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

In the Matter of the Accusation Against:	)	
JONATHAN SOMMERS, M.D.	)	Case No. 12-2008-193482
Physician's and Surgeon's Certificate No. G 41535	)	
Respondent	)	

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted by the Medical Board of California, Department of Consumer Affairs, State of California as its Decision in the above entitled matter.

This Decision shall become effective at 5:00 p.m. on October 27, 2011

IT IS SO ORDERED October 20, 2011

MEDICAL BOARD OF CALIFORNIA

By: _____
Linda K. Whitney
Executive Director

KAMALA D. HARRIS
Attorney General of California
JOSE R. GUERRERO
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **JONATHAN DAVID SOMMERS, M.D.** **2924 Florida Street NE** **Albuquerque, NM 87110** **Physician's and Surgeon's Certificate** **No. G41535** Respondent.	Case No. 12-2008-193482 **STIPULATION FOR SURRENDER OF LICENSE**

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

PARTIES

1. Linda K. Whitney (Complainant) is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Russell W. Lee, Deputy Attorney General.

2. JONATHAN DAVID SOMMERS, M.D. (Respondent) is represented in this proceeding by attorney Michael Morrison, Esq., whose address is Janssen, Malloy, Needham,

Morrison, Reinholtsen, Crowley, & Griego, LLP, 730 Fifth Street, Eureka, CA 95501. Telephone (707) 445-1012.

JURISDICTION

3. On or about February 19, 1980, the Medical Board of California issued Physician's and Surgeon's License No. G41535 to JONATHAN DAVID SOMMERS, M.D. (Respondent). Unless renewed, it will expire on January 31, 2012.

4. On October 7, 2010, complainant, in her official capacity, filed Accusation No. 12-2008-193482 against Respondent, a true and correct copy of which is attached hereto as Exhibit A and incorporated by reference as if fully set forth herein.

5. On October 7, 2010, Respondent was served with a true and correct copy of Accusation No. 12 2008 193482, together with true and correct copies of all other statutorily required documents, at his address of record then on file with the Board: 2924 Florida Street NE, Albuquerque, NM 87110. A timely Notice of Defense was filed on Respondent's behalf by his attorney of record, Michael Morrison, Esq..

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, and fully understands the charges and allegations contained in Accusation No. 12-2008-193482, and has fully reviewed and discussed same with his attorney of record, Michael Morrison, Esq.

7. Respondent has carefully read, and fully understands the contents, force, and effect of this Stipulation For Surrender of License, and has fully reviewed and discussed same with his attorney of record, Michael Morrison, Esq.

8. Respondent is fully aware of his legal rights in this matter including his right to a hearing on the charges and allegations contained in Accusation No. 12 2008 193482, his right to present witnesses and evidence and to testify on his own behalf, his right to confront and cross-examine all witnesses testifying against him, his right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents, his right to reconsideration and court review of an adverse decision, and all other rights accorded him pursuant to the California Administrative Procedure Act, the California Code of Civil Procedure, and all other applicable

laws, having been fully advised of same by his attorney of record, Michael Morrison, Esq. Respondent, having the benefit of counsel, hereby knowingly, intelligently, freely and voluntarily waives and gives up each and every one of the rights set forth and/or referenced above.

9. Respondent is currently dealing with a serious illness and desires to resolve Accusation No. 12 2008 193482 without the expense and uncertainty of further proceedings. For the purpose of resolving said Accusation, respondent neither admits nor denies the charges in the Accusation, but agrees that, at a hearing, complainant could establish a factual basis for the charges in the Accusation. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges and agrees to surrender his Physician and Surgeon's Certificate No. G41535 for the Board's formal acceptance.

10. Respondent understands that by signing this Stipulation For Surrender of License ("stipulation"), he is enabling the Board to issue its order accepting the surrender of his Physician and Surgeon's Certificate No. G41535 without further process. Respondent understands and agrees that Board staff and counsel for complainant may communicate directly with the Board regarding this stipulation, without notice to or participation by respondent or his counsel. In the event that this stipulation is rejected for any reason by the Board, it will be of no force or effect for either party. The Board will not be disqualified from further action in this matter by virtue of its consideration of this stipulation.

11. Upon acceptance of the stipulation by the Board, respondent understands that he will no longer be permitted to practice as a Physician and Surgeon in California, and also agrees to surrender and cause to be delivered to the Board both his license and wallet certificate before the effective date of the decision.

12. Respondent fully understands and agrees that if he ever files an application for relicensure or reinstatement in the State of California, the Board shall treat it as a petition for reinstatement of a revoked license, the respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 12 2008 193482 will be deemed to be

true, correct and admitted to by respondent when the Board determines whether to grant or deny the petition.

13. All admissions and recitals contained in this stipulation are made solely for the purpose of settlement in this proceeding and for any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceedings.

14. The parties understand and agree that facsimile copies of this Stipulation For Surrender of License, including facsimile signatures thereto, shall have the same force and effect as the originals.

ACCEPTANCE

I, JONATHAN DAVID SOMMERS, M.D., have carefully read the above Stipulation For Surrender of License and enter into it freely and voluntarily with the advice of counsel, and with full knowledge of its force and effect, do hereby surrender my Physician and Surgeon's Certificate No. G41535 to the Medical Board of California for its formal acceptance.

I fully understand that, after signing this Stipulation For Surrender of License , I may not withdraw from it, that it shall be submitted to the Medical Board of California for its consideration, and that the Board shall have a reasonable period of time to consider and act on this Stipulation For Surrender of License after receiving it.

By signing this Stipulation For Surrender of License, I recognize that upon its formal acceptance by the Board, I will lose all rights and privileges to practice as a Physician and Surgeon in the State of California and I also will cause to be delivered to the Board both my license and wallet certificate before the effective date of the decision.

DATED: 09/14/2011

Jonathan David Sommers, M.D.
JONATHAN DAVID SOMMERS, M.D.
Respondent

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I have read and fully discussed with Respondent JONATHAN DAVID SOMMERS, M.D. the terms and conditions and other matters contained in this Stipulation For Surrender of License. I approve its form and content.

