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

In the Matter of the Accusation Against: ALAN J. COHEN, M.D. 6571 Liggett Drive Oakland, California 94611 Physician's and Surgeon's Certificate No. G 51201 Respondent.	Case No. 12 2002 135801 OAH No. N2004080541

DECISION AFTER NONADOPTION

Administrative Law Judge Nancy L. Rasmussen, Office of Administrative Hearings, State of California, heard this matter on December 7, 8 and 9, 2004, in Oakland, California. Deputy Attorney General Susan K. Meadows represented complainant David T. Thornton, Executive Director of the Medical Board of California (Board), in the Department of Consumer Affairs.[1] Attorney at Law John L. Fleer represented respondent Alan J. Cohen, M.D., who was present. The matter was submitted on December 9, 2004.

The Administrative Law Judge issued his Proposed Decision on May 17, 2005. The Proposed Decision of the Administrative Law Judge was not adopted by the Division of Medical Quality, Medical Board California ("Board"). The Board issued an Order of Nonadoption on August 3, 2005. On September 30, 2005, the Board issued its Notice of Hearing for Oral Argument.

Having reviewed the record in its entirety including the transcript and written argument submitted by both parties and oral argument on November 3, 2005 by both parties, the Board now makes and enters its Decision After Nonadoption as follows:

[1] At the time the accusation was filed, Mr. Thornton was Interim Executive Director of the Board.

FACTUAL FINDINGS

License and Employment Background

1. On September 2, 1983, the Board issued physician's and surgeon's certificate no. G 51201 to respondent Alan J. Cohen, M.D. The current expiration date is August 31, 2005.

2. Respondent received his medical degree in 1982 from Jefferson Medical College in Philadelphia. After a one-year internship at the University of California-San Francisco (UCSF), he completed a three-year residency in psychiatry at the Langley Porter Institute at UCSF. From 1984 to 1986, respondent had a part-time private practice on Saturdays at the Schuman-Liles Psychiatric Clinic in Oakland. He completed further training in diagnostic psychiatry during a one-year fellowship at the Institute of Pennsylvania Hospital from 1986 to 1987. From 1987 to 1990, respondent worked as an attending psychiatrist at San Francisco General Hospital. During this time, he had a small private practice. Respondent became board certified in psychiatry in 1989. In 1990, respondent joined Comprehensive Psychiatric Services, a private psychiatric group that owned East Bay Hospital in Richmond. Until he left that group in about 1996, he provided in-patient and out-patient psychiatric services, conducted some research studies and clinical drug trials and held various administrative positions at the hospital. Respondent saw patients in offices in Walnut Creek, Pinole, Oakland and Richmond. After leaving Comprehensive Psychiatric Services, he and a couple of other doctors from the group formed Bay Area Behavioral Care. Respondent saw patients in offices in Walnut Creek and Berkeley. He left Bay Area Behavioral Care after about a year, closing his office in Walnut Creek and consolidating his private practice in his Berkeley office. Respondent was in solo practice in Berkeley until February 2001. During this time, respondent continued to conduct research studies, including some formal trials funded by pharmaceutical companies. His primary research interests included psychopharmacology; treatment of antidepressant-induced sexual dysfunction, including with natural substances (e.g., Ginkgo biloba); thyroid dysfunction; and organic brain dysfunction.

Treatment of M.A.

3. The accusation alleges that in his psychiatric treatment of M.A., respondent committed gross boundary violations by engaging in sexual relations with her and using drugs recreationally with her. Further allegations include diverting Ritalin from M.A. for his personal use, giving her a plant containing a hallucinogenic chemical, preparing an evaluation of M.A. for a legal proceeding when his impartiality was impaired, and failing to refer her to another physician for treatment.

4. In January 1994, M.A., then age 49, began psychiatric treatment with respondent. She had a number of emotional problems and was in an unhappy marriage. She had also experienced some traumatic events in her life, including childhood sexual abuse, a serious car accident, caring for her mother before she died of brain cancer, and her son being

injured in a car accident. M.A. had hepatitis C, and respondent diagnosed her with Hashimoto's thyroiditis.

5. M.A. saw respondent initially once a week. In 1995, her visits increased to twice a week, and in 1997 they increased to three times a week. M.A.'s last visit to respondent's office was in early December 1999, although he continued to prescribe medications for her into 2000. Over the years, respondent's treatment focus shifted from psychotherapy more to medications management. Respondent prescribed various antidepressants for M.A., as well as thyroid supplements and Ativan. To treat M.A.'s severe fatigue and lack of energy, respondent started prescribing Ritalin in December 1995.[2]

6. The Ritalin made M.A. shaky, sick to her stomach and "very hyper," so she started breaking the pills in half and taking fewer pills than respondent prescribed. At some point, possibly around December 1996, M.A. brought her leftover Ritalin in to respondent's office. Telling him that it was a shame to waste the medication, she asked if some other patient could use the pills. Respondent took the Ritalin from M.A., and he later told her that he had a Medi-Cal patient who could use the medication. From then on, M.A. continued to fill her Ritalin prescriptions, but she used only a small portion of each prescription. She gave the bulk of the medication to respondent. Sometimes he drove to M.A.'s home to pick up her Ritalin – respondent would call and have her meet him at the driveway of her condominium complex, where she would hand him a brown paper bag containing the medication (occasionally, respondent's young children were in the car with him). M.A.'s prescriptions were covered by insurance, which respondent knew. He considered lowering M.A.'s Ritalin dosage, but he did not do so. In the patient chart, respondent did not record the actual amount of Ritalin M.A. was taking.

7. Respondent did not give M.A.'s leftover Ritalin to another patient. He took all of the Ritalin himself. In 1996, respondent diagnosed himself with Attention Deficit Disorder, and he asked his personal physician, Joseph Barrera, M.D., to prescribe Ritalin. Respondent felt Ritalin helped him focus, and he also found that it "balanced out" the sedating effects of the opiates he was taking. It is unclear whether respondent was taking opiates on a regular basis before an incident on December 17, 1996, when he tore his rotator cuff. He had been regularly exposed to opiates because of a chronic problem with kidney stones, and he had been treated with Vicodin for a neck and shoulder injury when he worked at San Francisco General Hospital.

8. On December 17, 1996, respondent tore his rotator cuff and aggravated his old shoulder injury while escaping from an assaultive patient who had a rifle. When Vicodin did not work to control respondent's pain, Dr. Barrera prescribed a stronger opiate, Levo-Dromoran, on respondent's recommendation. Respondent was also taking Ritalin at this time. As he developed a tolerance to the medications, he needed to take greater quantities. This was when respondent began to rely on M.A. to supplement his supply of Ritalin. (He

[2] Ritalin is a Schedule II controlled substance, as defined by Health and Safety Code section 11055.

was receiving the maximum standard dosage from Dr. Barrera and did not want to ask him for more.) Respondent knew it was illegal to divert the Ritalin he prescribed for M.A. for his own use, and he felt bad about doing it.

9. Almost from the beginning of therapy, M.A. developed emotional feelings for respondent. (As she testified, it was kind of like the "first love" of a teenager.) Within a few months of starting therapy, she expressed to respondent her feelings for him. They discussed transference and how that could be a useful tool in therapy. Between April 1994 and February 1997, respondent's notes of M.A.'s visits contain many entries indicating that they explored transference issues. According to respondent, he and M.A. maintained clear boundaries, with no physical contact. In May 1996, M.A. separated from her husband of 26 years, and respondent helped her through this difficult time.

10. During the holiday season in either 1995 or 1996, M.A. brought to one of her sessions with respondent a gift of Jewish art that she had purchased for him (the value was approximately $200). They discussed the ethical considerations of respondent accepting a gift from a patient, and M.A. told him that it was important to her to give him something. He accepted the gift and later displayed the art on his office wall. This made M.A. feel special. Thereafter, M.A. usually gave respondent gifts for the holidays, for Valentine's Day and for his birthday. Respondent accepted each of her gifts. In 1998, M.A. gave respondent Hanukkah gifts for his children.

11. At some point during the spring or early summer of 1999, respondent gave M.A. a San Pedro cactus plant. M.A. had expressed some interest in hallucinogens, and when respondent brought the plant to her home, he gave her a computer printout containing a "recipe" for cooking the cactus to extract a mildly hallucinogenic chemical from it. After reading about the plant on the website shown on the printout, M.A. followed the cooking instructions and made a juice from her cactus. M.A. eventually drank the cactus juice with her "ex-hippie" boyfriend present. The substance had a mild effect – M.A. recalls that colors were intensified. She had arranged with respondent to call him when she took the juice, and they talked on the phone for an hour to an hour and a half.

12. The first time respondent acknowledged M.A.'s birthday was in 1999. During one of her office visits in August, he gave her a birthday card and a gift. The gift was a box containing sachet, bath soaps, an item of Chinese lacquerware and a book called *Dogs in Love*. To M.A., this gift signified a change in her relationship with respondent, and she felt overwhelmed and happy. At that point, much of what went on in their sessions was not therapy, but a friendly discussion of what had been going on in their lives. M.A. had not paid respondent any money for his professional services since early 1998.

13. At some point in 1999, M.A. asked respondent to prepare a letter stating that she could work only part-time, because her ability to work was an issue in her divorce proceeding. Respondent prepared a detailed letter, dated October 11, 1999, discussing his medical and psychiatric treatment of M.A. as it pertained to her ability to maintain employment. M.A. and respondent had talked over an extended period of time about what

the letter should say, and M.A. had reviewed a draft, making comments and suggesting changes where she thought there were inaccuracies. The letter was sent to the attorney for M.A.'s husband. Respondent billed the attorney $1,650 for this evaluation, but he did not receive any payment.

