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

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against:	
Irwin Ira Rosenfeld, M.D.	**Case No. 800-2015-013696**
Physician's and Surgeon's Certificate No. G 34731	
Respondent	

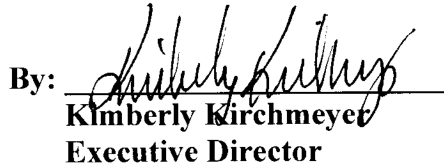
DECISION

The attached Stipulated Surrender of License and Order 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 September 19, 2016.

IT IS SO ORDERED September 9, 2016.

MEDICAL BOARD OF CALIFORNIA

By: 
Kimberly Kirchmeyer
Executive Director

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

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against: IRWIN IRA ROSENFELD, M.D. 23121 Plaza Pointe Drive, #150 Laguna Hills, CA 92653 Physician's and Surgeon's Certificate No. G 34731, Respondent.	Case No. 800 2015 013696 OAH No. 2015121069 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California ("Board"). She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Claudia Ramirez, Deputy Attorney General.

2. Irwin Ira Rosenfeld, M.D. ("Respondent") is represented in this proceeding by attorney David L. Rosner, Esq., whose address is 21781 Ventura Boulevard, Suite 516 Woodland Hills, California 91364.

3. On or about July 1, 1977, the Board issued Physician's and Surgeon's Certificate No.

1 G 34731 to Respondent. That certificate was in full force and effect at all times relevant to the
2 charges brought in First Amended Accusation and Petition to Revoke Probation No. 800 2015
3 013696 and will expire on February 28, 2017, unless renewed.

4 JURISDICTION

5 4. First Amended Accusation and Petition to Revoke Probation No. 800 2015 013696
6 was filed before the Board and is currently pending against Respondent. The First Amended
7 Accusation and Petition to Revoke Probation and all other statutorily required documents were
8 properly served on Respondent on December 21, 2015. Respondent timely filed his Notice of
9 Defense contesting the First Amended Accusation and Petition to Revoke Probation. A copy of
10 First Amended Accusation and Petition to Revoke Probation No. 800 2015 013696 is attached as
11 Exhibit A and incorporated by reference.

12 ADVISEMENT AND WAIVERS

13 5. Respondent has carefully read, fully discussed with counsel, and understands the
14 charges and allegations in First Amended Accusation and Petition to Revoke Probation No. 800
15 2015 013696. Respondent also has carefully read, fully discussed with counsel, and understands
16 the effects of this Stipulated Surrender of License and Order.

17 6. Respondent is fully aware of his legal rights in this matter, including the right to a
18 hearing on the charges and allegations in the First Amended Accusation and Petition to Revoke
19 Probation; the right to be represented by counsel, at his own expense; the right to confront and
20 cross-examine the witnesses against him; the right to present evidence and to testify on his own
21 behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the
22 production of documents; the right to reconsideration and court review of an adverse decision;
23 and all other rights accorded by the California Administrative Procedure Act and other applicable
24 laws.

25 7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and
26 every right set forth above.

27 CULPABILITY

28 8. Respondent understands that the charges and allegations in First Amended

1 Accusation and Petition to Revoke Probation No. 800 2015 013696, if proven at a hearing,
2 constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.
3 9. For the purpose of resolving the First Amended Accusation and Petition to Revoke
4 Probation without the expense and uncertainty of further proceedings, Respondent agrees that, at
5 a hearing, Complainant could establish a factual basis for the charges in the First Amended
6 Accusation and Petition to Revoke Probation and that those charges constitute cause for
7 discipline. Respondent hereby gives up his right to contest that cause for discipline exists based
8 on those charges.
9 10. Respondent understands that by signing this stipulation he enables the Board to issue
10 an order accepting the surrender of his Physician's and Surgeon's Certificate without further
11 process.
12 CONTINGENCY
13 11. This stipulation shall be subject to approval by the Board. Respondent understands
14 and agrees that counsel for Complainant and the staff of the Board may communicate directly
15 with the Board regarding this stipulation and surrender, without notice to or participation by
16 Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he
17 may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board
18 considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order,
19 the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this
20 paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not
21 be disqualified from further action by having considered this matter.
22 12. The parties understand and agree that Portable Document Format (PDF) and facsimile
23 copies of this Stipulated Surrender of License and Order, including Portable Document Format
24 (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.
25 13. In consideration of the foregoing admissions and stipulations, the parties agree that
26 the Board may, without further notice or formal proceeding, issue and enter the following Order:
27 **ORDER**
28 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 34731, issued