DATED: Sept 19 2011

MICHAEL MORRISON, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulation For Surrender of License is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: 9-22-11

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
JOSE R. GUERRERO
Supervising Deputy Attorney General

RUSSELL W. LEE
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 12-2008-193482

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Oct. 7, 2010
BY Brenda Allen ANALYST

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

In the Matter of the Accusation Against: **JONATHAN DAVID SOMMERS, M.D.** **2924 Florida Street NE** **Albuquerque, NM 87110** **Physician's and Surgeon's No. G41535** Respondent.	Case No. 12 2008 193482 **ACCUSATION**

Complainant alleges:

PARTIES

1. Linda K. Whitney (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about February 19, 1980, the Medical Board of California issued Physician's and Surgeon's Number G41535 to Jonathan David Sommers, M.D. ("Dr. Sommers" or "Respondent"). Unless renewed, it will expire on January 31, 2012. There is no Board record of previous disciplinary action having been taken against this certificate.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board)[1], Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code ("the Code") unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

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

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[1] The term "board" means the Medical Board of California. "Division of Medical Quality" shall also be deemed to refer to the board. (Bus. & Prof. Code §2002)

6. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

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

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

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

8. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic

procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

DRUGS

9. The following drugs are classified as set forth:

A. Seroquel, a trade name for quetiapine, is a dangerous drug within the meaning of Business and Professions Code section 4022, and is an oral antipsychotic drug used for treating schizophrenia and bipolar disorder. Although the mechanism of action of quetiapine is unknown, like other anti-psychotics, it inhibits communication between nerves of the brain. It does this by blocking receptors on the nerves for several neurotransmitters, the chemicals that nerves use to communicate with each other. It is thought that its beneficial effect is due to blocking of the dopamine type 2 (D2) and serotonin type 2 (5-HT2) receptors. Quetiapine can cause hypotension (low blood pressure) and therefore increase the blood pressure lowering effects of antihypertensive drugs. Quetiapine can increase the sedating effects of other drugs that sedate. Such drugs include narcotic pain relievers (for example, oxycodone and acetaminophen, Percocet, Roxicet, Tylox, Endocet), barbiturates, sedatives such as alprazolam (Xanax) and clonazepam

(Klonopin), ethanol, and blood pressure drugs that can cause orthostatic hypotension, such as prazosin (Minipress) and terazosin (Hytrin).

B. Depakote, trade name for valproic acid and its derivative, divalproex, is a dangerous drug as defined in Business and Professions Code section 4022. It is an oral drug that is used for the treatment of convulsions, migraines and bipolar disorder. The active ingredient in both products is valproic acid. (Divalproex is converted to valproic acid in the stomach).

C. Paxil, a trade name for paroxetine, is a dangerous drug within the meaning of Business and Professions Code section 4022, and is an oral drug that is used for treating depression. It is in a class of drugs called selective serotonin reuptake inhibitors (SSRIs), a class that also contains fluoxetine (Prozac), citalopram (Celexa), and sertraline (Zoloft). Paroxetine affects neurotransmitters, the chemicals that nerves within the brain use to communicate with each other. Neurotransmitters are manufactured and released by nerves and then travel and attach to nearby nerves. Thus, neurotransmitters can be thought of as the communication system of the brain. Serotonin is one neurotransmitter that is released by nerves in the brain. The serotonin either travels across the space that lies between nerves and attaches to receptors on the surface of nearby nerves or it attaches to receptors on the surface of the nerve that produced it, to be taken up by the nerve and released again (a process referred to as re-uptake).

D. Zyprexa, a trade name for olanzapine, is a dangerous drug within the meaning of Business and Professions Code section 4022, and is a drug that is used to treat schizophrenia and acute manic episodes associated with bipolar I disorder. Olanzapine belongs to a drug class known as atypical antipsychotics. Other members of this class include clozapine (Clozaril), risperidone (Risperdal), aripiprazole (Abilify) and ziprasidone (Geodon). The exact mechanism of action of olanzapine is not known. It may work by blocking receptors for several neurotransmitters (chemicals that nerves use to communicate with each other) in the brain. It binds to alpha-1, dopamine, histamine H-1, muscarinic, and serotonin type 2 (5-HT2) receptors.

E. Cogentin, a trade name for benztropine, is a dangerous drug within the meaning of Business and Professions Code section 4022, and is used to treat the symptoms of Parkinson's disease, such as muscle spasms, stiffness, sweating, drooling, and poor muscle control.

Benztropine is also used to treat and prevent these symptoms when they are caused by drugs such as chlorpromazine (Thorazine), fluphenazine (Prolixin), perphenazine (Trilafon), and others.

F. Risperdal, a trade name for risperidone, is a dangerous drug within the meaning of Business and Professions Code section 4022, and is an atypical antipsychotic drug used for treating schizophrenia, bipolar mania and autism. Other atypical antipsychotic drugs include Olanzapine (Zyprexa), Quetiapine (Seroquel), Ziprasidone (Geodon), Aripiprazole (Abilify) and paliperidone (Invega). Atypical antipsychotics differ from typical antipsychotics due to the lesser degree of extrapyramidal (movement) side effects and constipation.

G. Remeron, a trade name for mirtazapine, is a dangerous drug within the meaning of Business and Professions Code section 4022, and is a tetracyclic antidepressant similar to maprotiline (Ludiomil) and tricyclic antidepressants, for example, desipramine (Norpramin). Depression is an all-pervasive sense of sadness and gloom. It is believed that in some patients with depression, abnormal levels of neurotransmitters (chemicals that nerves use to communicate with each other) may be the cause of their depression. Mirtazapine elevates mood by raising the level of neurotransmitters (norepinephrine and serotonin) in nerves of the brain. Mirtazapine also blocks the effect of histamine.

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

I. Cymbalta, a trade name for duloxetine, is a dangerous drug within the meaning of Business and Professions Code section 4022. It is a selective serotonin and norepinephrine

reuptake inhibitor (SNRI) used for treating depression, anxiety disorder and pain associated with diabetic peripheral neuropathy or fibromyalgia. Other drugs in this class include milnacipran (Savella), venlafaxine (Effexor), and desvenlafaxine (Pristiq). Duloxetine affects neurotransmitters, the chemicals that nerves within the brain make and release in order to communicate with one another. Neurotransmitters either travel across the space between nerves and attach to receptors on the surface of nearby nerves or they attach to receptors on the surface of the nerves that produced them, to be taken up by the nerve and released again (a process referred to as re-uptake). Many experts believe that an imbalance among neurotransmitters is the cause of depression as well as other psychiatric disorders. Serotonin and norepinephrine are two neurotransmitters released by nerves in the brain. Duloxetine works by preventing the reuptake of serotonin and epinephrine by nerves after they have been released.

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

K. Trazodone hydrochloride, a triazolopyridine derivative antidepressant, sometimes marketed under the trade name Desyrel, is a dangerous drug within the meaning of Business and Professions Code section 4022. Trazodone is an oral antidepressant drug that affects the chemical messengers (neurotransmitters) within the brain that nerves use to communicate with (stimulate) each other. The major neurotransmitters are acetylcholine, norepinephrine, dopamine and serotonin. Many experts believe that an imbalance among the different neurotransmitters is the cause of depression. Although the exact mechanism of action of trazodone is unknown, it probably improves symptoms of depression by inhibiting the uptake of serotonin by nerves in the brain.