14. Sometime before Hanukkah began on December 3, 1999, M.A. drove to respondent's house to bring his children gifts. The children met her on the driveway, and she gave them gifts for each night of Hanukkah. Respondent was pleased with the gifts.

15. In early December 1999, respondent and M.A. first had physical contact. They met in the parking lot of M.A.'s condominium complex and walked around the complex holding hands and discussing whether to change their relationship to something more physical. Both of them were nervous. Respondent recalls that M.A. was pushing him to have a sexual relationship, and that he was resisting. Finally, he gave in and agreed to what she wanted, even though he knew that it was unethical. At the end of their walk, M.A. invited respondent to come to her house for dinner on an upcoming Saturday.

16. M.A.'s last visit to respondent's office was in early December 1999, after the above conversation. She believes she may have just been picking up a prescription. At some point around this time, M.A. sent respondent a long e-mail message telling him that she could not come in to the office anymore. She recalls telling him that they were not doing therapy anymore, but just "boy-girl stuff."

17. Respondent and M.A. engaged in sexual relations on two occasions. The first time was at respondent's house, on the Friday night before the Saturday dinner at M.A.'s house. Before they had sex, M.A. and respondent smoked marijuana that M.A. had brought with her. She recalls feeling uncomfortable and nervous. The following night, M.A. made an elaborate dinner for respondent. According to her, they smoked marijuana together, and respondent told her that he had crushed a Ritalin tablet and put it in the marijuana. In an April 22, 2003, conference with the Board's investigator and medical consultant, respondent stated that he remembered inhaling Ritalin and Oxycontin (crushed into a powder) with M.A.[3] (At the hearing, respondent asserted that what he told the Board might not have been accurate, because he does not now recall using Oxycontin with M.A.) Respondent and M.A. had sex, and then he took a bath. They discussed personal matters, including respondent's parents and sister, and problems he was having with his children and his ex-wife.

[3] In late 1998 or early 1999, respondent started taking Oxycontin, a Schedule II controlled substance per Health and Safety Code section 11055. Dr. Barrera moved out of the area during one of respondent's attacks of kidney stones, and he had to scramble around to find another physician to prescribe something stronger than Vicodin. Respondent found Mannie Joel, M.D., a pain management specialist in Pleasanton. After a short prescription of Levo-Dromoran (before that drug was discontinued by the manufacturer), Dr. Joel prescribed Oxycontin for respondent. Respondent sometimes crushed the Oxycontin and Ritalin and inhaled the medications for more immediate pain relief.

18. The last time M.A. saw respondent was on New Year's Eve. He was supposed to come by her house, but she ended up driving to his house and giving his children a bottle of sparkling cider. At this time, M.A. was introduced to a woman who was described as a "babysitter," but whom M.A. later learned was in a relationship with respondent. That night, M.A. and respondent hugged, and he told her something to the effect that they would always have a relationship and that he would be someone she could rely on in her life.

19. At no time did respondent discuss referring M.A. to another physician for psychiatric treatment. He was aware that in January 2000 she would be starting high-dose interferon induction therapy with ribavirin to treat her hepatitis C. The side effects of this treatment include nausea, vomiting, hair loss, flu-like symptoms and depression. Respondent's recollection is that M.A. said she was fine and did not want further treatment.

20. For some time in 2000, M.A. continued to get prescriptions from respondent and to refill his prescriptions. One time when she was feeling sick from her hepatitis C treatment, M.A. called respondent on his cell phone. He told her he was very busy, with lots of commitments. Then their conversation was cut off when the call got dropped in a dead zone. Respondent did not call M.A. back, which made her feel that he had abandoned her. Respondent believes he phoned M.A. once after she had called in for a prescription. In December 2000, M.A. filed a lawsuit against respondent.

Respondent's Violations

21. Respondent does not deny that he committed the violations alleged in the accusation. Complainant's expert witness, Laura Duskin, M.D., testified about respondent's misconduct with M.A., and she explained how he violated the standards of practice. The following matters were established:[4]

a. Respondent's having sexual relations with M.A. constituted sexual misconduct.

b. Respondent's having sexual relations with M.A. constituted an extreme departure from the standard of practice and unprofessional conduct.

c. Respondent's use of marijuana and Ritalin (and Oxycontin, if he also used that drug) with M.A. constituted an extreme departure from the standard of practice and unprofessional conduct.

[4] There are a number of other matters pertaining to M.A in which Dr. Duskin believes respondent departed from the standard of care, but no findings are made on those because they are not alleged in the accusation.

d. Respondent's gift to M.A. of the San Pedro cactus plant along with information about extracting the hallucinogenic chemical from it constituted an extreme departure from the standard of practice and unprofessional conduct.

e. Respondent acted fraudulently in obtaining Ritalin from M.A. for his own use under the pretense of giving the drug to another patient. And even if he had not been illegally diverting the drug to his own use, it was wrong for respondent to bring into his therapeutic relationship with M.A. the needs of another patient and his need to care for that patient.

f. Respondent's failure to record in M.A.'s medical records the actual amount of Ritalin she was taking, as opposed to the amount he was prescribing for her, constituted an extreme departure from the standard of practice and unprofessional conduct.

g. Respondent's preparation of the October 11, 1999 letter evaluating M.A.'s ability to work, at a time when his impartiality was impaired by illegally procuring drugs from her, was unethical and constituted unprofessional conduct.

h. In view of his numerous boundary violations with M.A., and the fact that she was starting interferon treatment in January 2000, respondent's failure to refer her to another physician for psychiatric treatment constituted an extreme departure from the standard of practice and unprofessional conduct.

Subsequent Events

22. In December 2000, when M.A. filed her lawsuit against him, respondent was still in solo practice in Berkeley, and he was using very high amounts of Ritalin and Oxycontin. In January 2001, respondent's assistant and two of his former group colleagues had an intervention, where they confronted him with his drug use and told him that he had a problem. (Respondent believes his assistant organized the intervention, because she had observed the deterioration in his quality of life and knew of his prescriptions for Ritalin and Oxycontin.) Respondent was instructed to call the Board's Diversion program.

23. Respondent met with Case Manager Chris Medrano and Jim O'Donnell from Diversion, but he denied having a drug problem. He claimed that he was taking the drugs to treat his chronic pain. Respondent understood that he would have to undergo an evaluation for chemical dependency, and he started attending Diversion group meetings and AA and NA meetings. Because he had been told by Diversion that he could not practice medicine, respondent's patients were being seen by colleagues of his. After a couple of weeks, respondent's denial had softened and he had settled on the Springbrook treatment program in Oregon. He closed his private practice in February 2001. Respondent went to Springbrook for a two-week evaluation, and he ended up staying for 90 days. Respondent's detoxification

period took several days, and for six weeks he felt impaired, depressed, weak and fatigued. He attended group sessions and AA/NA meetings all day. He received some physical therapy, and he was fitted for a TENS[5] unit, which helped with his pain. Respondent actively engaged in treatment, though he did not at first accept that he needed treatment.

24. On June 15, 2001, respondent left Springbrook and returned home. He pursued his plan to attend twice-weekly Diversion group meetings, to attend five meetings a week of AA/NA initially and later four meetings a week, and to have a case manager and sponsor. Respondent was very depressed, and it took him some time to locate psychiatrist Rick Lavine, M.D., and start therapy. (The therapist who had treated respondent since the incident on December 17, 1996, Catherine Freemire, L.C.S.W., would not enter into a contract with Diversion because it required her to breach the confidentiality of patient-therapist communications.)

25. On August 16, 2001, respondent signed a five-year contract with the Diversion program. After the Diversion Evaluation Committee gave respondent approval to return to the (non-private) practice of medicine, he found a job as a staff psychiatrist at Alameda County Behavioral Health Care Services (BHCS). In April 2002, he started employment there 24 hours per week. As of December 2004, respondent was working 32 hours per week at BHCS, and he had recently been granted a permanent civil service position.

Employment at BHCS

26. At BHCS, respondent treats clients in two out-patient clinics. He works 24 hours per week at the Eden Community Support Center in San Leandro, and he works eight hours per week at the BHCS clinic in Alameda. His clients are severely mentally ill adults, typically on Medi-Cal or Medicare. The majority of them have a dual diagnosis of chemical dependency as well as a psychiatric disorder, and respondent draws on his own experience with substance abuse and recovery to help his clients. The focus of respondent's treatment is on medications management, with little psychotherapy. He is part of a treatment team, working with case managers and other staff members. There are four other psychiatrists at the San Leandro clinic and one other psychiatrist at the Alameda clinic. Respondent feels this group setting is a good place for him to work. He enjoys the peer support, the consultative availability, and the regular hours with no on-call duties. He earns less money than he did in private practice, but he is able to make ends meet.

27. BHCS Chief Psychiatric Social Worker Miriam Mills, L.C.S.W., is respondent's worksite monitor for Diversion. She is the Director of the Eden Community Support Center, but she serves as respondent's monitor for his work at the Alameda clinic, too, with the approval of Diversion. Mills is required to submit quarterly reports to Diversion. Before respondent was hired by BHCS, he disclosed in a group interview his addiction to prescription medications and the fact that he was in Diversion. Sometime last year, respondent told Mills about his misconduct with M.A. – having sex with her, procuring

[5] Transcutaneous Electrical Nerve Stimulator.

Ritalin from her and using drugs with her. He explained that the recent lifting of a gag order in connection with the settlement of M.A.'s civil lawsuit enabled him to share this information. Mills reported this information to the BHCS Medical Director, but she has no concerns about respondent's professionalism. He gets along well with his co-workers, and there have been no complaints about him from patients or staff members. In her testimony at the hearing, Mills described respondent as a brilliant psychiatrist who forms a very therapeutic bond with patients. In treatment team meetings, he is supportive of case managers presenting cases and he is "very much a teacher." Mills reviews all charts on a six-month cycle, and respondent's chart notes are so well done that they have been used as a model in training. Respondent is a conscientious employee and a valued member of the BHCS staff.

