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

In the Matter of the Accusation Against:	)	
	)	
YANIRA MARIA OLAYA, M.D.	)	Case No. 10-2010-211148
	)	
	)	OAH No. 2012020012
Physician's and Surgeon's	)	
Certificate No. A 94208	)	
	)	
Respondent.	)	
	)	

DECISION AND ORDER

The attached Proposed Decision is hereby adopted by the Medical Board of California, Department of Consumer Affairs, State of California, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on June 5, 2013.

IT IS SO ORDERED May 6, 2013.

MEDICAL BOARD OF CALIFORNIA

By: _____
Reginald Low, M.D., Chair
Panel B

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

In the Matter of the Accusation Against: YANIRA MARIA OLAYA, M.D. 2103 Caminito Circulo Norte La Jolla, CA 92037 Physician's and Surgeon's Certificate No. A94208 Respondent.	Case No. 10-2010-211148 OAH No. 2012020012

PROPOSED DECISION

Administrative Law Judge Vallera J. Johnson, State of California, Office of Administrative Hearings, heard this matter in San Diego, California, on December 3, 4, 5, 10, 2012, and January 25, 28, 29, 31, and February 4, 2013.

Abraham Levy, Deputy Attorney General, represented Complainant Linda K. Whitney, Executive Director, Medical Board of California, Department of Consumer Affairs.

Frank S. Clowney, III, Esq., Law Office of Frank S. Clowney, III represented Respondent Yanira M. Olaya, M.D.

The matter was submitted on April 4, 2013.[1]

[1] During the hearing, Complainant moved for the admission of Exhibit 37 ("Complications of Alcohol Withdrawal," Alcohol Health and Research World, Vol. 22, No. 1, 1998) because there were references to this article during the hearing. Respondent objected. No expert witness relied on this document in rendering an opinion. No expert witness testified that this was considered to be a publication upon which reasonable physicians relied. Having considered the foregoing and the arguments of counsel, Exhibit 37 is admitted into evidence solely for the purpose of reference to the document but not to establish the truth of any of the matters set forth in that document.

The hearing concluded on February 4, 2013. The record remained open to permit the receipt of additional documentary evidence. The letter from Ronald C. Fischer, M.D. was

FACTUAL FINDINGS

1. Linda K. Whitney (Complainant) filed Accusation, Case No. 10-2010-21148, dated December 29, 2011, against Yanira Maria Olaya, M.D., in her official capacity as Executive Director, Medical Board of California, Department of Consumer Affairs (Medical Board). The Accusation alleged that Respondent committed repeated negligent acts in her care and treatment of patients C.M., R.W. and D.E.

Respondent filed a timely Notice of Defense, requesting a hearing in this matter.

2. On February 26, 2006, the Medical Board issued Physician's and Surgeon's Certificate Number A-94208 to Respondent. At all times relevant herein, said Physician's and Surgeon's Certificate was in full force and effect and will expire on May 31, 2013, unless renewed.

Respondent's Background

3. In addition to California, Respondent is licensed to practice medicine in the State of Florida.

Respondent was born in Miami, Florida and moved with her family to the Dominican Republic and attended American schools there. She attended and completed a six-year undergraduate/medical school program at Santo Domingo Technological Institute (1992 – 1998), one of the few medical doctorate programs accredited in the United States. Respondent participated in and completed a residency program in general psychiatry at the University of Florida, Gainesville (2002 – 2006). She participated in and completed a fellowship in forensic psychiatry at the University of Miami, Miami (2006 – 2007).

Respondent is board certified in general psychiatry and board certified in forensic psychiatry. She is a member of the American Psychiatric Association, American Academy of Psychiatry and Law, and the California Psychiatric Society.

Since 2006, Respondent has been in practice in a variety of settings, including prison settings and addiction treatment programs.

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dated and filed on February 5, 2013 and was marked Exhibit V. Without objection by Complainant, Exhibit V was admitted into evidence. The record was closed on February 6, 2013.

On April 2, 2013, the record was re-opened, and Complainant was ordered to provide the missing pages to complete Exhibit 11. On April 4, 2013, Complainant provided a complete copy of Exhibit 11. On April 4, 2013, the record was closed, and the matter was submitted.

Between December 2007 and July 2010, Respondent was employed as a staff psychiatrist at the San Diego County Psychiatric Hospital (SDCPH). During her tenure, she served as the Chief of Staff for the Crisis Recovery Unit as well as Vice-Chief of Staff. The incidents alleged in the Accusation occurred at SDCPH.