L. Wellbutrin, a trade name for bupropion, is a dangerous drug within the meaning of Business and Professions Code section 4022. It is an antidepressant medication that affects chemicals within the brain that nerves use to send messages to each other. These chemical messengers are called neurotransmitters. Many experts believe that depression is caused by an imbalance among the amounts of neurotransmitters that are released. Nerves, in a process referred to as reuptake, may recycle released neurotransmitters. Bupropion works by inhibiting the reuptake of dopamine, serotonin, and norepinephrine; an action that results in more dopamine, serotonin, and norepinephrine to transmit messages to other nerves.

M. Effexor, a trade name for venlafaxine, is a dangerous drug within the meaning of Business and Professions Code section 4022. It is in a newer class of anti-depressant medications that affects chemical messengers within the brain. These chemical messengers are called neurotransmitters, and some examples are serotonin, dopamine, and norepinephrine. Neurotransmitters are manufactured by nerve cells and are released by the cells. The neurotransmitters travel to nearby nerve cells and cause the cells to become more or less active. Many experts believe that an imbalance in these neurotransmitters is the cause of depression and also may play a role in anxiety. Venlafaxine is believed to work by inhibiting the release or affecting the action of these neurotransmitters.

N. Rozerem, a trade name for ramelteon, is a dangerous drug within the meaning of Business and Professions Code section 4022. It is a sedative, also called a hypnotic. It operates by affecting certain substances in the body that help regulate the "sleep-wake cycle." Rozerem is used to treat insomnia that is associated with having trouble falling asleep.

MEDICAL BOARD INVESTIGATION

10. During the course of an investigation by the Medical Board, pursuant to information received from the County of Humboldt's Department of Health and Human Service ("DHHS"), where respondent was employed as a physician, a review was performed relative to the treatment of and prescribing to several patients by Dr. Sommers.

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11. The Medical Board thereafter conducted an investigation which indicated that Dr. Sommers committed departures from the standard of practice with respect to five of the patients, hereinafter referred to as Patients A, B, C, D, and E,[2] as set forth in more detail hereinafter.

PATIENT A

12. The Medical Board investigation indicated as follows with respect to Dr. Sommers' treatment of Patient A (female born 1941):

A. Patient A's medical records indicated, in part, as follows:

(1) Humboldt Central Laboratory. January 3, 2007: Medical Test Request sheet. This requests a liver panel and a valproic acid level.

(2) Jonathan Sommers, M.D. January 3, 2008: Progress Note. There is a stamp indicating staff cancellation of visit and continues the same medications until the next scheduled visit.

(3) Jonathan Sommers, M.D. January 3, 2008: Prescription Change Order. Increase the Depakote to 500 mg, three at bedtime.

(4) Jonathan Sommers, M.D. February 2, 2008: Prescription for Zyprexa, 15 mg, two at bedtime.

(5) Jonathan Sommers, M.D. February 7, 2008: Prescription for three medications: 1) Depakote, 500 mg, two at bedtime; 2) Cogentin, 1 mg, one twice a day; and 3) Paxil, 30 mg, one in the morning.

(6) Jonathan Sommers, M.D. February 7, 2008: A Progress Note describes a 66-year-old patient with Schizoaffective Disorder, doing well except that the 1,500 mg of Depakote keeps her wobbling when walking. Depakote is reduced to 1,000 mg. Other medications noted as being prescribed simultaneously are Cogentin, 1 mg twice a day; Paxil, 20 mg a day; and Zyprexa, 15 mg at night. The patient on a checklist was indicated to have poor insight and judgment, although had "no gross cognitive deficits." The diagnosis is listed as SCUT stable on Axis I. Axis III notes mild ataxia due to VPA. No lab tests are performed.

[2] The full names of the patients will be provided upon Request for Discovery.

(7) Jonathan Sommers, M.D. April 10, 2008: A Progress Note indicates that the client failed to appear.

(8) Signature Illegible. January 3, 2008: This Progress Note appears with an "RN" after the signature. It indicates the patient arrived in time with the caregiver, but the physician was not available by 9:15 and they had to reschedule. The problem is the patient will not stay in her room at night, although she would go into the living room and fall asleep in a chair at night. The caregiver feels the problem is increased anxiety. The caregiver also reports increased depression, but anxiety is the main concern. The caregiver would like to give an as-needed medication to her, but indicates that she doesn't want to give any medication that would make the patient unsteady on her feet.

(9) Signature Illegible. February 11, 2008: A Progress Note is indicated to be a late entry for February 7, 2008. It states that a service necessity exists due to delusional thinking, which interferes with daily functioning. The assessment finds no evidence of delusional thinking, which is apparently the reason why the board and care visit was arranged.

(10) Signature Illegible. April 14, 2008: A Progress Note for a service date of April 10, 2008 indicates that the treater went to the board and care, but the patient was not there. The patient was at her day program. It indicates the patient had some issues she wanted to talk to her doctor about, but nothing that sounded urgent.

B. In a Physician Conference with the Medical Board, Dr. Sommers indicated as follows regarding his treatment of Patient A: Dr. Sommers stated this patient was a 66-year-old female with a history of schizoaffective disorder. The patient was treated with 1500 mg of Depakote. Dr. Sommers stated "this is a fairly standard dose of Depakote." Dr. Sommers said, "it kept her wobbling but, otherwise she had no complaints." Dr. Sommers concluded that the patient had mild ataxia due to the Depakote at that time (2/7/08). Dr. Sommers stated it was felt that the patient was doing well except for the unsteadiness of her gait. Dr. Sommers explained, this symptom is common when this medication is first prescribed. The patient was placed on 1000 mg of Depakote at bedtime, a reduction from the previous dose of 1500 mg. The medication was reduced rather than discontinued. Dr. Sommers stated that a discontinuation of

the medication could have allowed the patient to decompensate. Dr. Sommers stated that patients' responses to Depakote are quite variable. In addition to Depakote, this patient was also taking Paxil and Zyprexa. According to Dr. Sommers Zyprexa may cause some sedation in some patients. The patient was on low dose of Cogentin as well.

C. The applicable standard of care in 2007 would be that an elderly patient would receive approximately one-quarter to one-half of the dose of medication that a younger, healthier patient might receive. In cases where monitoring of blood levels is appropriate and routine, such as with Depakote, blood levels should be monitored on a periodic basis and especially before and after any change in dose. For the issue of treatment of anxiety in a patient who is "sundowning" and having difficulty sleeping in her bed, the standard of care in 2007 would be to first check to make sure that medications were not at such a level that they were causing cognitive difficulty and confusion, next to try behavioral methods to get the patient to sleep without changing medications, and third to try modest small changes in medications to improve the sleep pattern.

