were highly addictive. He failed to obtain laboratory tests, perform physical examinations, and gather pertinent histories. He failed to objectively gauge each patient's pain. Each patient's chronic pain was, at the least, suspect. He failed to obtain consultations, second opinions, and communicate with each patient's previous or concurrent health providers. He failed to obtain their previous records. Respondent's previous training in internal medicine does not remove his need to gather salient data when prescribing the kinds of narcotic medications at issue here. The opinions of Lymberis, Lavid, and Abrams established that even a seasoned internist would require greater information than what Respondent had on each patient's case to safely treat him or her, given the serious addiction and dependence issues that abounded with each of them. Within the absence of all of this information, and with knowledge of each patient's drug and alcohol addictions and dependencies, and with Respondent's suspicion, concern, or straightforward knowledge that each patient either overused the prescribed medications or used illegal drugs, Respondent's prescriptions and increased dosages and potencies of these addictive controlled substances constituted extreme departures from the standard of care as to each of the seven patients. Respondent's explanations were unpersuasive.

10. Several (although the record contains more) of Respondent's actions or omissions that constitute extreme departures from the standard of care are set forth *post*.

11. Respondent failed to act on the Costco Pharmacy's letter, by speaking with J.C. and documenting that event, and instead, he continued to prescribe highly addictive controlled substances. He also failed to address (other than by prescribing more addictive medications) and document the effects of J.C.'s daughter's and son's deaths.

12. Respondent's modified S.C.'s clinic-issued methadone without any contact with the methadone clinic.

13. Respondent documented D.P.'s purchase and use of heroin on more than one occasion, and his suicidal nature, yet after each of these events, and including after opiate detoxification, Respondent continued to prescribe opioids with no substantive explanation. Respondent took no action to modify his prescriptions or speak with D.P. after receiving information from the patient's insurance company that he was using multiple pharmacies and physicians.

14. Respondent continued and added prescriptions for addictive controlled substances while noting J.P.'s suicidal nature in June and July 2008. He took no other therapeutic action.

15. Without taking any other significant, therapeutic action, Respondent prescribed addictive controlled substances to D.A. while acknowledging his own concern that the patient was misusing them. He did not formally evaluate D.A. for ADHD, but diagnosed him as such. After last seeing D.A. in January 2010, Respondent continued prescribing 150 tablets of methadone monthly from February to August 2010 and without evaluating the patient.

16. Respondent failed to contact A.G.'s previous physician to elicit the reasons and history that led to his treatment termination. Respondent terminated treatment with A.G., but continued to prescribe Suboxone and, on one date, alprazolam, continuously for two months thereafter. He took the patient's word for wanting alprazolam and did not consider SSRIs.

17. Respondent prescribed Roxicodone to J.S. on the first appointment. He prescribed Oxycontin regularly thereafter, after being told by the patient that she used heroin. He diagnosed ADHD without any formal testing and prescribed Adderall, another addictive medication, and increased it thereafter, while acknowledging her need for detoxification. Respondent also prescribed a bridge prescription of Roxicodone to J.S., upon terminating her.

18. Overall, observing pain by seeing how a patient moves in the office is insufficient.

19. His "bridge" prescriptions were, as Lavid opined, unsafe. He was not monitoring each patient to ensure they were taking their medications in accordance with the dosing instructions or that their pain conditions, if genuine, were being met by the

medication, or whether they were experiencing negative effects based on drug interactions. Respondent's continuing prescriptions after terminating treatment with D.P., D.A., A.G., and J.S., were unsafe and confusing for the patients. These were all instances of gross negligence.

20. Cause exists to discipline Respondent's medical license for gross negligence in his care and treatment of patients J.C., S.C., D.P., J.P., D.A., A.G., and J.S., pursuant to Business and Professions Code section 2234, subdivision (b), as set forth in Factual Findings 1-228, and Legal Conclusions 1-19.

Repeated Negligent Acts

21. "[A] physician is required to possess and exercise, in both diagnosis and treatment, that reasonable degree of knowledge and skill which is ordinarily possessed and exercised by other members of his profession in similar circumstances." (*Landeros v. Flood* (1976) 17 Cal.3d 399, 408; see also, *Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997-998.)

22. "'Negligence is conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm.' [Citation.] Thus, as a general proposition one 'is required to exercise the care that a person of ordinary prudence would exercise under the circumstances.' [Citations.] Because application of this principle is inherently situational, the amount of care deemed reasonable in any particular case will vary, while at the same time the standard of conduct itself remains constant, i.e., due care commensurate with the risk posed by the conduct taking into consideration all relevant circumstances. [Citations.]" (*Flowers v. Torrance Memorial Hospital Medical Center, supra*, 8 Cal.4th at 997.) "Since the standard of care remains constant in terms of 'ordinary prudence,' it is clear that denominating a cause of action as one for 'professional negligence' does not transmute its underlying character. For substantive purposes, it merely serves to establish the basis by which 'ordinary prudence' will be calculated and [Respondent's] conduct evaluated." (*Id.*, at 998.)

23. Respondent's acts of gross negligence also constitute repeated negligent acts.

24. Cause exists to discipline Respondent's medical license for repeated negligent acts in his care and treatment of patients J.C., S.C., D.P., J.P., D.A., A.G., and J.S., pursuant to Business and Professions Code section 2234, subdivision (c), as set forth in Factual Findings 1-228, and Legal Conclusions 1-23.