San Diego Psychiatric Hospital

4. SDCPH provides emergency and inpatient care for the indigent, homeless and uninsured population of San Diego County afflicted with mental illnesses, sometimes exacerbated by their substance abuse. The hospital's patients typically suffer from various forms of psychosis and often lack the will or support system to cope with their illnesses. The patients often suffer from poor general health and personal hygiene issues.

The psychiatrists at the SDCPH treat the symptoms of the mental illnesses through the use of medications, typically with the goal of stabilizing their patients so that they return to a functional state and can be discharged.

Patients enter SDCPH through its Emergency Psychiatric Unit (EPU). Law enforcement officers, conservators or other psychiatric care facilities (that are unable to handle the patients due to their severe illness or dangerous behavior) may bring patients to the EPU. Patients might arrive involuntarily and be retained on a "72-hour hold"[2]. The

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[2] The terms of a 72-hour hold, also known as a 5150 hold, are set forth in Welfare and Institutions Code section 5150. This statute provides:

> When any person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, designated members of a mobile crisis team provided by Section 5651.7, or other professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation. Such facility shall require an application in writing stating the circumstances under which the person's condition was called to the attention of the officer, member of the attending staff, or professional person, and stating that the officer, member of the attending staff, or professional person has probable cause to believe that the person is, as a result of mental disorder, a danger to others, or to himself or herself, or gravely disabled. If the probable cause is based on the statement of a person other than the officer, member of the attending staff, or professional person, such person shall be liable in a civil action for intentionally giving a statement which he or she knows to be false.

Such facility shall require an application in writing stating the circumstances under which the person's condition was called to the attention of the officer, member of the attending staff, or professional person, and stating that the officer, member of the attending staff, or

patients undergo medical and psychiatric assessments in the EPU and thereafter may be admitted to the Crisis Recovery Unit (CRU), the inpatient portion of SDCPH. Psychiatrists in the CPU have caseloads of 16 patients at a time.

5. This case involved the care and treatment of three patients. All medical records at issue were provided in this case. The parties identified and stipulated to specific relevant pages of the medical records.

Expert Witnesses

6. In order to determine the standard of care and whether Claimant deviated from the standard of care in her care and treatment of three patients, the curriculum vitae, reports, opinions and testimony of the expert witnesses were considered.

Alan L. Schneider, M.D., DFAPA, FACAM (Dr. Schneider) was called by Complainant. He prepared three separate reports, dated August 29, 2011, December 10, 2011 and September 12, 2012.[3]

David Y. Kan, M.D., M.R.O. (Dr. Kan) was called by Respondent. He prepared a report, dated June 1, 2012.[4]

Each expert witness has extraordinary qualifications and experience, including education, training, certifications, teaching, research, publications and practice; in addition, each is qualified and has experience providing care and treatment to patients with co-morbid conditions that include addiction/substance abuse in facilities similar to SDCPH.

Overall, each expert witness relied on proper factual bases to render his opinions, including the complete medical records of the patients that are the subject of this proceeding. The testimony and reports of each expert witness was clear and straightforward. The testimony of each witness was consistent regarding patient R.W., but was inconsistent regarding patient C.M. and patient D.E.

The foregoing was considered in determining whether Respondent's care and treatment of each patient involved a deviation from the standard of care.

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professional person has probable cause to believe that the person is, as a result of mental disorder, a danger to others, or to himself or herself, or gravely disabled. If the probable cause is based on the statement of a person other than the officer, member of the attending staff, or professional person, such person shall be liable in a civil action for intentionally giving a statement which he or she knows to be false.

[3] Exhibits 24, 29, L, M and N

[4] Exhibit T

Patient C.M.

7. On May 26, 2010, patient C.M., then a 51-year old male, was brought to the EPU at SDCPH for a 5150 hold as gravely disabled. Mary Renzi (Dr. Renzi) was his admitting psychiatrist, and Ronald F. Fischer, M.D. (Dr. Fischer) was his admitting medical doctor. When medically cleared, on May 28, 2010, patient C.M. was transferred to the CPU; Respondent became his treating psychiatrist.

Patient C.M. told Dr. Renzi that he had been drinking all day, every day for 35 years; he said that he had not eaten in two days but that he had had "drinks" on that day; his blood alcohol content (BAC) at the time of his arrival at the hospital was zero; his urine drug screen was negative for all substances. Patient C.M. reported to Dr. Renzi that he was "having ongoing auditory or visual hallucinations"; he described this as "a movie that is constantly replaying".

