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

In the Matter of the Accusation Against:	No. 06-1996-65821
WILLIAM O. LEADER, M.D..	
Physician's and Surgeon's Certificate No.A41125,	
Respondent.	

DECISION AND ORDER

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

This Decision shall become effective on June 27, 2001 at 5:00 p.m.

Order Dated June 20, 2001.

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

IRA LUBELL, M.D.
President

BILL LOCKYER, Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **WILLIAM O. LEADER**, M.D. 822 N. McCadden Place Los Angeles, CA 90038 Physician and Surgeon's Certificate No. A-41125 Respondent.	NO. 06-1996-65821 OAH No.L-1999090218 **STIPULATED SURRENDER OF CERTIFICATE**

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

1. There is currently on file before the Medical Board of California (hereinafter "Board") a Fourth Amended Accusation in Case Numbers 06-1996-65821, 06-1997-79431, 06-1998-82571, 06-1999-100710, and 06-2000-116641, filed on April 27, 2001, directed against Certificate Number A-41125, held by William O. Leader, M.D. (hereinafter "respondent"). Respondent timely filed

a Notice of Defense applicable to all pending and prospective charges. Hearing on the charges commenced on January 8, 2001 and recessed on January 18, 2001 at the conclusion of complainant's case-in-chief. On or about February 28, 2001, the Third Amended Accusation was amended to conform the charges to the proof adduced at the hearing. The hearing is calendered to reopen on May 30, 2001. A copy of the Fourth Amended Accusation and Amendment of Accusation to Conform to Proof is attached as joint Exhibit A which is incorporated by reference herein.

2. The Complainant, Ron Joseph, brought this action solely in his official capacity as the Executive Director of the Medical Board of California ("Board") and is represented in this matter by Bill Lockyer, Attorney General of the State of California, through Richard Avila, Deputy Attorney General, and Paul C. Ament, Deputy Attorney General.

3. At all times relevant herein, respondent has been licensed by the Board under Physician and Surgeon's Certificate Number A-41125.

4. Respondent is represented in this matter by Attorneys Leslie H. Abramson, Esq., and Gerald Chaleff, Esq., acting as co-counsel.

5. Respondent and his counsel have fully read and discussed the charges contained in the Fourth Amended Accusation, Numbers 06-1996-65821 et. al., as amended to conform to proof; and respondent understands that, if proven at hearing, the charges would constitute cause for taking disciplinary action against his Physician and Surgeon's Certificate. Respondent has

been fully advised of his legal rights and the effects of this Stipulated Surrender of Certificate.

6. Respondent and his counsel are aware of each of respondent's rights, including his right to a hearing on the charges, his right to be represented by retained counsel in all proceedings connected with the charges, his right to confront and cross-examine witnesses who would testify against him, his right to testify and to present evidence on his own behalf, as well as to the issuance of subpoenas to compel the attendance of witnesses and the production of documents in both defense and mitigation of the charges, his right to seek reconsideration by the Division and review by the courts, and all other rights which are accorded him under the California Administrative Procedure Act and other applicable laws.

7. For the purpose of resolving the Fourth Amended Accusation, Numbers 06-1996-65821 et. al., as amended to conform to proof, without further proceedings, respondent freely, knowingly, intelligently, voluntarily and irrevocably waives and gives up each of the rights set forth at above numbered paragraph 6 herein, withdraws his notice of defense, and further agrees that, at a hearing, complainant can establish a factual basis for Causes 1, 4 to 7, 10 to 13, 17 to 19, 22 to 25, 28 to 29, 32 to 33, 36 to 38 and 41 of the Fourth Amended Accusation, as amended to conform to proof. Respondent hereby gives up his right to contest the assertion that cause for discipline exists based on said charges and agrees to surrender his Physician and Surgeon's Certificate for the Division's formal acceptance and to pay the

sum of $30,000 to the Division in cost recovery.

8. Upon acceptance of the Stipulated Surrender of Certificate by the Division, respondent understands that he will no longer be permitted to practice as a physician and surgeon in California, and agrees to surrender and cause to be delivered to the Division both his license and wallet certificate before the effective date of the decision.

9. Respondent fully understands and agrees that if he ever files an application for relicensure or reinstatement as a physician and surgeon in the State of California, the Division shall (a) treat it as a petition for reinstatement, requiring respondent to comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and (b) deem Causes 1, 4 to 7, 10 to 13, 16 to 19, 22 to 25, 28 to 29, 32 to 33, 36 to 38, and 41 presented in the Fourth Amended Accusation, as amended to conform to proof, to be true, correct and admitted by respondent for the purpose of determining whether to grant or deny the petition.

10. All admissions, recitals and stipulations contained herein are made solely for the purpose of resolving Case Numbers 09-1996-65821 et. al., and may not be used in any other proceeding, except a license denial or disciplinary proceeding maintained by a state medical board or similar federal or other governmental health care agency. This stipulation shall not be admissible in any criminal or civil proceeding unrelated to the enforcement of the stipulation and decision in this case,

nor shall it have any collateral estoppel or res judicata effect in any criminal or civil proceeding unrelated to the enforcement of the stipulation and decision in this case.

11. The parties stipulate and agree that the acceptance and endorsement section of the stipulation may be dated and signed by respondent and one of respondent's counsel and transmitted to complainant by facsimile mail, and that said signatures by respondent and respondent's counsel shall make the stipulation binding on both parties subject to the contingency expressed below.

12. Respondent agrees that upon his execution of this document, his hearing dates before the Office of Administrative Hearings will be vacated.

CONTINGENCY

This Stipulated Surrender of Certificate shall be subject to the approval of the Division of Medical Quality. Respondent understands and agrees that Board staff and counsel for complainant may communicate directly with the Division regarding this Stipulated Surrender without notice to or participation by respondent or his counsel. If the Division fails to adopt this Stipulated Surrender as its decision and order, the Stipulated Surrender shall be of no force or effect, it shall be inadmissible in any legal action between the parties, it shall not disqualify the Division from further action in this matter by virtue of its consideration of this Stipulated Surrender, and this matter shall be returned to the calender of the Office of Administrative Hearings for a resumption of the

hearing thereon on an expedited basis.

ACCEPTANCE

I have read the above Stipulated Surrender of my Physician and Surgeon's Certificate. I have fully discussed the terms, conditions and other matters contained therein with my attorney, Leslie H. Abramson. I understand the effect this Stipulated Surrender will have on my Physician and Surgeon's Certificate and agree to be bound thereby. I enter this Stipulated Surrender freely, knowingly, intelligently and voluntarily.

DATED: 5/8/01.

William Leader.

WILLIAM O. LEADER, M.D.
Respondent

I have read and fully discussed the terms and conditions and other matters contained in the above Stipulated Surrender with respondent, William O. Leader, M.D., and approve of its form and content.

DATED: 5-8-01

Leslie H. Abramson

LESLIE H. ABRAMSON
Attorney for Respondent

ENDORSEMENT

The attached Stipulated Surrender of Certificate is respectfully submitted for the consideration of the Division of Medical Quality, Medical Board of California.

DATED: 5-8-01

BILL LOCKYER,
Attorney General
PAUL C. AMENT,
Deputy Attorney General

Richard Avila

RICHARD AVILA
Deputy Attorney General
Attorneys for Complainant

EXHIBIT A

Fourth Amended Accusation No. 06-1996-65821
& Amendment of Accusation to Conform to Proof

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of the State of California
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **WILLIAM O. LEADER, M.D.** 822 N. McCadden Place Los Angeles, California 90038 Physician and Surgeon's Certificate No. A-41125, Respondent.	Case Nos. 06-1996-65821, 06-1997-79431, 06-1998-82571 06-1999-100710 OAH No.L-1999090218 **FOURTH AMENDED ACCUSATION**

The Complainant alleges:

PARTIES

1. Ron Joseph ("Complainant") brings this Fourth Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California (hereinafter the "Board"). The initial Accusation was filed on July 22, 1999, and was amended by First Amended Accusation on March 30, 2000, Second Amended Accusation on July 11,2000, Third Amended Accusation on August 18, 2000, corrected for errata on November 17, 2000, and Amendment of Accusation to Conform to Proof on February 28, 2001.

2. On or about August 20, 1984, Physician and Surgeon's Certificate No. A-41125 was issued by the Board to William Leader, M.D. (hereinafter "respondent"). At all times relevant to the charges brought herein, this license has been in full force and effect. Unless renewed, it will expire on March 31, 2000.

JURISDICTION

3. This Third Amended Accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), under the authority of the following sections of the Business and Professions Code (hereinafter "Code"), Health and Safety Code, and Welfare and Institutions Code:

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

B. Section 2234 of the Code provides that unprofessional conduct includes, but is not limited to, the following:

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

(b) Gross negligence.

(c) Repeated negligent acts.

(d) Incompetence.

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

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

C. Section 725 of the Code provides that repeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon.

D. Section 2242, subdivision (a), of the Code provides that prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without a good faith prior examination and medical indication therefor, constitutes unprofessional conduct.

E. Section 2241 of the Code provides that unless otherwise provided by this section, the prescribing, selling, furnishing, giving away, or administering or offering to prescribe, sell, furnish, give away, or administer any of the drugs or compounds mentioned in Section 2239 to an addict or habitue constitutes unprofessional conduct.

F. Section 2238 of the Code provides that a violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating

dangerous drugs or controlled substances constitutes unprofessional conduct.

G. Section 11153, subdivision (a) of the Health and Safety Code provides in pertinent part that a prescription for a controlled substance shall only be issued for a legitimate medical purpose. An order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use, is not a legitimate medical purpose under this statute.

H. Section 11156 of the Health and Safety Code provides that no person shall prescribe for or administer, or dispense a controlled substance to an addict or habitual user, or to any person representing himself as such, except as permitted by this division.

I. Section 2261 of the Code provides as follows:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

J. Section 2262 of the Code provides, in pertinent part, as follows:

"Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record,

with fraudulent intent, constitutes unprofessional conduct."

K. Section 2266 of the Code provides as follows:

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

DRUGS

L. Section 4022 of the Code provides in pertinent part that a "dangerous drug" is any drug which is unsafe for self-medication and includes any drug or device which by federal or state law can be lawfully dispensed only on prescription. At all times relevant herein, the following were classified as dangerous drugs, and as controlled substances as defined herein below:

1) Catapres, a trade name for clonidine, a prescribed medication used to treat narcotic withdrawal syndrome, congestive heart failure, menopausal "hot flashes", dysmenorrhea, vascular headache, high blood pressure.

2) Chloral Hydrate, a Schedule IV controlled substance, as defined in Health and Safety Code section 11057, used to treat anxiety and insomnia.

3) Darvon, a trade name for dextropropoxyphene or propoxyphene hydrochloride, a Schedule IV controlled narcotic substance, as defined in Health and Safety Code section 11057, used to relieve pain and suppress cough.

4) Desyrel, a trade name for trazodone

hydrochloride, a prescription medication used to treat mental depression and anxiety.

5) Klonopin, a trade name for clonazepam, a Schedule IV controlled substance, as defined in Health and Safety Code section 11057, used to control seizures.

6) Phenergan with codeine, a trade name for promethazine hydrochloride and codeine phosphate, a Schedule V controlled substance, as defined in Health and Safety Code section 11058, used to suppress cough.

7) Tegretol, a trade name for carbamazepine, a prescription medication used to control seizures.

8) Vicodin, a trade name for acetaminophen with hydrocodone bitartrate or dihydrocodeinone, a Schedule III controlled narcotic substance, as defined in Health and Safety Code section 10056(e)(3), used to relieve pain and suppress cough.

9) Vistaril, a trade name for hydroxyzine pamoate, a prescription medication used to treat anxiety, tension and agitation.

10) Xanax, a trade name for alprazolam, a Schedule IV controlled substance, as defined in Health and Safety Code section 11057, used to treat nervousness and tension.

11) Atarax, a trade name for hydroxyzine hydrocloride, a prescription medication used to treat anxiety and tension.

12) Valium, a trade name for Diazepam, a Schedule IV

controlled substance as defined in Health and Safety Code section 11057(d)(7), used in the management of anxiety disorders or for the short-term relief of the symptoms of anxiety.

13) Tylenol #3, a trade name for Acetaminophen with Codeine, a Schedule III controlled substance as defined in Health and Safety Code section 11056(e)(3), used in the treatment of moderate to severe pain.

14) Phenobarbital, a central nervous system depressant and Schedule IV controlled substance as defined in Health and Safety Code section 11057(d)(19), used as a sedative/hypnotic.

15) Lortab, a trade name for Hydrocodone, a Schedule III controlled substance as defined in Health and Safety Code section 11056(e)(3) or opioid, used for the relief of moderate to moderately severe pain.

16) Lorcet, a trade name for Hydrocodone, a Schedule III controlled substance as defined in Health and Safety Code section 11056(e)(3) or opioid, used for the relief of moderate to moderately severe pain.

17) Soma, a trade name for Carisoprodel, a dangerous drug as defined in section 4022 of the Code, used to ease the pain associated with acute musculoskeletal conditions.

18) Norco, a trade name for Hydrocodone Bitatrate and Acetaminophen, a Schedule III controlled substance as defined in Health and Safety Code section 11056(e)(3) or opioid, used in the relief of moderate to moderately severe

pain.

19) Ambien, a Schedule IV controlled substance as defined in Health and Safety Code section 11057(d)(10) and a dangerous drug as defined in section 4022 of the Code, used for short-term treatment of insomnia.

20) Ativan, a Schedule IV controlled substance as defined in Health and Safety Code section 11057(d)(19) and a dangerous drug as defined in section 4022 of the Code, also known as Lorazepam, used in the treatment of anxiety disorders and for the short term relief of symptoms of anxiety and depression.

21) Claritin, a dangerous drug as defined in section 4022 of the Business and Professions Code, used for the relief of nasal and non-nasal symptoms due to infections or irritations.

22) Depakote, a dangerous drug as defined in section 4022 of the Business and Professions Code, used in the treatment of manic disorders associated with bipolar disorder.

23) Elavil, a dangerous drug as defined in section 4022 of the Business and Professions Code, also known as Amitriptyline, used to treat symptoms of depression.

24) Paxil, a dangerous drug as defined in section 4022 of the Business and Professions Code, also known as Parozxetine Hydrochloride, used for the treatment of depression.

25) Prilosec, a dangerous drug as defined in section 4022 of the Business and Professions Code, used for the short

term treatment of an active duodenal ulcer.

26) Halcion, a dangerous drug as defined in section 4022 of the Business and Professions Code and section 1308.14(c)(47) of the Federal Code of Regulations, also known as Triazolam, used to treat insomnia.

27) Haldol, a dangerous drug as defined in section 4022 of the Business and Professions Code, used to manage manifestations of psychotic disorders.

28) Tylenol #4, a Schedule III controlled substance as defined in Health and Safety Code section 11056(e)(3) and a dangerous drug as defined in section 4022 of the Business and Professions Code, also known as Fioricet with Codeine, used to relieve mild to moderate pain.

29) Zoloft, a dangerous drug as defined in section 4022 of the Business and Professions Code, used to treat depression.

30) Zyprexa, a dangerous drug as defined in section 4022 of the Business and Professions Code, used to treat manifestations of psychotic disorders.

31) Wellbutrin, a dangerous drug as defined in section 4022 of the Business and Professions Code, used to treat depression.

32) Amitriptyline, a dangerous drug as defined in section 4022 of the Business and Professions Code, used as an antidepressant with sedative effects.

COST RECOVERY

M. Section 125.3 of the Code provides, in part,

that the Division may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Division a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

MEDI-CAL PARTICIPATION

N. Section 14124.12 of the Welfare and Institutions Code of the State of California provides, in pertinent part, that:

(a) Upon receipt of written notice from the Medical Board of California, . . .that a licensee's license has been placed on probation as a result of a disciplinary action, the department may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation . . . that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim . . . as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation.

(b) The Medical Board of California . . . shall work in

conjunction with the State Department of Health Services to provide all information that is necessary to implement this section. . . .

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

4. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that he has committed acts of gross negligence while treating a patient under his care. The circumstances are as follows:

A. On or about March 10, 1995, patient E.W. [initials used to protect right of privacy] first presented to respondent, a psychiatrist, complaining of severe back and wrist pain, nervousness, depression, insomnia, two-plus obesity, diarrhea, and a history of high blood pressure. Respondent's documented history on that date notes that E.W. denied using alcohol or illegal drugs, but admitted current use of Catapres, Vicodin and Xanax. Respondent's documented physical examination of that date notes a blood pressure of 110/80, and the overall findings as being unremarkable. Respondent's documented assessment notes a plan to evaluate E.W. for panic disorder, major depression, obesity, hypertension, carpal tunnel syndrome, and degenerative disc disease. Respondent's documented treatment for E.W. that day notes prescriptions for Vicodin-ES [i.e., Extra Strength], Lomitil and Xanax.

(1) On or about March 24, 1995, or 16 days

following E.W.'s first examination by respondent, E.W. returned for a follow-up examination. Respondent's documented history for that day notes that E.W. had been seen by different medical doctors and that she promised to deliver her prior x-rays to respondent. Absent from E.W.'s chart for that day is a signed authorization for the release of her medical records addressed to her other physicians. Respondent's documented treatment of E.W. that day notes prescriptions for Vicodin-ES and Xanax at double the previous dosage strength.

B. On or about May 30, 1995, E.W. presented to respondent with a complaint of severe panic attacks with cough. Respondent's documented treatment for E.W. that day notes prescriptions for Phenergan syrup with codeine, Vicodin-ES and Xanax.

C. On or about June 9, 1995, or 10 days following her last visit to respondent's medical office, E.W. presented with complaints of continuous, severe back pain, coughing and insomnia. Respondent's documented treatment of E.W. that day notes prescriptions for Phenergan syrup with codeine and Vicodin-ES.

E. On or about June 28, 1995, or 19 days following E.W.'s last visit to respondent's medical office, she presented appearing quite depressed and complaining of severe, intermittent back pain. Respondent's documented history notes a disclosure of prior seizures, and E.W.'s request for Klonopin and Darvon, in lieu of Vicodin. Also noted therein is E.W.'s disclosure that Halcion had not relieved her

insomnia. Respondent's documented treatment of E.W. that day notes prescriptions for Chloral Hydrate, Darvon N-100 and Klonopin. Respondent's documented plan of that day notes that lumbar spine photos had been ordered.

F. On or about July 19, 1995, E.W. presented to respondent with a complaint of depression. Respondent's documented treatment of E.W. that day notes prescriptions for Chloral Hydrate, Desyrel and Vicodin-ES.

G. On or about August 11, 1995, E.W. presented to respondent and informed him that she was scheduled for surgery to correct carpal tunnel syndrome the following Tuesday. Respondent's documented history notes that E.W. complained about the Klonopin and requested Tegretol. Respondent's documented treatment of E.W. that day notes prescriptions for Atarax, Desyrel, Tegretol, Vicodin-ES and Xanax.

H. On or about September 27, 1995, E.W. presented to respondent and informed him that her surgery for carpal tunnel syndrome had been postponed. Respondent's documented history notes that E.W. was more depressed, as manifested by loss of energy, lethargy, insomnia and feelings of helplessness and hopelessness. Respondent's history also notes a plus-two anxiety level. Respondent's documented treatment of E.W. for that day notes prescriptions for Chloral Hydrate, Desyrel and Xanax.

I. On or about November 15, 1995, E.W. informed respondent that she had been using heroin and was at that time undergoing the 16th day of a 20-day Methadone based

detoxification program. Respondent's documented history notes that E.W. requested Darvon for pain. Respondent's documented treatment of E.W. for that day notes prescriptions for Catapres, Chloral Hydrate, Darvon N-100 and Vicodin-ES.

J. On or about January 23, 1996, E.W. presented to respondent and informed him that her use of heroin had spanned many years. Respondent's documented history also notes that E.W. expressed an unwillingness to use an antidepressant medication. Respondent's documented treatment of E.W. for that day notes prescriptions for Catapres, Darvon N-100 and Desyrel.

K. On or about March 19, 1996, E.W. presented to respondent with complaints of lower back and wrist pain. Respondent's documented history notes that E.W. appeared resistant and refused antidepressant medication, but promised to deliver her x-rays.

L. On or about March 23, 1996, respondent's documented treatment of E.W. for that day notes prescriptions for Atarax, Catapres, Chloral Hydrate, Darvon N-100 and Vicodin-ES.

M. On or about April 5, 1996, or 12 days following respondent's last prescriptions for E.W., the latter presented to respondent and disclosed more information about her drug abuse problem. Respondent's documented history notes that E.W. appeared depressed, and that she again refused antidepressant medication. Respondent's documented treatment of E.W. for that day notes prescriptions for Atarax, Catapres,

Chloral Hydrate and Vicodin-ES.

N. On or about April 18, 1996, or 13 days following respondent's last prescriptions for E.W., she presented to respondent with a complaint of severe pain, and a claim that her medication had been stolen. Respondent's documented history also notes that E.W. was no longer taking Methadone, and that she provided more information regarding her seizure history. Also noted therein is E.W.'s failure to deliver her x-rays. Respondent's documented treatment of E.W. for that day notes prescriptions for Chloral Hydrate, Klonopin, Vicodin-ES and Vistaril.

