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

In the Matter of the Accusation Against:	)	
Guy Rogers Gullion, M.D.	)	**File No. 800-2014-008007**
Physician's and Surgeon's Certificate No. A 50284	)	
Respondent	)	

DECISION

The attached Proposed Decision is hereby amended, pursuant to Government Code section 11517(c)(2)(c) to correct technical or minor changes that do not affect the factual or legal basis of the proposed decision. The proposed decision is amended as follows:

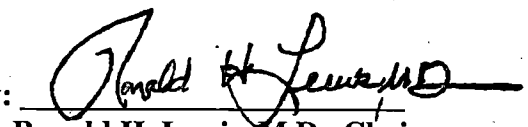
1. **Page 3, paragraph 9: "respondent" will be replaced with "Patient A" so the following sentence reads: "Respondent's primary diagnosis for Patient A is OCD; he also diagnosed her with MDD."**
2. **Page 4, Footnote 5: "one week" will be replaced with "two weeks" so the following sentence reads: "Respondent's progress notes indicate that Patient A was initially prescribed Zoloft on January 4, 2012, or possibly two weeks earlier, on December 21, 2011."**
3. **Page 10, paragraph 41: "petitioner" will be replaced with "respondent" throughout the paragraph.**

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on December 8, 2017.

IT IS SO ORDERED November 8, 2017.

MEDICAL BOARD OF CALIFORNIA

By: 

Ronald H. Lewis, M.D., Chair
Panel A

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

In the Matter of the Accusation Against:	
GUY ROGERS GULLION, M.D.	Case No. 800-2014-008007
Physician's and Surgeon's Certificate No. A 50284,	OAH No. 2017040706
Respondent.	

PROPOSED DECISION

Administrative Law Judge Diane Schneider, State of California, Office of Administrative Hearings, heard this matter on September 11 and 12, 2017, in Oakland, California.

Joshua M. Templet, Deputy Attorney General, represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California.

John L. Fleer, Attorney at Law, represented respondent Guy Rogers Gullion, M.D., who was present.

The record closed and the matter was submitted for decision on September 12, 2017.

FACTUAL FINDINGS

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

2. On December 17, 1991, the Board issued Physician's and Surgeon's Certificate (Certificate) No. A 50284 to Guy Rogers Gullion, M.D. (respondent). Respondent's Certificate was in full force and effect at the times of the acts set forth below and will expire on August 31, 2019, unless renewed.

3. The Accusation alleges that respondent committed unprofessional conduct (repeated acts of negligence, incompetence, excessive prescribing, and failure to maintain

adequate and accurate medical records) in the treatment of Patient A.[1] Respondent filed a notice of defense and this hearing followed.

4. The standard of proof applied in making the factual findings is clear and convincing evidence to a reasonable certainty.

Expert testimony at hearing

5. Zachary D. Torry, M.D., has practiced psychiatry for about seven years. In addition to his private practice, Dr. Torry works part-time as a Staff Psychiatrist at San Quentin State Prison. Dr. Torry is also a medical reviewer for the Board, and offered expert testimony on behalf of complainant. Dr. John George Rosenberg, M.D., M.P.H., has practiced psychiatry for about 31 years, and offered expert testimony at hearing on behalf of respondent. He has worked as the Medical Director of various units at Alta Bates Medical Center and is past President of the Alta Bates Medical Staff. Dr. Rosenberg is currently a Staff Psychiatrist at the Berkeley Therapy Institute, where he specializes in performing work related to physician impairment.

6. Each expert was familiar with the standard of care and laws applicable to the professional conduct of psychiatrists in California. Each expert reviewed the Accusation, Patient A's medical records, and the transcript of the Board's interview with respondent, in addition to other materials, and offered an opinion as to whether respondent's treatment of Patient A constituted unprofessional conduct.

Respondent's background

7. Respondent received his medical degree from the University of Texas. Respondent completed his residency in psychiatry at Napa State Hospital and has practiced medicine for 31 years. He has treated hundreds of patients who suffer from obsessive-compulsive disorder. Respondent was board-certified in psychiatry until December 2011. Respondent has practiced psychiatry in a number of mental health clinics, including Sonoma County Mental Health and Marin County Mental Health. He was also the Chairman of the Department of Psychiatry at Sutter Medical Center, Santa Rosa from 2008 to 2011. He has a long-term interest in the area of psychopharmacology, and has made presentations in the area.

Patient A's history, diagnoses and treatment prior to respondent

8. Patient A was 63 years old when she began treatment with respondent at the Occidental office of the West County Health Centers, in December 2011.[2] She had a history of suffering from major depressive disorder, recurrent, severe, and without psychotic

---

[1] The patient is referred to by the initial "A" to protect her privacy.