28. Lynn Ellen Marcus, L.M.F.T., is a clinical case manager and team leader at Eden Community Support Center. Respondent is the assigned doctor for 10 of her clients, and they sometimes meet together with a client. Marcus has daily contact with respondent when he is in the clinic, and they sit down once a week to discuss their clients. Not long after he came to work at BHCS, respondent told Marcus that he was in Diversion for his addiction to prescription drugs. In recovery herself for 23 years, Marcus talks with respondent about his recovery program. Over the years she has known him, she has seen his commitment to recovery grow and deepen. Later on in the time they worked together, respondent told Marcus about having sex with a patient and using drugs with her. Marcus sees that as a part of respondent's past. In her experience with him at BHCS, respondent is respectful of patients and scrupulous about maintaining boundaries. He has helped others with boundary issues, offering good insight. In her testimony, Marcus described respondent as an excellent doctor, therapist, co-worker and team member who is reliable in following through on his promises and commitments.

29. BHCS Medical Director Richard P. Singer, M.D., wrote a letter on respondent's behalf. In his letter, he stated that there have been no problems with respondent's charts, there have been no complaints or concerns raised by the clinic supervisor, and respondent is a valuable member of the BHCS medical staff.

Rehabilitation

30. Respondent now realizes that in the 1990's he did not fully appreciate the importance of maintaining strict boundaries with patients. He was already prone to cutting corners when it came to boundaries, but as his judgment became impaired by drug addiction respondent made less of an effort to resist M.A.'s personal overtures. Accepting gifts from her was a "slippery slope," and his boundaries with M.A. gradually eroded as their relationship became more personal and friendly, and they were doing less and less psychotherapy. Things were "out of control" by the end of 1999, when he had sex with her. Respondent feels very remorseful for his misconduct with M.A. and the suffering he caused her.

31. Besides contributing to his misconduct with M.A., respondent's drug addiction had a negative impact on his practice in many ways. He neglected his billing for close to a year; he did not work as hard as he should have, and he was sometimes late, sleepy or suffering from a headache when he met with a client; he lost patients who did not come back; and an error was made in an important publication because no one checked the final draft. At the time, respondent did not want to acknowledge that these problems were related to his drug use.

32. Respondent's agreement with Diversion includes strict requirements pertaining to attendance of 12-step meetings and Diversion group meetings, engaging in individual therapy, drug testing, submitting semi-annual reports, etc. Respondent is required to abstain from the use of alcohol and all psychotropic drugs except those prescribed by another physician and approved by Diversion. During the three and one-half years he has been in Diversion, respondent has complied with all of these requirements and he has had no positive drug tests. (There have been some changes to the requirements since the original agreement.) Respondent had one kidney stone attack when he had to be treated with narcotics, but this treatment was approved by Diversion.

33. Respondent attends four 12-step meetings and one Diversion group meeting per week, and he has a 12-step sponsor with whom he meets on a weekly basis. He has told the story of his addiction at AA/NA meetings. His Diversion group is a source of support from other health care professionals with substance abuse problems. Respondent's recovery program also includes daily meditation and prayer, a practice which he developed during his residential treatment at Springbrook. He knows that he is always at risk for relapse, but he feels confident that he is doing the right things to stay drug-free.

Treatment with Dr. Lavine

34. In September 2001, respondent started individual therapy with Dr. Lavine. Dr. Lavine is a psychiatrist who specializes in treating people with chemical dependency. Respondent sees him about two to three times per month. (As of December 2004, they had had a total of 80 sessions.) Respondent has ongoing problems with depression and anxiety, related to the damage done by his substance abuse and boundary violations, the loss of his practice, his divorce and his chronic pain. The focus of respondent's therapy has been on dealing with this depression and anxiety and maintaining his recovery from addiction. In his testimony at the hearing, Dr. Lavine described how respondent originally was resistant to treatment and angry at Diversion. His attitude gradually changed as mutual trust developed between respondent and Diversion, and Diversion became a supportive force in his life. Going back to work in 2002 helped, because respondent regained his self-respect. Dr. Lavine believes that respondent has a good recovery program and the prognosis is good for his staying drug-free. Respondent attends all the meetings required by Diversion, he is compliant with recommendations, he has made positive lifestyle changes, and he takes responsibility for his actions rather than blaming others.

35. Dr. Lavine and respondent have discussed boundary issues, including his boundary violations with M.A. Dr. Lavine views these violations as secondary to respondent's drug addiction, because addicts who are using drugs have impulse control problems. Before Diversion allowed respondent to return to work, Chris Medrano asked Dr. Lavine to look at respondent for a possible sexual disorder. Finding no history of a psychosexual disorder or paraphilia, Dr. Lavine concluded that respondent presented no threat of acting out sexually in his practice. Addiction and depression are respondent's only psychological disorders – there is no evidence of an Axis II personality disorder. Respondent understands that what he did with M.A. was wrong, and he makes no excuses for his misconduct. In Dr. Lavine's discussion with him of boundaries, respondent has gained a clearer understanding about certain boundary issues. He is now very attuned to such issues and careful to maintain appropriate boundaries in his work at BHCS. Dr. Lavine has told respondent that he would support him if he wanted to open a small private practice and sought permission from Diversion to do so, but respondent has not been interested in doing this. He is happy at BHCS, working in a matrix of people where he feels he is appreciated and he is doing important work.

36. Dr. Lavine acknowledges the potential conflict of interest between his obligation as respondent's treating doctor and his duty to be honest in testifying in this proceeding, and he has discussed this with respondent. Dr. Lavine asserts that he is not totally objective, but he is being honest. If he thought he could not be honest and act in respondent's best interest, he would not have agreed to testify. Dr. Lavine believes respondent has been candid with him – as he put it, respondent "wears his heart close to the surface" and is not able to hide much. Dr. Lavine also has talked to the Diversion group leader and others about respondent and his recovery. Dr. Lavine's opinion is that respondent is safe to practice, and he believes his opinion is valid.

Dr. Duskin's Concerns

37. Complainant's expert, Dr. Duskin, questions whether respondent is safe to practice. Pointing out that most drug-addicted doctors do not procure drugs from their patients or have sex with them, she asserts that with all the focus on respondent's addiction not enough attention has been given to his boundary problems. Dr. Duskin notes that respondent had "very porous" boundaries and multiple dual relationships before he became addicted to drugs. For example, Rachelle Bradley, the nurse respondent hired as his research assistant in 1998 or 1999, had been a patient of his for a brief time in the early 1990's. Her husband had been respondent's patient when Bradley came to respondent with interpersonal issues, some of which involved her husband. After advising the couple of the possible conflict of interest, respondent agreed to see Bradley for a short period of treatment. Sometime after she saw respondent for treatment, Bradley came to work as the infection control nurse at East Bay Hospital, and she assisted respondent in a research study at that facility.

Dr. Duskin discounts any opinion by respondent's treating psychiatrist about respondent's safety to practice, because of his inherent conflict of interest. She points out that there has been no evaluation of respondent's safety to practice by an independent evaluator.

Costs of Investigation and Enforcement

38. As of December 2, 2004, the Board had incurred the following costs of investigation and enforcement in this accusation against respondent:

Investigative Services			
2002:	6.25 hrs. @ $110.84/hr.	$ 692.75	
2003/2004	65.25 hrs. @ $111.38/hr.	$ 7,267.54	
			$ 7,960.29
Expert Reviewer Services			
2003/2004	37.00 hrs. @ $100.00/hr.		$ 3,700.00
Deputy Attorney General Legal Services			
2003/2004	47.50 hrs. @ $132.00/hr.	$ 6,270.00	
2004/2005	46.00 hrs. @ $139.00/hr.	$ 6,394.00	
			$12,664.00
		Total	$24,324.29

LEGAL CONCLUSIONS

Respondent's Violations

1. Findings 21-a and 21-b: Cause for disciplinary action exists under Business and Professions Code[6] section 726 (sexual misconduct/unprofessional conduct); section 2234, subdivision (b) (gross negligence/unprofessional conduct); and section 2234 (unprofessional conduct).

2. Finding 21-c: Cause for disciplinary action exists under section 2234, subdivision (b) (gross negligence/unprofessional conduct); and section 2234 (unprofessional conduct).

3. Finding 21-d: Cause for disciplinary action exists under section 2234, subdivision (b) (gross negligence/unprofessional conduct); and section 2234 (unprofessional conduct).

4. Finding 21-e: Cause for disciplinary action exists under section 2234 (unprofessional conduct) as that section interacts with section 2238 (violation of a drug statute), by reason of respondent's violation of Health and Safety Code section 11173,

[6] Unless otherwise indicated, all cited code sections are in the Business and Professions Code.

subdivision (a) (obtaining controlled substance by fraud, deceit, misrepresentation or subterfuge). Cause for disciplinary action also exists under section 2234, subdivision (e) (dishonesty or corruption/unprofessional conduct).

5. Finding 21-f: Cause for disciplinary action exists under section 2234 (unprofessional conduct) as that section interacts with section 2261 (false representation in medical document). Cause for disciplinary action also exists under section 2234, subdivision (b) (gross negligence/unprofessional conduct).

6. Finding 21-g: Cause for disciplinary action exists under section 2234 (unprofessional conduct).

7. Finding 21-h: Cause for disciplinary action exists under section 2234, subdivision (b) (gross negligence/unprofessional conduct).

8. Findings 21-b, 21-c, 21-d, 21-f and 21-h: Cause for disciplinary action exists under section 2234, subdivision (c) (repeated negligent acts/unprofessional conduct).

