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

In the Matter of the Accusation Against: Frederick M. Silvers, M.D. 10921 Wilshire Blvd., #514 Los Angeles, California 90024 Physician's and Surgeon's Certificate No. A 23192, Respondent.	Case No. 18-2012-226384 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about February 14, 1969, the Board issued Physician's and Surgeon's Certificate Number A 23192 to Frederick M. Silvers, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2015, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, 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, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states:

"The board 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.

"(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.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Patients A.R. and K.R.)

6. Respondent, a psychiatrist, is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in his care and treatment of patients A.R. and K.R. and in his record keeping for both patients. The circumstances are as follows:

Patient A.R.

7. Respondent treated Patient A.R. from approximately May 2012 to August 2012. She had a history of attention deficit disorder[1] ("ADD"), addiction, depression, and sexual trauma. She also had a history of an eating disorder.

8. At the time she sought treatment with Respondent, Patient A.R. was participating in an inpatient substance abuse rehabilitation program. She signed a consent for Respondent and the inpatient substance abuse rehabilitation program to communicate and exchange information. She gave Respondent the name of the psychiatrist who she consulted with through the inpatient substance abuse rehabilitation program.

9. Respondent knew Patient A.R. had a substance abuse problem and was in a substance abuse rehabilitation program at the time of his first meeting with Patient A.R.

[1] Attention deficit disorder is also known as Attention deficit hyperactivity disorder ("ADHD"). Symptoms include difficulty staying focused and paying attention, difficulty controlling behavior, and hyperactivity (over-activity). ADHD has three subtypes: (1) Predominantly hyperactive-impulsive; (2) Predominantly inattentive; (3) Combined hyperactive-impulsive and inattentive.

10. At the time that Patient A.R. first met with Respondent, she was being prescribed Strattera 100 mg, Klonopin 0.5 mg, and Prozac 10 mg by her primary care physician.

11. Respondent diagnosed Patient A.R. with ADHD. With the exception of a Brown ADD Scale[2] for Patient A.R., Respondent did not discuss in Patient A.R.'s medical records present or prior symptoms to establish a diagnosis of ADHD. Respondent did not review prior treatment records to support the diagnosis of ADHD. Patient A.R. may have had ADHD, but Respondent's records do not address that diagnosis, except to accept Patient A.R.'s self-report.

12. Respondent mistakenly believed Patient A.R. was taking Zoloft 50 mg. Zoloft is an antidepressant. Patient A.R. was not taking Zoloft prior to treating with Respondent. On or about May 18, 2012, Respondent increased Patient A.R.'s prescription for Zoloft to 100 mg per day. The mistaken substitution of Zoloft for Prozac (also an antidepressant) reflects the carelessness of Respondent's approach to Patient A.R.

13. Respondent also mistakenly believed that Patient A.R. was taking Adderall XR 10 mg. Adderall[3] is an amphetamine.[4] Patient A.R. was not taking Adderall prior to treating with Respondent. Amphetamines are widely abused and highly addicting. They can be abused by patients with eating disorders in the belief they promote weight loss. Patients may misreport taking amphetamines to obtain "diet" pills. Prescribers need to be careful about providing abusable controlled medications to identified substance abusers.

14. On or about May 24, 2012, Respondent prescribed Adderall 10 mg tabs #60 to be taken bid and a prescription for Adderall 15 mg XR caps #60 without directions on how to take them. Shortly after, Patient A.R. had a relapse. She reported to Respondent that she began drinking alcohol and was self-mutilating.

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[2] The Brown ADD Scale is a 40-item frequency scale intended to measure the executive functioning (the mental processes that enable us to plan, focus attention, remember instructions, and juggle multiple tasks successfully) aspects of cognition associated with ADD/ADHD in adults.

[3] Adderall (Amphetamine) is a Schedule II drug.