D. Dr. Sommers committed the following departures from the standard of care in his treatment of Patient A:

(1) Dr. Sommers prescribed Depakote, Paxil, and/or Zyprexa to Patient A in amounts which might conceivably be necessary for a very disturbed, much younger patient, but given that Patient A was elderly, the amounts were approximately double the amounts she should have been prescribed, particularly as elderly patients have a greater difficulty with larger medication loads and multiple medications.

(2) Dr. Sommers increased Depakote to treat Patient A's reported anxiety and sleeping in a chair as opposed to sleeping in her bed; however, he failed to adequately first determine and/or document whether there was overmedication and secondly whether or not behavioral methods could have been used successfully before increasing the Depakote.

PATIENT B

13. The Medical Board investigation indicated as follows with respect to Dr. Sommers' treatment of Patient B (male born 1931):

A. Patient B's medical records indicated, in part, as follows:

(1) Andrea Patt, R.N. March 20, 2008: Medication Clinic Narrative Progress Note. The patient showed up on time for the appointment. However, the patient did report two medications had been changed at the doctor's appointment when none had been changed. The patient could not name a single medication that he was on. The patient agreed to call if there were problems.

(2) Andrea Patt, R.N. May 22, 2008: Medication Clinic Narrative Progress Note. The patient is described as with normal affect. It is emphasized to the patient that he must take his medications at bedtime.

(3) Jonathan Sommers, M.D. March 20, 2008: Prescriptions of the sleeping medication Ambien, 5 mg at bedtime; the antipsychotic Risperdal, 3 mg in the morning; and the antidepressant Remeron, .30 mg at night.

(4) Jonathan Sommers, M.D. March 20, 2008: The Progress Note indicates a 77-year-old man treated for major depression with psychosis having "crazy thoughts and dreams." It indicates having been placed on Risperdal, his sleep was better and his symptoms have abated. Other medications noted to be given are Ambien, 5 mg at night (sleeping medication); Risperdal, 3 mg a day (antipsychotic); Remeron, 30 mg at night (antidepressant); and Cymbalta, 60 mg in the morning (antidepressant). Sleep is checked off as being normal in a checkoff area. On the checkoff sheet, no problems were found with thought content or process. The patient was found to be oriented, appropriate, well-groomed, and in a normal mood. He received a 2 out of 10 score for depression. The diagnosis, on Axis I is Major Depression with Psychotic Features, in Partial Remission. The GAF is indicated to be 55.

(5) Jonathan Sommers, M.D. March 22, 2008: The Medication Progress Note states this is a 77 year-old single white male with Major Depressive Disorder, Recurrent, Severe, with Psychotic Features. It notes insomnia, racing thoughts and an increase in mild irritability, which is interpreted by Dr. Sommers as bipolar spectrum, even though he failed to meet the full bipolar criteria. Dr. Sommers' notes he will consolidate the Risperdal (antipsychotic) into a single dose and add an antidepressant dose of Seroquel at night to help him sleep. Other medications noted to be prescribed are the sleeping medication Ambien, 5 mg at night; the

antidepressant Remeron, 30 mg at night; the antidepressant Cymbalta, 60 mg in the morning; and the antipsychotic Risperdal, 3 mg at night. On the mental status exam, insomnia was checked off as initial, mid and terminal. No problems were checked off for thought content and process. The patient was noted to be oriented, calm, cooperative and appropriate. Mood was noted to be neither elevated nor depressed by the checkoff sheet. There is a comment, "Patient knows how to access ER services." The diagnosis, on Axis I is Major Depressive Disorder, Recurrent, with Psychotic Features, and Insomnia. The GAF is indicated to be 45. Medication changes are indicated to be Seroquel, 400 mg at night; and Risperdal, 3 mg at night.

(6) Jonathan Sommers, M.D. May 22, 2008: Prescriptions for Risperdal, 3 mg at bedtime (antipsychotic); Ambien, 5 mg at night (sleeping medication); and Seroquel, 400 mg at night (antipsychotic). There is also a prescription for Remeron, 30 mg at night (antidepressant) and Cymbalta, 60 mg in the morning (antidepressant).

(7) Signature Illegible. March 20, 2008: Outpatient Services Progress Note. It does not appear this note is authored by Dr. Sommers. It indicates service necessity exists due to depression which interferes with daily functioning. The assessment indicated he did not appear to have any of those symptoms. He appeared to be well-groomed, happy, living at Silvercrest.

(8) Signature Illegible. May 22, 2008: Outpatient Services Progress Note. It does not appear this is authored by Dr. Sommers. It states service necessity indicated due to depression which interferes with daily functioning. Patient indicated that he was doing well except having a hard time sleeping through the night. It indicates no other problems.

B. In a Physician Conference with the Medical Board, Dr. Sommers indicated as follows regarding his treatment of Patient B: Dr. Sommers stated this patient was a 77-year-old male followed for recurrent major depression, severe, with psychotic features, increased sleep latency, insomnia, and racing thoughts with mild irritability. Dr. Sommers stated this type of presentation suggests bipolar type of illness because of the racing thoughts and the irritability. The patient was taking Remerol 30 mg, Ambien 5 mg, and Resperdol 3 mg and still not sleeping. Dr. Sommers added Seroquel (5/22/08) in what he described as an "aggressive dose" of 400 mg at hs (bedtime). Dr. Sommers stated that he prescribed this amount in an attempt to "keep the

patient out of the hospital" and "get him some sleep." When asked, Dr. Sommers described his experience with the prescribing of Seroquel, as mostly with inpatient status frequently prescribing Seroquel in dosages of 200 mg, 300 mg, and 400 mg, depending on the level of the patient's symptomatology and the patient's resistance to control may have been. Dr. Sommers described his typical discussion with a patient for whom he is prescribing Seroquel. Dr. Sommers informs the patient that the medication is for sleep; that the patient may feel dizzy at times; that they do need to sit on the edge of the bed and be careful when standing up. Additionally he typically states that should the patient not tolerate the medicine, to let the nurse know and have the nurse call him so he can lower the dose. Dr. Sommers stated he tries to reserve this medication (Seroquel) for patients who "really need it."

C. The applicable standard of care in 2007 would be that an elderly patient would receive approximately one-quarter to one-half of the dose of medication that a younger, healthier patient might receive. Seroquel is primarily an antipsychotic to be used in a patient with psychotic symptoms. It has other uses such as in lower doses it might be used as an adjunctive treatment for depression or in a patient with a history of psychosis a small amount might be used as a sleeping medication. In patients with Obsessive Compulsive Disorder (OCD), a small amount might be used to help OCD symptoms.