[2] Respondent treated Patient A until November 2013.

behavior (MDD) and obsessive-compulsive disorder (OCD). Before she began treatment with respondent, Patient A had been prescribed various psychiatric medications by her prior psychiatrists: in 2008 she tried Lexapro and Celexa, which were not effective. She tried Wellbutrin in 2009, and that was not effective. In 2011, she was prescribed Effexor, Seroquel, and Zyprexa, which brought some symptom relief. Patient A, however, sought a different medication plan, as she had gained 30 pounds and could not afford the medications.

9. Prior to meeting with Patient A, respondent reviewed her psychiatric records, including the evaluations that had been performed by her prior psychiatrists at the clinic. At the time she met with respondent on December 21, 2011, Patient A had been taking a number of medications, including Zyprexa, Seroquel and Effexor. Respondent's primary diagnosis for respondent was OCD; he also diagnosed her with MDD. Respondent's progress notes indicated that Patient A's medication regimen would be altered because Patient A had gained 30 pounds on this regimen, and she could not afford the medications.

Errors in connection with prescribing Zoloft[3]

EXCESSIVE DOSES AND DOCUMENTATION ERRORS

10. In connection with respondent's prescribing of Zoloft, complainant alleges that respondent was negligent and incompetent in that respondent prescribed excessive doses of Zoloft to Patient A. Complainant also alleges that respondent began treatment of Zoloft in an amount that was well above the manufacturer's recommended initial dose of 50 mg; and that respondent failed to wait a sufficient amount of time before increasing her initial dose.

11. Complainant also alleges that respondent failed to document an increase in Patient A's symptoms or decreased functioning to justify an increase in her medication; and he failed to document that he informed Patient A of the indications for, and risks and benefits of, treating her with high doses of Zoloft. The Accusation alleges that this conduct constitutes repeated negligent acts and incompetence.

12. Respondent's progress notes as to when he started Patient A on Zoloft, the starting dose, and the increments by which he increased her dosages, are unclear. What is clear, however, is that beginning on December 21, 2011 or January 4, 2012, respondent began prescribing Zoloft to Patient A, and by February 22, 2012, he had increased her dose to 400 mg per day.

13. Respondent's treatment plan on December 21, 2011, was to substitute Latuda for Zyprexa and "try Prozac or Zoloft in OCD doses."[4] Respondent thought that due to

---

[3] Zoloft is the brand name for Sertraline, an antidepressant medication in a group of drugs referred to as selective serotonin reuptake inhibitors (SSRI's).

[4] An "OCD dose" refers to the practice of treating patients with OCD by prescribing Zoloft in doses that exceed the manufacturer's and FDA-recommended maximum dose. This

Patient A's "multiple failures" on other SSRI's, she "probably required a true OCD level of Zoloft, which is at least 300 mg." Although this note states that he is going to initiate treatment with Prozac or Zoloft, the treatment section of the progress notes does not state the amount of the initial prescription for Zoloft. It is respondent's practice to advise his patients of the potential side effects of the medications he prescribes; and he tells patients to tell him "everything that occurs" after they begin taking medication. He is certain that he had a conversation with Patient A regarding the risks and benefits of his treatment plan, but he acknowledges that he did not document that conversation.

14. At hearing, respondent testified that he "feels certain" that he prescribed Zoloft to Patient A on December 21, 2011. Respondent testified that he is certain that he prescribed Patient A 50 mg of Zoloft per day to start, and he has "never started anyone on more than that." He routinely tells patients that they can gradually increase their dosage.

15. Although the amount of the dosage increases between December 21, 2011 and February 22, 2012, are also not clear from respondent's records, it appears that as of January 4,[5] 2012, respondent recommended that Patient A "continue" with Zoloft, at 200 mg per day. (Respondent views this note as further support for his having started Patient A on Zoloft on December 21, 2011.) According to respondent's progress notes, he continued the prescription for 200 mg of Zoloft per day on January 11 and January 18, 2012. On February 1, 2012, respondent prescribed 300 mg of Zoloft per day. He noted:

> We are probably going to continue to increase the Zoloft by 50 mg for three days and then 50 mg more. We are probably going to try to get 400 mg Zoloft a day, an anti-obsessive dose.

On February 8, 2012, the prescription for 300 mg per day was continued; the progress notes, however, state that Patient A was taking 250 mg of Zoloft per day. Respondent's February 15, 2012, progress note states that Patient A was "[a]t 350 mg Zoloft." On February 22, 2012, Patient A was prescribed 400 mg of Zoloft; respondent's progress notes state that Patient A was doing great. At hearing respondent remarked that the increase in dose from December 2011 to February 22, 2012, represented an increase of 15 mg of Zoloft per week, until Patient A reached "the level of Zoloft that [respondent] initially imagined."

