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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO December 29, 2011
BY _____ ANALYST

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

In the Matter of the Accusation Against: **YANIRA MARIA OLAYA, M.D.** **2103 Caminito Circulo Norte** **La Jolla, CA 92037** **Physician's and Surgeon's Certificate No. A94208** Respondent.	Case No. 10-2010-211148 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Linda K. Whitney (hereinafter "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 24, 2006, the Medical Board of California issued Physician's and Surgeon's Certificate Number A 94208 to Yanira Maria Olaya, M.D. (hereinafter "Respondent"). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2013, unless renewed.

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JURISDICTION

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

4. 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, be publicly reprimanded, or have such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states:

"The Division of Medical Quality[1] 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.

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[1] California Business and Professions Code section 2002, as amended and effective January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in the State Medical Practice Act (Business and Professions Code sections 2000, et. seq.) means the "Medical Board of California," and references to the "Division of Medical Quality" and "Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

"(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.

". . . ."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

6. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that she committed gross negligence in her care and treatment of patient C.M., as more particularly alleged hereinafter:

A. At all relevant times, respondent was employed as psychiatrist at the San Diego County Psychiatric Hospital.

B. On or about May 26, 2010, patient C.M., then a 51-year old male, was brought to the Emergency Psychiatric Unit (EPU) at the San Diego County Psychiatric Hospital for a Section 5150 hold[2] for being gravely disabled. He told the admitting physician he had been drinking all day, every day, for about 35 years. He also said he had not eaten or had anything to drink in two days. Patient C.M. had been diagnosed with alcohol dependence in 2007, and he had several prior arrests for being drunk in public. Patient C.M. was admitted to the psychiatric unit with the diagnoses of alcohol dependence, psychotic disorder, asthma, chronic obstructive pulmonary disease (COPD), and chronic back pain. On admission, the treatment plan was to place patient C.M. on an alcohol withdrawal protocol.

[2] Section 5150 of the California Welfare and Institutions Code allows a qualified officer or clinician to involuntarily confine a person deemed to have a mental disorder that makes them a danger to him or herself, and/or others and/or gravely disabled.

C. On or about May 28, 2010, patient C.M.'s care was transferred to respondent. Respondent noted that the patient had a history of withdrawal symptoms, though he had not had seizures. Respondent placed patient C.M. on alcohol withdrawal precautions that consisted of taking his vital signs every eight hours, for forty-eight hours, and then daily. In addition, she ordered "on demand" withdrawal parameters - that patient C.M. receive Ativan,[3] 2 mg. every four hours for blood pressures greater that 149/99, or pulse rates greater than 99 beats per minute, and Vistaril,[4] 50 mg. every four hours as needed for anxiety. She did not use a CIWA (Clinical Institute Withdrawal Assessment for Alcohol) scale to objectively measure the level of the patient's withdrawals symptoms at any given time in the process.

D. On or about June 1, 2010, respondent scheduled a dose of Trazodone,[5] 100 mg., to be given to patient C.M. for insomnia. The following day, on June 2, 2010, patient C.M. woke up and went to breakfast. During breakfast, he became shaky, disoriented, dropped his coffee mug, and had "seizure-like" shaking in his body. Patient C.M. was transported to the emergency room at University of California San Diego (UCSD) Medical Center where he underwent diagnostic tests. Patient C.M. was transported back to San Diego Psychiatric Hospital the same day (June 2), and Trazodone was discontinued. Though UCSD Medical Center concluded that patient C.M. probably suffered an orthostatic hypotension[6] episode associated with the use of Trazodone, respondent did not believe that was the cause.

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[3] Ativan is a brand name for Lorazepam, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It belongs to a group of drugs called benzodiazepines.

[4] Vistaril is a brand name for hydroxyzine and a dangerous drug pursuant to Business and Professions Code section 4022. It is used as a sedative to treat anxiety and tension.

[5] Trazodone is a dangerous drug pursuant to Business and Professions Code section 4022. It is used to treat depression and anxiety disorders (e.g., sleeplessness, tension) and chronic pain.

[6] Orthostatic hypotension is a form of low blood pressure that happens when standing up from a sitting or lying down position.

E. Even though respondent did not believe the patient's seizure had been caused by the Trazadone, and knew or should have known his seizure-type episode was likely an alcohol withdrawal symptom, respondent did not change the patient's alcohol dexification regimen to include the administration of appropriately scheduled anti-withdrawal medications.