Dr. Fischer reported that patient C.M. was a severe drug and alcohol abuser who had been homeless for at least 15 years and that he had had multiple episodes of delirium tremens (DTs) and withdrawal seizures; patient C.M. "curiously not exhibiting any signs of alcohol this week". At the time of his admission, patient C.M.'s blood pressure was 110/70, and his heart rate was 76. It was noted that patient C.M. had a history of gait ataxia and cerebellar degeneration likely due to alcohol abuse.

Patient C.M. was admitted to the CPU with diagnoses of alcohol dependence, psychotic disorders, asthma, chronic obstructive pulmonary disease (COPD), and chronic back pain. On admission, the treatment plan was to place patient C.M. on an alcohol withdrawal protocol.

8. On May 28, 2010, patient C.M.'s care was transferred to Respondent. Among other things, Respondent noted that patient C.M. had an ongoing alcohol abuse history for some time; at that time, he had minimal withdrawal symptoms; his last drink was four to five days prior; he had been "endorsing visual hallucinations in the context of alcohol withdrawal." "He has a history of withdrawal symptoms, but denies any seizures."

Patient C.M. had been admitted to the hospital in 2007 and diagnosed with alcohol dependence.

Patient C.M. had multiple arrests for, among other things, public intoxication and assault and illegal lodging.

In her treatment plan, Respondent stated, in pertinent part:

> He will be allowed to sign in as voluntary. He has agreed to have the treatment team monitor his withdrawal symptoms so that he can transition to potentially a residential rehab facility. At this time he will go on alcohol withdrawal precautions with vital signs every eight hours for 48 hours and then daily. Ativan as needed will be

available for vital signs of blood pressure greater than 149/99 or a pulse greater than 99. Nutritional supplements include Multivitamin daily, Folic Acid 1 mg daily and Thiamine 100 mg daily. He will be provided Vistaril for anxiety. He has been encouraged to attend groups regularly. Treatment team will assess him daily to determine efficacy of medications and withdrawal symptoms, at which point he will be reevaluated for disposition arrangements, which may include a residential rehab, a crisis house or to self/shelter.

9. On June 1, 2010, Respondent scheduled a dose of Trazodone, 100 mg, to be given to patient C.M. for insomnia. On June 2, 2010, patient C.M. woke up and went to breakfast. During breakfast, he became shaky, disoriented, dropped his coffee mug and had "seizure-like" shaking in his body. At the time, of the episode, he was under observation. Nurse Nwagbo's note states, "Pt continued bending over and shaking but responsive." Patient C.M. was wheeled outside, and it was noted that he was dragging his foot. In attempting to transfer him out of his wheelchair, he answered to his name and then became non-responsive with a thread pulse. He was monitored until an ambulance arrived. His oxygen level de-saturated to 88%-97% on room air, and his pulse was irregular at 73 beats per minute.

Patient C.M. was transported to the emergency room at University of California, San Diego (UCSD) Medical Center where he underwent diagnostic tests. Patient C.M. was discharged back to SDCPH the same day. The physicians at UCSD Medical Center concluded that patient C.M. probably suffered an orthostatic hypotension episode associated with the use of Trazodone. The Trazodone was discontinued. Respondent did not change patient C.M.'s alcohol detoxification regimen.

10. On June 4, 2010, Respondent discharged patient C.M. from the psychiatric hospital to UCSD Bridges to Recovery Program, a sober living environment, and as needed, to the Jane Westin Center, a walk-in center dealing with psycho-social issues.

11. Complainant alleged that Respondent's management of patient C.M. constituted a single negligent act in that:

- She failed to recognize that patient C.M. probably had a withdrawal seizure on June 2, 2010 and failed to add the appropriate course correction for the patient with an appropriately scheduled anti-seizure medication.
- She prematurely discharged patient C.M. on June 4, 2010, without sufficiently observing and monitoring the patient's condition after the seizure incident of June 2, 2010, to ensure the acute symptoms of withdrawal had concluded.

12. Respondent considered alcohol withdrawal seizure among her differential diagnoses for patient C.M.'s fainting episode and eliminated this as a possibility.

13. Having considered the testimony of the expert witnesses and Respondent's testimony, as well as the documentary evidence (particularly Respondent's medical records and SDCPH's protocol for alcohol withdrawal in existence in June 2010, as described in Respondent's treatment plan [Finding 8]), Dr. Kan's opinion regarding patient C.M. was determined to be more reliable and logical than Dr. Schneider's.