[4] Amphetamine is a stimulant and an appetite suppressant. It stimulates the central nervous system (nerves and brain) by increasing the amount of certain chemicals in the body. This increases heart rate and blood pressure and decreases appetite, among other effects. Amphetamine is used to treat narcolepsy and ADHD.

15. On or about June 19, 2012, Respondent nevertheless prescribed Adderall XR 15 mg #60. Patient A.R. picked up a prescription for Adderall XR 15 mg on or about July 2, 2014.

16. On or about July 11, 2012, Respondent increased Patient A.R.'s Adderall XR to 20 mg bid. There is no indication of the number prescribed.

17. On or about August 13, 2012, Respondent wrote a prescription for Adderall XR 20 mg bid, but did not record the quantity prescribed.

18. As stated above, Patient A.R. was not receiving amphetamines prior to treating with Respondent. Respondent made no attempt to contact the inpatient substance abuse rehabilitation program or the psychiatrist who Patient A.R. consulted through the inpatient substance abuse rehabilitation program to obtain medical information. Respondent did not contact Patient A.R.'s primary care physician, did not obtain her prior medical records, and did not verify her medical history or the drugs she was taking.

19. Respondent committed gross negligence by prescribing Adderall, an amphetamine and abusable controlled substance, to Patient A.R., a substance abusing patient, by giving her increasing doses without clinical support.

20. Respondent also committed gross negligence in that his treatment records for Patient A.R. are illegible and would not allow a provider to determine what services were provided to Patient A.R., what symptoms she had, or the basis for the prescriptions she was provided. Although Respondent provided a transcription of his handwritten progress notes, the handwritten notes remain illegible and there is no way to verify whether the transcription accurately reflects what is in the handwritten notes. Furthermore, Respondent does not discuss in Patient A.R.'s medical records present or prior symptoms to establish a diagnosis of ADHD.

Patient K.R.

21. Respondent treated Patient K.R. from approximately September 2011 to November 2011. Patient K.R. sought treatment for "Major Depressive Disorder." She informed Respondent about her struggles with depression and anxiety. She also told him about her past history of alcohol and drug abuse, including abuse of stimulant class substances. She informed him that she

was taking Lexapro[5] and Adderall for her medical conditions. She gave him her prior psychiatrist's name.

22. Patient K.R. also told Respondent that she was studying for the Law School Admission Test ("LSAT") and that she needed her medications (namely Adderall) to help her study because the time was getting close for her to take the exam. Respondent increased Patient K.R.'s dose of Adderall 20 mg XR bid by adding Adderall 10 mg for prn use. In his treatment notes, Respondent acknowledged that he prescribed Adderall to help her study at night for the LSAT. The Adderall helped Patient K.R. focus and study.

23. Respondent diagnosed Patient K.R. with ADHD. He also diagnosed her with "History of Polysubstance Abuse (ecstasy, cocaine, hallucinogens, alcohol) currently in remission." Respondent did not discuss in Patient K.R.'s medical records present or prior symptoms to support a diagnosis of ADHD. Respondent did not review prior treatment records to support such a diagnosis.

24. Patient K.R.'s medical records show that the diagnosis of ADHD was a pretext diagnosis to justify the prescription of stimulant medication to Patient K.R., a known stimulant abuser. Respondent's notes state that the amphetamines helped Patient K.R. focus and study. This is not evidence of ADHD. Prescribing stimulant medications to help a student improve his or her test scores is not a medical indication.

25. Respondent committed gross negligence in that he prescribed Adderall, an amphetamine and abusable controlled substance, to Patient K.R., a patient with a substance abuse diagnosis, based only on her self-report. Respondent did not communicate with Patient K.R.'s other providers to learn what medications she was taking, why she was taking them, and what her responses to treatment were. Adderall can be abused by patients with stimulant abuse histories and students preparing for examinations.

26. Respondent also committed gross negligence in that his treatment records for Patient

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[5] Lexapro is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors. It is used to treat anxiety in adults and major depressive disorder in adults and adolescents who are at least 12 years old.