D. Dr. Sommers committed the following departures from the standard of care in his treatment of Patient B:

(1) Dr. Sommers failed to adequately determine and/or document that Patient B suffered from bipolar spectrum disorder, prior to prescribing the antipsychotic Risperdal, two separate antidepressants (Remeron, 30 mg and Cymbalta, 60 mg), and the sleeping medication (Ambien, 5 mg), at close to what would be full doses for younger patients.

(2) Dr. Sommers prescribed Seroquel at 400 mg in an elderly patient for the documented symptom of insomnia. The use of Seroquel, if indicated for insomnia, would be at a much lower dose of 50 mg or at the maximum of 100 mg for a healthy younger person. In an elderly person, such as Patient B., the use of 400 mg of Seroquel for the documented symptoms was excessive.

PATIENT C

14. The Medical Board investigation indicated as follows with respect to Dr. Sommers' treatment of Patient C (female born 1936):

A. Patient C's medical records indicated, in part, as follows:

(1) Jonathan Sommers, M.D. February 21, 2008: Medication Progress Note. This Progress Note describes a 71-year-old female, presenting for follow-up of depression. It describes that she recently became toxic on her lithium carbonate with a level of 1.6 on a dose of 900 mg a day. Lithium was dropped because her GFR [probably glomerular filtration rate] dropped 60 to 33, thus proving renal insufficiency. It notes impaired cognition due to lithium toxicity with memory slightly impaired. She refused to go on higher doses of her current medication. She is not suicidal. The checkoff mental status did not indicate any problems with cognition or orientation. The patient is checked off as being appropriate, calm, cooperative, appropriately dressed, with some depressed mood and affect. A comment at the bottom is, "Patient knows how to access E.R. Services." The diagnoses, on Axis I, are Mood Disorder, NOS; Anxiety Disorder NOS, Primary Insomnia (Resolved on Medication). Medication changes are to stop the lithium carbonate permanently.

(2) Jonathan Sommers, M.D. February 21, 2008: Prescriptions for Klonopin, an antianxiety agent, prescribed at half a milligram twice a day; Risperdal, an antipsychotic agent, prescribed at 1 mg at bedtime; the antidepressant; Effexor XR, 75 mg, prescribed at 225 mg in the morning; the sedating antidepressant, Trazodone, 100 mg, prescribed at bedtime; and an antidepressant, Cymbalta, is prescribed at 60 mg in the morning.

(3) Jonathan Sommers, M.D. March 20, 2008: Progress Note. This Progress Note indicates a 71-year-old female being followed for anxiety and mood disorders and primary insomnia. It indicates she was having frightening nightmares of being somewhere she could not get out of and the dreams increased her anxiety. Otherwise she was doing well. She was requesting that her Risperdal be increased to help her quash the dark thoughts that follow her nightmares during the following day. She said she was less depressed since she started Cymbalta. Other medications indicated as being prescribed are Risperdal, 1 mg at night (antipsychotic);

Effexor, 225 mg a day (antidepressant); Klonopin, 0.5 mg b.i.d. (antianxiety agent); trazodone, 100 mg at night (antidepressant agent often used to help sleep); and Cymbalta, 60 mg a day (antidepressant). Under the checkoff mental status, poverty of thought was noted; otherwise no cognitive or orientation problems were noted. Mood was not depressed or elevated. She is noted to be improving. The diagnoses, on Axis I are Anxiety NOS, Mood Disorder, NOS, and Primary Insomnia. Her GAF is indicated to be 51. The medication change is to increase Risperdal to 1 mg twice a day.

(4) Jonathan Sommers, M.D. March 20, 2008: Prescription for Risperdal, 0.5 mg twice a day.

(5) Jonathan Sommers, M.D. May 22, 2008: Medication Progress Note. This Progress Note indicates that there is anxiety, fear of death and dying, and that the patient has advanced perioral T.D. (most likely tardive dyskinesia). Dr. Sommers decided to stop the Risperdal and feels she is likely to respond better to Seroquel at what he describes as the antidepressant dose of 300 mg. Other medications noted to be given at that time are the antidepressant Effexor, 225 mg a day; the antidepressant Cymbalta at 60 mg a day; and the antianxiety agent Klonopin at 1mg twice a day. The mental status checkoff sheet does not indicate any problems with cognition. Orientation is good for person, place and situation. She is appropriate with some depressed mood and affect. The comment is, "Patient knows how to access E.R. services." The diagnoses, on Axis I, are Generalized Anxiety Disorder, Mood, Disorder, NOS, and Primary Insomnia. The GAF is indicated to be 40. The medication change is to stop Risperdal and to start Seroquel.

(6) Andrea Patt, RN. February 21, 2008: Medication Clinic Narrative Progress Note. This Progress Note indicates that the patient is disheveled with grooming poor and smelling of urine and wearing the same clothes on February 19th and February 20th; walks with a shuffling gate; poor eye contact; and slurred speech. She has to have questions repeated for her to answer them. She is described as Dysthymic [low grade chronic depression]. It indicates she did not eat the morning of the visit. The patient reports she cannot figure out how to

use her microwave oven in order to eat the frozen food in her apartment. The patient cannot figure out how she is going to get home.

(7) Andrea Patt, RN. March 20, 2008: Medication Clinic Narrative Progress Note. The patient is described as being poorly groomed, dysthymic, cooperative and friendly. The patient seemed to understand medication changes.

(8) Andrea Patt, RN. March 20, 2008: Handwritten Note. This note indicates that the patient is getting back to her normal condition.

(9) Andrea Patt, RN. May 22, 2008: Medication Clinic Narrative Progress Note. The patient is described as with adequate grooming, speech clear and coherent, dysthymic [low grade depression]. It indicates that there will be an attempt made to find Seroquel samples for the patient to try.

(10) Illegible Signature. February 21, 2008: Outpatient Services Progress Note (not authored by Dr. Sommers). This describes services necessary due to depression interfering with daily functioning. The outreach worker found that the patient did not remember her appointment. The apartment was messy. The patient had not eaten anything that day. She looked disheveled and tired.