O. On or about May 14, 1996, respondent's last documented visit of E.W. to his medical office, respondent noted in E.W.'s chart that she did not appear too depressed. Respondent's documented treatment of E.W. that day notes prescriptions for Chloral Hydrate, Klonopin, Vicodin-ES and Vistaril.

P. On or about June 15, 1996, E.W. died. The cause of death was officially noted as heroin intoxication. The autopsy revealed traces of codeine and morphine in E.W.'s heart blood, substances found in Darvon, Vicodin and Phenergan with codeine, all of which are used to lessen the discomfort from the use of heroin. The autopsy of E.W. also revealed the presence of needle track marks on the back of both hands.

Q. Overall, respondent prescribed the following controlled substances to E.W:

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DATE	DRUG	QUANTITY
03/10/95	Vicodin-ES 7.5 mg	80
03/10/95	Xanax 1 mg	90
03/24/95	Xanax 2 mg	90
03/24/95	Vicodin-ES 7.5 mg	80
05/30/95	Vicodin-ES 7.5 mg	80
05/30/95	Xanax 2 mg	90
05/30/95	Phenergan/cod. 240 mls.	
06/09/95	Phenergan/cod. 240 mls.	
06/09/95	Vicodin-ES 7.5 mg	80
06/28/95	Darvon N-100	100
06/28/95	Chloral Hyd. 500 mg	30
06/28/95	Klonopin 2 mg	90
07/19/95	Vicodin-ES 7.5 mg	90
07/19/95	Chloral Hyd. 500 mg	30
07/19/95	Desyrel 50 mg	30
08/11/95	Desyrel 50 mg	30
08/11/95	Atarax 50 mg	60
08/11/95	Tegretol 200 mg	60
08/11/95	Vicodin-ES 7.5 mg	100
08/11/95	Xanax 2 mg	90
09/27/95	Xanax 2 mg	100
09/27/95	Desyrel 100 mg	100
09/27/95	Chloral Hyd. 500 mg	30
11/15/95	Chloral Hyd. 500 mg	60
11/15/95	Catapres .3 mg	100
11/15/95	Darvon N-100	30
11/15/95	Vicodin-ES 7.5 mg	100
01/23/96	Darvon N-100	100
01/23/96	Desyral 50 mg.	30
01/23/96	Catapres .3 mg	100
03/23/96	Catapres .3 mg	100
03/23/96	Atarax 50 mg	30
03/23/96	Chloral Hyd. 500 mg	60
03/23/96	Darvon N-100	20
03/23/96	Vicodin-ES 7.5 mg	80
04/05/96	Vicodin-ES 7.5 mg	100
04/05/96	Choral Hyd. 500 mg	60
04/05/96	Catapres .3 mg	100
04/05/96	Atarax 50 mg	30
04/18/96	Klonopin 2 mg	100
04/18/96	Chloral Hyd. 500 mg	60
04/18/96	Vistaril 50 mg	30
04/18/96	Vicodin-ES 7.5 mg	100
05/14/96	Vicodin-ES 7.5 mg	100
05/14/96	Chloral Hyd. 500 mg	60
05/14/96	Klonopin 2 mg	100
05/14/96	Vistaril 50 mg	30

R. Respondent has subjected his license to

discipline in that he failed to do the following in regard to his care of E.W.:

(1) Refrain from prescribing narcotic substances to E.W., known to respondent as a heroin addict, while she was undergoing a detoxification program with Methadone;

(2) Consult with the physician directing E.W.'s Methadone detoxification program before continuing treatment with narcotic substances, and/or fail to document same;

(3) Consult with E.W.'s other physicians who had or were then treating her low back pain, and/or fail to document same;

(4) Consult with E.W.'s other physicians who had or were then providing prescription medications to her, and/or fail to document same;

(5) Consult with E.W.'s physician who was scheduled to perform carpal tunnel surgery, and/or fail to document same;

(6) Obtain imaging studies (i.e., MRI, x-rays) to confirm or rule out the preliminary diagnosis of low back pain secondary to degenerative disc disease prior to continuing prescriptions for Vicodin and Darvon beyond the period when physical and psychological dependency could be expected to take hold, and/or fail to document same.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

5. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent has committed repeated acts of negligence while treating a patient under his care. The circumstances are as follows:

A. The facts alleged in above subparagraphs 4.A. to 4.Q. are incorporated by reference herein as if fully set forth.

B. The repeated negligent acts are as follows:

(1) Respondent failed to refrain from prescribing narcotic substances to E.W., known to him as a heroin addict, while she was undergoing a detoxification program with Methadone;

(2) Respondent failed to consult with the physician directing E.W.'s Methadone based detoxification program before continuing treatment with narcotic substances, and/or failed to document same;

(3) Respondent failed to consult with E.W.'s other physicians who had or were then providing prescription medications to her, and/or failed to document same;

(4) Respondent failed to consult with E.W.'s other physicians who had or were then treating her low back pain, and/or failed to document same;

(5) Respondent failed to consult with E.W.'s physician who was scheduled to perform carpal tunnel surgery on her, and/or failed to document same;

(6) Respondent failed to obtain imaging studies (i.e., MRI, x-rays) to confirm or rule out the preliminary diagnosis of low back pain secondary to degenerative disc disease prior to continuing prescriptions for Vicodin and Darvon beyond the period when physical and psychological dependence could be expected to take hold, and/or failed to document same.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

6. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent has committed acts of incompetence while treating a patient under his care. The circumstances are as follows:

A. The facts and expert opinions alleged in above subparagraphs 4.A. to 4.R. are incorporated by reference herein as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

7. Respondent is subject to disciplinary action under sections 725 and 2234 of the Code, in that respondent has committed acts of clearly excessive prescribing of Vicodin and Darvon while treating a patient under his care. The circumstances are as follows:

A. The facts alleged in above subparagraphs 4.A. to 4.R. are incorporated by reference herein as if fully set forth.

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FIFTH CAUSE FOR DISCIPLINE

(Prescribing Without Good Faith Examination)

8. Respondent is subject to disciplinary action under sections 2234 and 2242, subdivision (a) of the Code, in that respondent has committed acts of prescribing dangerous drugs without a good faith prior examination and medical indication therefor. The circumstances are as follows:

A. The facts alleged in above subparagraphs 4.A. to 4.R. are incorporated by reference herein as if fully set forth.

SIXTH CAUSE FOR DISCIPLINE

(Prescribing To An Addict)

9. Respondent is subject to disciplinary action under sections 2234, 2238, and 2241 of the Code, as well as Health and Safety Code sections 11153 and 11156, in that respondent prescribed controlled substances for other than a legitimate medical purpose, to wit, for an addict. The circumstances are as follows:

A. The facts alleged in above subparagraphs 4.A. to 4.R. are incorporated by reference herein as if fully set forth.

SEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence)

10. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that respondent committed acts of gross negligence while treating a patient under his care. The circumstances are as follows:

A. Patient S.M. was admitted to Edgemont Hospital on or about August 5 to 12, 1996, on or about October 18 to 28, 1996, on or about November 3 to 15, 1996, and on or about December 24 to 27, 1996. The first three of these hospitalizations resulted in involuntary holds for violent conduct associated with chemical dependency. The third hospitalization followed an emergency stay at Hollywood Presbyterian Hospital from an overdose of heroin. S.M.'s first two discharges from Edgemont were accompanied by diagnoses for Bipolar Disorder, Intermittent Explosive Disorder, Benzodiazepine Dependency, Antisocial Personality, Migraine Headaches, low back pain, and mild right hearing loss. S.M.'s third and fourth discharges from Edgemont were accompanied by diagnoses for Atypical Schizoaffective Disorder, Chronic Pain Syndrome, Cephalgia, Chronic Obstruction Pulmonary Disease, Chronic Upper Back Pain, Migraine Headache, and recent seizure. S.M.'s primary physician at Edgemont, Dr. Freinhar, prescribed Valium 10 mg. tid, Sinequan 300 mg. qhs, Moban [antipsychotic] 25 mg. bid, 175 mg qhs,, and Amantadine 100 mg. bid. S.M. was advised to see Dr. Chase for follow-up care. S.M.'s fourth discharge from Edgemont was against medical advice.

B. S.M. first saw respondent for medical care on or about January 28, 1997. Respondent noted the names of Dr. Freinhar and Dr. Chase in the patient chart. Respondent also noted complaints of terminal throat cancer, back pain, shoulder pain, neck pain, nightmares and migraines.

Respondent diagnosed Adjustment Disorder/Anxiety and Migraine Headaches. A prescription for the Benzodiazepine, Valium 10 mg. #100, was given to S.M. for severe anxiety.

C. S.M. next saw respondent for treatment on or about February 27, 1997. Respondent noted a continuation of anxiety, insomnia and nervousness. Respondent prescribed Ambien 10 mg. #30 for insomnia, and Valium 10 mg. #100 for severe anxiety. Respondent noted that S.M. was taking 4 Valium tablets per day.

D. S.M. returned to respondent for treatment on or about March 24, 1997. Respondent noted that Codeine didn't work for S.M., and that the later refused to take Percodan. Respondent prescribed Valium 10 mg. #100 for anxiety, and Vicodin #60 for severe pain.

E. S.M. received more treatment from respondent on or about April 1, 1997, after presenting with complaints of insomnia, nervousness and sadness about cancer. Respondent prescribed Phenobarbital 100 mg. #30.

F. S.M. was admitted for the fifth time to Edgemont Hospital on or about April 5, 1997. He was placed on a 72 hour hold for being a danger to himself. Complaints of decreased energy, appetite, sleep and socialization, as well as violent outbursts, were noted in connection with the ingestion of large quantities of Valium and Phenobarbital. Dr. Freinhar diagnosed Benzodiazepine and Barbiturate Abuse, Bipolar Affective Disorder and Depression. S.M.'s confession of Phenobarbital abuse over a two year period was noted in his

hospital chart. S.M. succeeded in avoiding a 14-day hold and discharged himself against medical advice on April 11, 1997.

G. On or about the same day, April 11, 1997, S.M. returned to respondent for treatment. Respondent noted S.M.'s hospitalization at Edgemont under the care of Dr. Freinhar, but attributed the hospital stay to a concussion sustained during an assault. Respondent prescribed Valium 10 mg. #45 for severe anxiety and Phenobarbital 100 mg. #30.

H. S.M. next presented to respondent for treatment on or about April 14, 1997. Respondent noted that S.M. had an addiction problem, but did not specify its cause or nature. Respondent prescribed Valium 10 mg. #60 and Phenobarbital 100 mg. #60.

I. For the period January 28 to April 14, 1997, there is no indication in respondent's records for S.M. that respondent requested or received S.M.'s records from Edgemont Hospital covering S.M.'s hospitalizations there of August 5 to 12, 1996, October 18 to 28, 1996, November 3 to 15, 1996, December 24 to 27, 1996, and April 5 to 11, 1997, or that respondent ever discussed S.M.'s care and treatment at Edgemont with Dr. Freinhar or Dr. Chase.

J. S.M. was admitted for the sixth time to Edgemont Hospital on or about April 24, 1997. He was placed on a 72-hour hold for being a danger to himself. The admitting note cited assaultive, threatening behavior, agitated depression and suicidal ideation. On or about April 26 and 28, 1997, S.M. assaulted another patient at the hospital with the result

that he was restrained and placed in seclusion. On or about April 30, 1997, a 14-day hold was approved. Upon S.M.'s discharge on or about May 12, 1997, follow-up care with Dr. Chase was recommended and the following diagnoses were made: Atypical Bipolar Disorder, Benzodiazepine and Barbiturate Dependence, and Sociopathic Personality Traits. Prescriptions were given to S.M. for Trilafon [antipsychotic] 32 mg. p.o. qhs 30 day supply, and Valium 10 mg. tid #15 (5-day supply).

K. On the same day of S.M.'s discharge from Edgemont, on or about May 12, 1997, S.M. was seen and treated by respondent. Respondent noted that S.M. had been involved in fights with patients and staff at the hospital, and that he had been under Dr. Freinhar's care for 3 years. Respondent also noted that Phenobarbital was aiding S.M.'s sleep. Respondent prescribed Valium 10 mg. #45 and Phenobarbital 100 mg. #60. Respondent made no notation in S.M.'s records that he had requested or received S.M.'s records from Edgemont Hospital covering the hospitalization of April 24 to May 12, 1997, or that he discussed S.M.'s care and treatment at Edgemont during this period with Dr. Freinhar or Dr. Chase.

L. S.M. was admitted for the seventh time to Edgemont Hospital on May 15, 1997. He was placed on a 72-hour hold for threatening his mother. S.M. reported that he was depressed from excessive use of medication. S.M.'s speech was slurred. A urine drug screen was positive for Barbiturates = 360 [normal being 1 to 199], Benzodiazepines = 441 [normal being 1 to 199], and THC = 181 [normal being 1 to 99]. S.M.

was discharged on May 16, 1997, after Dr. Freinhar lifted the 72-hour hold.

M. S.M. returned to see respondent on or about May 19, 1997. Respondent noted that S.M. was stable. Respondent prescribed the Barbiturate, Phenobarbital 100 mg. #60, and Valium 10 mg. #100. Respondent failed to note that he had requested or received S.M.'s records from Edgemont Hospital covering the hospitalization of May 15 to 16, 1997, or that he had discussed S.M.'s care and treatment at Edgemont during this two-day period with Dr. Freinhar or Dr. Chase.

N. S.M. next saw respondent for treatment on or about June 10, 1997. Respondent noted that S.M. was stable, pleasant and sleeping well. Respondent prescribed Phenobarbital 100 mg. #60 and Valium 10 mg. #100. Respondent failed to note that he had requested or received S.M.'s records from Edgemont Hospital covering his treatments there, or that he had discussed S.M.'s care and treatment at Edgement Hospital with Dr. Freinhar or Dr. Chase.

O. S.M. returned to see respondent for treatment on or about June 20, 1997. Respondent noted that S.M. had been arrested and jailed for 5 days for assault and trespassing, and was saddened by his cancer condition. Respondent prescribed Phenobarbital 100 mg. #60 and Valium 10 mg. #120. Respondent failed to note that he had requested or received S.M.'s records from Edgemont Hospital covering S.M.'s treatments there, or that he had discussed S.M.'s care and treatment at Edgemont Hospital with Dr. Freinhar or Dr. Chase.

P. For the period January 28 to June 20, 1997, there is no indication in respondent's records for S.M. that respondent ever verified the existence of a cancer diagnosis for S.M. through the request and/or receipt of S.M.'s medical records from the primary diagnostician of the cancer condition, or through respondent's own independent examination and laboratory analysis.

Q. S. M. returned to see respondent for treatment on or about July 1, 1997. Respondent noted that S.M.'s speech was slurred and that he was falling asleep in the waiting room. Respondent also noted a referral to Dr. Istvar. No prescriptions were noted.

R. S.M. returned to see respondent for treatment on or about July 11, 1997. Respondent noted that S.M.'s speech was slurred, that he was citoxic and complaining about oversleeping. No prescriptions were noted.

S. S.M. was admitted for the eighth time to Edgemont Hospital on or about July 15, 1997. He was placed on a 72-hour hold for being a danger to himself. On admission, S.M. presented with slurred speech and appeared sedated. S.M. was in possession of one bottle of Valium 10 mg. and one and one half bottles of Phenobarbital 100 mg. The nursing record noted that S.M. was confused, lethargic and unsteady. An internal medicine consultation disclosed aches and pains, bruising from a series of falls connected with the use of alcohol, Phenobarbital and Valium. A urine drug screen was positive for Barbiturates = 363 [1 to 199 being normal],

Benzodiazepines = 372 [1 to 199 being normal], and THC = 192 [1 to 99 being normal]. S.M. reported taking 160 mg. of Valium each day plus 200 mg. qhs of Phenobarbital. At discharge, Dr. Freinhar recommended outpatient and inpatient drug rehabilitation, and noted that S.M. insisted on returning to the "outpatient community psychiatrist who prescribed to him these high doses of benzodiazepines and barbiturates." S.M. was discharged with the following diagnoses: Atypical Bipolar Disorder, Benzodiazepine Abuse, Barbiturate Abuse and a history of Polysubstance Abuse.

T. S.M. was admitted for the ninth time to Edgemont Hospital on or about July 24, 1997, and was placed on 72-hold. On admission, S.M. presented with slurred speech and unsteady gait. A urine drug screen was positive for Barbiturates = 396 [1 to 199 being normal], Benzodiazepines = 428 [1 to 199 being normal], and THC = 179 [1 to 99 being normal]. A detoxification program was recommended by Dr. Solof. On discharge, S.M. was diagnosed with Atypical Bipolar Disorder. Prescriptions were given for Valium 10 mg. tid and Trilafon [antipsychotic]. After being referred to Alcoholics Anonymous, S.M. was discharged on August 11, 1997.

U. S.M. was admitted for the tenth time to Edgemont Hospital on or about August 13, 1997. S.M. was placed on a 72-hour hold for being a danger to himself, and this hold was extended to 14 days. A urine drug screen was positive for Amphetamines = 1007 [1 to 199 being normal], Barbiturates = 366 [1 to 199 being normal], Benzodiazepines = 435 [1 to 199

being normal], and THC = 159 [1 to 99 being normal]. S. M. was examined by Dr. Westmoreland, a psychiatrist, and then discharged with the following diagnoses: Schizoaffective Disorder-Bipolar Type, Benzodiazepine and Phenobarbital Dependence, Cannabis Dependence, poor compliance with treatment by history, and history of Polysubstance Abuse. Prescriptions were given for Valium 10 mg. qid (one month supply or 120 tablets), Trilafon 8 mg. qhs, Tegretol 200 mg. tid, 400 mg. qhs, and Benadryl 100 mg qhs. A chemical dependency program and follow-up with Dr. Kirshbaum were recommended.

V. S.M. returned to respondent for treatment on or about September 2, 1997. Respondent noted that S.M. looked like a "sad vegetable." Respondent prescribed Valium 10 mg. #120 and Phenobarbital 100 mg. #60.

W. S.M. next saw respondent for treatment on or about September 9, 1997. Respondent noted that S.M. exhibited slurred speech and complained of insomnia. Respondent diagnosed Adjustment Disorder with Mixed Anxiety and Depressed Mood, questionable General Anxiety Disorder, and Migraine Headaches. Respondent prescribed Dalmane 30 mg. #10.

X. S.M. returned to respondent for treatment on or about September 15, 1997. Respondent noted that S.M. had jumped off a second story roof and been admitted at Edgemont Hospital for mental illness. Respondent also noted that S.M. had been over-medicated with Phenobarbital. Respondent reiterated the previous diagnoses in the chart, and prescribed

Valium 10 mg. #60 and Phenobarbital 100 mg. #30.

Y. S.M. next saw respondent for treatment on or about September 30, 1997. Respondent noted that S.M. had seen Dr. Kirshbaum. Respondent diagnosed S.M.'s condition as Bipolar Disorder.

Z. For the period April 15 to September 30, 1997, there is no indication in respondent's records for S.M. that respondent requested or received S.M.'s records from Edgemont Hospital covering his hospitalizations there of April 24 to May 12, 1997, May 15 to 18, 1997, July 15 to 18, 1997, July 24 to August 11, 1997, and August 13 to 27, 1997, or that respondent ever discussed S.M.'s care and treatment at Edgemont Hospital with Dr. Freinhar, Dr. Chase, Dr. Westmoreland or Dr. Kirshbaum.

AA. S.M. was admitted for the eleventh time to Edgemont Hospital on or about October 7, 1997. He was placed on a 72-hour hold, which was extended to a 14-day hold in a locked unit after he threatened the staff. On admission, S.M. was reported to have been self-medicating himself with 20 mg. Valium doses, and experiencing seizures from a 3 week withdrawal from Phenobarbital. He was treated through a detoxification program under the supervision of Dr. Richard Miller. A urine drug screen was positive for Amphetamines = 364 [1 to 199 being normal], Benzodiazepines = 382 [1 to 199 being normal], and THC = 179 [1 to 99 being normal]. S.M. was discharged on or about October 14, 1997 with diagnoses of Schizoaffective Disorder-Depressed Type with Acute

Exacerbation, Valium Dependence, Phenobarbital Dependence-Early Remission, and Polysubstance Abuse.

BB. S.M. returned to respondent for treatment on or about October 16, 1997. Respondent noted S.M.'s recent lock-up and vegetable state. Respondent also noted "no more phenobarbital" and Valium qid. Respondent diagnosed Acute Bipolar I Disorder with Mixed Anxiety and Depressed Mood, and Migraine Headaches. Respondent prescribed Valium 10 mg. #120 for severe anxiety.

CC. On or about October 19, 1997, respondent noted that S.M.'s mother had reported a phone call wherein S.M. admitted taking 100 tablets of Phenobarbital and 60 tablets of Valium.

DD. On or about October 21, 1997, S.M.'s mother discovered her son's dead body. According to the Office of the County Coroner, S.M.'s death was caused by Phenobarbital and Benzodiazepine overdose, and was ruled a suicide.