K.R. are illegible and would not allow a provider to determine what services were provided to Patient K.R., what symptoms she had, or the basis for the prescriptions she was provided. Although Respondent provided a transcription of his handwritten progress notes, the handwritten notes remain illegible and there is no way to verify whether the transcription accurately reflects what is in the handwritten notes. In addition, in the transcription, Respondent states that he cannot follow his own handwritten notes and that he believes notes may be missing. Furthermore, Respondent does not discuss in Patient K.R.'s medical records present or prior symptoms to establish a diagnosis of ADHD.

27. Respondent's acts and/or omissions as set forth in paragraphs 7 through 26, inclusive above, whether proven individually, jointly, or in any combination therefore, constitute grossly negligent acts pursuant to section 2234, subdivision (b), of the Code. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(General Unprofessional Conduct – Patients A.R. and K.R.)

28. Respondent is subject to disciplinary action under section 2234 of the Code, in that Respondent engaged in acts and omissions in the care and treatment of patients A.R. which constitute unprofessional conduct. Respondent made a number of intrusive, seductive, and inappropriate sexual comments to patients A.R. and K.R. The circumstances are as follows:

29. Paragraphs 6 through 27 are incorporated by reference as if fully set forth herein.

Patient A.R.

30. Patient A.R. was twenty years old when she was treated by Respondent. Her first two psychiatric sessions occurred at his business office. The sessions lasted approximately 30-40 minutes, and were psychiatric consultations. During these sessions, Respondent discussed his failing marriage, children, and politics.

31. Respondent scheduled the next sessions at his home office. The sessions at his home office were long, lasting approximately 90-120 minutes. The frequency of her appointments were increased to two times per week. Respondent scheduled the appointments late at night, at 9:30 p.m. and 10:00 p.m., and usually scheduled her as his last patient. Respondent told her that this

scheduling was done intentionally and indicated that she had to see him frequently because she "needed it."

32. When Patient A.R. started seeing Respondent at his home office, Respondent began making inappropriate comments to her. Many of the comments were sexual in nature and caused Patient A.R. to feel uncomfortable and embarrassed, which Respondent seemed to like. When she became quiet or noticeably embarrassed, Respondent would say, "You're so cute."

33. When speaking about Patient A.R.'s recurring nightmares involving her father, Respondent asked Patient A.R., "Do you want to fuck him?" and "Does he turn you on?"

34. Respondent would dwell on the topic of Patient A.R.'s sex life and ask questions such as, "What do you like?" and "Do you like it rough?" In response to her answers, Respondent stated, "Oh boy...Dr. Silvers...I'm attracted to you. I really am."

35. On one occasion Respondent told Patient A.R., "I know you want the doctor thing, but you're not ready."

36. On at least one occasion Patient A.R. advised Respondent that she was uncomfortable with his frequent sexual comments. In response, Respondent said, "You don't get it. There's not a fucking thing you can do. The way the stars go, we are aligned. You and me, we have something, something really special. And you won't be ready for us for a few years, but it will happen. Once we get you back to having healthy sex."

37. On another occasion, Respondent said, "You know, we're something. We've got a special connection. I know this. It's all in the stars. You and I, we [*sic*] wait a few years until you're ready...."

38. During sessions, Respondent spent a lot of time talking about his marriage, his personal life and his sex addiction. He talked about religion. He often told Patient A.R. that women gravitated towards him and are attracted to him. Respondent told her that he has had sex with multiple women on the same night.

39. Respondent told her of a lingerie party he was invited to. He asked her if he should attend the party and told her that women love doctors and there would be prostitutes at the party. On Patient A.R.'s next visit, Respondent reported that he went to the party late, but the party had

been broken up by police by the time he arrived.

40. Respondent told Patient A.R. that his wife knew that there was something happening between the two of them and that she was jealous.

41. In reply to her need for validation of the opposite sex, Respondent stated, "You know, women just gravitate towards me. They're everywhere! And they just come to me!"