B. In a Physician Conference with the Medical Board, Dr. Sommers indicated as follows regarding his treatment of Patient C: Dr. Sommers stated this was a "difficult patient, I remember her." The patient was followed for anxiety, mood disorder, and insomnia. Dr. Sommers stated that he did not know where the patient received the diagnosis of insomnia. The patient was also said to be experiencing a lot of nightmares. The patient requested that her medication of Resperdol be increased. The patient was taking Cymbalta 60 mg. Dr. Sommers stated that this was a "very high strung lady" with a mood disorder. The patient was a 72-year-old. She was receiving Klonopin 5 mg twice a day, Trazodone 100 mg at night, Resperdol 1 mg and Effexor XR at a dose of 225 mg per day. According to Dr. Sommers, it is not uncommon for a patient to require two antidepressants. He stated that the Effexor was started in order to get an antianxiety effect. The patient's Klonopin dose was increased to 1 mg twice a day for anxiety. The patient complained of depression, poor sleep, and anxiety of death and dying. The patient

developed tardive dyskinesia symptoms and the Resperdol was discontinued. Dr. Sommers added Seroquel 300 mg at bedtime. According to Dr. Sommers these doses of medication were not excessively high for a 72-year-old female with this degree of symptomatology. Dr. Sommers stated that the medications were chosen to give the patient some sleep and pull her out of her depression. Dr. Sommers stated that the patient had a possible bipolar spectrum disorder and was a difficult case to manage. The patient did have side effects from the Seroquel. Dr. Sommers learned subsequently of the incident(s) that the patient had fallen. Dr. Sommers mentioned that this patient had central macular degeneration. Dr. Sommers indicated that someone had felt that the patient was not tolerating the Seroquel. Dr. Sommers stated had he known, he would have decreased the dosage.

C. The applicable standard of care in 2007 would be that an elderly patient would receive approximately one-quarter to one-half of the dose of medication that a younger, healthier patient might receive.

D. Dr. Sommers committed the following departures from the standard of care in his treatment of Patient C:

(1) Dr. Sommers prescribed 300 mg of Seroquel to replace 0.5 mg twice a day of the antipsychotic Risperdal, which is excessive. If adjusted for her age and assuming that the effect was at least twice as much as the dose, such dosage would be an equivalent dose for a younger patient of 600 mg of Seroquel, which is about the dose which might be used for an acute psychotic inpatient. In addition, the patient had multiple medications that might interfere with metabolism and reduced renal functioning. The Seroquel was initiated at an excessive dose.

PATIENT D

15. The Medical Board investigation indicated as follows with respect to Dr. Sommers' treatment of Patient D (female born 1938):

A. Patient D's medical records indicated, in part, as follows:

(1) Jonathan Sommers, M.D. March 6, 2008: Medication Progress Note. This note indicates that the patient was there for a follow-up of Major Depressive Disorder, Recurrent. It indicates no increase in depression, but difficulty with sleep. The plan is to start her

on Seroquel, 30 mg, for the antidepressant and soporific effects. Other medications noted to be given are Ambien, 10 mg (sleeping medication) and the antidepressants Trazodone, 50 mg at night, Wellbutrin, 300 mg a day, and Cymbalta, 60 mg a day. There is also the sleeping medication Rozerem, 8 mg at night. The mental status checkoff indicates no problems with cognition or orientation. The patient describes having good rapport, being appropriately groomed, having some depressed mood and affect. Depression was scored as 4 on a scale of 10 and mood lability as 4 on a scale of 10. The diagnosis, on Axis I, was Major Depressive Disorder, Recurrent, Moderate. The GAF was indicated to be 50. Medication changes were to add Seroquel.

(2) Jonathan Sommers, M.D. March 6, 2008: Prescription for Seroquel, 300 mg at bedtime, Trazodone, 50 mg at bedtime, Wellbutrin XL, 300 mg in the morning, Cymbalta, 60 mg in the morning, and Rozerem, 8 mg at bedtime.

(3) Jonathan Sommers, M.D. May 8, 2008: Prescriptions for the antidepressant Trazodone, 150 mg at bedtime, the antidepressant Cymbalta, 90 mg in the morning, and the sleeping medication Rozerem, 8 mg at night. It notes that the antidepressant Wellbutrin XL has been discontinued.

(4) Jonathan Sommers, M.D. May 8, 2008: A Medication Progress Note indicates there is a 69-year-old white female there for a re-check. She has been off her Wellbutrin for one month because her pharmacist had advised her that her decongestants might interfere with the Wellbutrin. Dr. Sommers increased her Cymbalta to 90 mg a day. The patient indicated "sub-syndromal depressive symptoms." Trazodone was also increased to 150 mg at night for "non-bipolar insomnia." Follow-up is in three months. The checkoff mental status indicates no problems with thought content or process. Orientation is appropriate for person, place and situation. The patient describes being calm and cooperative. Some depressed mood and affect was noted. The clinician rating for depression was 6 out of 10 (10 being the worst); for mood lability 5 out of 10; for agitation 2 out of 10; and for anxiety 3 out of 10. The diagnosis, on Axis I was Major Depression, Recurrent, Moderate. Axis III indicated breast cancer with spinal

metastases. The GAF was indicated to be 45. Under Plan, Medication Changes, it is indicated "None."

(5) Illegible Signature May 8, 2008: Medication Clinic Narrative Progress Note. It is indicated that the patient arrived on time for a doctor's appointment. There was good rapport with the patient.

B. In a Physician Conference with the Medical Board, Dr. Sommers indicated as follows regarding his treatment of Patient D: Dr. Sommers stated this patient was a 69-year-old female who was seen (3/6/08) for follow up for major depression. The patient reportedly was not sleeping well and depressed. The patient was receiving Ambien, Trazodone, Wellbutrin, and Cymbalta. Dr. Sommers added Seroquel 300 mg at bedtime to see if he "couldn't get her some sleep" for the patient. Dr. Sommers plan was to see the patient again in six weeks time.

C. The applicable standard of care in 2007 would be that an elderly patient would receive approximately one-quarter to one-half of the dose of medication that a younger, healthier patient might receive.

D. Dr. Sommers committed the following departures from the standard of care in his treatment of Patient D:

(1) Dr. Sommers has prescribed Seroquel for sleep which might possibly be used for sleep in depressed patients at lower doses. However, Dr. Sommers prescribed the medication at a dose which, when age adjusted, would be equivalent to the dose necessary to treat a full-blown psychotic episode in an inpatient. Such dose was excessive for this particular patient.

PATIENT E

16. The Medical Board investigation indicated as follows with respect to Dr. Sommers' treatment of Patient E (male born 1990):

A. Patient E 's medical records indicated, in part, as follows:

(1) Jonathan Sommers, M.D. April 27, 2008: Preliminary Treatment Plan. Under Medication it indicates Zyprexa Zydis, 10 mg by mouth every four hours as needed for anxiety; Ativan, 1 mg as needed for anxiety every four hours; and Zyprexa Zydis, 10 mg at night.

These are all crossed out. The other medication is Xopenex inhaler, one to two puffs as needed. Discharge plans were to be discharged to his mother with referral to housing and youth supports.