F. On or about June 4, 2010, respondent discharged patient C.M. from the psychiatric hospital to UCSD Bridges to Recovery Program, a sober living environment, and as-needed, to the Jane Westin Center, a walk-in center dealing with psycho-social issues. Neither facility was a medical facility that would be equipped to address the patient's medical component of withdrawal.

7. Respondent committed gross negligence in her care and treatment of patient C.M., which included, but was not limited to, the following:

A. Respondent failed to recognize that patient C.M. probably had a withdrawal seizure on or about June 2, 2010, and failed to add the appropriate treatment course correction for the patient with an appropriately scheduled anti-withdrawal medication.

B. Respondent prematurely discharged patient C.M. on June 4, 2010, without sufficiently observing and monitoring the patient's condition after the seizure incident of June 2, 2010, to ensure the acute physical symptoms of withdrawal had concluded.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

8. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that she committed repeated negligent acts in her care and treatment of patients C.M., R.W., and D.E., as more particularly alleged hereinafter.

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Patient C.M.

A. Paragraphs 6 and 7, above, are hereby incorporated by reference.

B. Respondent failed to set up an appropriate detoxification protocol for patient C.M., thereby predisposing him to withdrawal seizures.

Patient R.W.

C. On or about December 7, 2009, patient R.W., then a 37-year old male, was brought to the EPU at San Diego County Psychiatric Hospital after having been arrested. Patient R.W. had a long history of psychotic disorders and polysubstance dependence. He was placed on a Section 5150 hold for being a danger to self and to others, and for being gravely disabled. He was prescribed several drugs including Haldol[7] 10 mg., Valium,[8] 10 mg., and Benadryl,[9] 50 mg. Subsequently, respondent evaluated the patient. Respondent prescribed Haldol, 5 mg., four times a day for psychosis, Ativan, 10 mg., four times a day for psychotic agitation, and Cogentin[10] 1 mg., four times a day for extrapyramidal symptoms (EPS)[11] prevention.

D. On or about December 17, 2009, respondent discontinued Ativan and ordered that patient R.W. be given 1500 mg. of Depakene[12] ER at bedtime for mood

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[7] Haldol is a brand name for haloperidol and a dangerous drug pursuant to Business and Professions Code section 4022. It is an antipsychotic agent.

[8] Valium is a brand name for diazepam, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[9] Benadryl is a brand name for diphenhydramine and a dangerous drug pursuant to Business and Professions Code section 4022. It is an antihistamine.

[10] Cogentin is a brand name for benztropine mesylate and a dangerous drug pursuant to Business and Professions Code section 4022. It is used to control tremors and stiffness of the muscles due to certain antipsychotic medicines.

[11] EPS is a group of side effects associated with antipsychotic medications which can include extreme restlessness, involuntary movements, and uncontrollable speech.

[12] Depakene is a brand name for valproic acid and a dangerous drug pursuant to Business and Professions Code section 4022. It is used to treat various types of seizure disorders.

lability.[13] Two days later, on or about December 19, 2009, patient R.W. was observed to exhibit signs of delirium. He walked into a wall with an unsteady gait and was confused. He had difficulty speaking and was unable to answer simple questions. Patient R.W. was transported to the emergency room at the UCSD Medical Center where he was evaluated. A toxicology test was performed which showed a valproic acid level of 65 mcg/mL and an elevated blood ammonia level of 94 µmol/L. Patient R.W. was diagnosed with valproate-induced hyperammonemic encephalopathy.[14]

E. On or about December 20, 2009, patient R.W. was discharged from UCSD Medical Center and was readmitted to San Diego County Psychiatric Hospital. The admitting physician documented under his treatment plan, "We will not renew Depakote[15] given this is the likely cause of patient's altered mental status which has since resolved." Patient R.W.'s history and physical examination prepared on or about December 21, 2009, stated that the patient "is now sensitive to encephalopathy caused by Depakote," and under Impression, "Resolved Encephalopathy Caused by Depakote," was noted. In addition, respondent noted in her Inpatient Psychiatric Evaluation, "Toxicology felt that the Depakote-induced hyperammonemia had caused the altered mental status. The Depakote was held." On or about December 23, 2009, patient R.W. was discharged home.

F. Less than three weeks later, on or about January 10, 2010, patient R.W. was again admitted to San Diego County Psychiatric Hospital. The next day, January 11, 2010, respondent assumed the care and treatment of patient R.W. She did not review the patient's chart from his prior admission. Respondent ordered that patient

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[13] Mood lability refers to frequent or intense mood changes or shifts.