16. Respondent's progress notes for Patient A include a section entitled "General Examination," which includes his general observations about Patient A's symptoms. The notes between December 2011 and February 22, 2012, the time period in which respondent

---

practice is approved by the American Psychiatric Association Guidelines, and is discussed at length in Factual Findings 17 and 22.

[5] The Accusation states that respondent initially prescribed Zoloft to Patient A on January 11, 2012. This is incorrect. Respondent's progress notes indicate that Patient A was initially prescribed Zoloft on January 4, 2012, or possibly one week earlier, on December 21, 2011.

increased Patient A's dose of Zoloft, do not specifically document an increase of Patient A's OCD symptoms or a decrease in functioning. Respondent did not think he needed to document the specific increase in her symptoms because he had already thought through the treatment plan of prescribing "OCD doses" of Zoloft. He believed, however, that the Zoloft was improving Patient A's OCD because she was functioning better by engaging in various activities. Aspects of her improvement were documented in his progress notes.

17. The manufacturer's recommended initial dose of Zoloft is 50 mg per day, and the maximum recommended dose is 200 mg per day. According to the American Psychiatric Association Practice Guidelines for the Treatment of Patients with Obsessive-Compulsive Disorder (APA Guidelines), it is occasionally acceptable to prescribe 400 mg per day of Zoloft to patients suffering from OCD. (American Psychiatric Association. Practice guideline for the treatment of patients with obsessive-compulsive disorder. Arlington, VA: American Psychiatric Association, 2007, page 24.) The APA Guidelines, at pages 24 to 25, also note that some psychiatrists prefer to increase the dose of Zoloft more rapidly, in weekly increments, if comfortably tolerated, rather than waiting one or two months before increasing the doses after evaluating the results.

18. Respondent admits that portions of his progress notes were inadequate and/or inaccurate, particularly in the treatment section where the amount of the prescription for Zoloft is listed. He agrees that his progress notes do not reflect that he informed Patient A of the indications for, and risks and benefits of, treating her with high doses of Zoloft, or the increase in symptoms to justify increasing the doses of Zoloft. Respondent also agrees that his notes are not clear as to the date that he first prescribed Zoloft, and they do not reflect that he prescribed Patient A 50 mg of Zoloft per day. He testified credibly however, that in spite of his initial prescription of 200 mg of Zoloft, he advised Patient A to start with 50 mg and increase it incrementally. He also noted that his progress note of June 27, 2012, incorrectly states that Patient A was treated with 100 mg of Zoloft per day. Respondent "knows" this is a mistake because he would not have prescribed Patient A less than 200 mg of Zoloft per day.

19. At the time he was treating Patient A at the Occidental office of the West County Health Centers, he was treating 16 patients per day for 30 minute slots. The patient load, combined with the challenges of the electronic medical record system, made it difficult to ensure the accuracy of his records.

EXPERTS' OPINIONS AND ULTIMATE FINDINGS RE EXCESSIVE DOSES

20. Dr. Torry opined that respondent's prescription of Zoloft to Patient A constituted a simple departure from the standard of care because, in a nutshell, respondent prescribed too much Zoloft too soon. In a report dated October 4, 2016, he explained:

> While sertraline 400 mg daily can be prescribed in patients who have inadequate therapeutic responses *after eight weeks or more at the usual maximum dose and mild side effects*, Dr. Gullion's

> use of this treatment regimen [for Patient A] was not justified. He started her at the usual *maximum* dose. He did not wait the recommended eight weeks but rather rapidly increased her to a dose that was above the manufacturer's recommended maximum dose.

(Emphasis in original.)

21. In his report, Dr. Torry also noted that "it is generally accepted that a patient should remain on a trial of serotonin reuptake inhibitor for 8-12 weeks with at least 4-6 weeks at the highest comfortably tolerated dose." Thus, in Dr. Torry's view, respondent erred by prescribing Patient A an initial dose of 200 mg of Zoloft; and respondent should have waited longer than seven weeks before increasing Patient A's dose of Zoloft to twice the maximum dose recommended by the manufacturer. At hearing, but not in his report, Dr. Torry stated that respondent's conduct also constituted incompetence, but he did not explain his reasons for this conclusion.