1 to Respondent Irwin Ira Rosenfeld, M.D., is surrendered and accepted by the Medical Board of
2 California.
3 1. The surrender of Respondent's Physician's and Surgeon's Certificate and the
4 acceptance of the surrendered license by the Board shall constitute the imposition of discipline
5 against Respondent. This stipulation constitutes a record of the discipline and shall become a part
6 of Respondent's license history with the Medical Board of California.
7 2. Respondent shall lose all rights and privileges as a Physician and Surgeon in
8 California as of the effective date of the Board's Decision and Order.
9 3. Respondent shall cause to be delivered to the Board his wall certificate and, if one
10 was issued, pocket license on or before the effective date of the Decision and Order.
11 4. If Respondent ever files an application for licensure or a petition for reinstatement in
12 the State of California, the Board shall treat it as a petition for reinstatement. Respondent must
13 comply with all the laws, regulations and procedures for reinstatement of a revoked license in
14 effect at the time the petition is filed, and all of the charges and allegations contained in First
15 Amended Accusation and Petition to Revoke Probation No. 800 2015 013696 shall be deemed to
16 be true, correct and admitted by Respondent when the Board determines whether to grant or deny
17 the petition.
18 5. If Respondent should ever apply or reapply for a new license or certification, or
19 petition for reinstatement of a license, by any other health care licensing agency in the State of
20 California, all of the charges and allegations contained in First Amended Accusation and Petition
21 to Revoke Probation No. 800 2015 013696 shall be deemed to be true, correct, and admitted by
22 Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or
23 restrict licensure.
24 ACCEPTANCE
25 I have carefully read the above Stipulated Surrender of License and Order and have fully
26 discussed it with my attorney, David L. Rosner, Esq. I understand the stipulation and the effect it
27 will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of
28 License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the

1 Decision and Order of the Medical Board of California.

2

3 DATED: 6-29-16 [signature]
IRWIN IRA ROSENFELD, M.D.
4 *Respondent*

5 I have read and fully discussed with Respondent Irwin Ira Rosenfeld, M.D. the terms and
6 conditions and other matters contained in this Stipulated Surrender of License and Order. I
7 approve its form and content.

8

9 DATED: June 29, 2016 [signature]
10 DAVID L. ROSNER, ESQ.
Attorney for Respondent

11

12 ENDORSEMENT

13 The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted
14 for consideration by the Medical Board of California of the Department of Consumer Affairs.

15 Dated: July 1, 2016 Respectfully submitted,

16 KAMALA D. HARRIS
Attorney General of California
17 JUDITH T. ALVARADO
Supervising Deputy Attorney General
18

19 [signature]
20 CLAUDIA RAMIREZ
Deputy Attorney General
21 *Attorneys for Complainant*

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Exhibit A

First Amended Accusation and Petition to Revoke Probation No. 800 2015 013696

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Dec 21 20 15
BY D. Richards ANALYST

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Attorneys for Complainant

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

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against: Irwin Ira Rosenfeld, M.D. 23121 Plaza Pointe Drive, #150 Laguna Hills, CA 92653 Physician's and Surgeon's Certificate No. G 34731, Respondent.	Case No. 800-2015-013696 **FIRST AMENDED ACCUSATION AND PETITION TO REVOKE PROBATION**

Complainant alleges:

PARTIES

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

2. On or about July 1, 1977, the Board issued Physician's and Surgeon's Certificate Number G 34731 to Irwin Ira Rosenfeld, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2017, unless renewed.