(2) Jonathan Sommers, M.D. April 28, 2008. Humboldt County Mental Health Branch, Sempervirens Admitting Psychiatric Evaluation. The record indicates the date of the evaluation is April 28, 2008 and a date of admission April 27, 2008. The following is described as the chief complaint: "I jumped into Humboldt Bay, but I didn't die. "It goes on to describe a 17-year-old who jumped into Humboldt Bay in a suicide attempt because he was "depressed. " He was rescued by the U.S. Coast Guard and medically cleared before being brought to Psychiatric Emergency Services. It is described that he has "no concept of what depression means." He is described as bored, narcissistic and oppositional as well as defiant. It indicates he shows no interest in the Raven Project, a drug rehab program for teens. He is noted to be disruptive. Under the section on substance use, dependence issues, it indicates marijuana. It is noted that there is an unresolved issue in "phase of life problem." Mental status indicates careless grooming and hygiene, uncooperative, oppositional, irritable, and dysphoric.

(3) Jonathan Sommers, M.D. Undated. Humboldt County Mental Health Sempervirens Inpatient Facility Discharge Summary. The record indicates an admission date of April 27, 2008 and a discharge date of April 28, 2008. Legal status is described as voluntary. The chief complaint for admission is, "I jumped into Humboldt Bay, but I didn't die." There is a history of the present illness, which describes a 17-year-old white male who jumped into Humboldt Bay in a suicide attempt. It describes he jumped into the bay because he was "depressed," but did not endorse criteria for an episode of Major Depressive Disorder. He was rescued by the U.S. Coast Guard and was medically cleared at St. Joseph's Hospital before being transported to Humboldt County Mental Health Psychiatric Emergency Services. It states, "He had no concept of what a depressive illness meant." He answered all open ended questions with, "I don't know." The patient admitted to using ecstasy before his suicide attempt, but appeared unconcerned about the outcome of events. He stated he was bored with the PES unit. The patient denied suicidal ideation. He is described as "very entitled, narcissistic, and oppositionally defiant." It indicates that the patient said he wanted help in staying off drugs, but showed no

interest in the Raven Project, a drug rehabilitation for teens. Dr. Sommers states, "No grounds for a 5150 as he did not meet the criteria for detention." The plan was for the mother to take him back into the family home. Past psychiatric history is described as disruptive behavior disorder. Drug and alcohol history is indicated as polysubstance experimentation and alcohol abuse. Social/family history indicates that the patient is a high school student who lives at home with his family. Dr. Sommers indicates that the patient is suffering a phase of life problem. There is a section labeled "Significant Findings on Admission." Under Mental Status it indicates that the patient had careless grooming and poor hygiene. His mood was dysphoric and irritable. Under Physical Concerns and Medical History, it indicates no physical exam was done due to the short length of the hospitalization. A drug urine screen was done indicating for THC. Under Hospital Course and Treatment, it indicates that the patient was admitted to Sempervirens for less than twelve hours before he stabilized in the structured milieu. He received a Xopenex inhaler to be taken at one or two puffs for shortness of breath. Otherwise he did not receive any medications. It is further indicated that on April 28, 2008 it was decided the patient could be discharged into the custody of Mark Goldhawk, a therapist at Children, Youth and Family Services to reunite him with his mother and Raven House. Response to treatment is described as "stabilized." Condition at discharge is described as without homicidal or suicidal ideation and not being overtly psychotic. Discharge diagnoses, on Axis I, were Adjustment Disorder with Depressed Mood, Dysthymic Disorder by History. Axis IV indicates a phase of life problem. Axis V indicates a GAF of 50 on both admission and discharge. Discharge plan was follow-up appointment at CYFS with his family with a Dr. Aniline or Dr. Edwalds.

(4) Jonathan Sommers, M.D. April 28, 2008: Humboldt County Mental Health Preliminary Treatment Plan Sempervirens. Under Problem/Reason for Hospitalization, it is indicated self-harm behavior, jumping from car while driving home with his mother into traffic, trying to get into other people's cars.

(5) Jonathan Sommers, M.D. April 29, 2008: Humboldt County Mental Health Branch, Sempervirens Admitting Psychiatric Evaluation. It indicates the 17-year-old is on a 5150. There is a chief complaint "I told my mom I would run away." It indicates that after

being discharged the patient jumped from the moving car into traffic, endangering his own life and the lives of others. He also jumped into other cars and was detained on a 5150. On arrival he threatened to assault staff and other patients and he was placed in seclusion and given the medications Haldol and Ativan. The diagnoses were Mood Disorder, NOS, Oppositional Defiant Disorder, and Disruptive Behavior Disorder. The patient is described as being uncooperative with a high level of irritability, 7 out of 10; a high level of agitation, 7 out of 10; and high levels of anxiety, fear and panic, and concentration and memory, both 5 out of 10. The diagnoses are, on Axis I, Conduct Disorder, Oppositional Defiant Disorder, and Mood Disorder NOS and Disruptive Behavior Disorder. Axis II is listed as Antisocial Features. The GAF is given as 25. The plan is to refer to a California Specialty Hospital. It indicates that the prognosis is poor.

(6) Humboldt County Department of Health and Human Services. April 27, 2008: Humboldt County Department of Health and Human Services, Mental Health Branch, Sempervirens, Inpatient Unit Aftercare Instructions. This is signed by the patient. No medications are ordered. There is an appointment set up at CYFS on April 29, 2008. The nature of the problem/illness is described as Adjustment Disorder with Depression. Expected course of recovery is described as "guarded." There is also a referral to the AOD, which is indicated to be the Alcohol and Other Drugs Program, and RAVEN Project Use Services.

(7) Humboldt County Department of Health and Human Services. April 28, 2008: Humboldt County Mental Health, Sempervirens Social Services Evaluation. The author of this document is indicated to be an LCSW, but the signature is illegible. It indicates no assessment was made because the patient was only there for 24 hours.

(8) Humboldt County Department of Health and Human Services. April 27, 2008: Nursing Assessment. The author of this document is an RN, but the signature is illegible. It finds no medical problems except for asthma.

(9) Humboldt County Department of Health and Human Services. April 27, 2008: Test Results. This indicates the presence of THC.

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(10) Humboldt County Department of Health and Human Services. April 27, 2008: Form. This form is unsigned. This has a section Admit Information and Pertinent History. This includes that the patient admits to street drug use, had run away from home and jumped into the bay, rescued" by Coast Guard. It indicates he was evaluated at St. Joseph's E.R., found with suicidal ideation without intent, and wants to stay at Psychiatric Emergency Services to stay away from drugs and be safe. The Axis I diagnosis is Adjustment Disorder with Mixed Disturbance of Emotion.