EE. For the period October 1 to October 21, 1997, there is no indication in respondent's records for S.M. that respondent requested or received S.M.'s records from Edgemont Hospital covering his hospitalization of October 7, 1997, or that respondent ever discussed S.M.'s care and treatment at Edgemont Hospital with Dr. Freinhar, Dr. Chase, Dr. Westmoreland, Dr. Kirshbaum or Dr. Miller.

FF. **[Extreme Departures from Standard of Practice]** Respondent engaged in extreme departures from the standard of practice in his care and treatment of S.M., as follows:

1. Respondent failed to formulate an accurate diagnosis for S.M.'s addiction to Phenobarbital and Valium, and failed to develop a competent plan of treatment for these addictions, and/ or failed to document an accurate diagnosis or treatment plan.

2. Respondent failed to provide competent treatment for S.M.'s Affective Disorder, either Schizoaffective Disorder or Atypical Bipolar Disorder, and/or failed to document a competent treatment plan.

3. Respondent not only failed to restrict his prescriptions of narcotics to a narcotics abusing patient, but excessively prescribed Valium and Phenobarbital on or about April 11, 1997, April 14, 1997, and May 12, 1997.

4. Respondent not only failed to restrict his prescriptions of narcotics to a patient with a history of Affective Disorder, including suicidal ideation, but prescribed large doses of Valium and Phenobarbital to the patient from January 29, 1997 to October 16, 1997.

5. Respondent failed to request and review the records of S.M.'s psychiatric and drug dependency hospitalizations predating and contemporaneous with respondent's care and treatment of S.M. from January 29, 1997 to October 16, 1997, and/or failed to document same.

EIGHTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

11. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent committed repeated acts of negligence while treating a patient under his care. The circumstances are as follows:

A. The facts alleged in above subparagraphs 10.A. thru 10.EE. are incorporated by reference herein as if fully set forth.

B. **[Repeat Negligent Acts]** Respondent engaged in repeated negligent acts in his care and treatment of S.M., as follows:

1. Respondent failed to formulate an accurate diagnosis for S.M.'s addiction to Phenobarbital and Valium, and failed to develop a competent plan of treatment for these addictions, and/or failed to document an accurate diagnosis or treatment plan.

2. Respondent failed to provide competent treatment for S.M.'s Affective Disorder, either Schizoaffective Disorder or Atypical Bipolar Disorder, and/ or failed to document a competent treatment plan.

3. Respondent not only failed to restrict his prescriptions of narcotics to a narcotics abusing patient, but excessively prescribed Valium and Phenobarbital on or about April 11 and 14, 1997, and May 12, 1997.

4. Respondent not only failed to restrict his prescriptions of narcotics to a patient with a history of Affective Disorder, including suicidal ideation, but prescribed large doses of Valium (i.e., 1160 10 mg. tablets over nine months) and Phenobarbital (i.e., 450 100 mg. tablets over six months) to the patient from January 29 to October 16, 1997.

5. Respondent failed to request and review the records of S.M.'s psychiatric and drug dependency hospitalizations predating and contemporaneous with respondent's care and treatment of S.M. from January 29 to October 16, 1997, and/or failed to document same.

NINTH CAUSE FOR DISCIPLINE

(Incompetence)

12. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent has committed acts of incompetence while treating a patient under his care. The circumstances are as follows:

A. The facts alleged in above subparagraphs 10.A. thru 10.EE, are incorporated by reference herein as if fully set forth.

B. The opinions reached in above subparagraph 10.FF., which are indicative of both lack of sound medical judgment and medical knowledge, are incorporated by reference herein as if fully set forth.

TENTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

13. Respondent is subject to disciplinary action under sections 725 and 2234 of the Code, in that respondent committed acts of clearly excessive prescribing of Valium and Phenobarbital while treating a patient under his care. The circumstances are as follows:

A. The facts and expert opinions alleged in above subparagraphs 10.A. to 10.FF. are incorporated by reference herein as if fully set forth.

ELEVENTH CAUSE FOR DISCIPLINE

(Prescribing Without Good Faith Examination)

14. Respondent is subject to disciplinary action under sections 2234 and 2242, subdivision (a) of the Code, in that respondent committed acts of prescribing dangerous drugs without a good faith prior examination and medical indication therefor. The circumstances are as follows:

A. The facts and expert opinions alleged in above subparagraphs 10.A. to 10.FF. are incorporated by reference herein as if fully set forth.

TWELFTH CAUSE FOR DISCIPLINE

(Prescribing To An Addict)

15. Respondent is subject to disciplinary action under sections 2234, 2238 and 2241 of the Code, in connection with Health and Safety Code sections 11153 and 11156, in that respondent prescribed controlled substances to an addict for other than a legitimate medical purpose. The circumstances are as follows:

A. The facts and expert opinions alleged in above subparagraphs 10.A. to 10.FF. are incorporated by reference herein as if fully set forth.

THIRTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence)

16. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that respondent committed acts of gross negligence while treating a patient under his care. The circumstances are as follows:

A. In 1988, at age 20, patient S.R. became addicted to heroin. She was first seen by respondent for treatment on or about May 12, 1994. Respondent diagnosed her condition as follows: Adjustment Disorder with Mixed Anxiety and Depressed Mood (DSM 309.28), Panic Disorder with Agoraphobia, Post-Traumatic Stress Disorder, Major Depression Disorder, Depressive Disorder, NOS.

B. S.R. was admitted to Queen of Angels Hospital for a drug use related coma on or about and between September 14 and 17, 1994, and was treated in the intensive care unit where she was placed on a ventilator. She was diagnosed as an abuser of I.V. drugs and Valium addict. When discharged, she was prescribed Chloral Hydrate for sleep, Valium for anxiety, Tylenol #3 w/Codeine for pain, and Klonopin for seizures. She also was referred to the Bay Area Addiction Research and Drug Treatment Program in Hollywood (hereinafter "BAART") for Methadone treatment.

C. S.R. returned to respondent for treatment on or

about September 23, 1994. Respondent noted the following in her chart: "Methadone Clinic 65 milligrams. Alcohol Abuse . . . Out of Klonopin." Respondent prescribed Tylenol #3 w/Codeine #45 1 prn severe back pain, Chloral Hyrdrate 500 mg. 3 tabs qhs #45, Ketley, 500 mg. 1 qhs #60, and Klonopin 2 mg. 1 tid #45 for seizures.

D. S.R. next saw respondent for treatment on or about September 24, 1994. Respondent noted that S.R. had been incarcerated in 1994 for possession of heroin. Bipolar Disorder was diagnosed. Respondent prescribed Chloral Hydrate 500 mg. #30, noting in the chart that the patient had reported the theft of the prior Chloral Hydrate prescription.

E. S.R. returned to respondent for treatment on or about December 13, 1995. Respondent noted in the chart that S.R. had been released from custody in October 1995. Respondent also noted that S.R. had a "heroin problem." Respondent prescribed Valium 10 mg. #100, Darvon N #100 for pain, Chloral Hyrdrate #100, Tylenol #3 w/Codeine #45 for pain, and Tetracycline #60.

F. Records from BAART for S.R. made on or about December 29, 1995, noted new and old track marks on both hands, the upper chest and the tops of both feet.

G. On or about January 12, 1996, S.R. was admitted to Queen of Angels Hospital for treatment of a heroin overdose.

H. On or about January 23, 1996, S.R. returned to respondent for treatment. Respondent prescribed Chloral

Hydrate #50.

I. S.R. next saw respondent for treatment on or about February 1, 1996. Respondent noted the following in her chart: "[O]verdosed on heroin and methadone, nearly died. ICU X 2 days. Five and one half days in Cedar Sinai. Bones were aching/was in Phoenix House, Venice . . . R/R meds." Respondent prescribed Chloral Hydrate #30 prn for insomnia, Tylenol #3 w/Codeine #21 for pain, Valium 10 mg. #15 for severe anxiety.

J. On or about April 17, 1996, respondent noted in his chart for S.R. that she was residing in the Sober Living House in Pasadena.

K. On or about May 21, 1996, respondent noted that S.R. was stable and on diet pills.

L. On or about May 22, 1996, respondent noted a telephone prescription of Phen-Fen diet pills for S.R. No weight information on S.R. was noted for this date.

M. Records from BAART for S.R. made on or about November 15, 1996, noted new track marks across her lower abdomen and upper buttocks.

N. S.R. returned to respondent for treatment on or about November 15, 1996. Respondent noted "twenty-one day methadone detox. Request Valium. Won't need Valium at the end of detox." Respondent prescribed Valium 10 mg. #30, Choral Hydrate #100, and Tylenol #3 w/Codeine #45.

O. Records from BAART for S.R. made on or about November 26, 1996, noted degenerative arthritis in the lower

back.

P. S.R. next saw respondent for treatment on or about November 30, 1996. Respondent noted "numb near right thigh and right knee." X-rays of the lumbosacral spine were ordered. [An x-ray of the same area, taken on December 20, 1994, and interpreted by Dr. Weiner, a radiologist, indicated "no abnormality demonstrated."

Q. S.R. returned to respondent for treatment on or about December 16, 1996. Respondent noted "end of detox. Methadone." Respondent prescribed Tylenol #3 w/Codeine, Chloral Hydrate 500 mg. #100, Valium 10 mg. #30, and Soma 350 mg. #30.

R. On or about and between January 14 and April 7, 1997, records from BAART showed that S.R. remained on Methadone.

S. S.R. returned to respondent for treatment on or about January 14, 1997, February 13, 1997, March 11, 1997, and April 7, 1997. Following each of these visits respondent gave S.R. prescriptions for Tylenol #3 w/Codeine #45, Valium 10 mg. #10, and Chloral Hydrate 500 mg. #100.

T. On or about April 16, 1997, S.R. was admitted to Mount Sinai Hospital in Florida for detoxification. She was discharged on May 2, 1997.

U. S.R. next saw respondent for treatment on or about May 5, 1997. Respondent noted that S.R. was "stable" and diagnosed Post Traumatic Stress Disorder. Respondent prescribed Tylenol #3 w/Codeine #45, Soma 350 mg. #45,

Klonopin 2 mg. #45, Chloral Hydrate #100, and Tigan #60 for nausea.

V. On or about May 8, 1997, S.R. was admitted to the Queen of Angels Hospital emergency and intensive care units for abuse of Klonopin 2 mg., Chloral Hyrdrate 500 mg., Tylenol #3 w/Codeine, and Soma. [Only 4 tablets of Klonopin were left from the May 5, 1997 prescription of 45 tablets made by respondent; only 34 tablets of Chloral Hydrate were left from the May 5, 1997 prescription of 100 tablets made by respondent; only 5 tablets of Tylenol #3 w/Codeine were left from the May 5, 1997 prescription of 45 tablets made by respondent; and only 25 tablets of Soma were left from the May 5, 1997 prescription of 45 tablets made by respondent.] S.R. was evaluated by Dr. Kurlisky, a psychiatrist, who reported that she denied having suicidal thoughts.

W. On or about May 10, 1997, S.R. died from a heroin overdose.

X. **[Extreme Departures from Standard of Practice]** Respondent engaged in extreme departures from the standard of practice in his care and treatment of S.R., as follows:

1. Respondent failed to make an accurate diagnosis of her opiate dependence and abuse of sedative/hypnotic substances, and/or failed to document same.

2. Respondent failed to obtain and review the records of her prior and contemporaneous psychiatric and drug dependence hospitalizations,

and/or failed to document same.

3. Respondent failed to consult with her other treating physicians and mental health counselors who were involved with the treatment of her substance abuse, and/or failed to document same.

4. Respondent failed to discontinue prescribing Valium, Chloral Hydrate and Codeine, even though he was aware of her drug addiction history and Methadone use.

5. Respondent failed to discontinue the excessive prescription of controlled substances to a known drug abuser with a history of drug overdoses and known suicide attempts, such as the suicide attempt of February 1, 1996.

FOURTEENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

17. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent committed repeated acts of negligence while treating a patient under his care. The circumstances are as follows:

A. The facts alleged in above subparagraphs 16.A. to 16.W. are incorporated by reference herein as if fully set forth.

B. **[Repeat Negligent Acts]** Respondent engaged in repeat negligent acts in his care and treatment of S.R., as follows:

1. Respondent failed to make an accurate diagnosis of her opiate dependence and abuse of sedative/hypnotic substances, and/or failed to document same.

2. Respondent failed to obtain and review the records of her prior and contemporaneous psychiatric and drug dependence hospitalizations, and/or failed to document same.

3. Respondent failed to consult with her other treating physicians and mental health counselors who were involved with the treatment of her substance abuse, and/or failed to document same.

4. Respondent failed to discontinue prescribing Valium, Chloral Hydrate and Codeine, even though he was aware of her drug addiction history and Methadone use.

5. Respondent failed to discontinue the excessive prescription of controlled substances to a known drug abuser with a history of drug overdoses and known suicide attempts, such as the suicide attempt of February 1, 1996.

FIFTEENTH CAUSE FOR DISCIPLINE

(Incompetence)

18. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent demonstrated incompetence while treating a patient under his care.

The circumstances are as follows:

A. The facts alleged in above subparagraphs 16.A. to 16.W. are incorporated by reference herein as if fully set forth.

B. The opinions reached in above subparagraph 16.X., which are indicative of both a lack of sound medical judgment and medical knowledge, are incorporated by reference herein as if fully set forth,

SIXTEENTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

19. Respondent is subject to disciplinary action under sections 725 and 2234 of the Code, in that respondent committed acts of clearly excessive prescribing of Valium, Chloral Hydrate and Tylenol #3 w/Codeine while treating a patient under his care. The circumstances are as follows:

A. The facts and expert opinions alleged in above subparagraphs 16.A. to 16.X. are incorporated by reference herein as if fully set forth.

SEVENTEENTH CAUSE FOR DISCIPLINE

(Prescribing Without Good Faith Examination)

20. Respondent is subject to disciplinary action under sections 2234 and 2242, subdivision (a) of the Code, in that respondent committed acts of prescribing dangerous drugs without a good faith prior examination and medical indication therefor. The circumstances are as follows:

A. The facts and expert opinions alleged in above subparagraphs 16.A. to 16.X. are incorporated by reference

herein as if fully set forth.

EIGHTEENTH CAUSE FOR DISCIPLINE

(Prescribing To An Addict)

21. Respondent is subject to disciplinary action under sections 2234, 2238 and 2241 of the Code, in connection with sections 11153 and 11156 of the Health and Safety Code, in that respondent has prescribed controlled substances for other than a legitimate medical purpose, to wit: for an addict. The circumstances are as follows:

A. The facts and expert opinions alleged in above subparagraphs 16.A. to 16.X. are incorporated by reference herein as if fully set forth.

NINETEENTH CAUSE FOR DISCIPLINE

(Gross Negligence)

22. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that respondent committed acts of gross negligence while treating a patient under his care. The circumstances are as follows:

A. Patient M.G. was first seen by respondent for treatment on or about March 25, 1994. Respondent diagnosed Adjustment Disorder and Anxiety. Respondent noted M.G.'s ongoing use of Lortab 7.5 mg. 1 q day and Vicodin-ES. Respondent also noted hypertension and cluster headaches, and M.G.'s treatment by Dr. Harold Weiner with an ace inhibitor. Also noted was Epstein Barr since 1986 and compulsive behavior. The performance of a mental status examination was not documented. No impression was noted. As a treatment

plan, respondent simply noted "follow-up prn." Respondent prescribed the following: Lortab 7.5 mg. #100, Sinequan tab #100, Soma 350 mg 1 q day #100.

B. M.G. returned to respondent for treatment on or about April 8, 1994. Respondent noted headaches, a review of medical records, the absence of side-effects, and follow-up. Respondent prescribed Lortab 7.5 mg 1 qid #100 and Soma 350 mg 1 q day #100. [No notation was made to explain how M.G. had run out of 100 Lortab tablets in 2 weeks.]

C. M.G. next saw respondent for treatment on or about April 25, 1995. Respondent prescribed Lortab 7.5 mg #100 and Lorcet 1 tab qid #100. [No reason was noted for giving M.G. two Hydrocodone based narcotics.]

D. M.G. returned to respondent for treatment on or about August 25, 1994. Respondent noted a review of medications, the absence of side effects, and discussion of the addictive nature of the medications with M.G. Respondent prescribed Lorcet #100.

E. M.G. again saw respondent for treatment on or about August 29, 1994. Respondent prescribed Lorcet #100 tid for severe back pain.

F. M.G. returned to respondent for treatment on or about September 20, 1994. Respondent noted the following: "[G]athered info from pharmacy - maybe Vicodin and Soma problem - may be seeing Dr. Ho & Dr. Alsell - will move slowly - he changes doctors when confronted too brusquely."

G. M.G. next saw respondent for treatment on or

about November 1, 1994. Respondent noted the following: "[S]till trying to evaluate situation properly - I requested he bring me X-rays to show that he actually had lumbar pain - see scripts - explained he cannot continue - will confer with pharmacist to assess situation more accurately." Respondent prescribed Soma 350 mg. 1 tid #100 for lumbar pain, Lorcet prn #100 for severe chronic intractable lumbar pain, Lortab 7.5 mg. 1 tid prn #100 for severe chronic intractable lumbar pain. [No follow-up on the requested X-ray was noted.]

H. On or about November 1, 1994, respondent issued the following additional prescriptions for M.G: Lortab 7.5 mg tid prn #100 for severe chronic intractable lumbar pain, Lorcet 1 tid prn #100 for severe chronic intractable lumbar pian, and Soma 350 mg. 1 tid #100 for lumbar pain. [No explanation was noted for these duplicate, same day prescriptions.]

I. M.G. returned to respondent for treatment on or about February 3, 1995. Respondent noted the following: "[B]ecoming apparent that [M.G.] has been using Lortab, Lorcet and Soma for approx. 13 yrs. - he actually nods out at times - wife is aware of problem - difficulty in dealing with situations - pt's lack of insight and unwillingness to change - many friends are also concerned about situation including pharmacist . . . lack of forthrightness." Respondent then prescribed Soma 350 mg q 4 hrs, 2 q 6 hrs. #100, Lorcet 10 mg q 4-6 hrs prn severe pain #100, and Lortab 7.5 mg 1 q 4-6 hrs prn severe pain #100.

J. M.G. returned to respondent for treatment on or about February 22, 1995. Respondent noted Epstein Barr, severe pain, a 20 pound weight loss, and follow-up on a blood test to be forwarded. Respondent repeated the identical prescriptions for Soma, Lorcet and Lortab given on February 3, 1995.

K. From on or about February 22, 1995 to October 13, 1998, respondent continued to prescribe 300 of the same pills to M.G., after each visit, at the rate of twice per month. For example, in September 1996, respondent issued the following prescriptions to M.G: 100 tablets of Hydrocodone or Vicodin 7.5 mg. on September 4th; 100 tablets of Hydrocodone or Vicodin 7.5 mg. on September 6th; 100 tablets of Lortab **10 mg** on September 18th; 100 tablets of Lorcet **10 mg.** on September 19th; 100 tablets of Hydrocodone or Vicodin 7.5 mg. on September 24th; and 100 tablets of Lortab **10 mg.** on September 28th.

L. On or about August 19, 1998, M.G. informed respondent that he was taking 30 to 55 pills per day. On or about the same date, M.G. told Riverside Sheriffs that respondent would prescribe controlled substances for him without conducting a physical examination.

M. **[Extreme Departures from Standard of Practice}** Respondent engaged in extreme departures from the standard of practice in his care and treatment of M.G., as follows:

1. Respondent prescribed narcotic substances to M.G. without good faith prior examination or

medical indication therefor, and/or failed to document a good faith prior examination or medical indication therefor.

2. Respondent failed to consult with M.G.'s other treating physicians to coordinate his care and treatment, and/or failed to document same.

3. Respondent failed to refer M.G. to physicians specializing in internal medicine and orthopedics, in order to verify the cause or causes of his intractable lower back pain complaints, and or failed to document same.

4. Respondent failed to discontinue or restrict the prescriptions of Lortab and Lorcet, both of which contain the narcotic Hydrocodone, when their use by M.G. reached a potentially addictive level.

5. Respondent excessively prescribed Lortab and Lorcet on November 1, 1994 and September 1996.

6. Respondent failed to diagnose M.G.'s addiction to opiates, but only diagnosed Adjustment Disorder with Anxiety and Depressive Disorder and then failed to treat these conditions with anti-anxiety or anti-depressant medications, and/or failed to document same.

TWENTIETH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

23. Respondent is subject to disciplinary action under

section 2234, subdivision (c) of the Code, in that respondent engaged in repeated acts of negligence while treating a patient under his care. The circumstances are as follows:

A. The facts alleged in above subparagraphs 22.A. to 22.L. are incorporated by reference herein as if fully set forth.

B. **[Repeated Negligent Acts]** Respondent engaged in repeated negligent acts in his care and treatment of M.G., as follows:

1. Respondent prescribed narcotic substances to M.G. without good faith prior examination or medical indication therefor, and/or failed to document a good faith prior examination or medical indication therefor.

2. Respondent failed to consult with M.G.'s other treating physicians to coordinate his care and treatment, and/or failed to document same .