3. In the Matter of the Accusation Against Irwin Ira Rosenfeld, M.D., Case Number 09-2008-193536, the Board issued a Decision on November 23, 2011, effective December 23, 2011,

in which Respondent was issued a five-year probationary Physician's and Surgeon's Certificate with certain terms and conditions. A copy of the 2011 Decision is attached as Exhibit A and is incorporated by reference.

JURISDICTION

4. This First Amended Accusation and Petition to Revoke Probation 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.

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.

". . ."

7. 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."

8. Section 2238 of the Code states:

"A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

9. Section 2241 of the Code states:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or

prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

"(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

(d)(1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.

10. Section 2241.5 of the Code states:

(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable

pain.

(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

(2) Violates Section 2241 regarding treatment of an addict.

(3) Violates Section 2242 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs.

(4) Violates Section 2242.1 regarding prescribing on the Internet.

(5) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Sec. 801 et seq.), or pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A physician and surgeon shall keep records of his or her purchases and disposals of these controlled substances or dangerous drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall otherwise comply with all state recordkeeping requirements for controlled substances.

(6) Writes false or fictitious prescriptions for controlled substances listed in the California Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

1 (d) A physician and surgeon shall exercise reasonable care in determining whether a
2 particular patient or condition, or the complexity of a patient's treatment, including, but not
3 limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a
4 more qualified specialist.
5 (e) Nothing in this section shall prohibit the governing body of a hospital from taking
6 disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and
7 809.5.
8 11. Section 2242 of the Code states:
9 "(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022
10 without an appropriate prior examination and a medical indication, constitutes unprofessional
11 conduct.
12 "(b) No licensee shall be found to have committed unprofessional conduct within the
13 meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of
14 the following applies:
15 "(1) The licensee was a designated physician and surgeon or podiatrist serving in the
16 absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs
17 were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return
18 of his or her practitioner, but in any case no longer than 72 hours.
19 "(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed
20 vocational nurse in an inpatient facility, and if both of the following conditions exist:
21 "(A) The practitioner had consulted with the registered nurse or licensed vocational nurse
22 who had reviewed the patient's records.
23 "(B) The practitioner was designated as the practitioner to serve in the absence of the
24 patient's physician and surgeon or podiatrist, as the case may be.
25 "(3) The licensee was a designated practitioner serving in the absence of the patient's
26 physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized
27 the patient's records and ordered the renewal of a medically indicated prescription for an amount
28 not exceeding the original prescription in strength or amount or for more than one refill.

1 "(4) The licensee was acting in accordance with Section 120582 of the Health and Safety
2 Code."
3 12. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain
4 adequate and accurate records relating to the provision of services to their patients constitutes
5 unprofessional conduct."
6 13. Health and Safety Code section 11153, subdivision (a) of the Health and Safety Code
7 provides that "[a] prescription for a controlled substance shall only be issued for a legitimate
8 medical purpose by an individual practitioner acting in the usual course of his or her professional
9 practice. The responsibility for the proper prescribing and dispensing of controlled substances is
10 upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist
11 who fills the prescription. Except as authorized by this division, the following are not legal
12 prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course
13 of professional treatment or in legitimate and authorized research; or (2) an order for an addict or
14 habitual user of controlled substances, which is issued not in the course of professional treatment
15 or as part of an authorized narcotic treatment program, for the purpose of providing the user with
16 controlled substances, sufficient to keep him or her comfortable by maintaining customary use."
17 14. Health and Safety Code section 11156 provides:
18 (a) Except as provided in Section 2241 of the Business and Professions Code, no person
19 shall prescribe for, or administer, or dispense a controlled substance to, an addict, or to any person
20 representing himself or herself as such, except as permitted by this division.
21 (b)(1) For purposes of this section, "addict" means a person whose actions are characterized
22 by craving in combination with one or more of the following:
23 (A) Impaired control over drug use.
24 (B) Compulsive use.
25 (C) Continued use despite harm.
26 (2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due
27 to the inadequate control of pain is not an addict within the meaning of this section.
28 15. Health and Safety Code section 11171 provides that "[n]o person shall prescribe,

administer, or furnish a controlled substance except under the conditions and in the manner provided by this division."