22. Dr. Rosenberg disagreed with Dr. Torry that respondent's prescription of Zoloft to Patient A fell below the standard of care. He opined that respondent's prescription of Zoloft to Patient A was not excessive and was within the dosing recommendations for Zoloft contained in the APA Guidelines. According to Dr. Rosenberg, the dosing recommendations in the APA Guidelines represent the range of reasonable approaches to treat various psychiatric problems; and in some cases, the APA Guidelines allow for doses higher than 400 mg per day. In formulating his opinion Dr. Rosenberg took into account that Patient A was "treatment resistant" in that she had failed to respond to other treatment. Patients such as Patient A often require a more aggressive approach, such as the one used by respondent. Dr. Rosenberg also noted that Patient A's psychiatrist prior to respondent, Arnold Zeff, M.D., prescribed Effexor to Patient A in an amount that exceeded the manufacturer's recommended dose. Dr. Rosenberg opined that using high doses of Zoloft early in the treatment of Patient A was reasonable and within the standard of care, particularly since she had a history of not responding to other treatment.

Dr. Rosenberg added that doctors often write prescriptions for an intended dose but explain to their patients to "work up" to the intended dose, and this was respondent's practice. For this reason, Dr. Rosenberg did not find that respondent began Patient A's treatment with an excessive amount of Zoloft. Dr. Rosenberg also found that respondent's rate of increasing Patient A's doses of Zoloft was not outside of the standard of care. Dr. Rosenberg noted that almost eight weeks had passed between the time that respondent initiated treatment in late December 2011, to February 22, 2012, when he prescribed 400 mg of Zoloft per day. Dr. Rosenberg noted that Zoloft is considered extremely safe with side effects that are milder than other medications that he could have used.

23. Dr. Rosenberg's opinion, particularly his discussion of dosing allowed under the APA Guidelines, was more persuasive than that offered by Dr. Torrey. It was therefore not

established that respondent's prescription of Zoloft to Patient A, including the rate at which he increased the dosages, was excessive, negligent or incompetent.

EXPERT OPINIONS AND ULTIMATE FINDINGS RE DOCUMENTATION ERRORS

24. Dr. Torry opined that a psychiatrist must document a patient's inadequate treatment response in order to justify prescribing in excess of the manufacturer's recommended dose, and respondent's notes do not contain such information. Dr. Torry found that respondent failed to adequately document Patient A's symptoms to justify his increase of Zoloft; and that respondent failed to document that he discussed with Patient A the reasons for treatment, and the risks and benefits of such treatment. Dr. Torry did not find that respondent's inadequate documentation constituted a simple departure from the standard of care or was incompetent.

25. Dr. Rosenberg opined that respondent's documentation regarding his reasons for increasing the dosage of Zoloft was adequate. Dr. Rosenberg observed that respondent was monitoring her progress, and that according to a progress note dated February 22, 2012, Patient A was "doing great." Dr. Rosenberg found that respondent's records were sufficient to state a goal of prescribing "OCD doses" of Zoloft to Patient A as an alternative to her prior medication regimen. Once respondent formulated a treatment plan it was acceptable for him to move to a higher dose to implement the plan. Dr. Rosenberg was comfortable with the amount and the rate that respondent increased the doses of Zoloft. He also acknowledged, however, that respondent's progress notes did not clearly document Patient A's initial dose of Zoloft or an increase in OCD symptoms or a decrease in functioning to justify an increase in her medication.

26. Dr. Torry's opinion that portions of respondent's medical records are inadequate and inaccurate is supported by the evidence. The opinion offered by Dr. Torry did not establish that respondent's inadequate and inaccurate documentation constituted negligence or incompetence.

Failure to investigate Patient A's diarrhea in the context of the high dose of Zoloft

27. According to the APA Guidelines, gastrointestinal distress is one of the most common side effects from SSRI's, particularly in the first weeks of treatment. The APA Guidelines recommend lowering the drug dose as an initial step to alleviate the side effect.

28. Complainant alleges that respondent failed to investigate Patient A's diarrhea in the context of the high dose of Zoloft he was prescribing; and that he failed to document any such investigation or collaboration with Patient A's primary care provider.[6] Complainant alleges this transgression constitutes negligence and incompetence.

---

[6] Patient A was diagnosed with collagenous colitis in 2014. Complainant does not allege that the high doses of Zoloft prescribed to Patient A caused Patient A's colitis, only

29. In a progress note dated February 28, 2012, Patient A's primary care provider, Trina Bowen, M.D., notes:

> Happy working with Dr. Gullion, however current psychiatric meds not as helpful in managing her symptoms so far. . . . Zoloft takes the edge off depression. . . . . Mentions that she's been having diarrhea, couple X/day, for few wks – predates current medication. Has spring water, filters it. No signif abd pain. No nausea.