14. In Dr. Kan's opinion, Respondent's care and treatment of patient C.M. was within the standard of care.

Patient C.M. was admitted for complications largely related to alcohol dependence. He evidenced depressed mood and some psychotic symptoms on presentation. Respondent accurately diagnosed him with alcohol dependence. She ordered an alcohol protocol with objective parameters for medication. Patient C.M. received frequent vital signs and assessments by nursing staff.

Alcohol withdrawal seizures are most common between six and 48 hours from the last alcoholic drink; however three to 10 percent of the population have alcohol withdrawal seizures up to 20 days after the last alcoholic drink. Considering that patient C.M.'s BAC was negative when he initially evaluated, and he received close monitoring of his vital signs for at least 48 hours, close observation for alcohol withdrawal was done. Also, he was receiving every 15-minute observation while on the CRU.

Respondent appropriately ordered Trazadone 100 mg for sleep on June 1, 2010. Insomnia is the most common complication for newly sober alcoholics, and the initiation of Trazadone was medically appropriate in indication and dose. Trazadone is the most commonly prescribed sedative in most acute psychiatric units due to its low abuse potential and high efficacy. Though not known for its propensity to cause orthostatic hypotension, orthostasis is a known complication of Trazadone.

In Dr. Kan's opinion, the fainting episode (that occurred on June 2, 2010) was likely the result of either vasovagal or orthostatic syncope, possibly related to Trazodone, diagnosed by the UCSD Medical Center doctors. A review of the patient's chart showed no indication of post-ictal symptoms. He was conscious and responsive as the fainting episode began and while he was shaking. It was not until he was transferred from his wheelchair that he fully lost consciousness. In addition, he had COPD that put him at high risk for oxygen desaturation during a syncopal episode.

15. Respondent ordered an appropriate detoxification protocol. Patient C.M. was in the hospital between May 26, 2010, and June 4, 2010. During this time, he received close observation; he exhibited no alcohol withdrawal symptoms such as tremors, diaphoresis, hallucinations, agitation or discomfort.

According to Dr. Kan, there was no evidence that patient C.M. suffered a withdrawal seizure. He was not persistently tremulous nor did he show unstable vital signs or any other symptoms that would be consistent with alcohol withdrawal. The fainting episode occurred

seven days after his admission. Alcohol withdrawal seizures are highly improbable seven days after a last drink. He was well out of the danger zone for suffering an alcohol withdrawal seizure.

16. Considering the facts (Findings 7, 8, 9, 10, 12, 13, 14 and 15), it was not established that Respondent failed to recognize that patient C.M. probably had a withdrawal seizure on June 2, 2010. As such, it would have been inappropriate to treat him with anti-seizure medication.

17. The fainting incident occurred on June 2, 2010. He remained in the hospital (almost 48 hours) until June 4, 2010. On that date, patient C.M. requested to be discharged. He was stable, and there was no basis to retain him on a 5150 hold. Given the facts, he remained in the hospital an adequate period of time for sufficient observation and monitoring of his condition. As such, Respondent did not prematurely discharge patient C.M. on June 4, 2010.

18. Considering the facts (Findings 7, 8, 9, 10, 12, 13, 14, 15, 16 and 17), Respondent acted within the standard of care in her care, treatment and management of patient C.M.

Patient R.W.

19. On December 7, 2009, after being arrested, patient R.W. was brought to the EPU at SDCPH. He was placed on a 5150 hold for being a danger to himself and to others and for being gravely disabled. He had a history of psychotic disorder, cocaine use and noncompliance with medication. Patient R.M. was prescribed several drugs, including Haldol (10 mg), Valium (10 mg), and Benadryl (50 mg).

On December 8, 2009, Respondent evaluated patient R.W. and prescribed:

- Haldol (5 mg) [four times a day] for psychosis,
- Ativan (1 mg) [four times a day] for psychotic agitation, and
- Cogentin (1 mg) [four times a day] for extrapyramidal symptoms (EPS) prevention.

In addition, in her treatment plan, Respondent stated that patient R.M. would be assessed on a daily basis to determine the efficacy of the medications and disposition planning.

20. On December 17, 2009, Respondent discontinued Ativan and ordered that patient R.W. be given 1500 mg of Depakene ER at bedtime for mood lability.

21. On December 19, 2009, patient R.W. was observed to have an elevated temperature and altered mental state. Patient R.W. was transported to the emergency room at

UCSD Medical Center where he was evaluated. By the time patient R.W. arrived at UCSD Medical Center, his temperature and vital signs were normal. A toxicology test was performed that showed a valproic acid level of 65 and an elevated blood ammonia level of 94. Patient R.W. was diagnosed with valproate-induced hyperammonemia encephalopathy.