16. Health and Safety Code section 11210 provides in pertinent part:

"A physician. . .may prescribe for, furnish to, or administer controlled substances to his or her patient when the patient is suffering from a disease, ailment, injury, or infirmities attendant upon old age, other than addiction to a controlled substance.

"The physician. . .shall prescribe, furnish, or administer controlled substances only when in good faith he or she believes the disease, ailment, injury, or infirmity requires the treatment.

"The physician. . .shall prescribe, furnish, or administer controlled substances only in the quantity and for the length of time as are reasonably necessary."

17. Article 2 of Chapter 5 of Division 10 of the Health and Safety Code provides in pertinent part, as follows:

Article 2

Treatment of Addicts for Addiction

§ 11215.

(a) Except as provided in subdivision (b), any narcotic controlled substance employed in treating an addict for addiction shall be administered by:

(1) A physician and surgeon.

(2) A registered nurse acting under the instruction of a physician and surgeon.

(3) A physician assistant licensed pursuant to Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code acting under the patient-specific authority of his or her physician and surgeon supervisor approved pursuant to Section 3515 of the Business and Professions Code.

(b) When acting under the direction of a physician and surgeon, the following persons may administer a narcotic controlled substance orally in the treatment of an addict for addiction to a controlled substance:

(1) A psychiatric technician licensed pursuant to Chapter 10 (commencing with Section 4500) of Division 2 of the Business and Professions Code.

(2) A vocational nurse licensed pursuant to Chapter 6.5 (commencing with Section 2840) of Division 2 of the Business and Professions Code.

(3) A pharmacist licensed pursuant to Chapter 9 (commencing with Section 4000) of Division 2 of the Business and Professions Code.

(c) Except as permitted in this section, no person shall order, permit, or direct any other person to administer a narcotic controlled substance to a person being treated for addiction to a controlled substance.

§ 11217.

Except as provided in Section 11223, no person shall treat an addict for addiction to a narcotic drug except in one of the following:

(a) An institution approved by the State Department of Health Care Services, and where the patient is at all times kept under restraint and control.

(b) A city or county jail.

(c) A state prison.

(d) A facility designated by a county and approved by the State Department of Health Care Services pursuant to Division 5 (commencing with Section 5000) of the Welfare and Institutions Code.

(e) A state hospital.

(f) A county hospital.

(g) A facility licensed by the State Department of Health Care Services pursuant to Division 10.5 (commencing with Section 11750).

(h) A facility as defined in subdivision (a) or (b) of Section 1250 and Section 1250.3.

A narcotic controlled substance in the continuing treatment of addiction to a controlled substance shall be used only in those programs licensed by the State Department of Health Care Services pursuant to Article 1 (commencing with Section 11839) of Chapter 10 of Part 2 of Division 10.5 on either an inpatient or outpatient basis, or both.

This section does not apply during emergency treatment, or where the patient's addiction is complicated by the presence of incurable disease, serious accident, or injury, or the infirmities of

old age.

Neither this section nor any other provision of this division shall be construed to prohibit the maintenance of a place in which persons seeking to recover from addiction to a controlled substance reside and endeavor to aid one another and receive aid from others in recovering from that addiction, nor does this section or this division prohibit that aid, provided that no person is treated for addiction in a place by means of administering, furnishing, or prescribing of controlled substances. The preceding sentence is declaratory of preexisting law.