Costs of Investigation and Enforcement

9. Complainant has requested that respondent be ordered to pay the Board the costs of investigation and enforcement of the case. Section 125.3 provides that respondent may be ordered to pay the Board "a sum not to exceed the reasonable costs of the investigation and enforcement of the case." That section also provides that the Board's certification of the actual costs constitutes prima facie evidence of the reasonable costs. The costs set forth in Finding 38, $24,324.29, were established by such a certification. In the absence of any evidence to the contrary, this amount is determined to be reasonable.

Respondent does not question the amount of time put in to the investigation and prosecution of the case, but he urges the Board to reduce the amount of cost recovery, taking into consideration 1) that he has always been willing to accept probation in this case, and 2) his limited financial means as a part-time county employee. In view of these circumstances, it would not be fair or reasonable to require respondent to pay the full amount of the Board's costs of investigation and enforcement. It would be fair and reasonable to require respondent to pay $10,000 of the Board's costs.

Other Matters

10. There is no question that respondent engaged in misconduct of the most egregious sort with M.A., and respondent does not defend his actions. The only question is whether protection of the public requires that his license be revoked, as complainant contends, or whether the public can be adequately protected by placing respondent on probation. On this question, respondent has established that he is sufficiently rehabilitated that it is not necessary to revoke his license outright. It has been over five years since his misconduct, and during that time respondent has made major changes in his life and in his practice. After been forced to confront his drug addiction, he stopped using drugs and

entered the Board's Diversion program. Respondent has been in Diversion for three and one-half years, with no relapses, and he has developed a strong network of support for his continued recovery. In his therapy with Dr. Lavine, respondent has addressed boundary issues as well as other matters, and he understands how his inattention to boundaries (apart from his drug addiction) played a significant role in his misconduct with M.A. While Dr. Lavine is not an independent evaluator, his opinion that respondent is safe to practice should be considered, since he has gotten to know respondent well during their 80 sessions and is in a good position to assess the changes in respondent's thinking and in his approach to his practice. Most importantly, respondent has demonstrated in his employment at BHCS that he can practice safely. For three years, he has worked with severely mentally ill clients in a clinic environment completely different from the isolated solo practice he used to have. Respondent has thrived in this collaborative group setting, he has provided excellent care to his patients, and he has become a valued member of the staff. Scrupulous about maintaining boundaries, he has been a model of professionalism. It would not be contrary to the public interest to allow him to continue to practice under appropriate terms and conditions for a lengthy period of probation. Probationary conditions shall include a prohibition on solo practice and requirements that respondent continue in Diversion and psychotherapy and that he abstain from drugs. He shall be required to submit to drug testing if such testing is deemed necessary. An education course will be required during the first year, as well as a course in ethics. While the evidence does not support requiring a third party chaperone when respondent treats female patients, it does support imposition of a practice monitor to ensure that the public is protected. In accordance with section 2227, subdivision (a)(3), respondent shall be required to pay the costs of probation monitoring.

ORDER

Physician's and surgeon's certificate no. G 51201 issued to respondent Alan J. Cohen, M.D., is revoked pursuant to Legal Conclusions 1 through 8, separately and for all of them. However, the revocation is stayed and respondent is placed on probation for seven (7) years upon the following terms and conditions:

1. Controlled Substances - Abstain From Use: Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drugs as defined by Business and Professions Code section 4022, and any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed to respondent by another practitioner for a bona fide illness or condition.

Within 15 calendar days of receiving any lawful prescription medications, respondent shall notify the Board's Division of Medical Quality (Division) or its designee of the: issuing practitioner's name, address, and telephone number; medication name and strength; and issuing pharmacy name, address, and telephone number. The Division or its designee may waive this condition for any medications that are prescribed for respondent on an ongoing basis or when it is determined that such notification is no longer necessary.

2. Biological Fluid Testing: Respondent shall immediately submit to biological fluid testing, at his own expense, upon the request of the Division or its designee. A certified copy of any laboratory test results may be received in evidence in any proceedings between the Board and respondent. Failure to submit to, or failure to complete, the required biological fluid testing, is a violation of probation.

3. Diversion Program: Respondent shall continue to participate in the Board's Diversion Program until the Diversion Program determines that further treatment and rehabilitation are no longer necessary. If he has not already done so, respondent shall execute a release authorizing the Diversion Program to notify the Division when 1) respondent requires further treatment and rehabilitation, 2) respondent no longer requires treatment and rehabilitation, and 3) respondent may resume the practice of medicine. If he has not already done so, respondent shall execute a release authorizing the Diversion Program to provide confirmation to the Division whenever the Diversion Program has determined that respondent shall cease the practice of medicine.

Within 5 calendar days after being notified by the Diversion Program of a determination that further treatment and rehabilitation are necessary, respondent shall notify the Division in writing. The Division shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Diversion Program determines that further treatment and rehabilitation are no longer necessary. Within 24 hours after being notified by the Diversion Program of a determination that respondent shall cease the practice of medicine, respondent shall notify the Division and respondent shall not engage in the practice of medicine until notified in writing by the Division or its designee of the Diversion Program's determination that respondent may resume the practice of medicine. Failure to cooperate or comply with the Diversion Program requirements and recommendations, quitting the program without permission, or being expelled for cause constitutes a violation of probation.

4. Education Course: Within 60 calendar days of the effective date of this decision, respondent shall submit to the Division or its designee for its prior approval educational program(s) or course(s) which shall total not fewer than 40 hours. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be completed within the first year of probation. They shall be at respondent's expense, and they shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Division or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

5. Ethics Course: Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in ethics, at his own expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation.

An ethics course taken after the acts underlying the accusation but prior to the effective date of the decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this decision.

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

6. Psychotherapy: Respondent shall continue in psychotherapy with Rick Lavine, M.D., at the frequency of sessions determined (or later modified) by the Division or its designee. Alternatively, within 60 calendar days of the effective date of this decision, or within 10 days of discontinuing psychotherapy with Dr. Lavine, respondent shall submit to the Division or its designee for prior approval the name and qualifications of a board certified psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the Division or its designee deems that no further psychotherapy is necessary.

Upon the request of the Division or its designee, the psychotherapist shall consider any information provided by the Division or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the Division or its designee. Respondent shall cooperate in providing the psychotherapist any information and documents that the psychotherapist may deem pertinent. Respondent shall have the treating psychotherapist submit quarterly status reports to the Division or its designee. The Division or its designee may require respondent to undergo psychiatric evaluations by a Division-appointed board certified psychiatrist.

If, prior to the completion of probation, respondent is found to be mentally unfit to resume the practice of medicine without restrictions, the Division shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Division determines that respondent is mentally fit to resume the practice of medicine without restrictions. Respondent shall pay the cost of all psychotherapy and psychiatric evaluations.

Failure to undergo and continue psychotherapy treatment, or to comply with any required modification in the frequency of psychotherapy, is a violation of probation.

7. Solo Practice: Respondent is prohibited from engaging in the solo practice of medicine.

8. Notification: Within 10 calendar days of the effective date of this decision, respondent shall provide a true copy of the decision and accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to him, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days of the effective date of this decision.

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

9. Supervision of Physician Assistants: During probation, respondent is prohibited from supervising physician assistants.

10. Obey All Laws: Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and shall remain in full compliance with any court-ordered criminal probation, payments, and other orders.

11. Quarterly Declarations: Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

12. Probation Unit Compliance: Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of his business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Respondent shall not engage in the practice of medicine in his place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

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

13. Interview with the Division or its Designee: Respondent shall be available in person for interviews either at his place of business or at the probation unit office, with the Division or its designee, upon request at various intervals and either with or without prior notice throughout the term of probation.

14. Residing or Practicing Out-of-State: If respondent leaves California to reside or to practice, he shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return.

All time spent in an intensive training program outside California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the state. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if his periods of temporary or permanent residence or practice outside California total two years. However, respondent's license shall not be cancelled as long as he is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two-year period shall begin on the date probation is completed or terminated in that state.

15. Failure to Practice Medicine - California Resident: If respondent stops practicing medicine in California for any reason while continuing to reside in California, he shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in Business and Professions Code sections 2051 and 2052.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

16. Completion of Probation: Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

17. Violation of Probation: Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation, or petition to revoke probation, or an interim suspension order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

18. Cost Recovery: Within 90 calendar days from the effective date of the decision or other period agreed to by the Division or its designee, respondent shall reimburse the Division the amount of $10,000 for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by respondent shall not relieve him of his obligation to reimburse the Division for its costs.

19. License Surrender: Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of his license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificates to the Division or its designee and he shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of his license shall be deemed disciplinary action.

If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

20. Probation Monitoring Costs: Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

21. Practice Monitor: Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Division or its designee for prior approval as a practice monitor(s), the name and qualification of one or more licensed physician and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current

business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Division, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

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

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

The monitor shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine or billing, or both, and whether respondent is practicing medicine safely, billing appropriately or both.

It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Division or its designee within 10 calendar days

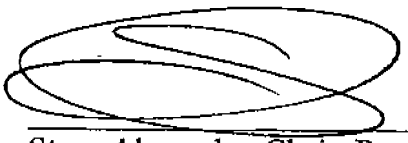
If the monitor resigns or is no longer available, respondent shall, within five calendar days of such resignation or unavailability, submit to the Division or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.

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

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

This Decision shall become effective at 5:00 p.m. on January 13, 2006.