30. Respondent read Dr. Bowen's note and Patient A's labs, but he did not document his collaboration with Dr. Bowen. He agrees that he shared responsibility for Patient A with Dr. Bowen. Respondent did not take steps to investigate Patient A's diarrhea, however, because he thought that Dr. Bowen was addressing Patient A's concerns; and he did not think that Patient A's diarrhea was a side effect of the Zoloft because he understood that it was present before she began taking large doses of Zoloft.

31. In a progress note dated March 7, 2012, respondent wrote that Patient A was experiencing "[e]xplosive diarrhea, 2 yrs, on & off. Dr. Bowen is looking for etiology." In a progress note dated March 14, 2012, respondent reported that "a major conflicting situation is ongoing severe diarrhea with negative tests for everything but Giardia, and that is pending." Respondent's progress notes for the remainder of March and in April 2012 indicate that respondent continued to raise the issue of her diarrhea. During this time respondent continued to prescribe her 400 mg of Zoloft per day.

32. Respondent's progress note dated May 16, 2012, states that Patient A's dose of Zoloft was decreased to 200 mg and that Patient A was "[f]eeling much better" and that her "stomach ache [was] gone." His progress notes are not clear as to when or why this decrease in dosage occurred.[7]

33. Patient A testified with credibility and candor regarding the distressing impact that her diarrhea had on her life. She described the diarrhea as being so unpredictable and severe that she ended up wearing adult diapers and sleeping on a plastic sheet. Patient A sought help from both Dr. Bowen and respondent. She denies telling respondent that she had experienced diarrhea for two years and believes this is a mistake in his records. Patient A also testified that respondent told her that he did not believe the diarrhea was a side effect of the Zoloft, and she believed him. She was not able to be specific with dates and times of

---

that respondent failed to investigate and collaborate with Patient A's primary care physician regarding the possible connection between Zoloft and her diarrhea.

[7] Respondent's progress notes for May 16, 2012, later state that Patient A will continue on 100 mg of Zoloft per day. At hearing respondent testified that this progress note is inaccurate.

these conversations because, as she explained, she suffers from "type two inattentive ADD, dates and times are hard for [her]." Patient A believes that respondent is a nice man who is genuinely concerned about his patients, but at the same time, she wishes that he would have investigated the connection between her diarrhea and the high dose of Zoloft. Patient A is now convinced that the Zoloft caused her severe diarrhea, and she does not want others to experience this distress.

EXPERTS' OPINIONS AND ULTIMATE FINDINGS RE FAILURE TO INVESTIGATE DIARRHEA

34. Dr. Torry opines that respondent should have investigated Patient A's diarrhea as potentially related to Patient A's use of high dosages of Zoloft. In drawing this conclusion, Dr. Torry points to the fact that Patient A's complaints to her primary care provider and to respondent regarding her diarrhea occurred within weeks after respondent had increased her dose of Zoloft to 400 mg per day. Although Patient A's primary care physician was investigating the cause of the diarrhea, Dr. Torry opines that respondent should have investigated the high dosages of Zoloft as a possible etiology of Patient A's diarrhea. His opinion was reinforced by Patient A's continued complaints regarding diarrhea in March and April of 2012. Dr. Torry opines that respondent's failure to investigate a possible correlation between Patient A's diarrhea and the Zoloft, and his failure to collaborate with Patient A's primary provider, constitutes a simple departure from the standard of care. The possibility that Patient A's diarrhea pre-dated respondent's recent prescription of Zoloft did not relieve him of his obligation to investigate the possibility that Patient A's diarrhea was related to her use of Zoloft. At hearing, but not in his report, Dr. Torry stated that respondent's conduct also constituted incompetence, but he did not explain the basis for his conclusion.

35. Dr. Rosenberg opines that respondent's failure to investigate Patient A's diarrhea did not fall below the standard of care. In forming his opinion he considered the facts that Dr. Bowen's note of February 28, 2012, states that Patient A's diarrhea predates her current medication, and that respondent's progress notes for March 7, 2012, state that Patient A had experienced diarrhea for two years, on and off. Although doctors have a duty to thoughtfully address symptoms that could be co-occurring with prescribed medications, Dr. Rosenberg believes that in this case, it was not reasonable for respondent to identify the diarrhea as having a relationship to her taking high doses of Zoloft, and did not require him to perform further investigation.

36. Dr. Torry's opinion was more persuasive than that offered by Dr. Rosenberg, particularly in view of Patient A's consistent complaints about diarrhea, coupled with her high dose of Zoloft. It was therefore established that respondent's failure to investigate Patient A's diarrhea in the context of the high dose of Zoloft constituted a simple departure from the standard of care.

37. At hearing, but not in his report, Dr. Torry also stated that respondent's conduct constituted incompetence. He did not explain the basis for drawing this conclusion;

and in the absence of any cogent analysis, it cannot be found that respondent's failure to investigate Patient A's diarrhea constitutes incompetence.

Rehabilitation evidence

38. Respondent was terminated from the West County Health Centers in January 2014. Respondent currently has a small private practice in Sebastopol, where he treats patients three days per week. Respondent now makes a more extensive assessment before prescribing high doses of Zoloft, and he uses a different and improved electronic medical records program to maintain his medical records.

39. Respondent submitted declarations from the following individuals who are familiar with, and think highly of, his work:

a. Susan Dubin-McNeil, Ed.D., is a psychologist who worked closely with respondent for about 12 years. Dr. Dubin-McNeil praises respondent for generously providing trainings to her interns, and for the care that respondent exhibited towards his patients.

b. David Beck, M.D., is a child psychiatrist who has had frequent discussions with respondent regarding clinical and complex pharmacological issues. Dr. Beck describes respondent as a well-respected and ethical practitioner who shows concern for his patients.

c. Ari Harrison, M.D., is a board certified psychiatrist who is familiar with respondent's work. Dr. Harrison opines that respondent is a thoughtful and caring psychiatrist.

Credibility finding

40. Respondent's testimony at hearing was candid and credible.

Prior disciplinary history

41. Effective January 14, 2014, petitioner's Certificate was revoked, the revocation was stayed, and petitioner was placed on probation for seven years, pursuant to a Stipulated Settlement and Disciplinary Order. In addition to standard probation conditions, petitioner was ordered to complete: education courses, a professionalism program (ethics course), a professional boundaries program, and a psychiatric evaluation. Respondent was also ordered to participate in psychotherapy, and to have his practice monitored.

LEGAL CONCLUSIONS

1. Unprofessional conduct is grounds for discipline of a physician's certificate pursuant to Business and Professions Code section 2234. Unprofessional conduct includes

repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)),[8] incompetence (Bus. & Prof. Code, § 2234, subd. (d)), excessive prescribing (Bus. & Prof. Code, § 725, subd. (a)),[9] and the failure to maintain adequate and accurate patient records (Bus. & Prof. Code, § 2266).

First cause for discipline (repeated negligent acts, incompetence, excessive prescribing)

2. The evidence failed to establish that respondent's prescription of Zoloft to Patient A was excessive, or that it constituted negligence or incompetence. (Factual Finding 23.) The evidence did establish that respondent failed to properly document an increase in Patient A's symptoms or decreased functioning to justify an increase in her medication; and that he failed to document that he informed Patient A of the indications for, and risks and benefits of, treating her with high doses of Zoloft, but it was not established that such documentation errors constituted negligence or incompetence. (Factual Finding 26.) The evidence established that respondent committed a single act of negligence by reason of his failure to investigate Patient A's diarrhea in the context of his prescribing high doses of Zoloft to her, but it was not established that his failure to do so constituted incompetence. (Factual Finding 36-37.) Accordingly, it was not demonstrated that respondent committed repeated acts of negligence, or that he was incompetent in his treatment of Patient A. Cause for license discipline does not exist pursuant to Business and Professions Code section 2234, subdivisions (c) or (d).

Second cause for discipline (failure to maintain adequate and accurate patient records)

3. By reason of the matters set forth in Factual Findings 13, 15, 18 and 26, the evidence established that respondent failed to maintain adequate and accurate records in connection with his treatment of Patient A. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2266, in conjunction with Business and Professions Code section 2234, subdivision (a).

Disciplinary determination

4. As cause for discipline has been established, it remains to determine the appropriate level of discipline to impose. At the outset, it is noted that the purpose of these proceedings is to protect the public from dishonest, immoral, disreputable or incompetent practitioners and not to punish the respondent. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Thus, the controlling question is what degree of discipline is necessary to carry out the Board's duty to protect the public?

---

[8] Under the language of the statute, in order to be repeated there must be two or more separate and distinct negligent acts. (Bus. & Prof. Code, § 2234, subd. (c).)

[9] Business and Professions Code, section 725, subdivision (a), prohibits "[r]epeated acts of clearly excessive prescribing . . . drugs."

The Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (Guidelines) recommends, at a minimum, stayed revocation and five years' probation, subject to appropriate terms and conditions, for respondent's failure to maintain adequate and accurate records. The maximum discipline is revocation. At hearing, complainant suggested that a stayed revocation and three years' probation, which deviates somewhat from the Guidelines' minimum penalty, would be sufficient to protect the public. (Respondent's suggestion that the Accusation be dismissed is inapposite to the instant discussion and is therefore not addressed.)

It is determined that a public reprimand, pursuant to Business and Professions Code section 2227, subdivision (a), is the appropriate discipline in the instant case. The facts in the instant case warrant a deviation from the Guidelines for several reasons: First, while respondent's documentation on multiple occasions was woefully inadequate and he was negligent for failing to follow-up on Patient A's complaints regarding her diarrhea, the evidence failed to support the more serious allegations that respondent was repeatedly negligent and incompetent and that he prescribed excessive amounts of Zoloft to Patient A. Second, respondent acknowledged that his documentation was inadequate and inaccurate, and he has taken measures to improve his record keeping to ensure that he will not commit similar errors in the future. To the extent that some of his errors stemmed from his large caseload, his current caseload in private practice is now greatly reduced. Third, respondent is currently on probation until January 2021. Under the terms of probation, his practice will be monitored, and he will complete a variety of other conditions geared to the protection of the public. Against this background, the protection of the public does not warrant the imposition of another probationary term on respondent. In conjunction with his public reprimand, respondent will be required to complete a course in medical record keeping.

ORDER

Respondent Guy Rogers Gullion, M.D., is publicly reprimanded pursuant to Business and Professions Code section 2227, subdivision (a)(4). Respondent shall enroll in a course in medical record keeping, approved by the Board, within 60 days from the effective date of this decision, and shall provide proof of his completion of the course no later than six months after his initial enrollment. This course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licenses.

DATED: October 12, 2017

DocuSigned by:
Diane Schneider
B77FF670BA7A431...

DIANE SCHNEIDER
Administrative Law Judge
Office of Administrative Hearings

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
JOSHUA M. TEMPLET
Deputy Attorney General
State Bar No. 267098
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5529
Facsimile: (415) 703-5480
Attorneys for Complainant

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

In the Matter of the Accusation Against: **Guy Rogers Gullion, M.D.** 120 Pleasant Hill Avenue N., Suite 340 Sebastopol CA 95472 Physician's and Surgeon's Certificate No. A50284, Respondent.	Case No. 800-2014-008007 **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 December 17, 1991, the Board issued Physician's and Surgeon's Certificate Number A50284 to Guy Rogers Gullion, M.D. (Respondent). The certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2017, unless renewed. The certificate has a prior history of discipline by the Board: On July 1, 2013, an Accusation was filed in Case No. 12-2012-226548; in a Decision and Order effective January 10, 2014, Respondent's certificate was revoked, stayed, and he was placed on probation for seven years with terms and conditions.

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 unless otherwise indicated.

4. Section 2004 of the Code provides that the Board shall have the responsibility for the enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

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.
>
> . . . .
>
> (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.
>
> . . . .

7. Section 725, subdivision (a), of the Code states in pertinent part:

> 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 . . . .

8. Section 2266 of the Code provides that the failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of patient services constitutes unprofessional conduct.

BACKGROUND

9. Patient A[1] was a 63-year-old female. Respondent conducted an initial psychiatric evaluation of Patient A on December 21, 2011, after which he began to treat her. Previously Patient A was under the care of another psychiatrist who had diagnosed her with Obsessive Compulsive Disorder (OCD) and Major Depressive Disorder, Recurrent, Severe. Respondent likewise diagnosed Patient A with Obsessive Compulsive Disorder and Major Depressive Disorder, Recurrent, Severe.

10. On January 4, 2012, Respondent began treating Patient A with sertraline[2] with a dosage of 200 mg per day. The recommended starting dosage of sertraline is 50 mg per day. Respondent did not document the reason for his prescribing the higher initial dosage.

11. On February 1, 2012, Respondent recommended increasing Patient A's daily dosage of sertraline by 50 mg for three days and then to increase the dosage by another 50 mg. Respondent did not document the reasons for his recommendations to increase the dosage.

12. In a February 8, 2012 progress note, Respondent reported that Patient A was taking 250 mg of sertraline daily. Respondent reported that the patient was "doing well" with an "okay" mood and full affect. In the same note, Respondent reported that he had increased the dosage to 300 mg. There was no documentation of any symptoms of OCD, and, therefore, no indication for an increased dose. Moreover, Respondent's patient had reached a dose that was about the recommended maximum just five weeks after the starting dose.

---

[1] The patient's name has been abbreviated to protect the patient's privacy. Respondent will have the opportunity to identify the patient and to obtain the records of the investigation during discovery.