Neither this section or any other provision of this division shall be construed to prohibit short-term narcotic detoxification treatment in a controlled setting approved by the director and pursuant to rules and regulations of the director. Facilities and treatment approved by the director under this paragraph shall not be subject to approval or inspection by the Medical Board of California, nor shall persons in those facilities be required to register with, or report the termination of residence with, the police department or sheriff's office.

§ 11217.5

Notwithstanding the provisions of Section 11217, a licensed physician and surgeon may treat an addict for addiction in any office or medical facility which, in the professional judgment of such physician and surgeon, is medically proper for the rehabilitation and treatment of such addict. Such licensed physician and surgeon may administer to an addict, under his direct care, those medications and therapeutic agents which, in the judgment of such physician and surgeon, are medically necessary, provided that nothing in this section shall authorize the administration of any narcotic drug.

§ 11218.

A physician treating an addict for addiction may not prescribe for or furnish to the addict more than any one of the following amounts of controlled substances during each of the first 15 days of that treatment:

(a) Eight grains of opium.

(b) Four grains of morphine.

(c) Six grains of Pantopon.

(d) One grain of Dilaudid.

(e) Four hundred milligrams of isonipecaine (Demerol).

§ 11219.

After 15 days of treatment, the physician may not prescribe for or furnish to the addict more than any one of the following amounts of controlled substances during each day of the treatment:

(a) Four grains of opium.

(b) Two grains of morphine.

(c) Three grains of Pantopon.

(d) One-half grain of Dilaudid.

(e) Two hundred milligrams of isonipecaine (Demerol).

§ 11220.

At the end of 30 days from the first treatment, the prescribing or furnishing of controlled substances, except methadone or LAAM,[1] shall be discontinued.

§ 11222.

In any case in which a person is taken into custody by arrest or other process of law and is lodged in a jail or other place of confinement, and there is reasonable cause to believe that the person is addicted to a controlled substance, it is the duty of the person in charge of the place of confinement to provide the person so confined with medical aid as necessary to ease any symptoms of withdrawal from the use of controlled substances.

In any case in which a person, who is participating in a narcotic treatment program, is incarcerated in a jail or other place of confinement, he or she shall, in the discretion of the director of the program, be entitled to continue in the program until conviction.

§ 11223.

Notwithstanding any other provision of law, a physician and surgeon who is registered with the federal Attorney General pursuant to Section 823(g) of Title 21 of the United States Code may

[1] LAAM (Levomethadyl acetate) works very much like methadone. LAAM and methadone are both synthetic opiates, and when given to opiate-dependent drug users, they both take away feelings of withdrawal and drug cravings.

provide treatment for addiction pursuant to this federal law.

18. Section 823(g) of Title 21 of the United States Code provides:

(g) Practitioners dispensing narcotic drugs for narcotic treatment; annual registration; separate registration; qualifications; waiver

(1) Except as provided in paragraph (2), practitioners who dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment shall obtain annually a separate registration for that purpose. The Attorney General shall register an applicant to dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment (or both)

(A) if the applicant is a practitioner who is determined by the Secretary to be qualified (under standards established by the Secretary) to engage in the treatment with respect to which registration is sought;

(B) if the Attorney General determines that the applicant will comply with standards established by the Attorney General respecting (i) security of stocks of narcotic drugs for such treatment, and (ii) the maintenance of records (in accordance with section 827 of this title) on such drugs; and

(C) if the Secretary determines that the applicant will comply with standards established by the Secretary (after consultation with the Attorney General) respecting the quantities of narcotic drugs which may be provided for unsupervised use by individuals in such treatment.

(2)(A) Subject to subparagraphs (D) and (J), the requirements of paragraph (1) are waived in the case of the dispensing (including the prescribing), by a practitioner, of narcotic drugs in schedule III, IV, or V or combinations of such drugs if the practitioner meets the conditions specified in subparagraph (B) and the narcotic drugs or combinations of such drugs meet the conditions specified in subparagraph (C).