22. On December 20, 2009, patient R.W. was discharged from UCSD Medical Center and was readmitted to SDCPH. The admitting physician documented under her treatment plan, "We will not renew Depakote given this is the likely cause of patient's altered mental status which has since resolved."

On or about December 21, 2009, patient R.W.'s documented history and physical examination, under Allergies, in bold print, it was reported "He is now sensitive to encephalopathy caused by Depakote," and under Impression, "Resolved Encephalopathy Caused by Depakote" was noted.

In her inpatient psychiatric evaluation, Respondent noted: "Toxicology felt that the Depakote-induced hyperammonemia had caused the altered mental status. The Depakote was held."

23. On December 23, 2009, patient R.W. was discharged.

24. On January 10, 2010, patient R.W. was readmitted to SDCPH. On the next day, Respondent assumed the care and treatment of patient R.W. She did not review patient R.W.'s chart from his prior admission. Respondent prescribed the following medications for patient R.W.

- Valproic Acid (Depakote) (500 mg) [four times a day] for mood lability,
- Haldol (5mg)[four times a day] for psychosis and mania, and
- Congentin (1 mg)[four times a day] for extrapyramidal symptom prevention (EPS)

Respondent documented that she had discussed the risks, benefits and side effects of the medication with patient R.W. and that the patient had received these medications in the past.

Patient R.W. received Depakote as prescribed from January 11 through 16, 2010.

25. On January 17, 2010, patient R.W. became confused and had another adverse reaction to Depakote. This medication was discontinued on January 18, 2010.

26. Complainant alleged that Respondent committed repeated negligent acts in her care, treatment and management of patient R.W. in that:

- Before prescribing the medication, Respondent failed to review the patient's previous chart entries at SDCPH that would have reminded her that the patient had a documented adverse drug reaction to Depakote.
- Respondent improperly prescribed Depakote to patient R.W. when she knew or should have known from his prior admission that he had a prior adverse drug reaction to the medication.

27. Despite SDCPH's policy, on December 19, 2010, the first physicians who identified the adverse drug reaction to Depakote did not report it to the hospital's pharmacy or in the computer system of SDCPH. Had the physicians done so, the pharmacist would not have dispensed the medication even though Respondent had prescribed it. The failure of the first physician to report the adverse drug reaction resulted in the pharmacist dispensing the medication to patient R.W. when Respondent subsequently ordered the Depakote.

28. On January 10, 2010, when patient R.W. was readmitted to the EPU, in the admitting doctor's assessment, there was no mention of known allergies or prior adverse drug reaction to Depakote in the admitting chart.

29. On January 2010, when she assumed care, treatment and management of patient R.W., Respondent did not review his chart entries from prior admissions. Irrespective of the facts in Findings 27 and 28, Respondent acknowledged that, as patient R.W.'s treating physician, it was her responsibility to review his prior records.

Respondent testified that she did not review patient R.W.'s prior medical record because he had been admitted to SDCPH two to three times prior to his admission in January 2010, and "she felt some degree of familiarity with the patient"; in addition, "there was nothing pressing that caused her to believe that she needed to go back to the prior chart at the time." Respondent stated that not reviewing patient R.W.'s medical records prior to providing treatment was a "failure on her part".

Respondent acknowledged that, had she taken the time to review patient R.W.'s chart in its entirety, she would have discovered that patient R.W. had had a prior adverse reaction to Depakote and would not have prescribed it on the second occasion.

Respondent learned from the experience. She felt terrible about what happened to her patient and she was embarrassed. Since patient R.W.'s case, Respondent has made it a priority in each case to obtain any and all prior records on patients to confirm that the collateral information that she receives is accurate, rather than relying on what is familiar and/or the current chart.

Respondent did not dispute that her conduct constituted a single negligent act, but counsel persuasively argued that her conduct did not constitute repeated negligent acts in that she did not review his chart prior to providing his care and treatment; had she done so, she

would have learned of his prior adverse drug reaction to Depakote and therefore would not have prescribed it when she provided care and treatment in January 2010.

Patient D.E.

30. On January 15, 2010, patient D.E. was transferred from the Alpine Treatment Center (Alpine) to the EPU at SDCPH after he assaulted one, possibly two, resident(s) of Alpine in response to command auditory hallucinations from God. He had a history of

- chronic paranoid schizophrenia and psychiatric hospitalizations;
- medication noncompliance;
- having cut off his finger in response to command auditory hallucinations from God;
- multiple medication trials, including a trial of Clozaril

Patient D.E. had been in a conservatorship at least since 2007.