IT IS SO ORDERED December 14, 2005



Steve Alexander, Chair, Panel A
Division of Medical Quality
MEDICAL BOARD OF CALIFORNIA

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

In the Matter of the Accusation Against:	
ALAN J. COHEN, M.D.	Case No.: 12 2002 135801
Physician's & Surgeon's Certificate No.: G 51201	OAH No.: N2004080541
Respondent	

NOTICE OF NON-ADOPTION OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted.** The Medical Board of California, Division of Medical Quality, will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit, including in particular, argument directed to the question of whether the proposed penalty should be modified. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact California Reporting, LLC, 52 Longwood Drive, San Rafael, CA 94901. The telephone number is (415) 457-4417.

To order a copy of the exhibits, please contact the Transcript Clerk, Office of Administrative Hearings, 1515 Clay Street, Suite 206, Oakland, CA 94612. The telephone number is (510) 622-2722.

In addition to written argument, oral argument will be scheduled if any party files with the Division within 20 days from the date of this notice a written request for oral argument. If a timely request is filed, the Division will serve all parties with written notice of the time, date and place for oral argument. Oral argument shall be directed only to the question of whether the proposed penalty should be modified. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Division. The mailing address of the Division is as follows:

Division of Medical Quality
MEDICAL BOARD OF CALIFORNIA
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2639

Dated: August 3, 2005

Valerie Moore
Enforcement Legal Unit

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

In the Matter of the Accusation Against: ALAN J. COHEN, M.D. 6571 Liggett Drive Oakland, California 94611 Physician's and Surgeon's Certificate No. G 51201 Respondent.	Case No. 12 2002 135801 OAH No. N2004080541

PROPOSED DECISION

Administrative Law Judge Nancy L. Rasmussen, Office of Administrative Hearings, State of California, heard this matter on December 7, 8 and 9, 2004, in Oakland, California.

Deputy Attorney General Susan K. Meadows represented complainant David T. Thornton, Executive Director of the Medical Board of California (Board), in the Department of Consumer Affairs.[1]

Attorney at Law John L. Fleer represented respondent Alan J. Cohen, M.D., who was present.

The matter was submitted on December 9, 2004.

FACTUAL FINDINGS

License and Employment Background

1. On September 2, 1983, the Board issued physician's and surgeon's certificate no. G 51201 to respondent Alan J. Cohen, M.D. The current expiration date is August 31, 2005.

[1] At the time the accusation was filed, Mr. Thornton was Interim Executive Director of the Board.

2. Respondent received his medical degree in 1982 from Jefferson Medical College in Philadelphia. After a one-year internship at the University of California-San Francisco (UCSF), he completed a three-year residency in psychiatry at the Langley Porter Institute at UCSF. From 1984 to 1986, respondent had a part-time private practice on Saturdays at the Schuman-Liles Psychiatric Clinic in Oakland. He completed further training in diagnostic psychiatry during a one-year fellowship at the Institute of Pennsylvania Hospital from 1986 to 1987. From 1987 to 1990, respondent worked as an attending psychiatrist at San Francisco General Hospital. During this time, he had a small private practice. Respondent became board certified in psychiatry in 1989. In 1990, respondent joined Comprehensive Psychiatric Services, a private psychiatric group that owned East Bay Hospital in Richmond. Until he left that group in about 1996, he provided in-patient and out-patient psychiatric services, conducted some research studies and clinical drug trials and held various administrative positions at the hospital. Respondent saw patients in offices in Walnut Creek, Pinole, Oakland and Richmond. After leaving Comprehensive Psychiatric Services, he and a couple of other doctors from the group formed Bay Area Behavioral Care. Respondent saw patients in offices in Walnut Creek and Berkeley. He left Bay Area Behavioral Care after about a year, closing his office in Walnut Creek and consolidating his private practice in his Berkeley office. Respondent was in solo practice in Berkeley until February 2001. During this time, respondent continued to conduct research studies, including some formal trials funded by pharmaceutical companies. His primary research interests included psychopharmacology; treatment of antidepressant-induced sexual dysfunction, including with natural substances (e.g., Ginkgo biloba); thyroid dysfunction; and organic brain dysfunction.

Treatment of M.A.

3. The accusation alleges that in his psychiatric treatment of M.A., respondent committed gross boundary violations by engaging in sexual relations with her and using drugs recreationally with her. Further allegations include diverting Ritalin from M.A. for his personal use, giving her a plant containing a hallucinogenic chemical, preparing an evaluation of M.A. for a legal proceeding when his impartiality was impaired, and failing to refer her to another physician for treatment.

4. In January 1994, M.A., then age 49, began psychiatric treatment with respondent. She had a number of emotional problems and was in an unhappy marriage. She had also experienced some traumatic events in her life, including childhood sexual abuse, a serious car accident, caring for her mother before she died of brain cancer, and her son being injured in a car accident. M.A. had hepatitis C, and respondent diagnosed her with Hashimoto's thyroiditis.

5. M.A. saw respondent initially once a week. In 1995, her visits increased to twice a week, and in 1997 they increased to three times a week. M.A.'s last visit to respondent's office was in early December 1999, although he continued to prescribe medications for her into 2000. Over the years, respondent's treatment focus shifted from psychotherapy more to medications management. Respondent prescribed various

antidepressants for M.A., as well as thyroid supplements and Ativan. To treat M.A.'s severe fatigue and lack of energy, respondent started prescribing Ritalin in December 1995.[2]

6. The Ritalin made M.A. shaky, sick to her stomach and "very hyper," so she started breaking the pills in half and taking fewer pills than respondent prescribed. At some point, possibly around December 1996, M.A. brought her leftover Ritalin in to respondent's office. Telling him that it was a shame to waste the medication, she asked if some other patient could use the pills. Respondent took the Ritalin from M.A., and he later told her that he had a Medi-Cal patient who could use the medication. From then on, M.A. continued to fill her Ritalin prescriptions, but she used only a small portion of each prescription. She gave the bulk of the medication to respondent. Sometimes he drove to M.A.'s home to pick up her Ritalin – respondent would call and have her meet him at the driveway of her condominium complex, where she would hand him a brown paper bag containing the medication (occasionally, respondent's young children were in the car with him). M.A.'s prescriptions were covered by insurance, which respondent knew. He considered lowering M.A.'s Ritalin dosage, but he did not do so. In the patient chart, respondent did not record the actual amount of Ritalin M.A. was taking.

7. Respondent did not give M.A.'s leftover Ritalin to another patient. He took all of the Ritalin himself. In 1996, respondent diagnosed himself with Attention Deficit Disorder, and he asked his personal physician, Joseph Barrera, M.D., to prescribe Ritalin. Respondent felt Ritalin helped him focus, and he also found that it "balanced out" the sedating effects of the opiates he was taking. It is unclear whether respondent was taking opiates on a regular basis before an incident on December 17, 1996, when he tore his rotator cuff. He had been regularly exposed to opiates because of a chronic problem with kidney stones, and he had been treated with Vicodin for a neck and shoulder injury when he worked at San Francisco General Hospital.

8. On December 17, 1996, respondent tore his rotator cuff and aggravated his old shoulder injury while escaping from an assaultive patient who had a rifle. When Vicodin did not work to control respondent's pain, Dr. Barrera prescribed a stronger opiate, Levo-Dromoran, on respondent's recommendation. Respondent was also taking Ritalin at this time. As he developed a tolerance to the medications, he needed to take greater quantities. This was when respondent began to rely on M.A. to supplement his supply of Ritalin. (He was receiving the maximum standard dosage from Dr. Barrera and did not want to ask him for more.) Respondent knew it was illegal to divert the Ritalin he prescribed for M.A. for his own use, and he felt bad about doing it.

9. Almost from the beginning of therapy, M.A. developed emotional feelings for respondent. (As she testified, it was kind of like the "first love" of a teenager.) Within a few months of starting therapy, she expressed to respondent her feelings for him. They discussed transference and how that could be a useful tool in therapy. Between April 1994 and

[2] Ritalin is a Schedule II controlled substance, as defined by Health and Safety Code section 11055.

February 1997, respondent's notes of M.A.'s visits contain many entries indicating that they explored transference issues. According to respondent, he and M.A. maintained clear boundaries, with no physical contact. In May 1996, M.A. separated from her husband of 26 years, and respondent helped her through this difficult time.

10. During the holiday season in either 1995 or 1996, M.A. brought to one of her sessions with respondent a gift of Jewish art that she had purchased for him (the value was approximately $200). They discussed the ethical considerations of respondent accepting a gift from a patient, and M.A. told him that it was important to her to give him something. He accepted the gift and later displayed the art on his office wall. This made M.A. feel special. Thereafter, M.A. usually gave respondent gifts for the holidays, for Valentine's Day and for his birthday. Respondent accepted each of her gifts. In 1998, M.A. gave respondent Hanukkah gifts for his children.

11. At some point during the spring or early summer of 1999, respondent gave M.A. a San Pedro cactus plant. M.A. had expressed some interest in hallucinogens, and when respondent brought the plant to her home, he gave her a computer printout containing a "recipe" for cooking the cactus to extract a mildly hallucinogenic chemical from it. After reading about the plant on the website shown on the printout, M.A. followed the cooking instructions and made a juice from her cactus. M.A. eventually drank the cactus juice with her "ex-hippie" boyfriend present. The substance had a mild effect – M.A. recalls that colors were intensified. She had arranged with respondent to call him when she took the juice, and they talked on the phone for an hour to an hour and a half.

12. The first time respondent acknowledged M.A.'s birthday was in 1999. During one of her office visits in August, he gave her a birthday card and a gift. The gift was a box containing sachet, bath soaps, an item of Chinese lacquerware and a book called *Dogs in Love*. To M.A., this gift signified a change in her relationship with respondent, and she felt overwhelmed and happy. At that point, much of what went on in their sessions was not therapy, but a friendly discussion of what had been going on in their lives. M.A. had not paid respondent any money for his professional services since early 1998.