42. In sharing about his sex addiction, Respondent stated, "If I told you, you wouldn't believe it! You wouldn't. Even my doctors [*sic*] said that. How do you have time? I didn't know. I would fuck 3 a night and wake a new one up in the morning. You wouldn't even believe it. Oh boy. You wouldn't."

43. On her body issues, Respondent commented, "You've got a great body, and you're very sexy. Very. Oh boy.... Oh boy...."

44. On her recent nightmare about having sexual intercourse with an old man, Respondent stated, "It was probably me. Women love doctor play. I know you do too. Why wouldn't you? Oh boy.... That old man was me."

45. At one session, Respondent lifted his shorts to show Patient A.R. a tattoo of the Virgin Mary that was on his waist/hip-bone area. He grabbed the bottom portion-seam of his shorts and lifted it up towards his waist and showed her the tattoo.

46. During Patient A.R.'s last session, she asked Respondent to lower the dosage of her Zoloft. She told Respondent that the dosage she was taking at the time caused her to feel numb to emotion. Respondent refused to lower her dosage and went into an approximately thirty-minute rant, wherein he accused Patient A.R. of not trusting him, compared her to his other patients, who he said did not question his judgment, insulted Patient A.R., by making specific references to her personal problems which she had shared with him over the course of her treatment, and sarcastically indicated that maybe he should stop talking to her, since she was clearly doing just fine.

47. Respondent taunted Patient A.R., who had become quiet during his episode, asking her what was wrong and if she could no longer talk and threw the pharmacology desktop book at her lap, and told her, "You don't get it." Patient A.R. left feeling humiliated and unable to trust

physicians. She did not return to Respondent for treatment.

48. Respondent engaged in unprofessional conduct for making intrusive, seductive, and otherwise inappropriate sexual comments to Patient A.R., which did not relate to her medical treatment. It is inappropriate for a psychiatrist to talk to a patient about the psychiatrist's sexual prowess. It is particularly more egregious when treating a patient like Patient A.R., who has a history of sexual trauma. Respondent embarrassed Patient A.R. and caused her emotional and mental trauma and discomfort.

Patient K.R.

49. Patient K.R. was twenty-one years old when she was treated by Respondent. Like Patient A.R., Patient K.R. was also the subject of inappropriate sexual, personal, and insensitive comments from Respondent. Among other things, Respondent told her that he belonged to a tennis club and stated, "I could be fucking any of the women there at any time if I wanted to- They are all so desperate." He often said a lot of women desired him.

50. Respondent told her "You better not put your hair back like that or I'll get too turned on" and "If you were just a little bit older, my wife would have some real competition."

51. Respondent spent the majority of the time during Patient K.R.'s sessions talking about himself, women, and his religious views. He also made frequent inappropriate racial comments about minorities.

52. Patient K.R. informed her mother about Respondent's comments. Her mother became upset and did not want her to continue seeing Respondent. Patient K.R. stopped seeing Respondent.

53. Patient K.R. and Patient A.R. do not know each other.

54. Respondent engaged in unprofessional conduct for making sexual, personal, and insensitive comments to Patient K.R., which did not relate to her medical treatment. It is inappropriate for a physician to talk to a patient about the patient's sexual desirability, the physician's attraction to the patient, or the sexual attraction of other people to the physician. Physicians must be sensitive about political, religious and racial issues in communicating with patients. Respondent embarrassed Patient K.R. and caused her emotional discomfort.

55. Respondent's acts and/or omissions as set forth in paragraphs 29 through 54, inclusive above, whether proven individually, jointly, or in any combination therefore, constitute unprofessional conduct pursuant to section 2234 of the Code. Therefore, cause for discipline exists.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 23192, issued to Respondent Frederick M. Silvers, M.D.;

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

3. Ordering Respondent, if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as the Board deems necessary and proper.

DATED: July 30, 2015

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant