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

In the Matter of the Accusation Against: **Salvador A. Arella, M.D.** **1601 East Palmdale Blvd., Suite B** **Palmdale, CA 93550** **Physician's and Surgeon's Certificate No. A49797,** Respondent.	Case No. 800-2014-004113 **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 August 6, 1991, the Medical Board issued Physician's and Surgeon's Certificate Number A49797 to Salvador A. Arella, M.D. (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 August 31, 2015, 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 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 board deems proper.

6. 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 scheduled by the Board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

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7. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

8. 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."

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9. 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."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – 4 Patients)

10. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code for the commission of acts or omissions involving gross negligence in the care and treatment of patients K.W., R.F., L.W., and L.C.[1] The circumstances are as follows:

Patient K.W.

11. Patient K.W. (or "patient") is a female patient who treated with Respondent, a psychiatrist, from approximately 2007 to the present.[2] On her Mental Disorder Questionnaire, the

[1] The patients are identified by initial to protect their privacy.

[2] Respondent reported that his first initial evaluation of this patient was on May 15, 2007, which is documented in a billing statement. However, the first note of a clinical encounter in the medical records provided by Respondent is January 8, 2009. Specifically, the Board was (continued...)

patient complains of depression, fatigue, trouble sleeping, anxiety, and the like. Throughout his treatment of this patient, Respondent diagnosed the patient with Bipolar Disorder, Depression, and adult ADHD (Attention Deficit Hyperactive Disorder).[3] Records indicate that from 2009 to April 2013, Respondent wrote many prescriptions to the patient including Depakote, Zyprexa, Vicodin (Hydrocodone and Acetaminophen), Klonopin, Ambien, Clonidine, Gabapentin, Xanax, Lithobid, Ativan, Doxepin, Neurontin, Seroquel, Valium (Diazepam), Trazodone, Lithium, and Strattera.[4]

12. The records provided by Respondent are incomplete. Respondent stated that he evaluated the patient in 2007, but there is no record of that visit. The notes for the visits are brief and there is no way to understand Respondent's psychiatric thinking and assessment treatment options and the patient's response to treatment. Respondent made many medication changes, but he did not provide the rationale therefor. By itself, Respondent's medical records for this patient does document his assessment of Bipolar Disorder, but the records provide no basis for such assessment or treatment options offered or the patient's response to the treatment(s) (e.g. the patient's progress throughout the treatment) in an understandable manner.

13. Records also indicate that Respondent prescribed opiates to the patient over the years with no justification from a psychiatric standpoint for writing the medication.[5] Respondent was also writing prescriptions for pain medication, which is outside the scope of Respondent's psychiatric practice, without any type of standardized assessment and treatment of pain or in collaboration with any pain management physicians.[6]

14. Respondent's failure to maintain accurate and complete psychiatric records for the patient, as well as his prescribing of opiates over the years with no justification from a psychiatric

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(...continued)
provided and reviewed records for patient K.W. from January 8, 2009 to March 30, 2015.

[3] Respondent's diagnosis of adult ADHD is unsupported by the records.

[4] All dangerous drugs with potentially addictive traits and side effects, if used improperly and/or overused.

[5] Respondent did insinuate in his interview with the Board that he was also writing prescriptions to treat the patient's pain, which he thought was made worse by depression.

[6] For example, Respondent wrote Vicodin three times a day, which he acknowledges is a high dose.

standpoint for writing the medication, and for reasons (e.g. for pain management) which are outside the scope of Respondent's psychiatric practice, constitutes an extreme departure from the standard of care.

Patient R.F.

15. Patient R.F. (or "patient") is a female patient who treated with Respondent from approximately March 2004 to approximately March 2014.[7] Records during this treatment period indicate that Respondent wrote many prescriptions for this patient including Zyprexa, Effexor, Xanax, Seroquel, Topamax, Invega, and Vicodin (hydrocodone and acetaminophen).[8]

16. Respondent's records for this patient are very sparse. There is no documentation of Respondent's basis for his assessment, treatment options offered, or the patient's tolerance and response to treatment.[9] The medical records also do not provide any explanation why Respondent was prescribing Vicodin to this patient for many years, and why he is treating the patient for pain, as there is no discussion of any type of pain monitoring, nor is there any documentation of any liver function tests or other laboratory findings to monitor the patient's tolerance to this pain medication.[10]

17. There is no documentation of the care ending with this patient. The last documented visit in the medical records is January 6, 2013, but prescription records indicate that Respondent was writing Vicodin prescriptions for this patient until March 2014. Respondent did not provide any documentation or explanation as to why the patient-physician relationship ended, and there

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[7] Respondent provided the Board with records beginning March 1, 2004, when he makes the diagnosis of Bipolar Disorder and depression. After this initial evaluation, there are no records for this patient until August 15, 2006, continuing to approximately March 2014, when Respondent apparently stops treating the patient.

[8] Records indicate that Respondent provided many refills for Vicodin ES for this patient from April 2011 through March 2014. Respondent also acknowledged that some of the Vicodin prescriptions had a high dosage of acetaminophen, which could affect the patient's liver function. However, there were no labs in the chart to indicate that Respondent was writing for Vicodin, and Respondent stated that the laboratory findings may have been lost when he moved his offices.

[9] Even Respondent, when asked about the patient's initial evaluation in 2004 and having the records available to him, could not provide an account of what happened. Specifically, Respondent, through his own notes, could not remember how he came to make the diagnosis of Bipolar Disorder in this patient.

[10] The risk of prescribing opiate medications empirically for pain is that the medications are inherently addictive and associated with tolerance and withdrawal and therefore dangerous, especially in patients who are vulnerable in suffering from addiction.

was no documentation that Respondent took a proactive role in ensuring continuity of psychiatric care for his patients, either with Respondent at a new location or with another doctor.

18. Respondent's care and treatment of patient R.F., as described above, constitutes an extreme departure from the standard of care.

Patient L.W.

19. Patient L.W. (or "patient") is a female patient who treated with Respondent from approximately January 4, 2012 through July 25, 2014 for Bipolar Disorder and panic attacks. Records during this treatment period indicate that Respondent wrote many prescriptions for this patient including Seroquel, Xanax, Invega, Trazodone, Lithobid (lithium), Cymbalta, Diazepam, and Alprazolam.

20. Respondent's records document no basis for his assessment of Bipolar Disorder. Moreover, there is no documented basis for not including some of the other conditions the patient reported suffering from, such as Post-Traumatic Stress Disorder (PTSD), and Generalized Anxiety Disorder.[11] There was no documentation that Respondent evaluated the patient for PTSD.

21. Moreover, Respondent prescribed to this patient Seroquel, Xanax, and Cymbalta, despite the patient indicating that she had past medication problems with these same drugs. There is no explanation as to why these medications were re-started. Also, there is no documentation in the initial evaluation if the patient was even prescribed psychotropic medication and there is no basis or reasoning given for prescribing three psychotropic medications at the same time (Seroquel, Xanax, and Invega). Also, throughout the time Respondent was treating this patient, there were many medication changes, however, the medical records do not document any basis therefore. In reviewing these records, there is no understanding as to why the assessment was made or not made, and why psychotropic medications were initially prescribed and changed.

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[11] The patient reported that her mental health issues began in 2000 when she was raped, and that she had been previously diagnosed with PTSD and had been prescribed psychotropic medication in the past.

22. Respondent also started his treatment of this patient with two antiposychotics/mood stabilizers on his initial evaluation of Seroquel 900 mg, which exceeds the FDA maximum dose (800 mg) of the medication, coupled with the medication in the same class, the anti-psychotics/mood stabilizer Invega at a mid-range dose of 6 mg daily, which was overly-aggressive treatment. Also, Respondent prescribed Lithium, but there were no laboratory results in the records to indicate that there was serology monitoring, or that the kidney and thyroid functions were monitored. Moreover, Respondent prescribed high doses of Xanax, as well as Valium to a patient with a history of addiction. Lastly, Respondent moved his office and terminated the physician-patient relationship with this patient without ensuring that the patient had continuity of psychiatric care.