3. Respondent failed to refer M.G. to physicians specializing in internal medicine or orthopedics, in order to verify the cause or causes of his intractable lower back pain complaints, and/or failed to document same.

4. Respondent failed to discontinue or restrict the prescriptions for Lortab and Lorcet, both of which contain the narcotic Hydrocodone, when their use by M.G. reached a potentially addictive level.

5. Respondent excessively prescribed Lortab and Lorcet on November 1, 1994 and September 1996.

6. Respondent failed to diagnose M.G.'s addiction to opiates, but only diagnosed Adjustment Disorder with Anxiety and Depressive Disorder and then failed to treat these conditions with anti-anxiety or anti-depressant medications, and/or failed to document same.

TWENTY-FIRST CAUSE FOR DISCIPLINE

(Incompetence)

24. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent has demonstrated incompetence while treating a patient under his care. The circumstances are as follows:

A. The facts alleged in above subparagraphs 22.A. to 22.L. are incorporated by reference herein as if fully set forth.

B. The opinions reached in above subparagraph 22.M., which are indicative of both lack of sound medical judgment and medical knowledge, are incorporated by reference herein as if fully set forth.

TWENTY-SECOND CAUSE FOR DISCIPLINE

(Excessive Prescribing)

25. Respondent is subject to disciplinary action under sections 725 and 2234 of the Code, in that respondent committed acts of clearly excessive prescribing of Lortab and Lorcet while treating a patient under his care. The circumstances are as

follows:

A. The facts and expert opinions alleged in above subparagraphs 22.A. to 22.M. are incorporated by reference herein as if fully set forth.

TWENTY-THIRD CAUSE FOR DISCIPLINE

(Prescribing Without Good Faith Examination)

26. Respondent is subject to disciplinary action under sections 2234 and 2242, subdivision (a) of the Code, in that respondent prescribed dangerous drugs without a good faith prior examination and medical indication therefor. The circumstances are as follows:

A. The facts and expert opinions alleged in above subparagraphs 22.A. to 22.M. are incorporated by reference herein as if fully set forth.

TWENTY-FOURTH CAUSE FOR DISCIPLINE

(Prescribing To An Addict)

27. Respondent is subject to disciplinary action under sections 2234, 2238 and 2241 of the Code, in connection with sections 11153 and 11156 of the Health and Safety Code, in that respondent prescribed controlled substances to an addict for other than a legitimate medical purpose. The circumstances are as follows:

A. The facts and expert opinions alleged in above subparagraphs 22.A. to 22.M. are incorporated by reference herein as if fully set forth.

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TWENTY-FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence)

28. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that respondent committed acts of gross negligence while treating a patient under his care. The circumstances are as follows:

A. On or about September 1, 1998, patient E.Z., an investigator working undercover for the Medical Board, accompanied the formerly identified patient M.G. to respondent's medical office. During this visit, respondent asked E.Z. to state his complaint, whereupon E.Z. stated that he had no complaint. E.Z. then indicated that he wanted respondent to give him some "Norco" because it made him feel good. Respondent informed E.Z. that Norco was for pain and that he couldn't prescribed it except for pain. E.Z. asked respondent if he would prescribe it for him if E.Z. claimed he was in pain. Respondent stated that he would not, but then gave E.Z. a prescription for Norco 1-325 #60 q 6 hrs prn severe pain, and advised him not to return to his office. Respondent did not examine E.Z., or take a medical history. Respondent noted the making of the Norco prescription, as well as the performance of a "psychological evaluation" resulting in a diagnosis of Adjustment Disorder/Anxiety.

B. E.Z. returned to respondent's office on or about October 13, 1998. During this visit, respondent asked E.Z. if he still had pain, and if he had brought the X-ray previously requested. E.Z. stated that he did not have back pain but

just wanted a prescription for Norco. Respondent reminded E.Z. about his admonition not to return to the clinic and that he would not prescribe without a medical indication or X-ray. Respondent then handed E.Z. his chart and had E.Z. leave the office. For this visit, respondent noted that he had conducted 20 to 30 minutes of psychotherapy with E.Z.

C. **[Extreme Departures from Standard of Practice]** Respondent engaged in extreme departures from the standard of practice in his care and treatment of E.Z., as follows:

1. Respondent failed to obtain a history prior to prescribing a narcotic, Norco, and/or failed to document same.

2. Respondent failed to perform a mental status examination prior to prescribing a narcotic, Norco, and/or failed to document same.

3. Respondent failed to perform a physical examination prior to prescribing a narcotic, Norco, and/or failed to document same.

4. Respondent failed to consult with E.Z.'s treating physician prior to prescribing a narcotic, Norco, and/or failed to document same.

TWENTY-SIXTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

29. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent engaged in repeated acts of negligence while treating a patient under his care. The circumstances are as follows:

A. The facts alleged in above subparagraphs 28. A. to 28.B. are incorporated by reference herein as if fully set forth.

B. **[Repeated Negligent Acts]** Respondent engaged in repeated negligent acts in his care and treatment of E.Z., as follows:

1. Respondent failed to obtain a history prior to prescribing a narcotic, Norco, and/or failed to document same.

2. Respondent failed to perform a mental status examination prior to prescribing a narcotic, Norco, and/or failed to document same.

3. Respondent failed to perform a physical examination prior to prescribing a narcotic, Norco, and/or failed to document same.

4. Respondent failed to consult with E.Z.'s treating physician prior to prescribing a narcotic, Norco, and/or failed to document same.

TWENTY-SEVENTH CAUSE FOR DISCIPLINE

(Incompetence)

30. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent demonstrated incompetence while treating a patient under his care. The circumstances are as follows:

A. The facts alleged in above subparagraphs 28.A. to 28.B. are incorporated by reference herein as if fully set forth.

B. The opinions reached in above subparagraph 28.C., which indicate both a lack of sound medical judgment and medical knowledge, are incorporated by reference herein as if fully set forth.

TWENTY-EIGHTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

31. Respondent is subject to disciplinary action under sections 725 and 2234 of the Code, in that respondent excessively prescribed Norco while treating a patient under his care. The circumstances are as follows:

A. The facts and expert opinions alleged in above subparagraphs 28.A. to 28.C. are incorporated by reference herein as if fully set forth.

TWENTY-NINTH CAUSE FOR DISCIPLINE

(Prescribing Without Good Faith Examination)

32. Respondent is subject to disciplinary action under sections 2234 and 2242, subdivision (a) of the Code, in that respondent prescribed a dangerous drug without a good faith prior examination and medical indication therefor. The circumstances are as follows:

A. The facts and expert opinions alleged in above subparagraphs 28.A. to 28.C. are incorporated by reference herein as if fully set forth.

THIRTIETH CAUSE FOR DISCIPLINE

(Making False Statements)

33. Respondent is subject to disciplinary action under section 2261 of the Code, in that respondent made false statements

regarding a patient under his care. The circumstances are as follows:

A. The facts alleged in above subparagraphs 28.A. (i.e., performance of psychological evaluation on September 1, 1998) and 28.B. (i.e., performance of 20 to 30 minutes of psychotherapy on October 13, 1998) are incorporated by reference herein as if fully set forth.

THIRTY-FIRST CAUSE FOR DISCIPLINE

(Alteration of Medical Records)

34. Respondent is subject to disciplinary action under section 2262 of the Code, in that respondent created a false medical record with fraudulent intent. The circumstances are as follows:

A. The facts alleged in above subparagraphs 28.A. (i.e., performance of psychological evaluation on September 1, 1998) and 28.B. (i.e., performance of 20 to 30 minutes of psychotherapy on October 13, 1998) are incorporated by reference herein as if fully set forth.

THIRTY-SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

35. Respondent is subject to disciplinary action under section 2266 of the Code, in that respondent failed to maintain adequate and accurate records relating to the provision of services to a patient. The circumstances are as follows:

A. The facts alleged in above subparagraphs 28.A. (i.e., performance of psychological evaluation on September 1, 1998) and 28.B. (i.e., performance of 20 to 30 minutes of

psychotherapy on October 13, 1998) are incorporated by reference herein as if fully set forth.

THIRTY-THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

36. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that respondent committed acts of gross negligence while treating a patient under his care. The circumstances are as follows:

A. On or about April 4, 1996, patient E.D., who had a history of psychiatric hospitalizations and substance abuse, first presented to respondent. Respondent diagnosed Bipolar Affective Disorder (hereinafter "BAD"), Agoraphobia, Panic Disorder, Post-Traumatic Stress Disorder (hereinafter "PTSD") and Migraine. Respondent prescribed Halcion 25 mg #30, Fioricet w/codeine #45 and Valium 10 mg. #60.

B. On or about April 23, 1996, E.D. returned to respondent for follow-up. Respondent noted that E.D. was "stable" but facing possible criminal charges for "interfering with a flight attendant." Also noted were the drugs Xanax and Serzone in connection with a Dr. Sandler. Respondent prescribed Halcion 25 mg #30, Fioricet w/codeine #45 and Valium 10 mg. #60.

C. On or about April 26, 1996, respondent ordered the following prescriptions for E.D. to be issued at the Rite Aid Pharmacy: Triazolam 25 mg. #30, Fioricet w/codeine #60 and Diazepam [Valium] 10 mg. #60.

D. On or about May 13, 1996, Triazolam 25 mg. #30

and Valium 10 mg. #60 were dispensed to E.D. at the Rite Aid Pharmacy.

E. On or about May 21, 1996, E.D. was arrested in New York for possession of controlled substances.

F. On or about June 25, 1996, E.D. presented to respondent, who noted a seven year history of "anxiety attacks." Respondent diagnosed Adjustment Disorder with Mixed Anxiety and Depressed Mood or Depression Disorder, NOS. Respondent prescribed Xanax .5 mg. #100, Halcion .25 mg. #50, Fioricet w/codeine #45, Valium 10 mg. #60 and Phenergan w/codeine 16 oz.

G. On or about June 28, 1996, an original prescription from respondent for Xanax .5 mg. #120 was issued to E.D. at the Garfield Pharmacy. [Thus from June 25 to 28, 1996, respondent made an average of 33 tablets of Xanax .5 mg. available to E.D. for daily consumption.]

H. On or about July 3, 1996, respondent issued the following telephone prescriptions for E.D: Xanax .5 mg. #60, Fioricet w/codeine #45, Halcion .25 mg. #30, Valium 10 mg. #60. [Thus from June 25 to July 3, 1996, respondent made an average of 24 tablets of Xanax .5 mg. available to E.D. for daily consumption.]

I. On or about July 11, 1996, E.D. presented to respondent with a complaint of insomnia. Respondent diagnosed Adjustment Disorder and Depressive Disorder, NOS. Respondent prescribed Xanax 1 mg. #100, Valium 10 mg. #100 and Fioricet w/codeine #45.

J. On or about July 16, 1996, E.D. was sentenced to serve 30 days in jail for the incident involving the flight attendant.

K. On or about August 17, 1996, E.D. was admitted to the Silver Hill Hospital in Connecticut. He was diagnosed with Bipolar 1 Disorder. His eight year history of substance abuse involving alcohol, crack cocaine, benzodiazepines and Fioricet was documented. E.D.'s Bipolar Disorder was successfully treated with Depakote, Lithium Carbonate and Tegretol.

L. On or about September 3, 1996, while E.D. was still a patient at Silver Hill Hospital, respondent issued a telephone prescription of Robitussin AC, a cough medicine with codeine 240 mg., for E.D. [There is no indication in the records that this prescription was issued in consultation with E.D.'s treating physician at Silver Hill Hospital.]

M. On or about October 19, 1996, E.D. was transferred from Silver Hill Hospital to The Cottage, a partial hospitalization program.

N. On or about November 28, 1996, E.D. was transferred from The Cottage to the outpatient department of Silver Hill Hospital.

O. On or about November 29, 1996, respondent received a letter from Lee Merak of MEDCO Managed Care Corporated, warning that respondent's contemporaneous prescriptions of the sedative hypnotics, Valium and Xanax, were duplicative and clinically unnecessary, and suggesting

that one of these drugs be discontinued. Respondent answered this letter in writing, stating in part that "my patient and I will decide, at our leisure, what action to take next."

P. On or about December 3, 1996, Dr. Sheehy of the Silver Hill Hospital documented that E.D. had tested positive on a urine test for barbiturates, benzodiazepines, opiates and cocaine. Dr. Sheehy also noted that E.D. disclosed receiving Fioricet and Xanax from a physician in California.

Q. On or about December 21, 1996, respondent wrote the following prescriptions for E.D: Valium 10 mg. #60, Fioricet w/codeine #45 and Triazolam .25 mg. #50.

R. On or about January 27, 1997, E.D. presented to respondent, who noted E.D.'s use of Lithium 900 mg. and Fioricet. Respondent prescribed Xanax 1 mg. #100, Valium 10 mg. #100, Fioricet w/codeine and Halcion .25 mg. #60.

S. On or about January 27, 1997, respondent authorized a prescription for Valium 10 mg. #60 for E.D. at the Mickey Fine Pharmacy.

T. On or about February 7, 1997, respondent authorized the following prescriptions for E.D. from the Rite Aid Pharmacy: Xanax **2 mg**. #63, Valium 2 mg. #60, Ambien 10 mg. #30 and Fioricet w/codeine #100. [Thus from January 27 to February 7, 1997, respondent made an average of 9 tablets of Xanax 1 mg., 9 tablets of Valium 10 mg. and 9 tablets of Fioricet w/codeine available to E.D. for consumption on a daily basis.]

U. On or about February 9, 1997, E.D. was arrested

after an auto accident for being under the influence of controlled substances, as shown by a urine test. Respondent's records for E.D. contain a copy of the laboratory report on the urine test showing that at the time of the incident excessive levels of barbiturates, benzodiazepines and opiates were in E.D.'s system. [From January 27 to February 9, 1997, respondent made an average of 9 tablets of Xanax 1 mg., 9 tablets of Valium and 9 tablets of Fioricet w/codeine available to E.D. for consumption on a daily basis.]

V. On or about February 28, 1997, E.D. presented to respondent, who noted dry mouth and slurred speech. Respondent also noted the manifestation of a "quick temper" and "suicidal" thinking. Respondent prescribed Elavil 25 mg. #60, Phenergan w/codeine 480 mg., Klonopin 2 mg. #60 and Paxil 20 mg. #45.

W. On or about March 3, 1997, respondent wrote a letter to E.D.'s attorney, Mr. Murphy, stating that the serum levels found in E.D.'s urine sample taken following the auto accident of February 9, 1997, as noted in the Long Beach Toxicology Report of February 11, 1997, "should not cause intoxication." [This laboratory report showed 3.9 ugs/ml of morphine, 1.9 ugs/ml of codeine, 1.2 ugs/ml of carbamazepine and 1.4 ugs/ml of butalbital.]

X. On or about March 3, 1997, respondent issued a prescription to E.D. for Promethazine w/codeine 90 mg., which was filled at the Rite Aid Pharmacy the next day.

Y. On or about March 12, 1997, respondent diagnosed

E.D. with BAD, migraine, PTSD, Panic Disorder and left armplegia, and noted a history of cocaine and amphetamine dependence.

Z. On or about March 16, 1997, E.D. was admitted to The Meadows in Arizona for treatment of his mental disorder and addictions. E.D. was diagnosed with Cocaine Dependence; Alcohol Dependence; Sedative Hypnotic Dependence (i.e., Xanax, Klonopin, Ambien); BAD; Panic Disorder without Agoraphobia; PTSD; Borderline Personality Disorder Traits; and Nerve Injury - Left Arm, resolved. Respondent noted that at the Meadows, E.D. received prescriptions for Depakote 6 pills per day, Lithium 6 pills per day, Xanax, Valium, Tegretol x 2, Paxil 20 mg. #28 and Ambien 10 mg. #4.

AA. On or about March 25, 1997, while E.D. was still under another physician's care at The Meadows, respondent authorized prescriptions for E.D. of Elavil 25 mg. #21, Klonopin 2 mg. #28 and Phenergan w/codeine 480 mg. Separate prescriptions for the codeine syrup were made for each of the ensuing two days.

BB. On or about April 3, 1997, respondent requested that E.D. be retained at The Meadows until late April 1997. On or about the same date, respondent wrote a letter to the judge in E.D.'s pending criminal case, wherein respondent represented that he had treated E.D. as often as three times per week during the later part of February and early March 1997, though respondent's records show that he provided treatment to E.D. during this period at the rate of once per

week.

CC. On or about April 21, 1997, the Meadows agreed in writing to pay respondent $25 per week to provide E.D. with 26 treatment sessions as part of its aftercare program.

DD. On or about April 28, 1997, E.D. was discharged from The Meadows for not following the rules. E.D. was discharged with the following prescriptions: Desyrl 125 mg. #4, Depakote 500 mg. #7, Effexor 50 mg. #8, Elavil 150 mg. #5, Buspar 10 mg. #16 and Tegretol 100 mg. #13. E.D. then transferred to Serenity Springs in Newport Beach, California.

EE. On or about May 5, 1997, E.D. was sentenced to 3 years probation for possessing narcotic drugs when arrested on May 21, 1996. E.D. faxed a letter to respondent requesting prescriptions. Respondent prescribed the following drugs for E.D: Xanax 1 mg. #18, Fioricet w/codeine #8, Prilosec 20 mg. #30, Desyrel #12, Tegretol 200 mg. #12, Depakote 500 mg. #12 and Elavil 100 mg. #5.

FF. On or about May 9, 1997, respondent issued the following telephone prescriptions for E.D. to Simon's Pharmacy: Xanax 1 mg. #84, Acetamenophen w/codeine 60 mg. #28, Claritin 10 mg. #14 and Triazalam .25 mg. #14.

GG. On or about May 19, 1997, respondent entered the following comments in E.D.'s medical file: "stopped Li," "Hypomanic," "angry," "Brotman psych Hosp.," "backed into a parked car > trial pending," "Meadows > Serenity Springs > kicked out." Respondent diagnosed BAD, PTSD and Panic Disorder. Respondent prescribed Elavil 100 mg. #15, Depakote

500 mg. #60, Desyrel 50 mg. #45.

HH. On or about May 31, 1997, respondent issued telephone prescriptions for E.D. at the Marvin Pharmacy as follows: Xanax 1 mg. #84, Tylenol w/codeine #29, Carbamazepine #45, Trazadone 50 mg. #45, Amitriptyline 100 mg. #15 and Depakote 500 mg. #60.

II. On or about June 11, 1997, respondent issued telephone prescriptions for E.D. at Simon's Pharmacy as follows: Triazolam .25 mg. #15, Xanax 1 mg. #75 and Fioricet w/codeine #28.

JJ. On or about June 12, 1997, the Rite Aid Pharmacy filled the following prescriptions issued by respondent for E.D: Xanax 1 mg. #150, Fioricet w/codeine #28, Desyrel 50 mg. #45 and Halcion .25 mg. #25. [From June 11 to 12, 1997, respondent made 225 tablets of Xanax 1 mg. available to E.D.]

KK. On or about June 25, 1997, E.D. presented to respondent, who noted that E.D. was "stable, pleasant, no se [side effects]." Billing records show that respondent faxed the following prescriptions to New York for E.D: Desyrel 50 mg. #45, Fioricet w/codeine #28, Elavil 100 mg. #15, Tegretol 200 mg. #45, Depakote 250 mg. #60 and Halcion .25 mg. #45.

LL. On or about June 25, 1997, respondent noted a prescription to E.D. of Xanax 1 mg. 5 qd [each day]. [From June 11 to 25, 1997, respondent made an average of 15 tablets of Xanax 1 mg. available to E.D. for consumption on a daily basis.]

MM. On or about July 14, 1997, respondent issued the following telephone prescriptions for E.D. to the Garfield Pharmacy: Xanax 1 mg. #75, Fioricet w/codeine #28, Tegretol 200 mg. #45, Depakote 250 mg. #60, Desyrel 50 mg. #45, Halcion .25 mg. #15 and Amitriptyline 100 mg. #15.

NN. On or about July 18, 1997, E.D. presented to respondent, who diagnosed BAD, PTSD, Panic Disorder, migraine, and a history of cocaine/amphetamine dependence. Respondent prescribed Fioricet w/codeine #45, Valium 10 mg. #30 and Lorazepam 2 mg. #30.

OO. On or about July 25, 1997, E.D. was arrested for battery.

PP. On or about August 5, 1997, respondent issued the following prescriptions for E.D: Xanax 1 mg. #70, Fioricet w/codeine #28, Elavil 100 mg. #15, Depakote 250 mg. #60, Paxil 10 mg. #45 and Tegretol 200 mg. #45.

QQ. On or about September 9, 1997, respondent diagnosed BAD, PTSD, Panic Disorder and migraine for E.D. Respondent issued the following prescriptions to E.D., which were filled at Rexall Long Drugs: Xanax 1 mg. #70, Fioricet w/codeine #28, Elavil 100 mg. #15, Depakote 250 mg. #60, Paxil 10 mg. #45 and Tegretol 200 mg. #45. Respondent also billed for 30 minutes of psychotherapy, though there is no indication in E.D.'s chart that this service was provided.

RR. On or about September 10, 1997, respondent issued a telephone prescription for E.D. of Fioricet w/codeine.

SS. On or about September 22, 1997, respondent issued the following telephone prescriptions for E.D. to the Garfield Pharmacy: Xanax 1 mg. #105, Fioricet w/codeine #42 and Halcion .25 mg. #21. Respondent also billed for 30 minutes of psychotherapy, though there is no indication in E.D.'s chart that this service was provided.

TT. On or about October 2, 1997, respondent noted a 7-day renewal of prescriptions for E.D. by telephone order, as follows: Xanax 1 mg. #35, Fioricet w/codeine # 14 and Halcion .25 mg. #8. Respondent also noted a 30 minute psychotherapy session on E.D.'s outpatient form, though there is no description in E.D.'s chart of such a session.

UU. On or about October 17, 1997, respondent noted a 14-day renewal of prescriptions for E.D. by telephone order to Thrifty Pharmacy, as follows: Xanax 1 mg. #70 (5 per day), Fioricet w/codeine #28 and Halcion .25 mg 1 qhs #14. Respondent diagnosed BAD, and noted that E.D. was stable.

VV. On or about October 30, 1997, respondent issued telephone orders for prescriptions of Xanax and Halcion for E.D. to Thrifty Pharmacy on Sunset Boulevard in Los Angeles, and also issued telephone orders to the Manhattan Plaza Pharmacy in New York City for E.D. of the following: Xanax 1 mg. 5 qd #70, Fioricet w/codeine #28, Depakote 250 mg. x 6 [refills], Tegretol x 3 [refills], Desyrel x 3 [refills], Elavil 100 mg. 1 qhs and Halcion .25 mg. #15. The latter prescriptions were filled the next day.

WW. On or about November 12, 1997, respondent

issued telephone orders for the following prescriptions for E.D. to the Garfield Pharmacy: Xanax 1 mg. #21 x 5 [refills], Fioricet w/codeine #28, Elavil 100 mg. #21 x 1 [refill] and Halcion #21.

XX. On or about December 2, 1997, respondent noted renewals for the following prescriptions for E.D. ordered from Rite Aid in Los Angeles: Xanax 1 mg. #105 x 5 [refills], Fioricet w/codeine #42, Elavil 100 mg. #21 x 1 [refill] and Halcion .25 mg. #21.

YY. On or about December 5, 1997, E.D. was admitted involuntarily to Gracie Square Hospital in New York City, following his arrest for inappropriate touching of a girl on a high school campus and subsequent observation at Bellevue Hospital, where he was described as "agitated, not cooperative, with pressured speech, bizarre behavior and anxious mode." E.D. was medicated with Librium, Depakote, Thiamine, Klonopin, Haldol and Cogentin.

ZZ. On or about December 10, 1997, E.D. was discharged from Gracie Square Hospital against medical advice. The diagnoses on discharge were Bipolar 1 Disorder without psychotic features, most recent episode mixed; Alcohol Abuse, episodic; Cocaine Abuse, episodic. E.D. was discharged with the following 10-day supply of medications: Depakote 750 mg. bid, Haldol 2 mg. bid, bed; Klonopin 1 mg. tid; Cogentin 1 mg. bid, bed. A referral and treatment plan were sent to respondent, which included a recommendation of follow-up laboratory testing for liver function, Depakote level and

complete blood count.

AAA. On or about January 8, 1998, respondent noted a telephone renewal of prescriptions for E.D. to Simon's Discount Pharmacy, as follows: Xanax 1 mg. #105 x 5 [refills], Fioricet w/codeine bid #42, Halcion .25 mg. #21, Elavil 100 mg. #21 and Prilosec 20 mg. #21. Respondent diagnosed BAD, PTSD, Panic Disorder, migraine and drug abuse. [The medications used at Gracie Square Hospital to treat E.D.'s Bipolar Disorder, i.e., Depakote and Haldol, were not renewed; nor was follow-up laboratory testing for liver function, Depakote level, or complete blood count prescribed and/or documented.]

BBB. On or about January 27, 1998, respondent noted Depakote 250 mg. x 3[refills], "D/C Haldol, D/C Cogentin." Copies of prescriptions for Haldol 5 mg. #30 and Cogentin 2 mg. #100 were placed in E.D.'s chart. Respondent noted the renewal of the following "Gracie Square" medications: Klonopin 1 mg. #105 x 5[refills], Halcion .25 mg. #21 x 4[refills] and Loritab Plus #62. [No diagnosis was documented to substantiate the Loritab prescription.]

CCC. On or about January 28, 1998, respondent issued prescriptions for Loritab 10 - 500 #42 [which is composed of 10 mg. Hydrocodone and 500 mg. Acetaminophen].

DDD. On or about March 12, 1998, respondent issued the following prescriptions for E.D: Xanax 1 mg. #150, Fioricet w/codeine #63, Elavil 50 mg. #30, Haldol 5 mg. #30 and Halcion .25 mg. #21.

EEE. On or about March 13, 1998, the Garfield Pharmacy noted the following prescriptions from respondent for E.D: Xanax 1 mg. #105, Elavil 50 mg. #21, Haldol 5 mg. #21 and Halcion .25 mg. #21.

FFF. On or about March 18, 1998, respondent prescribed Fioricet w/codeine #42 to E.D. for severe pain.

GGG. On or about May 4, 1998, respondent diagnosed E.D. as having BAD, PTSD and Panic Disorder. Respondent described E.D. as "stable." Respondent placed a copy of a letter, dated May 4, 1998, that he had provided for E.D.'s court case, in E.D.'s medical record. In this letter, respondent stated that he was treating E.D. for tendonitis lumbar spine (726.90) and migraine with Fioricet w/codeine and Xanax 1 mg. (5 per day), and that E.D. was unable to perform physical labor. Respondent issued telephone prescriptions for E.D. to Marvin's Pharmacy, as follows: Xanax 1 mg. #105 and Halcion .25 mg. #21. Respondent also issued telephone prescriptions for E.D. to Consumer Pharmacy, as follows: Xanax 1 mg. #105, Halcion .25 mg. #21, Elavil 50 mg. #30, Wellbutrin 75 mg. #60, Fioricet w/codeine #63. [Thus, on May 4, 1998, respondent prescribed 210 tablets of Xanax 1 mg. to E.D.]

HHH. On or about May 28, 1998, respondent prescribed the following drugs for E.D: Xanax 1 mg. #105, Fioricet w/codeine #63, Desyrel 50 mg. #60, Elavil 50 mg. #30 and Halcion .25 mg. #21. [From May 4 to 28, 1998, respondent made an average of 9 tablets of Xanax 1 mg. available to E.D. for consumption on a daily basis.]

III. On or about June 30, 1998, respondent issued telephone orders for the following prescriptions for E.D. to the Garfield Pharmacy: Xanax 1 mg. #105, Fioricet w/codeine #100, Desyrel 50 mg. #42, Elavil 50 mg. #21 and Halcion .25 mg. #30.

JJJ. On or about August 17, 1998, respondent noted that E.D. was "doing well" and performing "community service - graffiti." Respondent also noted a Duragesic 100 ugs patch [i.e., fentanyl transdermal system for chronic pain; fentanyl being an oral opiate analgesic]. Respondent prescribed Halcion .25 mg. #21, Wellbutrin 75 mg. #60, Ativan 1 mg. #105, Vicodin ES #63 [7.5 mg. Hydrocodone and 750 mg. Acetaminophen] and Elavil 50 mg. #30.

KKK. On or about September 29, 1998, respondent diagnosed Panic Disorder, but noted that E.D. was "stable" and "pleasant." Respondent prescribed Vicodin ES #63, Depakote 250 mg. #180 (3 per day), Desyrel 50 mg. #50 (2 per day) and Halcion .25 mg. (1 prn).

LLL. On or about October 21, 1998, respondent noted that E.D. had been on Xanax for two years without side effects. Respondent diagnosed E.D. with Panic Disorder. Respondent prescribed Xanax 2 mg. #105, Desyrel 50 mg. #60, Immodium #30, Halcion .25 mg. #21, Vicodin ES #63 and Zyprexa 10 mg. #21. Respondent also issued telephone prescriptions for E.D. to the Consumer Discount Pharmacy, as follows: Xanax 2 mg. #100 and Zyprexa 5 mg. #60. [Thus on this date respondent prescribed 205 tablets of Xanax 1 mg. to E.D.]

MMM. On or about November 5, 1998, respondent noted a review of E.D.'s medications and a finding of no side effects. E.D. was described as being stable. Respondent prescribed Wellbutrin 75 mg. #60, Halcion .25 mg. #21, Vicodin ES #63 and Depakote 250 mg. #180.

NNN. On or about November 20, 1998, E.D. was admitted to The Menninger Clinic in Kansas on a voluntary basis, following an incident with a stewardess on an airline flight. E.D. was hospitalized for acute intoxication. A urine test proved positive for cocaine. Wellbutrin was discontinued. E.D.'s intake of benzodiazepines, Vicodin and Depakote were systematically reduced.

OOO. On or about December 7, 1998, E.D. was discharged from the hospital and admitted to the Clinic's residential program. E.D. was discharged from the program three days later when a drug screen came back positive for cocaine. By this date, E.D.'s intake of psychotropic medications had been reduced, and he was receiving Klonopin 1 mg. bid as needed. The diagnoses at discharge included Polysubstance Dependence; Bipolar Disorder, Mixed; Depression, recurrent; PTSD, chronic, delayed; Panic Disorder without Agoraphobia; Mixed Personality Disorder with Borderline Features.

PPP. On or about December 18, 1998, respondent noted "R/R meds, stable, negative ses [side effects]." Respondent diagnosed E.D. with BAD. Respondent issued telephone orders for prescriptions for E.D. to the Garfield

Pharmacy, as follows: Xanax 2 mg. #100, Zoloft 50 mg. #30, Desyrel #30, Immodium 2 mg. #30, Halcion .25 mg. #30 and Fioricet w/codeine #63. [No prescription for a mood stabilizer was documented as having been ordered and/or provided.]

QQQ. On or about January 11, 1999, respondent prescribed Xanax 2 mg. #105 for E.D.

RRR. On or about January 13, 1999, respondent noted that E.D. was "stable and pleasant." Respondent prescribed Zyprexa 10 mg. #30, Vicodin ES #63, Xanax 2 mg. #105 and Halcion .25 mg. #21, which were filled at Marvin's Pharmacy. Respondent also issued telephone prescriptions for E.D. to the Consumer Discount Pharmacy for the following: Zyprexa 10 mg. #30, Halcion .25 mg #21, Xanax 2 mg. #105, Vicodin ES #63 and Depakote 250 mg. #180. Respondent also issued telephone prescriptions for E.D. to the Garfield Pharmacy for the following: Zyprexa 10 mg. #30, Halcion .25 mg. #21, Vicodin ES #63 and Xanax 2 mg. #105. [Thus on this date respondent provided E.D. with 315 tablets of Xanax 2 mg., 189 tablets of Vicodin ES, and 63 tablets of Halcion .25 mg.]

SSS. On or about January 26, 1999, respondent noted that E.D. was without side effects and appeared "stable and pleasant." Respondent prescribed Xanax 2 mg. #105, Vicodin ES #63 and Halcion .25 mg. #21. [From January 13 to 26, 1999, respondent provided E.D. with 420 tablets of Xanax 2 mg., an average of 30 tablets per day.]

TTT. On or about February 5, 1999, respondent noted that E.D. has lost 15 pounds and was manifesting a mid-life

crisis, but remained stable and without side effects. Respondent prescribed Klonopin 2 mg. #105, Vicodin ES #63, Halcion .25 mg. #21 and Lomotil #45. Respondent also issued telephone prescriptions for E.D. to Consumer Discount Pharmacy for Klonopin 2 mg. #105 and Lomotil #45. Respondent also issued a telephone prescription for E.D. to Garfield Pharmacy for Vicodin #100.

UUU. On or about March 5, 1999, respondent reviewed E.D.'s medications and found no side effects. Respondent described E.D. as being stable and pleasant. Respondent prescribed Vicodin ES #63, Klonopin 2 mg. #105, Halcion .25 mg. #21 and Lomotil #45.

VVV. On or about March 15, 1999, E.D. was seen at respondent's office by Dr. Raymond Reynolds. E.D. claimed that his medications had been mistakenly thrown away, and requested refills. Dr. Reynolds prescribed Vicodin ES #90, Halcion .25 mg. #30, Klonopin 2 mg. #150 and Lomotil #60.

WWW. On or about April 1, 1999, E.D. was admitted to Cedars Sinai Medical Center for emergency treatment of a possible drug overdose. E.D. reported taking 8 tablets of Percocet 250 mg. for back pain and 6 tablets of Halcion .25 mg. on March 31, 1999. Later than day, E.D. went into cardiac arrest (i.e., pulseless, apneiac, cyanotic). E.D. was treated for aspiration pneumonia and anoxic encephalopathy.

XXX. On or about April 12, 1999, E.D. was admitted to the Thalians Mental Health Center for detoxification on a 14-day involuntary hold.

YYY. On or about April 19, 1999, E.D. was transferred to The Menninger Clinic for treatment of drug dependance. E.D.'s speech was slurred, which Dr. Eaton indicated was due to diparthia and dysphonia secondary to anoxia from cardiac arrest. Neuropsychological testing performed on April 28, 1999 showed mild to moderate deficits in general intellectual functioning, speech, expressive language, all aspects of memory and learning, lateral manual speed and dexterity. Repeat testing on July 9, 1999, showed improvements in neuro-cognitive functioning. E.D. was discharged on July 16, 1999, to return to Los Angeles for legal proceedings.

ZZZ. On or about July 27, 1999, respondent noted that E.D. was "pleasant and stable." Respondent prescribed Xanax 2 mg. #120, Halcion .25 mg. #30, Fioricet w/codeine #100 and Lomotil #60. Respondent noted receiving a telephone call from E.D.'s mother, during which the latter informed respondent of E.D.'s recent stay at Menninger and promised to report respondent to the medical authorities if he treated E.D. again.

AAAA. On or about August 1, 1999, E.D. was seen at Cedars Sinai. E.D. reported using alcohol and drugs, the latter received from a physician in Los Angeles. E.D. was noted as displaying extremely inappropriate behavior, agitation and confusion. E.D. was admitted to the Thalians Psychiatric Unit but suffered a respiratory arrest and was transferred to the medical emergency room, where he was

intubated and then placed in the intensive care unit. After being stabilized E.D. was returned to the psychiatric unit on August 3, 1999. Dr. Park noted that a SPECT Scan revealed a "bilateral frontal lobe impairment as a result of his overdose in 1999." E.D. was diagnosed with BAD, mixed; Status Post-Polysubstance Overdose; Abuse and Dependence - Opiates, Benzodiazepines, Alcohol; and Respiratory Arrest, secondary to polysubstance overdose.

BBBB. **[Extreme Departures from Standard of Practice]** Respondent engaged in extreme departures from the standard of practice in his care and treatment of E.D., as follows:

1. Respondent failed to consistently prescribe a mood stabilizer, such as Lithium or other anti-convulsant medication, to a patient with Bipolar Disorder, and/or failed to document same.

2. Respondent failed to obtain therapeutic blood level monitoring of medications along with blood tests for liver function, electrolytes and complete blood count, and/or failed to document same.

3. Respondent over-prescribed benzodiazepines and narcotic pain medications to a patient with a documented history of long-term alcohol and drug abuse problems.

4. Respondent continued to over-prescribe controlled substances to a patient following the patient's completion of drug rehabilitation programs at various facilities, as well as after the Menninger Clinic, which contributed to the patient's respiratory

arrest and resulting brain damage.

5. Respondent failed to obtain or attempt to obtain information (i.e., records, consultations) from the treating psychiatrists and other physicians involved in the patient's drug rehabilitation programs at Silver Hill Hospital in Connecticut, the Meadows in Arizona, Serenity Springs in Newport Beach, Gracie Square Hospital in New York, the Menninger Clinic in Kansas, or the Thalians Psychiatric Unit in Los Angeles, and/or failed to document same.

6. Respondent failed to adequately and accurately document in the progress notes for the patient the conditions being treated and the effects of the psychotropic medications prescribed for said conditions.

7. Respondent treated a patient with Bipolar Disorder, Anxiety Disorder and poly-substance dependence with large dosages of benzodiazepines and narcotics over a three year, three month period.

THIRTY-FOURTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

37. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent engaged in repeated acts of negligence while treating a patient under his care. The circumstances are as follows:

A. The facts and expert opinions alleged in above numbered subparagraphs 36.A. to 36.AAAA are incorporated by reference herein as if fully set forth.

B. Respondent engaged in repeated departures from the standard of practice in his care and treatment of E.D., as follows:

1. Respondent failed to consistently prescribe a mood stabilizer, such as Lithium or other anti-convulsant medication, to a patient with Bipolar Disorder, and/or failed to document same.

2. Respondent failed to obtain therapeutic blood level monitoring of medications along with blood tests for liver function, electrolytes and complete blood count, and/or failed to document same.

3. Respondent over-prescribed benzodiazepines and narcotic pain medications to a patient with a documented history of long-term alcohol and drug abuse problems.

4. Respondent continued to over-prescribe controlled substances to a patient following the patient's completion of drug rehabilitation programs at various facilities, as well as after the Menninger Clinic, which contributed to the patient's respiratory arrest and resulting brain damage.

5. Respondent failed to obtain or attempt to obtain information (i.e., records, consultations) from the treating psychiatrists and other physicians involved in the patient's drug

rehabilitation programs at Silver Hill Hospital in Connecticut, the Meadows in Arizona, Serenity Springs in Newport Beach, Gracie Square Hospital in New York, the Menninger Clinic in Kansas, or the Thalians Psychiatric Unit in Los Angeles, and/or failed to document same.

6. Respondent failed to adequately and accurately document in the progress notes for the patient the conditions being treated and the effects of the psychothropic medications prescribed for said conditions.

7. Respondent prescribed large dosages of benzodiazepines and narcotics over a three year, three month period to a Bipolar, poly-substance dependent patient.

8. Respondent coded psychotherapy sessions performed on September 9, 22 and October 2, 1997 [see above numbered subparagraphs 36.QQ., 36.SS. and 36.TT.] for billing purposes, though respondent's records show that only telephone renewals for medication were performed.

9. Respondent presented to the patient's lawyer in a pending criminal case a letter for use in court, wherein respondent represented that the serum levels noted in a laboratory report connected to the patient's arrest were not intoxicating, though the laboratory report showed high levels of

morphine, codeine, carbamazepine and butalbital [see above numbered subparagraph 36.W: March 3, 1997].

10. Respondent represented to a judge in the patient's pending criminal case that the patient was receiving treatment three times a week in February and March 1997, though respondent's records show that respondent treated the patient only once a week during this period [see above numbered subparagraph 36.BB: April 3, 1997].

11. Respondent presented to the patient's lawyer in a pending case a letter for use in court, wherein respondent stated that he was treating the patient for tendonitis lumber spine (726.90), which disabled the patient from doing physical labor, though respondent's records fail to show confirmation of this condition through examination, diagnostic testing, or referral to physicians in internal medicine or orthopedics [see above numbered subparagraph 36.GGG: May 4, 1998].

THIRTY-FIFTH CAUSE FOR DISCIPLINE

(Incompetence)

38. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent demonstrated incompetence while treating a patient under his care. The circumstances are as follows:

A. The facts alleged in above numbered subparagraphs

36.A. to 36.AAAA. are incorporated by reference herein as if fully set forth.

B. The opinions reached in above numbered subparagraphs 36.BBBB. and 37.B., which indicate both a lack of sound medical judgment and medical knowledge, are incorporated by reference herein as if fully set forth.

THIRTY-SIXTH CAUSE FOR DISCIPLINE

(Prescribing To An Addict)

39. Respondent is subject to disciplinary action under sections 2234, 2238 and 2241 of the Code, in connection with sections 11153 and 11156 of the Health and Safety Code, in that respondent prescribed controlled substances to an addict for other than a legitimate medical purpose. The circumstances are as follows:

A. The facts and expert opinions alleged in above subparagraphs 36.A. to 36.BBBB. and 37.B. are incorporated by reference herein as if fully set forth.

THIRTY-SEVENTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

40. Respondent is subject to disciplinary action under sections 725 and 2234 of the Code, in that respondent committed acts of clearly excessive prescribing of benzodiazepines and narcotics while treating a patient under his care. The circumstances are as follows:

A. The facts and expert opinions alleged in above numbered subparagraphs 36.A. to 36.BBBB. are incorporated by reference herein as if fully set forth.

THIRTY-EIGHTH CAUSE FOR DISCIPLINE

(Prescribing Without Good Faith Examination)

41. Respondent is subject to disciplinary action under sections 2234 and 2242, subdivision (a) of the Code, in that respondent committed acts of prescribing dangerous drugs without a good faith prior examination and medical indication therefor. The circumstances are as follows:

A. The facts and expert opinions alleged in above numbered subparagraphs 36.A. to 36.BBBB. are incorporated by reference herein as if fully set forth.

THIRTY-NINTH CAUSE FOR DISCIPLINE

(Making False Statements)

42. Respondent is subject to disciplinary action under section 2261 of the Code, in that respondent made false statements regarding a patient under his care. The circumstances are as follows:

A. The facts alleged in above numbered subparagraph 37.B. (i.e., performance of psychotherapy sessions on Setpember 9 and 22, and October 2, 1997) are incorporated by reference herein as if fully set forth.

B. The facts alleged in above numbered subparagraph 37.B. (i.e., respondent's letters of March 3 and April 3, 1997, and May 4, 1998, in connection with the patient's legal cases) are incorporated by reference herein as if fully set forth.

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FORTIETH CAUSE FOR DISCIPLINE

(Alteration of Medical Records)

43. Respondent is subject to disciplinary action under section 2262 of the Code, in that respondent created a false medical record with fraudulent intent. The circumstances are as follows:

A. The facts alleged in above numbered subparagraph 37.B. (i.e., performance of psychotherapy sessions on September 9 and 22, and October 2, 1997) are incorporated by reference herein as if fully set forth.

B. The facts alleged in above numbered subparagraph 37.B. (i.e., respondent's letters of March 3 and April 3, 1997, and May 4, 1999, in connection with the patient's legal cases) are incorporated by reference herein as if fully set forth.

FORTY-FIRST CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

44. Respondent is subject to discipline under section 2266 of the Code, in that respondent failed to maintain adequate and accurate records relating to the provision of services to a patient. The circumstances are as follows:

A. The facts and expert opinions alleged at above numbered subparagraphs 36.A. to 36.BBBB and 37.B. are incorporated by reference herein as if fully set forth.

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FORTY-SECOND CAUSE FOR DISCIPLINE

(Dishonesty)

45. Respondent is subject to discipline under section 2234, subdivision (e) of the Code, in that respondent has engaged in acts of dishonesty in connection with his treatment of patients under his care. The circumstances are as follows:

A. The facts and expert opinions alleged in above numbered subparagraphs 28.A., 28.B., and 37.B.8-10 are incorporated by reference herein as if fully set forth.

FORTY-THIRD CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

46. Respondent is subject to discipline under section 2234 of the Code, in that respondent has engaged in general unprofessional conduct in his treatment of patients under his care. The circumstances are as follows:

A. The facts and expert opinions set forth in above numbered paragraphs 4 to 45 are incorporated by reference herein as if fully set forth.

FORTY-FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence)

47. Respondent is subject to discipline under section 2234, subdivision (b) of the Code, in that respondent committed acts of gross negligence in disclosing confidential patient information in a public proceeding for the purpose of defending himself against a petition for interim order of suspension. The circumstances are as follows:

A. On or about July 14, 2000, in O.A.H. Case No. L-

2000070071, a public, ex parte hearing on a petition for interim order of suspension filed against respondent by the Board was conducted before the Hon. H. Stuart Waxman, Administrative Law Judge.

B. On or about July 21, 2000, in O.A.H. Case No. L-2000070071, the Hon. H. Stuart Waxman, Administrative Law Judge, issued an interim order prohibiting respondent from prescribing any and all medication to patients, pending a noticed hearing and decision on the petition scheduled for hearing on August 1, 2000.

C. O.A.H. Case No. L-2000070071 presented all of the causes for discipline raised in the then pending Second Amended Accusation in Case Nos. 06-1996-65821, 06-1997-79531, 06-1998-82571 and 06-1999-100710.

D. On or about July 28, 2000, in O.A.H. Case No. L-2000070071, respondent, through his attorney, filed declarations and letters from his patients in opposition to the petition for interim order of suspension. None of these patient declarations and letters, which were signed by the patients using their full names, were accompanied by a written informed consent form signed by the patient, authorization for release of medical information signed by the patient, or similar documentation establishing a waiver of the patient's right to the privacy of the patient's medical history or current medical condition.

E. Many of these patient declarations and letters revealed essentially private, highly personal medical

information, as well as comments directed to the charges of overprescribing medication presented in the petition for interim order of suspension, and the interim order issued on July 21, 2000 prohibiting respondent from prescribing any and all medications to patients. The following patient declarations and letters, and their relevant content, were publicly disclosed by respondent:

1. Patient N.W., dated July 26, 2000, disclosed serious mental and physical illnesses.

2. Patient J.J. , dated July 25, 2000, disclosed a history of delusions.

3. Patient C.L., dated July 25, 2000, disclosed serious mental illnesses; medications prescribed by respondent to patient; knowledge of the existing prohibition against prescribing; and an assertion that respondent did not overprescribe medication.

4. Patient B.V., dated July 27, 2000, asserted no overprescribing of medication by respondent.

5. Patient F.A., dated July 27, 2000, disclosed serious mental and physical illnesses; and previous medication taken.

6. Patient N.W., dated July 27, 2000, disclosed history of delusions, criminal involvement and drug abuse; and knowledge of

the existing prohibition against prescribing.

7. Patient B.W., dated July 25, 2000, disclosed knowledge of the existing prohibition against prescribing; and an assertion that respondent did not overprescribe medication.

8. Patient M.S., dated July 25, 2000, disclosed mental disorders; medications prescribed by respondent to patient; and an assertion that respondent did not overprescribe medication.

9. Patient P.F., dated July 25, 2000, disclosed psychological problems and physical disabilities.

10. Patient J.S., dated July 27, 2000, disclosed serious mental disorders; medication prescribed by respondent to patient; and knowledge of the existing prohibition against prescribing.

11. Patient A.M., [undated], disclosed serious mental illness; medications prescribed by respondent to patient; and an assertion that respondent did not overprescribe medication.

12. Patient A.P., dated July 27,2000, disclosed a serious mental illness.

13. Patient P.G., dated July 27,2000,

disclosed a serious physical problem.

14. Patient W.H., dated July 25, 2000, disclosed serious mental illness; medication prescribed by respondent to patient; and an assertion that respondent did not overprescribe medication.

15. Patient D.T., dated July 25, 2000, disclosed serious mental illness; medications prescribed by respondent to patient and patient's three sons; and an assertion that respondent did not overprescribe medication.

16. Patient D.D., dated July 26, 2000, disclosed serious mental and physical problems; and medication prescribed by respondent to patient.

17. Patient S.R., dated July 25, 2000, disclosed serious mental illnesses involving delusions; medications prescribed by respondent to patient; and an assertion that respondent did not overprescribe medication.

18. Patient R.F., dated July 26, 2000, disclosed serious mental illnesses; medications prescribed by respondent to patient; and an assertion that respondent did not overprescribe medication.

19. Patient W.M., dated July 26, 2000, disclosed medication prescribed by respondent

to patient; and an assertion that respondent did not overprescribe medication.

20. Patient S.D., dated July 25, 2000, disclosed a serious mental disorder and physical disorders; and an assertion that respondent did not overprescribe medication.

21. Patient G.H., dated July 26, 2000, disclosed a serious mental disorder; and medication prescribed by respondent to patient.

22. Patient J.S., dated July 26, 2000, disclosed physical problem; medication prescribed by respondent to patient; and an assertion that respondent prescribed medication based only on examination and medical indication.

23. Patient J.L., dated July 24, 2000, disclosed serious mental and physical problems; and assertion that respondent did not overprescribe medication.

24. Patient G.B., dated July 24, 2000, disclosed receipt of medication from respondent.

25. Patient D.L., dated July 27, 2000, disclosed physical illness; medication prescribed by respondent to patient; and an assertion that respondent did not

overprescribe medication.

26. Patient G.C., dated July 27, 2000, disclosed medication prescribed by respondent to patient for specific condition.

27. Patient M.M., dated July 27, 2000, asserted that respondent prescribes medication moderately.

28. Patient C.H., dated July 27, 2000, disclosed receipt of medication from respondent.

29. Patient L.W., dated July 27, 2000, disclosed need for medication from respondent for self and boyfriend.

30. Patient S.B., dated July 24, 2000, disclosed serious mental and physical illnesses; medications prescribed by respondent to patient; and an assertion that respondent did not overprescribe medication.

31. Patient N.B., dated July 25, 2000, disclosed serious mental illness; and assertion that respondent prescribed medication with care.

32. Patient J.H., dated July 25, 2000, asserted that respondent did not overprescribe medication.

33. Patient R.L., dated July 24, 2000, disclosed medication prescribed by respondent

to patient; and an assertion that respondent did not overprescribe medication.

34. Patient T.W., dated July 25, 2000, disclosed receipt of medication from respondent.

35. Patient C.M., dated July 27, 2000, disclosed receipt of medication from respondent.

36. Patient S.W., dated July 27, 2000, disclosed medication received from respondent for mental health.

37. Patient B.V., dated July 28, 2000, disclosed severe mental illness; medication prescribed by respondent for patient; and an assertion that respondent did not authorize refills of the prescriptions issued.

38. Patient D.E., dated July 27, 2000, disclosed mental problem; medication prescribed by respondent to patient; and assertion that respondent did not overprescribe medication.

39. Patient J.B., dated July 29, 2000, asserts that respondent did not overprescribe medication.

40. Patient T.P., dated July 27, 2000, disclosed family dysfunction and serious physical problems; knowledge of the existing

prohibition against prescribing; and an assertion that respondent did not overprescribe medication.

41. Patient M.B., dated July 27, 2000, disclosed serious mental illness; and an assertion that respondent did not overprescribe medication.

42. Patient J.F., [no date], disclosed learning disability and physical illnesses; medication prescribed by respondent.

43. Patient J.T., dated July 27, 2000, disclosed serious mental illness; and assertion that respondent did not overprescribe medication. [Note: appears written in response to list of questions]

44. Patient J.D., dated July 26, 2000, disclosed knowledge of the existing prohibition against prescribing.

45. Patient L.M., dated July 25, 2000, disclosed medications prescribed for serious mental conditions; and an assertion that respondent did not overprescribe medication.

46. Patient J.C., dated July 26, 2000, disclosed receipt of medication from respondent.

47. Patient N.W., dated July 25, 2000, disclosed knowledge of the existing

prohibition against prescribing; and an assertion that respondent did not overprescribe medication.

48. Patient D.B., dated July 25, 2000, disclosed physical injury.

49. Patient J.F., dated July 25, 2000, disclosed receipt of prescription from respondent.

50. Patient J.M., dated July 25, 2000, disclosed mental illness.

51. Patient E. P-B., dated July 24, 2000, disclosed mental illness; medication prescribed to patient by respondent.

52. Patient J.S., dated July 25, 2000, disclosed physical illness; and an assertion that respondent did not overprescribe medication.

53. Patient R.C., dated July 25, 2000, disclosed serious mental illness.

54. Patient T.B., dated July 25, 2000, makes assertion that respondent does not overprescribe medication.

55. Patient B.T., dated July 24, 2000, makes assertion that respondent does not overprescribe medication.

56. Patient I.G., dated July 25, 2000, disclosed receipt of medication from

respondent.

57. Patient T.L., [undated], disclosed serious mental illness; knowledge of existing prohibition against prescribing.

58. Patient P.J., dated July 26, 2000, disclosed serious mental and physical illnesses; medication prescribed to patient by respondent; and an assertion that respondent did not overprescribe medication.

59. Patient G.S., dated July 26, 2000, disclosed severe psychiatric problems; medications prescribed to patient by respondent.

60. Patient J.P., dated July 26, 2000, disclosed mental problems; knowledge of existing prohibition against prescribing; and an assertion that respondent did not overprescribe medication.

61. Patient R.H., dated July 26, 2000, makes assertion that respondent did not overprescribe medication.

62. Patient K.G., [undated], disclosed neurological and mental disorders; and makes an assertion that respondent did not overprescribe medication.

63. Patient V.P., dated July 26, 2000, disclosed receipt of medications from

respondent.

64. Patient A.H., dated July 26, 2000, disclosed mental illnesses.

65. Patient J.K., dated July 26, 2000, disclosed medication prescribed to patient by respondent; and an assertion that respondent did not overprescribe medication.

66. Patient R.W., dated July 26, 2000, makes assertion that respondent did not overprescribe medication.

67. Patient A.T., dated July 26, 2000, makes assertion that respondent did not overprescribe medication.

68. Patient S.W., dated July 27, 2000, makes assertion that respondent did not overprescribe medication.

69. Patient S.K., dated July 27, 2000, disclosed medications prescribed to patient by respondent.

70. Patient R.D., dated July 26, 2000, disclosed chronic illnesses; knowledge of existing prohibition against prescribing; and an assertion that respondent did not overprescribe medication.

F. [**Extreme Departures From The Standard Of Practice**] Respondent engaged in extreme departures from the standard of practice in the care and treatment of each of the

patients identified in above subparagraphs E.1. through E.70, as follows:

1. The patient declarations and letters cited at above subparagraphs E.1. through E.70. show that respondent, or his agents acting in his behalf, discussed the pending allegations presented in the petition for interim order of suspension with said patients.

2. The patient declarations and letters cited at above subparagraphs E.1 through E.70 show that respondent, or his agents acting in his behalf, solicited the help of said patients in providing the declarations and letters for use in defense of the pending allegations presented in the petition for interim order of suspension, and publicly disclosed said declarations and letters.

3. The patient declarations and letters cited at above subparagraphs E.1 through E.70 show that respondent, or his agents acting in his behalf, received and publicly disclosed said declarations and letters, including those that respondent and/or his agents did not solicit, for use in his defense of the pending allegations presented in the petition for interim order of suspension, and did so without the benefit of signed informed consent

forms or waivers of the right to privacy from said patients.

FORTY-FIFTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

48. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent repeatedly committed acts of negligence in disclosing confidential patient information in a public proceeding for the purpose of defending himself against a petition for interim order of suspension. The circumstances are as follows:

A. The facts and opinions stated in above numbered paragraph 47 are incorporated by reference herein as if fully set forth.

FORTY-SIXTH CAUSE FOR DISCIPLINE

(Incompetence)

49. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent disclosed confidential patient information in a public proceeding for the purpose of defending himself against a petition for interim of order of suspension. The circumstances are as follows:

A. The facts and opinions stated in above numbered paragraph 47 are incorporated by reference herein as if fully set forth.

FORTY-SEVENTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

50. Respondent is subject to disciplinary action under section 2234, subdivision (a) of the Code, in that respondent,

while prohibited from prescribing any and all medications to patients through an interim order, violated said order. The circumstances are as follows:

A. The facts set forth in above numbered subparagraphs 47.A. through 47.C. are incorporated by reference herein as if fully set forth.

B. On or about August 10, 2000, in O.A.H. Case No. L-2000070071, the Hon. H. Stuart Waxman, Administrative Law Judge, issued an interim order prohibiting respondent from prescribing any and all medications to patients until a practice monitor, approved by the Division or its designee, had commenced the performance of his/her duties.

C. As of August 17, 2000, a monitor had not been approved by the Division or its designee.

D. On or about August 15, 2000, respondent admittedly wrote out prescriptions for Lorcet and Soma for the same patient, and had the prescriptions signed by another physician and surgeon (i.e., Dr. Keith S. Ditman).

E. The prescriptions for Lorcet and Soma referred to at above subparagraph 50.D. were presented to a pharmacist familiar with respondent's prescriptions to the patient, as well as the fact that respondent's prescribing privilege had been suspended. The pharmacist contacted respondent that same day and respondent admitted that he had written the prescriptions for Lorcet and Soma, and had Dr. Ditman sign them.

F. By ordering the above mentioned prescriptions

for Lorcet and Soma, filling out the prescription slips for them, and having Dr. Ditman sign them, respondent violated or attempted to violate, directly or indirectly, or assisted in or abetted the violation of the Division's interim order prohibiting respondent from prescribing medication.

[The FORTY-EIGHTH thru the SEVENTY-SEVENTH Causes for Discipline are stated in Complainant's Amendment of Accusation To Conform to Proof, filed on February 28, 2001, and are incorporated by reference herein as if fully set forth.]

SEVENTY-EIGHTH CAUSE FOR DISCIPLINE

(Gross Negligence)

51. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that respondent engaged in multiple extreme departures from the standard of practice in the care and treatment of a patient. The circumstances are as follows:

A. On or about October 31, 1990, W.M. was admitted to the Kaiser Permanente Hospital in West Los Angeles following a suicide attempt. She was diagnosed with chronic depression and a history of long-term abuse of L.S.D.was noted.

B. On or about March 20, 1992, W.M. was treated at Kaiser Permanente Hospital in West Los Angeles for depression and cocaine use. Anti-depressant medications were prescribed for W.M.

C. On or about August 24, 1996, W.M. was evaluated by a physician at Kaiser Permanente Hospital in West Los

Angeles and was considered as having a problem with Xanax (i.e., benzodiazepine) abuse.

D. On or about and between October 3 to 9, 1999, W.M. was treated at Kaiser Permanente Hospital in West Los Angeles for delirium and hepatitis from Vicodin and Xanax overuse. W.M. was instructed not to take any more narcotics and benzodiazepines. Librium 10 mg. one tablet each day as needed for anxiety was prescribed.

E. W.M.'s first visit to respondent for medical attention occurred on or about February 2, 1998. Respondent noted W.M.'s report of a five year history of panic attacks, prior use of Xanax and prior treatment by Dr. Kenyon and Dr. Zec. Respondent's initial diagnosis was panic disorder with agoraphobia. Respondent prescribed Xanax 2 mg. #60 for severe anxiety, and billed W.M. $75 for the initial clinical psychiatric evaluation. Respondent did not document a reason for prescribing a 2 mg. dose of Xanax rather than a lesser dose. A letter addressed to respondent from Dr. Kenyon, dated February 3, 1998, stated that W.M. was suffering from severe panic disorder for which she was taking Xanax 1 mg. 3 times a day.

F. On or about March 17, 1998, W.M. returned to respondent. Respondent documented that W.M. was "pleasant" but that the panic attacks "felt like jumping out of car." A major depressive disorder, single episode was diagnosed, and a diagnosis of panic disorder without agoraphobia was documented. Anti-depressant medications were listed on the

progress note, but respondent only prescribed Xanax 1 mg. #60 for severe anxiety. Respondent did not document a reason for reducing the dose of Xanax by half. Respondent billed W.M. $100 for an initial clinical psychiatric evaluation. Respondent did not consult, and/or document an attempt to consult, with Dr. Zec about W.M.'s prior treatment; he did not attempt to request W.M.'s medical records from Dr. Kenyon or Dr. Zec; and/or respondent failed to document an attempt to request W.M.'s medical records from Dr. Kenyon and Dr. Zec.

G. On or about June 1, 1998, W.M. returned to respondent for treatment. Respondent reviewed and renewed her medications and found no side effects. Respondent noted that she appeared "stable" and "pleasant," but diagnosed major depression, single episode, and panic disorder without agoraphobia. Respondent prescribed Ativan 1 mg. #60 for severe anxiety. Ativan, like Xanax, is a benzodiazepine.

H. On or about July 17, 1998, W.M. returned to respondent for treatment. Respondent noted information concerning W.M.'s parents. The same diagnoses were cited by respondent. Xanax 1 mg. #60 was prescribed for severe anxiety. Respondent billed $60 for a 20 to 30 minute session of psychotherapy with medications.

I. On or about August 6, 1998, respondent repeated the existing diagnoses but cited "migraine" as an additional condition. Xanax 1 mg. #30 was prescribed for severe anxiety. Vicodin ES #30, a narcotic analgesic, was prescribed for severe pain. Respondent did not document the bases for his

diagnosis of migraine or severe pain, or the reason for prescribing a narcotic analgesic prior to attempting to address the pain with a non-narcotic analgesic. Respondent did not document a referral for a physical evaluation of the pain complaint. W.M. was billed $60 for 20 to 30 minutes of psychotherapy with medications. Respondent documented that W.M.'s medications were reviewed with no side effects, and that she was "stable" and "pleasant."

J. On or about September 3, 1998, W.M. returned to respondent for treatment. Respondent documented the same diagnoses and described W.M. as "stable" and "pleasant." Xanax 1 mg. #60 was again prescribed for severe anxiety. Respondent billed W.M. $60 for 20 to 30 minutes of psychotherapy with medication.

K. On or about October 1, 1998, respondent saw W.M. and found her "stable" and "pleasant," and diagnosed major depression, panic disorder and migraine. No side effects from medication were found. Xanax 1 mg. #60 was prescribed for severe anxiety. Respondent billed $60 for 20 to 30 minutes of psychotherapy with medications. No physical findings or history of evaluation and treatment were documented in the progress note for this date to support the migraine diagnosis.

L. On or about October 29, 1998, respondent examined W.M. and found her "stable" and "pleasant," and diagnosed major depression, panic disorder and migraine. No side effects from the medication were found. Xanax 1 mg. #60 was prescribed for severe anxiety. Respondent billed $60 for

20 to 30 minutes of psychotherapy with medications. No physical findings or history of evaluation and treatment were documented in the progress note for this date to support the migraine diagnosis.

M. On or about November 25, 1998, respondent examined W.M. and entered the same findings in the progress note for this date as in the previous one. Xanax 1 mg. #60 was prescribed for severe anxiety. W.M. was billed $60 for 20 to 30 minutes of psychotherapy with medication. No physical findings or history of evaluation and treatment were documented in the progress note for this date to support the migraine diagnosis.