[2] Setraline (sold under the brand name of Zoloft) is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors. It is used to treat depression, obsessive-compulsive disorder, panic disorder, anxiety disorders, and post-traumatic stress disorder, among other disorders.

13. On February 15, 2012, Respondent reported that Patient A was "much less depressed" though not focusing well. At the same time, the patient was taking 350 mg of sertraline. One week later, on February 22, 2012, Respondent reported that his patient was "doing great." At the same time, now seven weeks after Patient A had started taking sertraline, Respondent prescribed her 400 mg of sertraline per day. There was no documentation of any symptoms of OCD and no indication why Respondent decided to increase the dose.

14. On February 28, 2012, Patient A saw her primary care physician and reported that her psychiatric medications were "not as helpful at managing her symptoms." She reported having diarrhea a few times per day for a few weeks. Following this, she saw Respondent on March 7, 2012. Respondent noted that she felt "down" and had "explosive diarrhea for two years on and off." Respondent continued the patient's daily dose of 400 mg sertraline.

15. Among the most common side effect of selective serotonin reuptake inhibitors, like sertraline, is gastrointestinal distress. Accordingly, to ensure patient safety and comfort, the treating psychiatrist should assess any gastrointestinal symptom that co-occurs with a patient's use of selective serotonin reuptake inhibitors. Such symptoms can be minimized by starting with low doses and implementing any increase in dosage slowly.

16. Documentation of treatment of Patient A by Respondent and her primary care physician establishes a direct correlation between the increased doses of sertraline prescribed by Respondent and the patient's complaints of gastrointestinal distress. Following Respondent's prescription of 400 mg per day of sertraline to Patient A, she complained of gastrointestinal distress. On February 28, 2012, Patient A reported "diarrhea a couple of times a day for a few weeks" to her primary care physician. She then reported "explosive diarrhea" to Respondent on March 7, 2012. Respondent noted that the primary care physician "is looking for etiology." There is no documentation that Respondent considered a high dose of sertraline as a potential etiology.

17. Patient A again reported her "ongoing severe diarrhea" and the negative impact it was having on her life to Respondent on March 14, 2012. Nonetheless, Respondent continued to prescribe her 400 mg of sertraline per day, including on March 28, 2012 and April 11, 2012. On

May 16, 2012, Patient A had decreased her daily dosage of sertraline to 200 mg and stated that her "stomachache was gone" and that she was feeling "much better, less depressed."

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts, Incompetence, Excessive Prescribing)

18. Respondent's prescription of excessive amounts of sertraline to Patient A as described above constitutes a departure from the standard of care.

19. Respondent began his patient's use of sertraline with a dosage well above the recommended initial dose of 50 mg daily. Thereafter, he did not wait the recommended eight weeks before increasing the dose, but rather rapidly increased it above the manufacturer's recommended maximum dose, to as high as 400 mg daily.

20. Respondent did not document an increase in Patient A's symptoms of OCD or decreased functioning as an effect of the patient's OCD to justify an increase in her medication. From January 11, 2012, when Respondent initially prescribed Patient A 200 mg of sertraline daily, until February 22, 2012, by which time he had increased her dosage to 400 mg of sertraline per day, Respondent did not document any symptoms of his patient's OCD. Further, there is no documentation in any of Respondent's progress notes that he had informed his patient of the indications for treatment, the risks and benefits of treatment, or that he was using a dose that was above the manufacturer- and FDA-recommended maximum dose.

21. Respondent's failure to investigate his patient's co-occurring diarrhea in the context of the high dose of sertraline he was prescribing to her constitutes an additional departure from the standard of care. Respondent did not document any investigation into this possible correlation nor did he document any collaboration with Patient A's primary care physician to discuss the patient's co-occurring diarrhea.

22. Respondent was repeatedly negligent and incompetent in his prescribing to and treatment of Patient A. Respondent's conduct constitutes unprofessional conduct and is cause for discipline pursuant to section 2234, subdivision (a) (violation of Medical Practice Act), subdivision (c) (repeated negligent acts), and subdivision (d) (incompetence).

23. Further, Respondent's repeated excessive prescribing of sertraline to Patient A is cause for discipline pursuant to section 725, subdivision (a) (excessive prescribing).

SECOND CAUSE FOR DISCIPLINE

(Inadequate Records)

24. Respondent's failure to maintain adequate records for Patient A, as described above, constitutes unprofessional conduct and is cause for discipline pursuant to section 2266.

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 A50284, issued to Guy Rogers Gullion, M.D.;

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

3. Ordering Guy Rogers Gullion, 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: March 9, 2017

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

SF2017202416
41692024.doc