On admission, patient D.E.'s mental status was described as intermittently cooperative, internally preoccupied, and non-elaborative. He appeared to be responding to internal stimuli but showed adequate impulse control. He was continued on Risperdal (4 mg)[twice a day] and Prozac (20 mg)[every morning], doses that he was taking at Alpine; his Depakote was increased from 1500 mg to 2000 mg [per day].

On January 18, 2010, at or about 11:50 a.m., responding to the voice of God, patient D.E. became agitated, ran towards a glass door but stopped at the door. At or about 3:45 p.m. the same day, patient D.E. became acutely paranoid and hit another resident in the face. Respondent ordered, and patient was given, Haldol (10 mg) for psychosis and Valium (10 mg) for agitation. In the same note, it was reported that patient D.E. was able to hold a conversation and admitted to auditory command hallucinations telling him to protect himself when he hit the other patient.

31. On January 19, 2010, at 8:45 a.m., Respondent ordered the patient's Haldol be increased to 10 mg, four times a day, orally, for psychosis; also, if patient D.E. refused to take the Haldol orally, it was to be administered by intramuscular injection. In addition, Respondent ordered Cogentin (1mg)[four times a day] for EPS prevention and discontinued Risperdal.

Within an hour after Respondent ordered the increased dose of Haldol, Karl M. Jacobs, M.D. (Dr. Jacobs) took over the care, treatment and management of patient D.E. He did not modify Respondent's Haldol order.

Later in the afternoon, while he was in bed, patient D.E. complained of unsteadiness since the time that his medication was changed.

During the early morning hours of January 20, 2010, patient D.E. fell and sustained a laceration to his forehead. He was taken to the emergency room at UCSD Medical Center where his laceration was sutured. Patient D.E. was returned to SDCPH, and Haldol was discontinued.

32. Complainant alleged that, in her care, treatment and management of patient D.E., Respondent engaged in repeated negligent acts in that Respondent, hastily and inappropriately ordered an unnecessarily high dose of Haldol without an appropriate medical basis. Overall, there was a dispute between the expert witnesses regarding this issue.

33. In Dr. Schneider's opinion, Respondent deviated from the standard of care in her care and treatment of patient D.E.

According to Dr. Schneider, there was no evidence from nursing notes or other attending physician's notes to support Respondent's concerns that patient D.E. was imminently dangerous in the CPU and required such a high dose of Haldol; further, there was no evidence that this was a refractory schizophrenic patient who would require supratherapeutic doses of a first or second generation antipsychotic; even if patient D.E. required such doses, the medication should have been titrated on a slower basis.

In Dr. Schneider's opinion, although Respondent believed that she was dealing with an imminently dangerous patient, she acted in haste and did not take the time to analyze the situation at hand. He testified that Respondent did not have sufficient information regarding what occurred at Alpine; that she did not spend enough time evaluating his behavior; and that she did not document her thinking process.

Further, Dr. Schneider opined that one can predict imminent violence within two to three hours only; in order to predict imminent violence, the following criteria should be utilized: (1) imminent agitation - what he is doing at the moment (within 10 minutes or so); (2) "redirectability"; (3) presence of substances, active intoxication or active withdrawal. In patient D.E.'s case, based on the foregoing criteria, when Respondent ordered the increased dose of Haldol patient D.E.'s risk for violence was low because he was (1) not showing acute agitation or imminently dangerous or assaultive behavior; (2) following directions and compliant with his medication; (3) not under the influence.

According to Dr. Schneider, rather than a "blast dose" of Haldol, Respondent should have put the patient on a standing moderate dose of Haldol (10 to 20 mg) with a backup of Ativan (5 mg). By ordering a "blast dose," rather than a lower dose, Respondent could not evaluate the impact of the medication on the patient; the patient's tolerance to the drug was not established. It sedated patient D.E.; she did not know if he was better or not.

34. Dr. Kan disagreed with Dr. Schneider's conclusion. In his opinion, Respondent acted within the standard of care in her care and treatment of patient D.E. Patient D.E. was admitted to the CRU with decompensated paranoid schizophrenia. He struck two individuals within two days and made a rush toward a glass door in response to

command auditory hallucinations with threat control override symptoms[5] in that he specifically responded to commands from God. Threat control override symptoms combined with a history of reactive behavior placed him at a particularly high risk for violence.