23. Respondent's care and treatment of patient L.W., as described above, constitutes an extreme departure from the standard of care.

Patient L.C.

24. Patient L.C. (or "patient") is a female patient who treated at the clinic since 2005 by at least three previous doctors. Respondent's first note of caring for this patient was April 14, 2014, and the last record of his treatment was on April 7, 2015.[12] He made the diagnoses of Bipolar Disorder and later Schizoaffective Disorder.[13] Records during Respondent's treatment of this patient indicate that Respondent wrote many prescriptions for this patient including Ambien, Valium, Lamictal, Lithium, Cymbalta, Klonopin, Latuda, and Topamax.

25. There is a large gap in the psychiatric treatment of this patient. Respondent makes multiple medication changes, however, there is no documentation of the rationale for these changes in the medical records provided for review. It is even difficult to determine from the records how long Respondent provided care for this patient. As such, there is no way to

[12] In his interview with the Board, Respondent reports that he is continuing to care for patient L.C. Respondent also stated that he did not have access to other clinicians' notes prior to the introduction of the current electronic medical record (EMR) system. Respondent also stated that he did not utilize CURES, and that his system for checking to see if patients were receiving multiple benzodiazepines from multiple providers would be having correspondence with the insurance company informing him of this.

[13] A mental illness that manifests with psychotic symptoms in combination with symptoms of a mood disorder.

understand Respondent's psychiatric thinking and assessment of the treatment options and the patient's response thereto. Also, the records do not reveal how Respondent made the diagnosis of Bipolar Disorder (e.g. from previous diagnoses made by others, etc.), and how or why Respondent later changed that diagnosis from Bipolar Disorder to Schizoaffective Disorder.

26. Respondent's care and treatment of patient L.C., as described above, as well as Respondent's failure to maintain accurate and complete psychiatric records of his notes for patient L.C. constitutes an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts – 5 Patients)

27. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in his care of patients K.W., R.F., L.W., L.C., mentioned in the First Cause for Discipline above, as well as K.H. The circumstances are as follows:

28. The facts and allegations in the First Cause for Discipline above, are incorporated by reference as if set forth in full herein.

Respondent also committed simple negligent acts in his care of patients K.W., R.F., L.W., L.C., mentioned in the First Cause for Discipline above, as well as K.H. The circumstances are as follows:

Patient K.W.

29. Respondent also committed repeated negligent acts in his care of patient K.W. above, by diagnosing the patient with ADHD, without any substantiation, and by prescribing to her benzodiazepines like Adderall on a chronic basis at relatively high doses for no diagnosed condition. These acts represent simple departures from the standard of care.

Patient R.F.

30. Respondent also committed negligent acts in his care of patient R.F. above, by prescribing Xanax to this patient with no clear reasoning provided in the medical record. The specific circumstances regarding patient R.F. are as follows:

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31. Patient R.F. was prescribed Seroquel, which is an antipsychotic and mood stabilizer that is commonly given to patients with Bipolar Disorder. Xanax is a benzodiazepine that is usually prescribed for anxiety, not Bipolar Disorder. However, there is no assessment of anxiety in the records reviewed. Moreover, there is a risk with empirical treatment of anxiety with Xanax, as Xanax can be abused. This is a simple departure from the standard of care in the psychiatric treatment offered to this patient, as she was prescribed Xanax with no clear reasoning provided in the medical records.

Patient L.W.

32. Respondent also committed negligent acts in his care and treatment of patient L.W. by failing to evaluate the patient for PTSD, which should have been addressed by Respondent based on how she filled out Respondent's intake questionnaire. This represents a simple departure from the standard of care.