Adequate and Accurate Records

25. Business and Professions Code section 2266 provides that, "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

26. None of the records for any one of the patients at issue here had adequate or accurate records. He failed to document his psychotherapy in every instance, particularly where he was starting or increasing opioids and where he suspected or had evidence of overuse of medications or illegal drugs. Notably, he failed to document the deaths of J.C.'s daughter and son; he did not document the effect or the absence of any effect on her. He did not document J.C.'s gap in treatment time between 2005 and 2007. He did not document the Costco Pharmacy communication. He described J.C. as functioning well at her job, based on her tidying up his waiting area. He had inconsistent notations regarding J.C.'s behavior with alcohol. As to D.P., Respondent would describe him as doing well, but further document depression, anxiety, and other problems. Respondent documented that D.P. required consultation with a pain specialist, but failed to document any such consultation. He failed to document any action with regard to D.P. appearing suicidal, other than prescribing Oxycontin. In similar fashion, Respondent failed to document his actions with regard to J.P., other than prescribing medications, after noting J.P.'s suicidal acts in June and July 2008.

27. Respondent argued that many of his inconsistent notations were due to his record keeping software's default notations that he would apparently forget to modify. Nevertheless, Respondent retains responsibility for those inconsistencies. Furthermore, his inadequate records went beyond those inconsistencies. As persuasively opined by Lymberis, Respondent took on a significant burden to document and explain his care and treatment of these patients with pain and substance abuse problems. The standard of care required him to document pertinent histories, the objective bases for his diagnoses, the reasons why the indicated medications were appropriate, his monitoring and the results of his monitoring, and contact with other healthcare providers. The standard of care required him to document the reasons for any modifications to his care and treatment, including changes in medications. Respondent's record keeping failed to meet these standards. He provided no persuasive defense.

28. Cause exists to discipline Respondent's medical license for failing to maintain adequate and accurate records as to his care and treatment of patients J.C., S.C., D.P., J.P., D.A., A.G., and J.S., pursuant to Business and Professions Code section 2266, as set forth in Factual Findings 1-20, 27-228, and Legal Conclusions 1-3, 5-7,and 25-27.

Determining the Appropriate License Discipline

29. Since cause exists to discipline Respondent's medical license, assessment of the proper discipline is required.

30. The purpose of a license disciplinary administrative proceeding is not to punish the licensee but to protect the public. (See *In re Kelley* (1990) 52 Cal.3d 487, 495; *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The goal is to, among other things, prevent future harm. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 772.) "To prohibit license discipline until the physician-licensee harms a patient disregards these purposes; it is far more desirable to discipline *before* a licensee harms any patient than after harm has occurred. (*Ibid.*, original italics.)

31. The Legislature directs ALJs hearing matters arising from this Board to exercise their disciplinary authority "wherever possible," to "take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence." (Bus. & Prof. Code, § 2229, subd. (b).) The Legislature further provides, however that "[w]here rehabilitation and protection [of the public] are inconsistent, protection shall be paramount." (Bus. & Prof. Code, § 2229, subd. (c).)

32. It is not concluded herein that Respondent could not have treated any of the seven patients with controlled substances for genuine pain. But, Respondent took few if any steps to do so within the standards of care. Respondent's defenses were unavailing. He was purportedly treating their psychiatric problems as their psychiatrist, but treating their chronic pain using his background in internal medicine. He prescribed controlled substances to avoid withdrawal and illegal drug use, but in doing so, he furthered and exacerbated their addictions and dependencies precisely because he failed to meet the standards of care in treating such patients and issuing such prescriptions. When criticized for his acts and omissions in prescribing, he asserted that he was acting solely as the patients' psychiatrist and deferred those required responsibilities to each patient's primary care physician. When criticized for his less-than-thorough psychiatric care, he asserted that his treatment required him to address their chronic pain and addiction problems and pointed to his internal medicine training. His attempts to avoid professional responsibility were inapposite when juxtaposed with his accepted obligation to treat each patient and his treatment decisions. His background failed to shield his deficiencies. At hearing, Respondent appeared to be thoughtful about each patient's treatment plan, but his actions, as set forth in the Factual Findings, belie that appearance. He not only failed to meet the standards of care, but saliently, he held steadfast at hearing to the assertion that his actions were appropriate and within community standards. He does not believe he treated the seven patients improperly, even today. His overall response to the allegations, together with his failure to grasp his deficiencies, leads to the conclusion that, if today, he were presented with new patients with chronic pain and substance abuse problems, Respondent would treat them similarly to the seven patients at issue in this matter (his assertion that he no longer treats addiction notwithstanding).

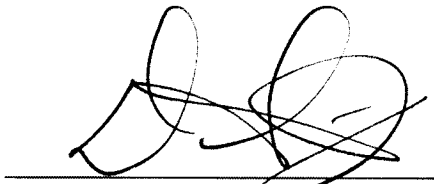
33. Respondent completed the PACE record keeping course in October 2011, but even after that course, he believes his record keeping was within community standards. It was not. Ordering a similar, additional course as a condition of probation, therefore, would not appear productive in re-educating Respondent as to record keeping.

34. There is therefore little indication that a probationary period would be fruitful in modifying Respondent's seemingly immovable mindset with regard to the proper care and treatment of patients in his practice. Revocation is, thus, the appropriate discipline.

ORDER

Certificate Number 69799, issued to Respondent David Mark Gudeman, is revoked pursuant to Legal Conclusions 20, 24, and 28.

October 8, 2013



DANIEL JUAREZ
Administrative Law Judge
Office of Administrative Hearings