(11) Humboldt County Department of Health and Human Services. April 27, 2008: Humboldt County Mental Health Branch, Sempervirens Admitting Nurse Assessment. This indicates past drug use, past treatment with Adderall and Ritalin. Another part of this note for the time interval April 27, 2008 14:30 to 15:30 indicated on arrival he had voiced suicidal ideation, that it was a voluntary admission. The nursing note April 27, 2008, 15:00 to 23:30 indicates he told the on-duty R.N. of his intent to leave his mom's home and jump back into the bay.

(12) Humboldt County Department of Health and Human Services. April 28, 2008: Humboldt County Mental Health Sempervirens Discharge and Aftercare Plan. The signature on this document is illegible. The admission date was April 27, 2008. The discharge date was April 28, 2008. It indicates the psychiatric diagnoses, on Axis I, are Adjustment Disorder with Depressed Mood and Dysthymia. Axis II is deferred. Axis V gives a GAF of 50. No medications were prescribed. The six-month prognosis is described as "poor" and the twelve-month prognosis is described as "poor." It indicates that there is follow-up at CYFS on April 29th at 1:30 p.m. and that the client was unemployed. Social needs included AA and NA. An anticipated problem was that the patient might be "oppositional and may act out." Later on the CYFS is defined as Children Youth and Family Services. In the section "How did the PATP prepare patient for discharge and aftercare?" it is stated: "Provided safe and secure environment without meds to stabilize client. Client denies suicidal ideation and is no longer a danger to himself." Client is to be released to his mother.

(13) Humboldt County Department of Health and Human Services. April 28, 2008: Humboldt County Mental Health Branch, Sempervirens Admitting Psychiatric Evaluation. The author's name is illegible. Suicidal/homicidal ideation had a line written through it, which the form indicates should be done if not present, as does hallucinations, delusions, and paranoia. The diagnoses are Adjustment Disorder with Depressed Mood, Oppositional Defiant Disorder, Dysthymic Disorder and Other/Unknown Substance-induced Mood Disorder. Axis II is deferred. Clinical ratings indicate irritability/anger at 5 on a 10-point scale; energy level 3 on a 10-point scale; depression 2 on a 10 point scale; mood lability 3 on a 10-point scale; agitation 2 on a 10-point scale; impulse control 8 on a 10-point scale; anxiety/fear of panic 5 on a 10-point scale. The GAF is indicated to be 55. The length of stay is 24 hours and prognosis is indicated to be poor.

(14) Genevieve Carlson, ASW. April 27, 2008: Social Service Progress Note. This describes him jumping into the bay after ongoing ecstasy use and alcohol abuse, denying feelings of self-harm. It indicates that the patient was hyperactive as a child and was prescribed Adderall and Ritalin. He has been depressed since the seventh grade and has not slept much for a couple of weeks and has been using street drugs. He has not been himself for a long time and he is at risk for suicide. The mother wants the patient to stay in the hospital. The patient is being discharged with a referral to CYFS.

B. In a Physician Conference with the Medical Board, Dr. Sommers indicated as follows regarding his treatment of Patient E: This patient was a 17-year-old male who was admitted on April 27, 2008. The medical record contained a discharge summary. Prior to the initial admission the patient reportedly jumped into the Humboldt Bay because he was depressed. The patient was rescued by the Coast Guard. When questioned, the patient reportedly denied suicidal intent. According to Dr. Sommers the patient did not meet the criteria for detention. The patient's mother agreed to take her son back home. The patient reportedly stayed less than 24 hours before he stabilized. Dr. Sommers stated that the patient did not "give up any hard criteria to hold him." Dr. Sommers stated that at the time (4/27/08) he thought that the best choice was to reunite the patient with his family and arrange to get the patient seen by a therapist. Apparently,

the patient attempted to jump out of the family vehicle on his way home following his discharge from the unit.

C. The applicable standard of care in 2007 would be that at the date of the evaluation in 2008, a prudent evaluating physician or psychiatrist that was evaluating a potentially suicidal patient would perform a careful assessment of suicidal ideation, taking into account all the possible contributing factors from evidence that he had available to him, both from the patient interview and other sources. Upon completing that assessment, the physician then should make efforts to place the patient in the appropriate level of care, psychiatric hospitalization, partial hospitalization, or outpatient therapy. The level of care should be the lowest level in which the patient would be safe.

D. Dr. Sommers committed the following departures from the standard of care in his treatment of Patient E:

(1) Dr. Sommers failed to adequately consider and/or document consideration of factors indicating a reasonable risk of repeat suicide attempt, including but not limited to:

(a) A recent suicide attempt which appeared quite serious.

(b) Intermittently expressed suicidal ideation, although without plan.

(c) A history of past psychiatric problems as indicated by necessitating past treatment with stimulant drugs.

(d) Information from the mother that the patient had a long-term depression and was probably not safe to go home.

(e) Recent information that indicated recent use of street drugs.

(f) Positive testing for THC (marijuana).

(g) Documentation in the medical records of depressed mood and irritability.

(h) A family history of mental illness in the form of bipolar disorder in the father.

(2) Dr. Sommers improperly discharged the patient to a home situation from which he had recently left and made a suicide attempt thus placing the patient at high-risk.

GROUNDS FOR DISCIPLINARY ACTION

17. Dr. Sommers' conduct in departing from the standard of care as set forth hereinabove with respect to Patients A and/or B and/or C and/or D and/or E constitutes grounds for disciplinary action as follows:

A. Dr. Sommers' conduct constitutes general unprofessional conduct and is cause for disciplinary action pursuant to section 2234 of the Code.

B. Dr. Sommers' conduct constitutes gross negligence and is cause for disciplinary action pursuant to section 2234(b) of the Code.

C. Dr. Sommer's conduct constitutes repeated negligent acts and is cause for disciplinary action pursuant to section 2234(c) of the Code.

D. Dr. Sommers' conduct constitutes unprofessional conduct in that he failed to maintain adequate and accurate records relating to the provision of services to the patient and is cause for discipline pursuant to section 2266 of the Code.

E. Dr. Sommers' conduct (with the exception of Patient E) constitutes repeated acts of clearly excessive prescribing or administering of drugs or treatment as determined by the standard of the community of licensees and is cause for disciplinary action pursuant to section 725 of the Code.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician and Surgeon Certificate Number G41535, issued to Jonathan David Sommers, M.D.;

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

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3. Ordering Jonathan David Sommers, M.D., if placed on probation, to pay the Medical Board of California the costs of probation monitoring; and

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

DATED: October 7, 2010

LINDA K. WHITNEY
Executive Director
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