(B) For purposes of subparagraph (A), the conditions specified in this subparagraph with respect to a practitioner are that, before the initial dispensing of narcotic drugs in schedule III, IV, or V or combinations of such drugs to patients for maintenance or detoxification treatment, the practitioner submit to the Secretary a notification of the intent of the practitioner to begin dispensing the drugs or combinations for such purpose, and that the notification contain the

following certifications by the practitioner:

(i) The practitioner is a qualifying physician (as defined in subparagraph (G)).

(ii) With respect to patients to whom the practitioner will provide such drugs or combinations of drugs, the practitioner has the capacity to refer the patients for appropriate counseling and other appropriate ancillary services.

(iii) The total number of such patients of the practitioner at any one time will not exceed the applicable number. For purposes of this clause, the applicable number is 30, unless, not sooner than 1 year after the date on which the practitioner submitted the initial notification, the practitioner submits a second notification to the Secretary of the need and intent of the practitioner to treat up to 100 patients. A second notification under this clause shall contain the certifications required by clauses (i) and (ii) of this subparagraph. The Secretary may by regulation change such total number.

(C) For purposes of subparagraph (A), the conditions specified in this subparagraph with respect to narcotic drugs in schedule III, IV, or V or combinations of such drugs are as follows:

(i) The drugs or combinations of drugs have, under the Federal Food, Drug, and Cosmetic Act [21 U.S.C.A. § 301 et seq.] or section 262 of Title 42, been approved for use in maintenance or detoxification treatment.

(ii) The drugs or combinations of drugs have not been the subject of an adverse determination. For purposes of this clause, an adverse determination is a determination published in the Federal Register and made by the Secretary, after consultation with the Attorney General, that the use of the drugs or combinations of drugs for maintenance or detoxification treatment requires additional standards respecting the qualifications of practitioners to provide such treatment, or requires standards respecting the quantities of the drugs that may be provided for unsupervised use.

(D)(i) A waiver under subparagraph (A) with respect to a practitioner is not in effect unless (in addition to conditions under subparagraphs (B) and (C)) the following conditions are met:

(I) The notification under subparagraph (B) is in writing and states the name of the practitioner.

(II) The notification identifies the registration issued for the practitioner pursuant to subsection (f) of this section.

(III) If the practitioner is a member of a group practice, the notification states the names of the other practitioners in the practice and identifies the registrations issued for the other practitioners pursuant to subsection (f) of this section.

(ii) Upon receiving a notification under subparagraph (B), the Attorney General shall assign the practitioner involved an identification number under this paragraph for inclusion with the registration issued for the practitioner pursuant to subsection (f) of this section. The identification number so assigned shall be appropriate to preserve the confidentiality of patients for whom the practitioner has dispensed narcotic drugs under a waiver under subparagraph (A).

(iii) Not later than 45 days after the date on which the Secretary receives a notification under subparagraph (B), the Secretary shall make a determination of whether the practitioner involved meets all requirements for a waiver under subparagraph (B). If the Secretary fails to make such determination by the end of the such 45-day period, the Attorney General shall assign the physician an identification number described in clause (ii) at the end of such period.

(E)(i) If a practitioner is not registered under paragraph (1) and, in violation of the conditions specified in subparagraphs (B) through (D), dispenses narcotic drugs in schedule III, IV, or V or combinations of such drugs for maintenance treatment or detoxification treatment, the Attorney General may, for purposes of section 824(a)(4) of this title, consider the practitioner to have committed an act that renders the registration of the practitioner pursuant to subsection (f) of this section to be inconsistent with the public interest.

(ii)(I) Upon the expiration of 45 days from the date on which the Secretary receives a notification under subparagraph (B), a practitioner who in good faith submits a notification under subparagraph (B) and reasonably believes that the conditions specified in subparagraphs (B) through (D) have been met shall, in dispensing narcotic drugs in schedule III, IV, or V or combinations of such drugs for maintenance treatment or detoxification treatment, be considered to have a waiver under subparagraph (A) until notified otherwise by the Secretary, except that such a practitioner may commence to prescribe or dispense such narcotic drugs for such purposes

prior to the expiration of such 45-day period if it facilitates the treatment of an individual patient and both the Secretary and the Attorney General are notified by the practitioner of the intent to commence prescribing or dispensing such narcotic drugs.