Patient L.C.

33. The facts and allegations with respect to patient L.C., mentioned in the First Cause for Discipline above, are incorporated by reference as if set forth in full herein.

Patient K.H.

34. Respondent also committed negligent acts in his care patient K.H. The circumstances are as follows:

35. The records available for review for respondent's treatment of patient K.H. (or "patient") were from approximately February 6, 2012 through January 7, 2015. According to these notes, Respondent was treating the patient for Schizoaffective Disorder. Records during this treatment period indicate that Respondent wrote many prescriptions for this patient including Seroquel, Abilify, Remeron, Benadryl, and Ambien. Also included were records from the patient's primary care physician (PCP) which indicated, among other things, that the patient was being prescribed potentially-addictive medications such as Vicodin, Soma, Xanax, and Phenergen with codeine cough syrup. It should also be noted that the PCP specifically

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documented in his (i.e. the PCP's) records that patient K.H. was seeking pain meds and should not be given refills.[14]

36. The initial record for review of this patient was February 6, 2012, but the patient was not a new patient, as documented in the February 6, 2012 evaluation. The initial evaluation to assess Respondent's psychiatric assessment of Schizoaffective Disorder was missing. Respondent kept the same assessment (i.e. Schizoaffective Disorder) throughout his time caring for this patient. There is no notation in the chart by Respondent that he had an understanding that the patient was deemed med-seeking by the PCP. Therefore, Respondent's assessment and evaluation is impaired because he did not seem to recognize any addiction in this patient, where it was recognized by the PCP and documented in the chart. This is a simple departure from the standard of care in the psychiatric evaluation of this patient provided by respondent in that he did not make an assessment that the patient was med-seeking and did not evaluate the patient for addiction.

37. Respondent made many changes and offered aggressive psychotropic medication (e.g. some prescriptions were written for dosages above the FDA recommendations) for the patient based on his complaints, and Respondent did not seem to consider whether the complaints were legitimate or whether the patient was "med-seeking." Respondent was also writing prescriptions (e.g. Seroquel, Remeron, Benadryl, Ambien, and Abilify) which can also be sedating. Writing these prescriptions to a patient who is noted to be potentially abusing Vicodin and Xanax, is not an effective treatment, as the sedative effects of the psychotropic medications that Respondent prescribed could mimic the sedative effects of drugs abuse and prescription medications that could be abused, such as Soma and Xanax. Therefore, that these medications were deemed effective in the patient, may be a function of the patient's addiction (and more reflective of a patient requesting sedating medications to mimic the sedative effects of drugs of

[14] When asked by the Medical Board as a matter of procedure and policy how he would detect if patients are receiving addictive medications from multiple providers, Respondent stated that he makes the assessment as to whether the patient is being manipulative. Respondent did not acknowledge any type of review of the CURES database.

abuse) rather than the patient actually suffering from mental illnesses such as Schizoaffective Disorder.

38. This is a simple departure from the standard of care in the psychiatric treatment offered to the patient in that he was prescribed a very aggressive psychotropic medication regimen that is extremely sedating and can be abused by patients with addiction.

THIRD CAUSE FOR DISCIPLINE

(Prescribing Without Exam/Indication)

39. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 2242 of the Code, in that Respondent prescribed dangerous drugs to patients K.W., R.F., L.W., L.C., and K.H. without an appropriate prior examination or medical indication therefor.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

40. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 725 of the Code, in that Respondent excessively prescribed dangerous drugs to patients K.W., R.F., L.W., L.C., and K.H.

FIFTH CAUSE FOR DISCIPLINE

(Inadequate Records)

41. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to maintain adequate and accurate records of his care and treatment of patients K.W., R.F., L.W., L.C., and K.H.

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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 Physician's and Surgeon's Certificate Number A49797, issued to Salvador A. Arella, M.D.;

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

3. Ordering Salvador A. Arella, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: July 28, 2015

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

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