Patient D.E. presented on a higher than normal dose of Risperidone combined with Depakote, which failed to control his symptoms. Inpatient units are the setting for medication alterations or close monitoring. Respondent's decision to switch from Risperidone (4mg BID) to Haldol (10 mg QID) was justifiable given the presence of recent violence and impulsive behavior, ongoing acute violence risk factors and failure of high dose of neuroleptics.

35. In this case, the expert witnesses disagreed regarding the criteria that should be considered in order to determine whether patient D.E. was sufficiently dangerous to justify the high dose of Haldol that Respondent ordered. Applying Dr. Schneider's criteria, the question is the patient's immediate conduct, while Dr. Kan considered the patient's history. Each opinion was reasonable, and neither expert was more persuasive than the other regarding which criteria should be used.

Dr. Kan did not dispute that the increased dose of Haldol was high and that it would result in sedation. Further, Dr. Kan testified that, when he increases medication in the fashion done by Respondent, he describes his thinking in a note set forth in the patient's chart. Respondent did not do that. Neither she nor Dr. Kan explained how she would know if the patient was better or not if he was sedated.

Considering the facts, Dr. Schneider's testimony/opinion regarding the reason that the medication should have been titrated was persuasive.

36. The evidence established that Respondent deviated from the standard of care in that she ordered an unnecessarily high dose of Haldol without an appropriate documented medical basis.

Community Reputation

37. Respondent submitted evidence regarding her reputation as a psychiatrist in the medical community, particularly at SDCPH. During her tenure at this hospital, on two separate occasions, her colleagues elected her as chief staff psychiatrist. In addition, she presented letters of support from Daniel Funkenstein, M.D., Li Liang, M.D. and Ronald C. Fischer, M.D. These physicians worked with Respondent at SDCPH and had an opportunity to observe her practice as a physician. One or more of them described her as an excellent clinician who practiced well above the community standard; she was technically competent, and was up to date on the medical management of psychiatric disorders, and exercised

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[5] Threat control override symptoms are when a patient feels that he is unable to control his actions and must respond to auditory hallucinations.

excellent judgment; she was a team player, provided excellent patient care and was a compassionate physician.

LEGAL CONCLUSIONS

1. Complainant bears the burden of proving the charges by clear and convincing evidence to a reasonable certainty. (*Ettinger* v. *Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) This requires that she present evidence "of such convincing force that it demonstrates, in contrast to the opposing evidence, a high probability of the truth" of the charges (BAJI 2.62), and be "so clear as to leave no substantial doubt." (*In re Angelia P.* (1981) 28 Cal.3d 908, 919; *In re David C.* (1984) 152 Cal.App.3d 1189, 1208.) If the totality of the evidence serves only to raise concern, suspicion, conjecture or speculation, the standard is not met.

2. A physician's conduct as a physician can be the subject of discipline if she has engaged in acts that are defined as "unprofessional conduct." In the administrative discipline context, unprofessional conduct refers to acts or omissions that satisfy the definition of gross negligence, repeated negligent acts, and/or incompetence.

Respondent had a duty to perform professional medical services for patients with the degree of learning and skill ordinarily possessed by a reputable physician practicing in the same or similar locality and under similar circumstances. It was her duty to use the care and skill ordinarily used in like cases by reputable members of her profession practicing in the same or similar locality under similar circumstances and to use reasonable diligence and her best judgment in the exercise of her professional skill and in the application of her learning, in an effort to accomplish the purpose for which she was consulted. A failure to fulfill any such duty is negligence. (*Keen v. Prisinzano* (1972) 23 Cal.App.3d 275, 279, 100 Cal.Rptr. 82, 84; *Huffman v. Lundquist* (1951) 37Cal.2d 465, 473, 234 Pac.2d 34, 38; BAJI 7th Ed. No. 6.00, 6.37.)

A physician is not necessarily negligent because she errs in judgment or because her efforts prove unsuccessful. She is negligent only if her error in judgment or lack of success is due to a failure to perform any of the duties required of reputable members of her profession practicing in the same or similar locality under similar circumstances. (*Norden v. Hartman* (1955) 134 Cal.App.2d 333, 337, 285 Pac.2d 977, 980; *Black v. Caruso* (1960) 187 Cal.App.2d 195, 9 Cal.Rptr. 634.)

3. Repeated negligent acts are an independent ground for which discipline can be imposed on a physician. The term refers to a pattern of behavior as opposed to an isolated incident. It is well recognized by law and common sense that to err is human. A simple isolated act of negligence by a medical professional has legal implications. However, the legal implications involve the civil courts; a simple departure from the standard of care does not trigger the imposition of administrative discipline. Repeated negligent acts denote a

pattern of negligent conduct that is strongly suggestive of a high degree of risk of harm to the public from this professional.