[14] Valproate-induced hyperammonemic encephalopathy (VHE) is a reaction to valproic acid (Depakote or Depakene) characterized by a decreasing level of consciousness, focal neurological deficits, cognitive slowing, vomiting, drowsiness, and lethargy.

[15] Depakote is another brand name for valproic acid and a dangerous drug pursuant to Business and Professions Code section 4022. It is used to treat various types of seizure disorders.

R.W. be given 500 mg of Valproic Acid (Depakote) four times a day for mood lability. She also prescribed Haldol, 5 mg., four times a day for psychosis and mania, and Cogentin 1 mg., four times a day for EPS prevention. Respondent documented that she had discussed with patient R.W. the risks, benefits and side effects of the medications, and the fact that the patient had received these medications in the past. Patient R.W. received Depakote as prescribed from on or about January 11 through 16, 2010.

G. On or about January 17, 2010, R.W. again became disoriented and had another adverse reaction to Depakote. The Depakote was held and discontinued the next day, on or about January 18, 2010.

H. Respondent committed repeated negligent acts in her care, treatment, and management of patient R.W., which included, but were not limited to, the following:

i. Before prescribing medication, Respondent failed to review the patient's previous chart entries at the San Diego Psychiatric Hospital that would have reminded her that the patient had a documented adverse reaction to Depakote.

ii. Respondent improperly prescribed Depakote to patient R.W. when she knew or should have known from his prior admission that he had a prior adverse reaction to the medication.

Patient D.E.

I. On or about January 15, 2010, patient D.E., then a 48-year old male, was transferred from the Alpine Treatment Center to the EPU at San Diego County Psychiatric Hospital after becoming aggressive and getting into a physical confrontation with another resident at the treatment center. Patient D.E. had a long history of chronic paranoid schizophrenia and psychiatric hospitalizations, and was on a conservatorship. On admission, patient D.E.'s mental status was intermittently cooperative, internally preoccupied, and non-elaborative. He appeared to be responding to internal stimuli but showed adequate impulse control. Patient D.E. was

given Risperdal, 4 mg., twice a day, Prozac, 20 mg. every morning, and Depakote 750 mg., twice a day. Patient D.E.'s care was transferred to respondent on or about January 17, 2010.

J. Around noon on or about January 18, 2010, patient D.E. became agitated and ran towards the door. Later in the day, he became acutely paranoid and hit another resident in the face. Respondent ordered that patient D.E. be given Haldol 10 mg., for psychosis, and Valium, 10 mg., for agitation. Shortly thereafter, patient D.E. was able to hold a conversation and acknowledged that he had had auditory command hallucinations when he hit the other patient.

K. Although patient D.E. did not thereafter show an escalation of violence or impulsive aggression that alarmed staff or endangered other patients, the next day, on January 19, 2010, respondent increased the patient's medication regimen to unsafe levels associated with various unwelcome side effects, including hypotension. Respondent increased her orders for Haldol, to 10 mg. orally, four times a day for psychosis. She also ordered that if patient D.E. refused to take the Haldol orally, it was to be given to him by intramuscular injection. In addition, she ordered Cogentin 1 mg., four times a day for EPS prevention, increased Depakote to 2000 mg. at bedtime for mood impulsivity, and discontinued Risperdal.

L. Later in the afternoon while he was in bed, patient D.E. complained of unsteadiness since the time his medications were changed. In the early morning of the next day (January 20, 2010), patient D.E. fell while trying to get to another bed, and sustained a laceration to his right forehead. He was taken to the emergency room at UCSD where his laceration was sutured. Patient D.E. was returned to the EPU, and Haldol was discontinued.

M. Respondent committed repeated negligence in her care, treatment, and management of patient D.E., by hastily and inappropriately ordering that patient D.E. receive an unnecessarily high dose of Haldol without an appropriate medical basis.

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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 respondent's Physician's and Surgeon's Certificate Number A94208, heretofore issued to Yanira Maria Olaya, M. D.;

2. Revoking, suspending or denying approval of authority for respondent Yanira Maria Olaya, M.D. to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering respondent Yanira Maria Olaya, M.D., to pay the Board, if placed on probation, the costs of probation monitoring; and

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

DATED: December 29, 2011

LINDA K. WHITNEY
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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