13. At some point in 1999, M.A. asked respondent to prepare a letter stating that she could work only part-time, because her ability to work was an issue in her divorce proceeding. Respondent prepared a detailed letter, dated October 11, 1999, discussing his medical and psychiatric treatment of M.A. as it pertained to her ability to maintain employment. M.A. and respondent had talked over an extended period of time about what the letter should say, and M.A. had reviewed a draft, making comments and suggesting changes where she thought there were inaccuracies. The letter was sent to the attorney for M.A.'s husband. Respondent billed the attorney $1,650 for this evaluation, but he did not receive any payment.

14. Sometime before Hanukkah began on December 3, 1999, M.A. drove to respondent's house to bring his children gifts. The children met her on the driveway, and she gave them gifts for each night of Hanukkah. Respondent was pleased with the gifts.

15. In early December 1999, respondent and M.A. first had physical contact. They met in the parking lot of M.A.'s condominium complex and walked around the complex holding hands and discussing whether to change their relationship to something more physical. Both of them were nervous. Respondent recalls that M.A. was pushing him to have a sexual relationship, and that he was resisting. Finally, he gave in and agreed to what she wanted, even though he knew that it was unethical. At the end of their walk, M.A. invited respondent to come to her house for dinner on an upcoming Saturday.

16. M.A.'s last visit to respondent's office was in early December 1999, after the above conversation. She believes she may have just been picking up a prescription. At some point around this time, M.A. sent respondent a long e-mail message telling him that she could not come in to the office anymore. She recalls telling him that they were not doing therapy anymore, but just "boy-girl stuff."

17. Respondent and M.A. engaged in sexual relations on two occasions. The first time was at respondent's house, on the Friday night before the Saturday dinner at M.A.'s house. Before they had sex, M.A. and respondent smoked marijuana that M.A. had brought with her. She recalls feeling uncomfortable and nervous. The following night, M.A. made an elaborate dinner for respondent. According to her, they smoked marijuana together, and respondent told her that he had crushed a Ritalin tablet and put it in the marijuana. In an April 22, 2003, conference with the Board's investigator and medical consultant, respondent stated that he remembered inhaling Ritalin and Oxycontin (crushed into a powder) with M.A.[3] (At the hearing, respondent asserted that what he told the Board might not have been accurate, because he does not now recall using Oxycontin with M.A.) Respondent and M.A. had sex, and then he took a bath. They discussed personal matters, including respondent's parents and sister, and problems he was having with his children and his ex-wife.

18. The last time M.A. saw respondent was on New Year's Eve. He was supposed to come by her house, but she ended up driving to his house and giving his children a bottle of sparkling cider. At this time, M.A. was introduced to a woman who was described as a "babysitter," but whom M.A. later learned was in a relationship with respondent. That night, M.A. and respondent hugged, and he told her something to the effect that they would always have a relationship and that he would be someone she could rely on in her life.

19. At no time did respondent discuss referring M.A. to another physician for psychiatric treatment. He was aware that in January 2000 she would be starting high-dose interferon induction therapy with ribavirin to treat her hepatitis C. The side effects of this

[3] In late 1998 or early 1999, respondent started taking Oxycontin, a Schedule II controlled substance per Health and Safety Code section 11055. Dr. Barrera moved out of the area during one of respondent's attacks of kidney stones, and he had to scramble around to find another physician to prescribe something stronger than Vicodin. Respondent found Mannie Joel, M.D., a pain management specialist in Pleasanton. After a short prescription of Levo-Dromoran (before that drug was discontinued by the manufacturer), Dr. Joel prescribed Oxycontin for respondent. Respondent sometimes crushed the Oxycontin and Ritalin and inhaled the medications for more immediate pain relief.

treatment include nausea, vomiting, hair loss, flu-like symptoms and depression. Respondent's recollection is that M.A. said she was fine and did not want further treatment.

20. For some time in 2000, M.A. continued to get prescriptions from respondent and to refill his prescriptions. One time when she was feeling sick from her hepatitis C treatment, M.A. called respondent on his cell phone. He told her he was very busy, with lots of commitments. Then their conversation was cut off when the call got dropped in a dead zone. Respondent did not call M.A. back, which made her feel that he had abandoned her. Respondent believes he phoned M.A. once after she had called in for a prescription. In December 2000, M.A. filed a lawsuit against respondent.

Respondent's Violations

21. Respondent does not deny that he committed the violations alleged in the accusation. Complainant's expert witness, Laura Duskin, M.D., testified about respondent's misconduct with M.A., and she explained how he violated the standards of practice. The following matters were established:[4]

a. Respondent's having sexual relations with M.A. constituted sexual misconduct.

b. Respondent's having sexual relations with M.A. constituted an extreme departure from the standard of practice and unprofessional conduct.

c. Respondent's use of marijuana and Ritalin (and Oxycontin, if he also used that drug) with M.A. constituted an extreme departure from the standard of practice and unprofessional conduct.

d. Respondent's gift to M.A. of the San Pedro cactus plant along with information about extracting the hallucinogenic chemical from it constituted an extreme departure from the standard of practice and unprofessional conduct.

e. Respondent acted fraudulently in obtaining Ritalin from M.A. for his own use under the pretense of giving the drug to another patient. And even if he had not been illegally diverting the drug to his own use, it was wrong for respondent to bring into his therapeutic relationship with M.A. the needs of another patient and his need to care for that patient.

f. Respondent's failure to record in M.A.'s medical records the actual amount of Ritalin she was taking, as opposed to the amount he was prescribing for her,

[4] There are a number of other matters pertaining to M.A in which Dr. Duskin believes respondent departed from the standard of care, but no findings are made on those because they are not alleged in the accusation.

constituted an extreme departure from the standard of practice and unprofessional conduct.

g. Respondent's preparation of the October 11, 1999 letter evaluating M.A.'s ability to work, at a time when his impartiality was impaired by illegally procuring drugs from her, was unethical and constituted unprofessional conduct.

h. In view of his numerous boundary violations with M.A., and the fact that she was starting interferon treatment in January 2000, respondent's failure to refer her to another physician for psychiatric treatment constituted an extreme departure from the standard of practice and unprofessional conduct.

Subsequent Events

22. In December 2000, when M.A. filed her lawsuit against him, respondent was still in solo practice in Berkeley, and he was using very high amounts of Ritalin and Oxycontin. In January 2001, respondent's assistant and two of his former group colleagues had an intervention, where they confronted him with his drug use and told him that he had a problem. (Respondent believes his assistant organized the intervention, because she had observed the deterioration in his quality of life and knew of his prescriptions for Ritalin and Oxycontin.) Respondent was instructed to call the Board's Diversion program.

23. Respondent met with Case Manager Chris Medrano and Jim O'Donnell from Diversion, but he denied having a drug problem. He claimed that he was taking the drugs to treat his chronic pain. Respondent understood that he would have to undergo an evaluation for chemical dependency, and he started attending Diversion group meetings and AA and NA meetings. Because he had been told by Diversion that he could not practice medicine, respondent's patients were being seen by colleagues of his. After a couple of weeks, respondent's denial had softened and he had settled on the Springbrook treatment program in Oregon. He closed his private practice in February 2001. Respondent went to Springbrook for a two-week evaluation, and he ended up staying for 90 days. Respondent's detoxification period took several days, and for six weeks he felt impaired, depressed, weak and fatigued. He attended group sessions and AA/NA meetings all day. He received some physical therapy, and he was fitted for a TENS[5] unit, which helped with his pain. Respondent actively engaged in treatment, though he did not at first accept that he needed treatment.

24. On June 15, 2001, respondent left Springbrook and returned home. He pursued his plan to attend twice-weekly Diversion group meetings, to attend five meetings a week of AA/NA initially and later four meetings a week, and to have a case manager and sponsor. Respondent was very depressed, and it took him some time to locate psychiatrist Rick Lavine, M.D., and start therapy. (The therapist who had treated respondent since the incident on December 17, 1996, Catherine Freemire, L.C.S.W., would not enter into a

[5] Transcutaneous Electrical Nerve Stimulator.

contract with Diversion because it required her to breach the confidentiality of patient-therapist communications.)

25. On August 16, 2001, respondent signed a five-year contract with the Diversion program. After the Diversion Evaluation Committee gave respondent approval to return to the (non-private) practice of medicine, he found a job as a staff psychiatrist at Alameda County Behavioral Health Care Services (BHCS). In April 2002, he started employment there 24 hours per week. As of December 2004, respondent was working 32 hours per week at BHCS, and he had recently been granted a permanent civil service position.

Employment at BHCS

26. At BHCS, respondent treats clients in two out-patient clinics. He works 24 hours per week at the Eden Community Support Center in San Leandro, and he works eight hours per week at the BHCS clinic in Alameda. His clients are severely mentally ill adults, typically on Medi-Cal or Medicare. The majority of them have a dual diagnosis of chemical dependency as well as a psychiatric disorder, and respondent draws on his own experience with substance abuse and recovery to help his clients. The focus of respondent's treatment is on medications management, with little psychotherapy. He is part of a treatment team, working with case managers and other staff members. There are four other psychiatrists at the San Leandro clinic and one other psychiatrist at the Alameda clinic. Respondent feels this group setting is a good place for him to work. He enjoys the peer support, the consultative availability, and the regular hours with no on-call duties. He earns less money than he did in private practice, but he is able to make ends meet.