N. On or about December 17, 1998, respondent examined W.M. and noted that she had "dysmenorrhea" but was "stable" and "pleasant." The prior diagnoses was restated. Xanax 1 mg. #60 and Vicodin ES #30 were prescribed. W.M. was billed $60 for 20 to 30 minutes of psychotherapy with medications. No physical findings or history of evaluation and treatment were documented in the progress note for this date to support the migraine diagnosis.

O. On or about January 5, 1999, respondent examined W.M. and noted that her father had died at age 63 and that her mother was 77. The same diagnoses were noted, minus the migraine diagnosis. Respondent did not document the reason for excluding migraine from the diagnoses. Xanax 1 mg. #60 was prescribed for severe anxiety. Vicodin ES #60 was prescribed for severe pain. Respondent did not explain the

reason for prescribing Vicodin ES, a narcotic analgesic, for pain, in lieu of a less addictive analgesic medication.

P. On or about February 8, 1999, according to respondent's billing records, W.M. presented to respondent for treatment. Xanax 1 mg. #60 was prescribed for severe anxiety and Vicodin ES #30 was prescribed for severe pain. Respondent's records for this date did not contain a progress note, or any other description or explanation of the examination conducted and findings made. W.M. was billed $60 for 20 to 30 minutes of psychotherapy with medications.

Q. On or about March 2, 1999, according to respondent's billing records, W.M. was seen by Dr. Reynolds at respondent's clinic. The same diagnoses is noted in the billing note. Dr. Reynolds prescribed Xanax 1 mg. #60 for severe anxiety and Vicodin #60 for severe pain. Respondent's records do not contain a progress note or any other writing for this date, to explain the reasons for the prescriptions or the nature of the treatment provided. No reason is documented for the increase in quantity of Vicodin from 30 to 60 tablets. W.M. was billed $60 for this visit.

R. On or about March 29, 1999, respondent saw W.M. and reviewed her medications. Respondent noted that she was "stable" and "pleasant." Xanax 1 mg. #75 was prescribed, but respondent did not document a reason for this increase in tablets from the previous level of 60 tablets. Vicodin ES # 30 was prescribed, but again respondent did not document a confirmed diagnosis for the use of this narcotic analgesic

prescription. W.M. was charged $60 for 20 to 30 minutes of psychotherapy with medications. W.M. was given a follow-up appointment in 28 days.April 25, 2001.

S. On or about April 14, 1999, or 16 days following her last visit to respondent, W.M. returned to respondent's clinic for treatment. Respondent reviewed her medications and found no side effects. Respondent described W.M. as "stable" and "pleasant." The same diagnoses were documented, as was a complaint of menstrual pain. Xanax 1 mg. #75 was prescribed, as was Vicodin ES #30. Respondent did not document whether W.M.'s return to the clinic on this date, **just two weeks following her last visit**, and the increased dosages of Xanax and Vicodin ES were considered as being indicative of a tolerance and dependency to Xanax and Vicodin. W.M. was billed $60 for 20 to 30 minutes of psychotherapy with medications.

T. On or about May 10, 1999, W.M. returned to respondent, who documented menstrual and headache pain. Vicodin ES #30 and Xanax 1 mg. **#100** were prescribed. Respondent did not document a reason for increasing the quantity of Xanax from 75 to 100 tablets, nor document a consideration of possible growing tolerance and dependency on the medication.

U. On or about and between **March 2 and June 7, 1999, a period of approximately 90 days, respondent provided prescriptions to W.M. authorizing her receipt of 310 tablets of Xanax 1 mg. and 150 tablets of Vicodin ES.**

V. On or about June 8, 1999, W.M. returned to respondent for treatment. Xanax 1 mg. #100 and Vicodin ES #30 were prescribed based on the same diagnoses of major depression and panic disorder. W.M. was billed $60 for 20 to 30 minutes of psychotherapy with medications.

W. On or about July 7, 1999, respondent prescribed Xanax 1 mg. #100 and Vicodin ES #60 for W.M. Respondent did not document a reason for increasing the quantity of Vicodin ES from 30 to 60 tablets. W.M. was described as pleasant and stable. Respondent did not document any consideration of the possibility that W.M. was developing a tolerance to and growing dependence upon the narcotic, Vicodin ES.

X. On or about August 6, 1999, W.M. signed an authorization for Dr. Kenyon to release her medical records to respondent, indicating that respondent had made no effort or failed to document his attempt to obtain W.M.'s records from her prior treating physician for 18 months. In his progress note for this date, respondent noted "labs; Vic. ES x 1 yr. On it x few years. Menstrual pain, Migraine. Pharmacy-Mikie, Edgemont; pleasant." The same diagnoses were cited. Xanax 1 mg. #100 and Vicodin ES #60 were prescribed. No physical findings or history of evaluation and treatment were documented in the progress note for this date to support the migraine diagnosis and menstrual pain complaint.

Y. On or about August 9, 1999, W.M. signed an authorization for Kaiser Permanente to release her medical records to respondent. The Kaiser records for W.M. found in

respondent's medical file on the patient show that on August 24, 1996, Dr. Schwartz noted that W.M. had five different prescription numbers for Xanax and that he repeatedly attempted to inform her that he would not refill a prescription for this controlled substance.

Z. On or about September 8, 1999, W.M. returned to respondent for treatment. In the progress note for this visit, respondent noted "labs check, X-rays . . . pleasant, negative...**illegal drugs**...Pain-menstrual and Migraine." The prior diagnoses were restated. Xanax 1 mg. #100 and Vicodin ES #60 were prescribed. No physical findings or history of evaluation and treatment were documented in the progress note for this date to support the migraine diagnosis and menstrual pain complaint.

AA. **On or about and between January 5 to October 12, 1999, approximately 270 days, respondent prescribed 420 tablets of Vicodin ES to W.M.**

BB. On or about October 13, 1999, respondent saw W.M. and found her "pleasant" and "stable." The same diagnoses were restated. Xanax 1 mg. #100 was prescribed. Vicodin ES was not prescribed, and respondent did not document a reason for discontinuing the narcotic. This visit followed W.M.'s hospitalization at Kaiser Permanente of October 3 to 9, 1999, for medical complications from the abuse of Xanax and Vicodin, during which time she alleges she telephoned respondent to inform him of her condition.

CC. On or about November 5, 1999, respondent saw

W.M. at his clinic and noted "+ labs. + H/S. Change Xanax to Librium 10 x 3. Pleasant. Stable." The same diagnoses were restated. Librium 10 mg. #100 was prescribed. Respondent did not note a reason for discontinuing the Xanax, and starting Librium.

DD. On or about November 9, 1999, W.M. returned to respondent at his clinic. Respondent noted a review of the Librium and no side effects, but issued a prescription for Xanax 1 mg. #100. Respondent did not document any consideration that W.M.'s return to the clinic **after just four days** may have been indicative of her dependency on Xanax.

EE. On or about December 2, 1999, respondent saw W.M. at his clinic and prescribed Xanax 1 mg. #100. She was given a follow-up appointment in 28 days.

FF. On or about December 16, 1999, according to a prescription record and an undated note immediately following the progress note of December 2, 1999, respondent saw W.M. and added a new diagnosis, i.e., Adjustment Disorder with Mixed Anxiety and Depressed Mood. Respondent also noted that W.M. was a "night owl." Ambien 10 mg. #30 for insomnia and Xanax 1 mg. #100 were prescribed.

GG. On or about January 5, 2000, respondent saw W.M. at his clinic and prescribed Ambien 10 mg. #30 and Xanax 1 mg. #100.

HH. On or about January 26, 2000, respondent saw W.M. at his clinic and prescribed Desyrel 100 mg. #30, a substance which can be used as a sleeping medication, Vicodin

ES #30 and Xanax 1 mg. #100. W.M. was given an appointment to return in 28 days.

II. On or about February 14, 2000, respondent saw W.M. at his clinic and noted the following: "D/C Vic. Desyrel doesn't work. R/R meds. -S/E, Stable. Pleasant." The prior diagnoses were restated. Xanax 1 mg. #100 was prescribed. Respondent did not note a reason for increasing the dosage of Xanax. W.M. was given an appointment to return in 28 days.

JJ. On or about February 24, 2000, respondent saw W.M. at his clinic and prescribed Serzone 100 mg.#30, an anti-depressant, and Xanax 1 mg. #100. Respondent did not note a reason for W.M.'s return for treatment 10 days after her last visit, or a reason for a renewal of the Xanax prescription.

KK. **On or about and between January 5 and February 24, 2000, respondent wrote four prescriptions of Xanax 1 mg. #100 for W.M., enabling her to have 400 tablets of Xanax 1 mg., or twice her normal dosage, for this two month-plus period. Respondent did not document any reason for this doubling in the quantity of Xanax prescribed to W.M.**

LL. On or about March 7, 2000, respondent saw W.M. at his clinic. Respondent noted that W.M. was having a "bad day" because her Social Security had been canceled. The prior diagnoses were restated. No medications were prescribed.

MM. On or about March 23, 2000, W.M. returned to see respondent, who prescribed Xanax 1 mg. #100.

NN. On or about April 21, 2000, W.M. returned to see respondent, who prescribed Xanax 1 mg. #100.

OO. On or about May 23, 2000, W.M. returned to see respondent, who prescribed Ativan 2 mg. #100.

PP. On or about June 27, 2000, W.M. returned to see respondent, who prescribed Ambien 10 mg.#30, Ativan 2 mg. #100 and Xanax 1 mg. #100. Respondent did not document an explanation for the prescription of two benzodiazepines at the same time for the same condition (i.e., anxiety).

QQ. **From on or about October 13, 1999 (a few days following W.M.'s hospitalization for hepatitis from Xanax or benzodiazepine and Vicodin abuse), through June 27, 2000, respondent prescribed 1100 tablets of Xanax 1 mg. and 200 tablets of Ativan 2 mg., both benzodiazepines, to W.M.**

RR. On or about July 26, 2000, W.M. returned to see respondent, who documented that he explained his restriction from practice, the patient's panic, his referral to "Drs. G/K," and the patient being reassured. On this date, respondent's authority to issue prescriptions was suspended by virtue of an ex parte interim order issued by Administrative Law Judge H. Stuart Waxman on July 21, 2000 [Exhibit 6 herein]. On this date, according to W.M., respondent personally asked W.M. to write a letter on his behalf, and respondent's receptionist, Beth, gave W.M. the materials to write the letter. W.M. observed other patients writing letters in support of respondent at the same time and then turning them over to Beth for proof reading and correction. W.M. observed that these patients were not allowed to schedule an appointment or leave the clinic until their letters were

accepted by Beth to her satisfaction. Under these circumstances, W.M. felt compelled to write a letter supporting respondent, in order to schedule a follow-up appointment and leave the clinic. In her letter, dated July 26, 2000, which respondent used to defend against interim suspension [see Exhibit 10 and numbered paragraph 47.E.19., Forty-Fourth Cause For Discipline, both of which are incorporated by reference herein as if fully set forth] W.M. disclosed the medication that respondent had been prescribing for her, and asserted that respondent had not overprescribed medication to her.

SS. On or about August 21, 2000, W.M. returned to see respondent at his clinic. Respondent's progress note for this date indicates that respondent again explained his prescribing restriction to W.M., reassured her, referred her to Dr. Ditman, and discontinued Ativan. On the same progress note is a written statement by Dr. Ditman, indicating zero meds. However, two prescriptions were issued to W.M. on this date, one for Ambien 10 mg. #30 and one for Xanax 1 mg. #100. The prescriptions were written on Dr. Ditman's prescription pad with his signature, but the actual prescription orders were in writing similar to that of respondent.

TT. On or about September 21, 2000, W.M. saw respondent at his clinic. On this date, H.W. received a prescription for Xanax 1 mg. #100. The prescription was written on Dr. Ditman's prescription pad with his signature, but the actual prescription order was in writing similar to

that of respondent's prior prescriptions for W.M.

UU. On or about October 23, 2000, W.M. saw respondent at his clinic. Respondent, whose restriction of prescribing had been temporarily stayed by a superior court, prescribed Xanax 1 mg. #100.

VV. On or about November 20, 2000, W.M. was seen by respondent at his clinic. Respondent prescribed Xanax 1 mg. #100 and Chloral Hydrate 150 cc for insomnia.

WW. On or about December 20, 2000, W.M. saw respondent at his clinic. Respondent and Dr. Ditman both made written entries in the progress note for this date. In respondent's medical file for W.M. are two unsigned prescriptions written on Dr. Ditman's prescription blank forms, one for Xanax 1 mg. #100 and one for Chloral Hydrate 150 cc, both in handwriting similar to respondent's. On or about this same date, W.M. had a prescription signed by Dr. Ditman for Xanax 1 mg. #100 filled at a pharmacy.

XX. On or about January 23, 2001, W.M. visited respondent's clinic. No progress note appears in respondent's records for the patient for this visit.

YY. On or about December 25, 2001, W.M. made the following statement: She was addicted to Xanax when she followed the advice of a fellow addict and sought out respondent to replace Dr. Kenyon, who had lost his license, as her physician. Her first visit to respondent lasted only a few minutes and no physical examination was performed. She would see respondent on a monthly basis for a few minutes.

Her longest visit with respondent during the entire period that she was his patient lasted no longer than ten (10) minutes. She alleged that she telephoned respondent in October 1999 to inform him about her hospitalization for delirium and hepatitis from possible drug abuse, including Xanax abuse. During November 2000, she informed respondent that she was addicted to Xanax and wished to quit taking it. On three separate occasions she received prescriptions from respondent in his writing and was told by respondent to take them to Dr. Ditman, who was located in the same building, for his signature, which she did.

ZZ. **[Extreme Departures from Standard of Practice]** Respondent engaged in extreme departures from the standard of practice in his care and treatment of W.M., as follows:

1. By proceeding to treat a psychiatric patient without performing an initial evaluation consistent with the standard of practice.

2. By failing to make an accurate diagnosis of the patient's substance abuse problem and depressive disorder.

3. By failing to prescribe antidepressant medication for the major depression diagnosed for the period March 17, 1998 through December 2, 1999.

4. By failing to consult with and request the patient's medical records from her prior and

current treating physicians, especially from Kaiser Permanente after August 8, 1999.

5. By prescribing a narcotic, Vicodin ES, without first exploring the effectiveness of non-narcotic, non-addictive modes of treatment and without substantiating through diagnostic techniques or history of previous evaluation and treatment the physical causes of the patient's pain complaints during the period August 6, 1998 through October 2, 1999; and/or failing to document same.

6. By formulating diagnoses of Migraine and menstrual pain, and prescribing a narcotic analgesic to treat them, without confirming the diagnoses through available diagnostic techniques or obtaining a history of previous evaluations and treatment; and/or failing to document same.

7. By prescribing Xanax in increasing quantities from February 2, 1998 through October 1, 1999, without considering whether the patient had developed a tolerance to the medication and become habitually dependent or addicted to it; and/or failing to document same.

8. By continuing to prescribe Xanax after being informed that the patient had

indications of abuse in 1996, had been hospitalized in October 1999 for delirium and hepatitis attributed to its overuse, had been addicted to it at least since November 2000, and had a history of abusing illegal substances (i.e., L.S.D., cocaine).

9. By increasing the prescriptions of Xanax 1 mg. from 200 tablets a month to 400 tablets a month during the period January 5 through February 24,2000 without a medical indication therefor; and/or failing to document same.

10. By prescribing Xanax 1 mg. #100 and Ativan 2 mg. #100, two benzodiazepines, on June 27, 2000, contrary to the assessment of the patient being stabile and pleasant, and without any indication of a medical necessity therefor; and/or failing to document the latter.

11. By writing prescription orders for controlled substances for the patient over the signature of his colleague while prohibited from doing so by the Medical Board through an interim order.

12. By soliciting a **psychiatric** patient, reliant on prescriptions written by him for controlled substances, to which she was either habitually dependent or addicted, to write a

letter publicly revealing her confidential psychiatric disorder and treatment for the purpose of using it to contest an interim order suspending respondent's authority to write prescriptions; and by allowing his receptionist to proof read and correct the letter and convey the impression that further medical treatment (i.e., prescriptions of narcotics and benzodiazepines) would be withheld unless the letter was written to the satisfaction of the receptionist.

SEVENTY-NINTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

52. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent engaged in repeated acts of negligence while treating a patient under his care. The circumstances are as follows:

A. The facts and expert opinions stated in above numbered subparagraphs 51.A. to 51.ZZ. are incorporated by reference herein as if fully set forth.

B. Respondent engaged in repeated departures from the standard of practice in his care and treatment of W.M., as follows:

1. By failing to make an accurate diagnosis of the patient's substance abuse problem.

2. By proceeding to treat a psychiatric patient without performing an initial

evaluation consistent with the standard of practice.

3. By failing to prescribe anti-depressant medication for the major depression diagnosed for the period March 17, 1998 through December 2, 1999.

4. By failing to consult with and request the patient's medical records from her prior and current treating physicians, especially from Kaiser Permanente after August 8, 1999.

5. By prescribing a narcotic, Vicodin ES, without first exploring the effectiveness of non-narcotic, non-addictive modes of treatment and without substantiating, through diagnostic techniques and a history of previous evaluations and treatment, the physical causes of the patient's pain complaints during the period August 6, 1998 through October 2, 1999; and/or failing to document same.

6. By formulating diagnoses of Migraine and menstrual pain, and prescribing a narcotic analgesic to treat them, without confirming the diagnoses through available diagnostic techniques and a history of previous evaluations and treatment; and/or failing to document same.

7. By prescribing Xanax in increasing

quantities from February 2, 1998 through October 1, 1999, without considering whether the patient had developed a tolerance to the medication and become habitually dependent or addicted to it; and/or failing to document same.

8. By continuing to prescribe Xanax after being informed that the patient had indications of abuse in 1996, had been hospitalized in October 1999 for delirium and hepatitis attributed to its overuse, had been addicted to it at least since November 2000, and had a history of abusing illegal substances (i.e., L.S.D., cocaine).

9. By increasing the prescriptions of Xanax 1 mg. from 200 tablets a month to 400 tablets a month during the period January 5 through February 24, 2000, without a medical indication therefor; and/or failing to document same.

10. By prescribing Xanax 1 mg. #100 and Ativan 2 mg. #100, two benzodiazepines, on June 27, 2000, contrary to the assessment of the patient being stabile and pleasant, and without any indication of a medical necessity therefor; and/or failing to document the latter.

11. By writing prescription orders for the patient over the signature of his colleague while prohibited from doing so by the Medical Board through an interim order.

12. By soliciting a **psychiatric** patient, reliant on prescriptions written by him for controlled substances, to which she was either habitually dependent or addicted, to write a letter publicly revealing her confidential psychiatric disorder and treatment for the purpose of using it to contest an interim order suspending respondent's authority to write prescriptions; and by allowing his receptionist to proof read and correct the letter and convey the impression that further medical treatment (i.e., prescriptions of narcotics and benzodiazepines) would be withheld unless the letter was written to the satisfaction of the receptionist.

EIGHTIETH CAUSE FOR DISCIPLINE

(Incompetence)

53. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent demonstrated incompetence while treating a patient under his care. The circumstances are as follows:

A. The facts stated in above numbered paragraph 51 are incorporated by reference herein as if fully set forth.

B. The expert opinions reached in subparagraph ZZ of above numbered paragraph 51, which indicate a lack of medical knowledge and medical judgment, are incorporated by reference herein as if fully set forth.

EIGHTY-FIRST CAUSE FOR DISCIPLINE

(Prescribing to Addict/Habitual User)

54. Respondent is subject to discipline under sections 2234, 2238, and 2241 of the Code, in connection with sections 11153 and 11156 of the Health and Safety Code, in that respondent prescribed controlled substances to an addict or habitual user for other than a legitimate medical purpose. The circumstances are as follows:

A. The facts and expert opinions stated in above numbered paragraph 51 are incorporated by reference herein as if fully set forth.

EIGHTY-SECOND CAUSE FOR DISCIPLINE

(Excessive Prescribing)

55. Respondent is subject to disciplinary action under sections 725 and 2234 of the Code, in that respondent committed acts of clearly excessive prescribing of benzodiazepines and narcotics while treating a patient under his care. The circumstances are as follows:

A. The facts and expert opinions stated in above numbered paragraph 51 are incorporated by reference herein as if fully set forth.

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EIGHTY-THIRD CAUSE FOR DISCIPLINE

(Prescribing Without Exam/Indication)

56. Respondent is subject to disciplinary action under sections 2234 and 2242, subdivision (a) of the Code, in that respondent committed acts of prescribing dangerous drugs without a good faith prior examination and medical indication therefor. The circumstances are as follows:

A. The facts and expert opinions stated in above numbered paragraph 51 are incorporated by reference herein as if fully set forth.

EIGHTY-FOURTH CAUSE FOR DISCIPLINE

(Inadequate Records)

57. Respondent is subject to disciplinary action under section 2266 of the Code, in that respondent failed to maintain adequate and accurate records relating to the provision of services to a patient. The circumstances are as follows:

A. The facts and expert opinions stated at subparagraphs F., I., K. L., M., N., O., P., Q., R., S. T., W., X., Z., BB., CC., DD., KK., PP., and XX of above numbered paragraph 51 are incorporated by reference herein as if fully set forth.