4. Cause exists to discipline Respondent for unprofessional conduct under Business and Professions Code section 2227 and 2234, as defined by 2234, subdivision (c) of the Code; Respondent deviated from the standard of care in her care and treatment of patients R.W. and D.E. by reason of Findings 19, 20, 21, 22, 23, 24, 25, 27, 28, 29, 30, 31, 33, 34, 35 and 36.

5. In determining the appropriate discipline, consideration has been given to the legislative intent that the purpose of the statutory scheme to license and discipline physicians and surgeons is to protect the public interest, rather than punish a wrongdoer. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810.)

In this case, Respondent engaged in negligent acts involving two patients. She admitted that, in her care of R.W., she made a mistake when she did not review his chart prior to providing his care and treatment; had she done so, she would have learned of his prior adverse drug reaction to Depakote and would not have prescribed this medication; she accepted responsibility for her acts and has changed her practice to avoid such a mistake in the future. Regarding patient D.E., Respondent ordered a "blast dose" of Haldol without explaining her thinking in her medical chart; she should have titrated the medication so that she could determine the impact on the patient. However, Complainant's expert witness testified that this constituted a simple negligence because "the risk to patient D.E. was relatively modest".

The Medical Board issued Physician's and Surgeon's Certificate number A-94208 to Respondent more than seven years ago. There is no evidence of prior discipline by the Medical Board. She established that she learned from her mistake regarding patient R.W. and that she has an excellent reputation as a psychiatrist, particularly among her colleagues at SDCPH.

Considering the facts, the violations and evidence of rehabilitation, the public is adequately protected if the Medical Board issues a letter reprimand and orders Respondent to attend a medical recordkeeping course and a physician-prescribing course.

6. Any factual and/or legal argument not addressed herein is determined not to be relevant and/or unsupported by the evidence and therefore rejected.

ORDER

The Medical Board of California shall issue a letter of reprimand to Yanira Maria Olaya, M.D. conditioned upon compliance with the following terms.

1. Record-Keeping Course

No later than 60 days from the effective date of this Decision, Yanira Maria Olaya shall enroll in a medical recordkeeping course at Yanira Maria Olaya, M.D.'s expense, approved in advance by the Medical Board of California, or its designee. She shall complete this medical recordkeeping course no later than six months from the effective date of this Decision, unless the Medical Board of California authorizes additional time for compliance.

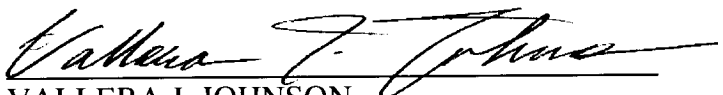
No later than 60 days from the effective date of this Decision, Yanira Maria Olaya, M.D. shall submit to the Medical Board of California or its designee proof of her enrollment in the approved medical recordkeeping course. No later than six months from the effective date of this Decision, she shall submit proof of her successful completion of this course to the Medical Board of California or its designee. Unless additional time is approved by the Medical Board of California, Yanira Maria Olaya's failure to provide proof of her enrollment in an approved recordkeeping course within 60 days or to provide proof of her completion of the medical recordkeeping course within one year of the effective date of the Decision shall constitute unprofessional conduct and shall be grounds for discipline.

2. Physician-Prescribing Course

No later than 60 days from the effective date of this Decision, Yanira Maria Olaya shall enroll in a physician-prescribing course at Yanira Maria Olaya, M.D.'s expense, approved in advance by the Medical Board of California, or its designee. She shall complete this physician-prescribing course no later than six months from the effective date of this Decision, unless the Medical Board of California authorizes additional time for compliance.

No later than 60 days from the effective date of this Decision, Yanira Maria Olaya, M.D. shall submit to the Medical Board of California or its designee proof of her enrollment in the approved physician-prescribing course. No later than six months from the effective date of this Decision, she shall submit proof of her successful completion of this course to the Medical Board of California or its designee. Unless additional time is approved by the Medical Board of California, Yanira Maria Olaya's failure to provide proof of her enrollment in an approved physician prescribing course within 60 days or to provide proof of her completion of the physician prescribing course within one year of the effective date of the Decision shall constitute unprofessional conduct and shall be grounds for discipline.

DATED: April 19, 2013



VALLERA J. JOHNSON
Administrative Law Judge
Office of Administrative Hearings