27. BHCS Chief Psychiatric Social Worker Miriam Mills, L.C.S.W., is respondent's worksite monitor for Diversion. She is the Director of the Eden Community Support Center, but she serves as respondent's monitor for his work at the Alameda clinic, too, with the approval of Diversion. Mills is required to submit quarterly reports to Diversion. Before respondent was hired by BHCS, he disclosed in a group interview his addiction to prescription medications and the fact that he was in Diversion. Sometime last year, respondent told Mills about his misconduct with M.A. – having sex with her, procuring Ritalin from her and using drugs with her. He explained that the recent lifting of a gag order in connection with the settlement of M.A.'s civil lawsuit enabled him to share this information. Mills reported this information to the BHCS Medical Director, but she has no concerns about respondent's professionalism. He gets along well with his co-workers, and there have been no complaints about him from patients or staff members. In her testimony at the hearing, Mills described respondent as a brilliant psychiatrist who forms a very therapeutic bond with patients. In treatment team meetings, he is supportive of case managers presenting cases and he is "very much a teacher." Mills reviews all charts on a six-month cycle, and respondent's chart notes are so well done that they have been used as a model in training. Respondent is a conscientious employee and a valued member of the BHCS staff.

28. Lynn Ellen Marcus, L.M.F.T., is a clinical case manager and team leader at Eden Community Support Center. Respondent is the assigned doctor for 10 of her clients, and they sometimes meet together with a client. Marcus has daily contact with respondent when he is in the clinic, and they sit down once a week to discuss their clients. Not long after he came to work at BHCS, respondent told Marcus that he was in Diversion for his addiction to prescription drugs. In recovery herself for 23 years, Marcus talks with respondent about his recovery program. Over the years she has known him, she has seen his commitment to recovery grow and deepen. Later on in the time they worked together, respondent told Marcus about having sex with a patient and using drugs with her. Marcus sees that as a part of respondent's past. In her experience with him at BHCS, respondent is respectful of patients and scrupulous about maintaining boundaries. He has helped others with boundary issues, offering good insight. In her testimony, Marcus described respondent as an excellent doctor, therapist, co-worker and team member who is reliable in following through on his promises and commitments.

29. BHCS Medical Director Richard P. Singer, M.D., wrote a letter on respondent's behalf. In his letter, he stated that there have been no problems with respondent's charts, there have been no complaints or concerns raised by the clinic supervisor, and respondent is a valuable member of the BHCS medical staff.

Rehabilitation

30. Respondent now realizes that in the 1990's he did not fully appreciate the importance of maintaining strict boundaries with patients. He was already prone to cutting corners when it came to boundaries, but as his judgment became impaired by drug addiction respondent made less of an effort to resist M.A.'s personal overtures. Accepting gifts from her was a "slippery slope," and his boundaries with M.A. gradually eroded as their relationship became more personal and friendly, and they were doing less and less psychotherapy. Things were "out of control" by the end of 1999, when he had sex with her. Respondent feels very remorseful for his misconduct with M.A. and the suffering he caused her.

31. Besides contributing to his misconduct with M.A., respondent's drug addiction had a negative impact on his practice in many ways. He neglected his billing for close to a year; he did not work as hard as he should have, and he was sometimes late, sleepy or suffering from a headache when he met with a client; he lost patients who did not come back; and an error was made in an important publication because no one checked the final draft. At the time, respondent did not want to acknowledge that these problems were related to his drug use.

32. Respondent's agreement with Diversion includes strict requirements pertaining to attendance of 12-step meetings and Diversion group meetings, engaging in individual therapy, drug testing, submitting semi-annual reports, etc. Respondent is required to abstain from the use of alcohol and all psychotropic drugs except those prescribed by another physician and approved by Diversion. During the three and one-half years he has

been in Diversion, respondent has complied with all of these requirements and he has had no positive drug tests. (There have been some changes to the requirements since the original agreement.) Respondent had one kidney stone attack when he had to be treated with narcotics, but this treatment was approved by Diversion.

33. Respondent attends four 12-step meetings and one Diversion group meeting per week, and he has a 12-step sponsor with whom he meets on a weekly basis. He has told the story of his addiction at AA/NA meetings. His Diversion group is a source of support from other health care professionals with substance abuse problems. Respondent's recovery program also includes daily meditation and prayer, a practice which he developed during his residential treatment at Springbrook. He knows that he is always at risk for relapse, but he feels confident that he is doing the right things to stay drug-free.

Treatment with Dr. Lavine

34. In September 2001, respondent started individual therapy with Dr. Lavine. Dr. Lavine is a psychiatrist who specializes in treating people with chemical dependency. Respondent sees him about two to three times per month. (As of December 2004, they had had a total of 80 sessions.) Respondent has ongoing problems with depression and anxiety, related to the damage done by his substance abuse and boundary violations, the loss of his practice, his divorce and his chronic pain. The focus of respondent's therapy has been on dealing with this depression and anxiety and maintaining his recovery from addiction. In his testimony at the hearing, Dr. Lavine described how respondent originally was resistant to treatment and angry at Diversion. His attitude gradually changed as mutual trust developed between respondent and Diversion, and Diversion became a supportive force in his life. Going back to work in 2002 helped, because respondent regained his self-respect. Dr. Lavine believes that respondent has a good recovery program and the prognosis is good for his staying drug-free. Respondent attends all the meetings required by Diversion, he is compliant with recommendations, he has made positive lifestyle changes, and he takes responsibility for his actions rather than blaming others.

35. Dr. Lavine and respondent have discussed boundary issues, including his boundary violations with M.A. Dr. Lavine views these violations as secondary to respondent's drug addiction, because addicts who are using drugs have impulse control problems. Before Diversion allowed respondent to return to work, Chris Medrano asked Dr. Lavine to look at respondent for a possible sexual disorder. Finding no history of a psychosexual disorder or paraphilia, Dr. Lavine concluded that respondent presented no threat of acting out sexually in his practice. Addiction and depression are respondent's only psychological disorders – there is no evidence of an Axis II personality disorder. Respondent understands that what he did with M.A. was wrong, and he makes no excuses for his misconduct. In Dr. Lavine's discussion with him of boundaries, respondent has gained a clearer understanding about certain boundary issues. He is now very attuned to such issues and careful to maintain appropriate boundaries in his work at BHCS. Dr. Lavine has told respondent that he would support him if he wanted to open a small private practice and sought permission from Diversion to do so, but respondent has not been interested in doing

this. He is happy at BHCS, working in a matrix of people where he feels he is appreciated and he is doing important work.

36. Dr. Lavine acknowledges the potential conflict of interest between his obligation as respondent's treating doctor and his duty to be honest in testifying in this proceeding, and he has discussed this with respondent. Dr. Lavine asserts that he is not totally objective, but he is being honest. If he thought he could not be honest and act in respondent's best interest, he would not have agreed to testify. Dr. Lavine believes respondent has been candid with him – as he put it, respondent "wears his heart close to the surface" and is not able to hide much. Dr. Lavine also has talked to the Diversion group leader and others about respondent and his recovery. Dr. Lavine's opinion is that respondent is safe to practice, and he believes his opinion is valid.

Dr. Duskin's Concerns

37. Complainant's expert, Dr. Duskin, questions whether respondent is safe to practice. Pointing out that most drug-addicted doctors do not procure drugs from their patients or have sex with them, she asserts that with all the focus on respondent's addiction not enough attention has been given to his boundary problems. Dr. Duskin notes that respondent had "very porous" boundaries and multiple dual relationships before he became addicted to drugs. For example, Rachelle Bradley, the nurse respondent hired as his research assistant in 1998 or 1999, had been a patient of his for a brief time in the early 1990's. Her husband had been respondent's patient when Bradley came to respondent with interpersonal issues, some of which involved her husband. After advising the couple of the possible conflict of interest, respondent agreed to see Bradley for a short period of treatment. Sometime after she saw respondent for treatment, Bradley came to work as the infection control nurse at East Bay Hospital, and she assisted respondent in a research study at that facility.

Dr. Duskin discounts any opinion by respondent's treating psychiatrist about respondent's safety to practice, because of his inherent conflict of interest. She points out that there has been no evaluation of respondent's safety to practice by an independent evaluator.

Costs of Investigation and Enforcement

38. As of December 2, 2004, the Board had incurred the following costs of investigation and enforcement in this accusation against respondent:

Investigative Services			
2002:	6.25 hrs. @ $110.84/hr.	$ 692.75	
2003/2004	65.25 hrs. @ $111.38/hr.	$ 7,267.54	
			$ 7,960.29
Expert Reviewer Services			
2003/2004	37.00 hrs. @ $100.00/hr.		$ 3,700.00

Deputy Attorney General Legal Services			
2003/2004	47.50 hrs. @ $132.00/hr.	$ 6,270.00	
2004/2005	46.00 hrs. @ $139.00/hr.	$ 6,394.00	
			$12,664.00
		Total	$24,324.29

LEGAL CONCLUSIONS

Respondent's Violations

1. Findings 21-a and 21-b: Cause for disciplinary action exists under Business and Professions Code[6] section 726 (sexual misconduct/unprofessional conduct); section 2234, subdivision (b) (gross negligence/unprofessional conduct); and section 2234 (unprofessional conduct).

2. Finding 21-c: Cause for disciplinary action exists under section 2234, subdivision (b) (gross negligence/unprofessional conduct); and section 2234 (unprofessional conduct).

3. Finding 21-d: Cause for disciplinary action exists under section 2234, subdivision (b) (gross negligence/unprofessional conduct); and section 2234 (unprofessional conduct).

4. Finding 21-e: Cause for disciplinary action exists under section 2234 (unprofessional conduct) as that section interacts with section 2238 (violation of a drug statute), by reason of respondent's violation of Health and Safety Code section 11173, subdivision (a) (obtaining controlled substance by fraud, deceit, misrepresentation or subterfuge). Cause for disciplinary action also exists under section 2234, subdivision (e) (dishonesty or corruption/unprofessional conduct).