EIGHTY-FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

58. Respondent is subject to disciplinary action under section 2234 of the Code, in that respondent engaged in general unprofessional conduct by writing prescription orders for a patient while prohibited from so doing by interim order. The circumstances

are as follows:

A. The facts and expert opinions stated at subparagraphs SS., TT., YY. and ZZ. of above numbered paragraph 51 are incorporated by reference herein as if fully set forth.

EIGHTY-SIXTH CAUSE FOR DISCIPLINE

(Making False Statements)

59. Respondent is subject to disciplinary action under section 2261 of the Code, in that respondent made false statements regarding a patient under his care. The circumstances are as follows:

A. The facts alleged in subparagraphs D., F., H., I., J., K., L., M., N., R., S., V. and YY. of above numbered paragraph 51 (i.e., claims of performance of psychiatric evaluations and/or 20 to 30 minute psychotherapy sessions for billing purposes when respondent never treated W.M. for longer than ten (10) minutes) are incorporated by reference herein as if fully set forth.

EIGHTY-SEVENTH CAUSE FOR DISCIPLINE

(Alteration of Medical Records)

60. Respondent is subject to disciplinary action under section 2262 of the Code, in that respondent created false medical records with fraudulent intent. The circumstances are as follows:

A. The facts alleged in above numbered paragraph 59 are incorporated by reference herein as if fully set forth.

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EIGHTY-EIGHTH CAUSE FOR DISCIPLINE

(Dishonesty)

61. Respondent is subject to disciplinary action under section 2234, subdivision (e) of the Code, in that respondent has engaged in acts of dishonesty in connection with his treatment of a patient. The circumstances are as follows:

A. The facts alleged in above numbered paragraph 59 are incorporated by reference herein as if fully set forth.

EIGHTY-NINTH CAUSE FOR DISCIPLINE

(Convictions of Crimes)

62. Respondent is subject to disciplinary action under sections 2234, 2236 and 2237 of the Code, in that respondent has been convicted of multiple offenses for violating a state law regulating dangerous drugs or controlled substances while engaged in the practice of medicine. The circumstances are as follows:

A. Section 2236 of the Code provides that it is unprofessional conduct for a physician and surgeon to be convicted of a criminal offense which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

B. Section 2237 of the Code provides that it is unprofessional conduct for a physician and surgeon to be convicted of a criminal offense involving a violation of any state or federal statute or regulation concerned with dangerous drugs or controlled substances, and that a record of conviction for such a violation shall be conclusive evidence of unprofessional conduct.

C. Section 2237 of the Code provides further that disciplinary action may be ordered "when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence. . . ."

D. Rule 31 of the California Rules of Court provides that a notice of appeal shall be filed with the clerk of the superior court within 60 days after the rendition of the judgment.

E. Section 1466 of the Penal Code provides for appeal to the appellate department of the superior court of any misdemeanor conviction.

F. Section 11156 of the Health and Safety Code of California provides that no person shall prescribe for or administer, or dispense a controlled substances to an addict or habitual user, or to any person representing himself as such, except as permitted by statute.

G. On or about July 27, 2000, in People v. William Leader, Case No. 0CR01126 of the Municipal Court of Los Angeles County, respondent was charged with sixteen counts of violating section 11156 of the Health and Safety Code during his care and treatment of two patients, S.M. and E.D., which are the same patients previously identified in the instant pleading. (See Seventh [S.M.] and Thirty-Third [E.D.] Causes for Discipline)

H. On or about January 22, 2001, in People v. William Leader, Case No 0CR01126 of the Superior Court of Los

Angeles County, the criminal complaint against respondent was amended, and two of the sixteen counts were dismissed in the interest of justice. A trial by jury then commenced.

I. On or about January 31, 2001, in People v. William Leader, Case No. 0CR01126 of the Superior Court of Los Angeles County, the jury returned guilty verdicts on the remaining fourteen counts of violating section 11156 of the Health and Safety Code.

I. On or about February 5, 2001, in People v. William Leader, Case No. 0CR01126 of the Superior Court of Los Angeles County, the Hon. Josh M. Fredricks, Judge of the Superior Court, entered a judgment of conviction against respondent on each of the fourteen counts of violating section 11156 of the Health and Safety Code upon which the jury had reached a verdict of guilty. On the same date, a judgment of sentence was entered by Judge Fredricks, ordering respondent to serve consecutive one year terms in the county jail for each of five convictions, or five years total. Sentence on the remaining nine convictions was suspended. Bail on appeal was granted.

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PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending Physician and Surgeon's Certificate Number A-41125, heretofore issued to respondent William O. Leader, M.D.;

2. As to the Eighty-Ninth Cause For Discipline, revoking or suspending Physician and Surgeon's Certificate Number A-41125, heretofore issued to respondent William O. Leader, M.D., when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence.

3. Revoking, suspending or denying approval of respondent's authority to supervise physician's assistants, pursuant to section 3527 of the Code;

4. Ordering respondent to pay the Division the reasonable costs of the investigation and enforcement of this case and, if placed on probation, the costs of probation monitoring;

5. Taking such other and further action as the Division deems necessary and proper.

DATED: April 27, 2001.

Ron Joseph (R.a.)

Ron Joseph
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

FILE COPY

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

In the Matter of the Accusation Against:	Case Nos. 06-1996-65821, 06-1997-79431, 06-1998-82571, 06-1999-100710
WILLIAM O. LEADER, M.D. 822 N. McCadden Place Los Angeles, CA 90038	OAH No.L-1999090218
Physician's and Surgeon's Certificate No. A41125, Respondent.	**AMENDMENT OF ACCUSATION TO CONFORM TO PROOF**

TO RESPONDENT AND COUNSEL FOR RESPONDENT:

1. Pursuant to section 11507 of the Government Code, complainant hereby amends the Third Amended Accusation to conform to proof based upon the completed testimony of witnesses, especially Timothy E. Botello, M.D., presented from January 8 through 18, 2001, during the presentation of complainant's case-in-chief at the administrative hearing, which is scheduled to resume on March 12, 2001 with the commencement of respondent's case-in-chief.

A. The following Causes For Discipline augment and further specify the existing Third Amended Accusation, beginning with the Forty-Eighth Cause For Discipline, designated as number "48" below:

PATIENT E.W:

48. Respondent is subject to disciplinary action, in that respondent engaged in an extreme departure from the standard of practice and incompetence, in violation of section 2234, subds. (b)[Gross Negligence] and (d)[Incompetence] of the Code, by failing to obtain a medical history from E.W. when she first presented to respondent on March 10, 1995, prior to prescribing Vicodin ES for the use of E.W.

49. Respondent is subject to disciplinary action, in that respondent engaged in an extreme departure from the standard of practice and incompetence, in violation of section 2234, subds. (b)[Gross Negligence], (c) [Repeated Negligent Acts] and (d)[Incompetence] of the Code, by failing to obtain a medical history from E.W. when she presented to respondent on March 24, 1995, prior to prescribing Vicodin ES for the use of E.W.

50. Respondent is subject to disciplinary action, in that respondent demonstrated incompetence, in violation of section 2234, subd. (d)[Incompetence] of the Code, by declaring under penalty of perjury in a signed statement presented to the Board in defense of a petition for an interim order of suspension [Exhibit "8"] that he never requested E.W.'s records from her prior and current physicians because they had never requested his records on E.W. from him.

51. Respondent is subject to disciplinary action, in that respondent engaged in two extreme departures from the standard of practice and twice demonstrated incompetence, in violation of section 2234, subds. (b)[Gross Negligence], (c)[Repeated Negligent Acts] and (c)[Incompetence] of the Code, by prescribing 180 Xanax tablets to E.W. from March 10 through 24, 1995, and doubling the dose thereof on March 24, 1995, without medical indication, which also twice violated sections 725 [Excessive Prescribing] and 2242, subd. (a)[Prescribing Without Medical Indication] of the Code.

52. Respondent is subject to disciplinary action, in that respondent engaged in two extreme departures from the standard of practice and twice demonstrated incompetence, in violation of section 2234, subds. (b)[Gross Negligence], (c)[Repeated Negligent Acts] and (d)[Incompetence], by prescribing 160 Vicodin ES tablets to E.W. from March 10 through 24, 1995, which also violated

sections 725[Excessive Prescribing] and 2242, subd. (a)[Prescribing Without Medical Indication] of the Code.

53. Respondent is subject to disciplinary action, in that respondent engaged in an extreme departure from the standard of practice and incompetence, in violation of section 2234, subds. (b)[Gross Negligence] and (d)[Incompetence] of the Code, by failing to refer E.W. to a medical specialist (e.g., internist, cardiologist, orthopedic surgeon) after respondent documented that from March 10 through 24, 1995, E.W. presented with symptoms of high blood pressure, severe diarrhea, severe anxiety, and severe intractable lower back pain.

54. Respondent is subject to disciplinary action, in that respondent prescribed a controlled substance to E.W. without a prior good faith examination or medical indication therefor, in violation of section 2242, subd. (a) of the Code, by prescribing Vicodin ES to E.W. on May 30, 1995, for "severe, chronic, intractable pain secondary to lumbar disc" without first obtaining a confirmed diagnosis of the condition as required under the standard of practice.

55. Respondent is subject to disciplinary action, in that respondent prescribed a controlled substance to E.W. without a prior good faith examination or medical indication therefor, in violation of section 2242, subd. (a) of the Code, by prescribing Catapres 0.03 mg. 100 tablets for E.W.'s hypertension on May 30, 1995, more than three times the amount previously prescribed, without documenting an elevated blood pressure or alternative diagnosis, which also violated section 725[Excessive Prescribing] of the Code.

56. Respondent is subject to disciplinary action, in that respondent prescribed a controlled substance to E.W. without a prior good faith examination or medical indication therefor, in violation of section 2242, subd. (a) of the Code, by prescribing Catapres 0.03 mg. 100 tablets for E.W.'s hypertension on June 9, 1995, or 200 tablets of Catapres from May 30 through June 9, 1995, without documenting an elevated blood pressure or alternative diagnosis, which also violated section 724[Excessive Prescribing] of the Code.

57. Respondent is subject to disciplinary action, in that respondent engaged in two extreme departures from the standard of practice and twice demonstrated incompetence, in violation

of section 2234, subds. (b)[Gross Negligence], (c)[Repeated Negligent Acts] and (c)[Incompetence] of the Code, by prescribing 160 Vicodin ES tablets, 180 Xanax 2 mg. tablets, 200 Catapres tablets and 16 oz. Of Phenergan with Codeine to E.W. from May 30 through June 9, 1995, which also violated sections 725[Excessive Prescribing] and 2242, subd. (a)[Prescribing Without Medical Indication] of the Code.

58. Respondent is subject to disciplinary action, in that respondent twice prescribed a controlled substance to E.W. without a prior good faith examination or medical indication therefor, in violation of section 2242, subd. (a)[Prescribing Without Medical Indication] of the Code, by prescribing Darvon and Vicodin, similar narcotic substances, on June 28 and July 19, 1995, for the use of E.W. without confirming a diagnosis for the prescriptions.

59. Respondent is subject to disciplinary action, in that respondent prescribed Klonopin 2 mg., a benzodiazepine-like substance, and Xanax 2 mg., a benzodiazepine, to E.W. on June 28 and July 19, 1995, without confirming a diagnosis for said prescriptions, in violation of section 2242, subd. (a) of the Code.

60. Respondent is subject to disciplinary action, in that respondent engaged in two extreme departures from the standard of practice and incompetence, in violation of section 2234, subds. (b)[Gross Negligence], (c)[Repeated Negligent Acts] and (d)[Incompetence] of the Code, by prescribing Darvon, Vicodin, Klonopin and Xanax to E.W. on June 28 and July 19, 1995.

PATIENT S.M:

61. Respondent is subject to disciplinary action, in that respondent engaged in an extreme departure from the standard of practice and incompetence, in violation of section 2234, subds. (b)[Gross Negligence] and (d)[Incompetence] of the Code, by prescribing 340 tablets of Valium 10 mg. and 180 tablets of Phenobarbital to S.M. from May 13 through September 9, 1997, which also violated sections 725[Excessive Prescribing], 2242, subd. (a)[Prescribing Without Medical Indication], 2238 and 2241[Prescribing to an Addict/Habitue] of the Code.

62. Respondent is subject to disciplinary action, in that respondent engaged in an extreme departure from the standard of practice and incompetence, in violation of section 2234,

subds. (b)[Gross Negligence] and (d)[Incompetence] of the Code, by billing for the performance of psychotherapy with S.M. on June 10, June 24 and September 2, 1997, contrary to respondent's treatment records for said dates, which also violated sections 2266[Adequate and Accurate Records], 2261[False Statements] and 2262[Alteration of Medical Records] of the Code.

63. Respondent is subject to disciplinary action, in that respondent demonstrated incompetence, in violation of section 2234, subdivision (d) of the Code, by proceeding to treat S.M., a psychiatric patient, without performing an initial evaluation of the patient consistent with the standard of practice.

PATIENT E.D:

64. Respondent is subject to disciplinary action, in that respondent engaged in an extreme departure from the standard of practice and incompetence, in violation of section 2234, subds. (b)[Gross Negligence] and (d)[Incompetence] of the Code, by prescribing 380 Xanax tablets to E.D. from June 25 through July 11, 1996, which also violated sections 725[Excessive Prescribing] and 2242, subd. (a)[Prescribing Without Medical Indication] of the Code.

65. Respondent is subject to disciplinary action, in that respondent engaged in an extreme departure from the standard of practice and incompetence, in violation of section 2234, subds. (b)[Gross Negligence] and (d)[Incompetence] of the Code, by prescribing 135 Fioricet with Codeine tablets [a narcotic substance] to E.D. from June 25 through July 11, 1996, which also violated sections 725[Excessive Prescribing] and 2242, subd.(a)[Prescribing Without Medical Indication] of the Code.

66. Respondent is subject to disciplinary action, in that respondent engaged in an extreme departure from the standard of practice and incompetence, in violation of section 2234, subds. (b)[Gross Negligence] and (d)[Incompetence] of the Code, by prescribing 163 Xanax tablets, 100 Valium tablets and 200 Tylenol with Codeine tablets [a narcotic] to E.D. from January 24 through February 7, 1997, which also violated sections 725[Excessive Prescribing] and 2242, subd. (a)[Prescribing Without Medical Indication] of the Code.

67. Respondent is subject to disciplinary action, in that respondent engaged in an extreme departure from the standard of practice and incompetence, in violation of section 2234, subds. (b)[Gross Negligence] and (d)[Incompetence] of the Code, by prescribing Phenergan with Codeine, a narcotic substance, three times and Klonopin 2 mg. 148 tablets to E.D. from February 21 through March 7, 1997, which also violated sections 725[Excessive Prescribing] and 2242, subd. (a)[Prescribing Without Medical Indication] of the Code.

68. Respondent is subject to disciplinary action, in that respondent engaged in an extreme departure from the standard of practice and incompetence, in violation of section 2234, subds. (b)[Gross Negligence] and (d)[Incompetence] of the Code, by prescribing 300 tablets of Xanax to E.D. from June 11 through 26, 1997, which also violated sections 725[Excessive Prescribing], 2242, subd. (a)[Prescribing Without Medical Indication], 2238 and 2241[Prescribing to an Addict/Habitue] of the Code.

69. Respondent is subject to disciplinary action, in violation of sections 2266[Adequate and Accurate Records], 2261[False Statements] and 2262[Alteration of Medical Records] of the Code, by billing for the performance of psychotherapy with E.D. on September 9, September 22, October 2, October 17 and October 30, 1997, and January 8 and December 18, 1998, contrary to respondent's treatment records for said dates.

70. Respondent is subject to disciplinary action, in violation of section 2266[Adequate and Accurate Records], 2261[False Statements] and 2262[Alteration of Medical Records] of the Code, by writing a letter on May 4, 1998, stating that E.D. had severe tendinitis of the lumbar spine, which was unsupported by any documentation of a confirmed diagnosis for said condition in respondent's medical records for E.D.

71. Respondent is subject to disciplinary action, in that respondent engaged in an extreme departure from the standard of practice and incompetence, in violation of section 2234, subds. (b)[Gross Negligence] and (d)[Incompetence] of the Code, by prescribing Lortab, a narcotic substance, to E.D. on January 27, 1998, which also violated section 2242, subdivision (a)[Prescribing Without Medical Indication], 2238 and 2241[Prescribing to an Addict/Habitue] of the Code.

.72. Respondent is subject to disciplinary action, in that respondent engaged in an extreme departure from the standard of practice and incompetence, in violation of section 2234, subds. (b)[Gross Negligence] and (d)[Incompetence] of the Code, by prescribing 255 Xanax tablets and 147 Tylenol with Codeine tablets to E.D. from March 12 through 18, 1998, which also violated sections 725[Excessive Prescribing], 2242, subd. (a)[Prescribing Without Medical Indication], 2238 and 2241[Prescribing to an Addict/Habitue] of the Code.

73. Respondent is subject to disciplinary action, in that respondent engaged in an extreme departure from the standard of practice and incompetence, in violation of section 2234, subds. (b)[Gross Negligence] and (d)[Incompetence] of the Code, by prescribing 315 Xanax tablets and 187 Codeine tablets to E.D. from May 4 through 28, 1998, which also violated sections 725[Excessive Prescribing], 2242, subd. (a)[Prescribing Without Medical Indication], 2238 and 2241[Prescribing to an Addict/Habitue] of the Code.

74. Respondent is subject to disciplinary action, in that respondent engaged in an extreme departure from the standard of practice and incompetence, in violation of section 2234, subds. (b)[Gross Negligence], (c)[Repeated Negligent Acts] and (d)[Incompetence] of the Code, by prescribing Fentinyl [a narcotic substance], Vicodin [a narcotic substance], Codeine [a narcotic substance] and Xanax to E.D. from August 31 through November 5, 1998, which also violated sections 725[Excessive Prescribing], 2242, subd. (a)[Prescribing Without Medical Indication], 2238 and 2241[Prescribing to an Addict/Habitue] of the Code.

75. Respondent is subject to disciplinary action, in that respondent engaged in an extreme departure from the standard of practice and incompetence, in violation of section 2234, subds. (b)[Gross Negligence], (c)[Repeated Negligent Acts] and (d)[Incompetence] of the Code, by prescribing Xanax, Vicodin, Klonopin and Codeine to E.D. from January 11 through July 27, 1999, which also violated sections 725[Excessive Prescribing], 2242, subd. (a)[Prescribing Without Medical Indication], 2238 and 2241[Prescribing to an Addict/Habitue] of the Code.

76. Respondent is subject to disciplinary action, in that respondent engaged in an extreme departure from the standard of practice and incompetence, in violation of section 2234,

subds. (b)[Gross Negligence] and (d)[Incompetence] of the Code, by failing to prescribe mood stabilizing medication to E.D. for his Bipolar Affective Disorder from February 15 through July 27, 1999.

77. Respondent is subject to disciplinary action, in that respondent engaged in an extreme departure from the standard of practice and incompetence, in violation of section 2234, subds. (b)[Gross Negligence] and (d)[Incompetence] of the Code,, by prescribing Depakote and Tegretol to E.D. from February 21, 1997 through January 13, 1999, without performing substance level, liver function and blood count tests to assess the therapeutic/toxic effects of the medications.

B. The following further modifications are made to the Third Amended Accusation:

1. At page 78, numbered paragraph 37.B.10. of the Third Amended Accusation, the allegation that respondent departed from the standard of practice by falsely representing in a letter intended to be used in a court proceeding that he provided treatment to E.D. three times per week in late February and early March 1997 has been clarified by respondent's subsequently filed declaration [Exhibit "8"] which identifies previously undated progress notes, and therefore this particular allegation is withdrawn as a factor supporting the Thirty-Fourth, Thirty-Ninth, Fortieth and Forty-Second Causes for Discipline.

2. At page 39, numbered paragraphs 16.X.1., 16.X.2., and 16.X.3. (within the Thirteenth Cause for Discipline [Gross Negligence]) are withdrawn. (The corresponding allegations in paragraphs 17.B.1., 17.B.2, and 17.B.3. are **not** withdrawn.) Paragraphs 16 X.4. and 16X.5. are **not** withdrawn.

3. At page 40, in paragraph 16.X.4., the words "Chloral Hydrate" are withdrawn.

4. At page 41, in paragraph 17.B.4., the words "Chloral Hydrate" are withdrawn.

5. At page 46, paragraph 22.M.2. is withdrawn. (The corresponding allegations in paragraph 23.B.2. are **not** withdrawn.)

6. At page 47, paragraph 22.M.3. is withdrawn. (The corresponding allegations in paragraph 23.B.3. are **not** withdrawn.)

7. At page 47, paragraph 22.M.4. is withdrawn. (The corresponding allegations in paragraph 23.B.4. are **not** withdrawn.)

8. At page 47, paragraph 22.M.6. is withdrawn.

9. At pages 48 through 49, paragraph 23.B.6. is withdrawn.

10. At page 49, paragraph 24 is withdrawn.

DATED: February 27, 2001.

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Attorneys for Complainant