5. Finding 21-f: Cause for disciplinary action exists under section 2234 (unprofessional conduct) as that section interacts with section 2261 (false representation in medical document). Cause for disciplinary action also exists under section 2234, subdivision (b) (gross negligence/unprofessional conduct).

6. Finding 21-g: Cause for disciplinary action exists under section 2234 (unprofessional conduct).

7. Finding 21-h: Cause for disciplinary action exists under section 2234, subdivision (b) (gross negligence/unprofessional conduct).

8. Findings 21-b, 21-c, 21-d, 21-f and 21-h: Cause for disciplinary action exists under section 2234, subdivision (c) (repeated negligent acts/unprofessional conduct).

[6] Unless otherwise indicated, all cited code sections are in the Business and Professions Code.

Costs of Investigation and Enforcement

9. Complainant has requested that respondent be ordered to pay the Board the costs of investigation and enforcement of the case. Section 125.3 provides that respondent may be ordered to pay the Board "a sum not to exceed the reasonable costs of the investigation and enforcement of the case." That section also provides that the Board's certification of the actual costs constitutes prima facie evidence of the reasonable costs. The costs set forth in Finding 38, $24,324.29, were established by such a certification. In the absence of any evidence to the contrary, this amount is determined to be reasonable.

Respondent does not question the amount of time put in to the investigation and prosecution of the case, but he urges the Board to reduce the amount of cost recovery, taking into consideration 1) that he has always been willing to accept probation in this case, and 2) his limited financial means as a part-time county employee. In view of these circumstances, it would not be fair or reasonable to require respondent to pay the full amount of the Board's costs of investigation and enforcement. It would be fair and reasonable to require respondent to pay $10,000 of the Board's costs.

Other Matters

10. There is no question that respondent engaged in misconduct of the most egregious sort with M.A., and respondent does not defend his actions. The only question is whether protection of the public requires that his license be revoked, as complainant contends, or whether the public can be adequately protected by placing respondent on probation. On this question, respondent has established that he is sufficiently rehabilitated that it is not necessary to revoke his license outright. It has been over five years since his misconduct, and during that time respondent has made major changes in his life and in his practice. After been forced to confront his drug addiction, he stopped using drugs and entered the Board's Diversion program. Respondent has been in Diversion for three and one-half years, with no relapses, and he has developed a strong network of support for his continued recovery. In his therapy with Dr. Lavine, respondent has addressed boundary issues as well as other matters, and he understands how his inattention to boundaries (apart from his drug addiction) played a significant role in his misconduct with M.A. While Dr. Lavine is not an independent evaluator, his opinion that respondent is safe to practice should be considered, since he has gotten to know respondent well during their 80 sessions and is in a good position to assess the changes in respondent's thinking and in his approach to his practice. Most importantly, respondent has demonstrated in his employment at BHCS that he can practice safely. For three years, he has worked with severely mentally ill clients in a clinic environment completely different from the isolated solo practice he used to have. Respondent has thrived in this collaborative group setting, he has provided excellent care to his patients, and he has become a valued member of the staff. Scrupulous about maintaining boundaries, he has been a model of professionalism. It would not be contrary to the public interest to allow him to continue to practice under appropriate terms and conditions for a lengthy period of probation. Probationary conditions shall include a prohibition on solo practice and requirements that respondent continue in Diversion and psychotherapy and that

he abstain from drugs. He shall be required to submit to drug testing if such testing is deemed necessary. An education course will be required during the first year, as well as a course in ethics. It is not necessary to require a third party chaperone when respondent treats female patients (even if that were feasible), because respondent is safe to treat female patients, as he has been doing at BHCS for three years. Furthermore, respondent's sexual misconduct with M.A. did not occur during office visits. In accordance with section 2227, subdivision (a)(3), respondent shall be required to pay the costs of probation monitoring.

ORDER

Physician's and surgeon's certificate no. G 51201 issued to respondent Alan J. Cohen, M.D., is revoked pursuant to Legal Conclusions 1 through 8, separately and for all of them. However, the revocation is stayed and respondent is placed on probation for seven (7) years upon the following terms and conditions:

1. Controlled Substances - Abstain From Use: Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drugs as defined by Business and Professions Code section 4022, and any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed to respondent by another practitioner for a bona fide illness or condition.

Within 15 calendar days of receiving any lawful prescription medications, respondent shall notify the Board's Division of Medical Quality (Division) or its designee of the: issuing practitioner's name, address, and telephone number; medication name and strength; and issuing pharmacy name, address, and telephone number. The Division or its designee may waive this condition for any medications that are prescribed for respondent on an ongoing basis or when it is determined that such notification is no longer necessary.

2. Biological Fluid Testing: Respondent shall immediately submit to biological fluid testing, at his own expense, upon the request of the Division or its designee. A certified copy of any laboratory test results may be received in evidence in any proceedings between the Board and respondent. Failure to submit to, or failure to complete, the required biological fluid testing, is a violation of probation.

3. Diversion Program: Respondent shall continue to participate in the Board's Diversion Program until the Diversion Program determines that further treatment and rehabilitation are no longer necessary. If he has not already done so, respondent shall execute a release authorizing the Diversion Program to notify the Division when 1) respondent requires further treatment and rehabilitation, 2) respondent no longer requires treatment and rehabilitation, and 3) respondent may resume the practice of medicine. If he has not already done so, respondent shall execute a release authorizing the Diversion Program to provide confirmation to the Division whenever the Diversion Program has determined that respondent shall cease the practice of medicine.

Within 5 calendar days after being notified by the Diversion Program of a determination that further treatment and rehabilitation are necessary, respondent shall notify the Division in writing. The Division shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Diversion Program determines that further treatment and rehabilitation are no longer necessary. Within 24 hours after being notified by the Diversion Program of a determination that respondent shall cease the practice of medicine, respondent shall notify the Division and respondent shall not engage in the practice of medicine until notified in writing by the Division or its designee of the Diversion Program's determination that respondent may resume the practice of medicine. Failure to cooperate or comply with the Diversion Program requirements and recommendations, quitting the program without permission, or being expelled for cause constitutes a violation of probation.

4. Education Course: Within 60 calendar days of the effective date of this decision, respondent shall submit to the Division or its designee for its prior approval educational program(s) or course(s) which shall total not fewer than 40 hours. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be completed within the first year of probation. They shall be at respondent's expense, and they shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Division or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

5. Ethics Course: Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in ethics, at his own expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation.

An ethics course taken after the acts underlying the accusation but prior to the effective date of the decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this decision.

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

6. Psychotherapy: Respondent shall continue in psychotherapy with Rick Lavine, M.D., at the frequency of sessions determined (or later modified) by the Division or its designee. Alternatively, within 60 calendar days of the effective date of this decision, or within 10 days of discontinuing psychotherapy with Dr. Lavine, respondent shall submit to the Division or its designee for prior approval the name and qualifications of a board

certified psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the Division or its designee deems that no further psychotherapy is necessary.

Upon the request of the Division or its designee, the psychotherapist shall consider any information provided by the Division or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the Division or its designee. Respondent shall cooperate in providing the psychotherapist any information and documents that the psychotherapist may deem pertinent. Respondent shall have the treating psychotherapist submit quarterly status reports to the Division or its designee. The Division or its designee may require respondent to undergo psychiatric evaluations by a Division-appointed board certified psychiatrist.

If, prior to the completion of probation, respondent is found to be mentally unfit to resume the practice of medicine without restrictions, the Division shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Division determines that respondent is mentally fit to resume the practice of medicine without restrictions. Respondent shall pay the cost of all psychotherapy and psychiatric evaluations.

Failure to undergo and continue psychotherapy treatment, or to comply with any required modification in the frequency of psychotherapy, is a violation of probation.

7. Solo Practice: Respondent is prohibited from engaging in the solo practice of medicine.

8. Notification: Within 10 calendar days of the effective date of this decision, respondent shall provide a true copy of the decision and accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to him, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days of the effective date of this decision.

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

9. Supervision of Physician Assistants: During probation, respondent is prohibited from supervising physician assistants.

10. Obey All Laws: Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and shall remain in full compliance with any court-ordered criminal probation, payments, and other orders.

11. Quarterly Declarations: Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

12. Probation Unit Compliance: Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of his business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Respondent shall not engage in the practice of medicine in his place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

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

13. Interview with the Division or its Designee: Respondent shall be available in person for interviews either at his place of business or at the probation unit office, with the Division or its designee, upon request at various intervals and either with or without prior notice throughout the term of probation.

14. Residing or Practicing Out-of-State: If respondent leaves California to reside or to practice, he shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return.

All time spent in an intensive training program outside California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the state. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if his periods of temporary or permanent residence or practice outside California total two years. However, respondent's license shall not be cancelled as long as he is residing and practicing medicine in another

state of the United States and is on active probation with the medical licensing authority of that state, in which case the two-year period shall begin on the date probation is completed or terminated in that state.

15. Failure to Practice Medicine - California Resident: If respondent stops practicing medicine in California for any reason while continuing to reside in California, he shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in Business and Professions Code sections 2051 and 2052.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

16. Completion of Probation: Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

17. Violation of Probation: Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation, or petition to revoke probation, or an interim suspension order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

18. Cost Recovery: Within 90 calendar days from the effective date of the decision or other period agreed to by the Division or its designee, respondent shall reimburse the Division the amount of $10,000 for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by respondent shall not relieve him of his obligation to reimburse the Division for its costs.

19. License Surrender: Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms

and conditions of probation, respondent may request the voluntary surrender of his license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificates to the Division or its designee and he shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of his license shall be deemed disciplinary action.

If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

20. Probation Monitoring Costs: Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

Dated: May 17, 2005

NANCY L. RASMUSSEN
Administrative Law Judge
Office of Administrative Hearings