(II) For purposes of subclause (I), the publication in the Federal Register of an adverse determination by the Secretary pursuant to subparagraph (C)(ii) shall (with respect to the narcotic drug or combination involved) be considered to be a notification provided by the Secretary to practitioners, effective upon the expiration of the 30-day period beginning on the date on which the adverse determination is so published.

(F)(i) With respect to the dispensing of narcotic drugs in schedule III, IV, or V or combinations of such drugs to patients for maintenance or detoxification treatment, a practitioner may, in his or her discretion, dispense such drugs or combinations for such treatment under a registration under paragraph (1) or a waiver under subparagraph (A) (subject to meeting the applicable conditions).

(ii) This paragraph may not be construed as having any legal effect on the conditions for obtaining a registration under paragraph (1), including with respect to the number of patients who may be served under such a registration.

(G) For purposes of this paragraph:

(i) The term "group practice" has the meaning given such term in section 1395nn(h)(4) of Title 42.

(ii) The term "qualifying physician" means a physician who is licensed under State law and who meets one or more of the following conditions:

(I) The physician holds a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties.

(II) The physician holds an addiction certification from the American Society of Addiction Medicine.

(III) The physician holds a subspecialty board certification in addiction medicine from the American Osteopathic Association.

(IV) The physician has, with respect to the treatment and management of opiate-dependent

patients, completed not less than eight hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that is provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or any other organization that the Secretary determines is appropriate for purposes of this subclause.

(V) The physician has participated as an investigator in one or more clinical trials leading to the approval of a narcotic drug in schedule III, IV, or V for maintenance or detoxification treatment, as demonstrated by a statement submitted to the Secretary by the sponsor of such approved drug.

(VI) The physician has such other training or experience as the State medical licensing board (of the State in which the physician will provide maintenance or detoxification treatment) considers to demonstrate the ability of the physician to treat and manage opiate-dependent patients.

(VII) The physician has such other training or experience as the Secretary considers to demonstrate the ability of the physician to treat and manage opiate-dependent patients. Any criteria of the Secretary under this subclause shall be established by regulation. Any such criteria are effective only for 3 years after the date on which the criteria are promulgated, but may be extended for such additional discrete 3-year periods as the Secretary considers appropriate for purposes of this subclause. Such an extension of criteria may only be effectuated through a statement published in the Federal Register by the Secretary during the 30-day period preceding the end of the 3-year period involved.

(H)(i) In consultation with the Administrator of the Drug Enforcement Administration, the Administrator of the Substance Abuse and Mental Health Services Administration, the Director of the National Institute on Drug Abuse, and the Commissioner of Food and Drugs, the Secretary shall issue regulations (through notice and comment rulemaking) or issue practice guidelines to address the following:

(I) Approval of additional credentialing bodies and the responsibilities of additional

credentialing bodies.

(II) Additional exemptions from the requirements of this paragraph and any regulations under this paragraph.

Nothing in such regulations or practice guidelines may authorize any Federal official or employee to exercise supervision or control over the practice of medicine or the manner in which medical services are provided.

(ii) Not later than 120 days after October 17, 2000, the Secretary shall issue a treatment improvement protocol containing best practice guidelines for the treatment and maintenance of opiate-dependent patients. The Secretary shall develop the protocol in consultation with the Director of the National Institute on Drug Abuse, the Administrator of the Drug Enforcement Administration, the Commissioner of Food and Drugs, the Administrator of the Substance Abuse and Mental Health Services Administration and other substance abuse disorder professionals. The protocol shall be guided by science.

(I) During the 3-year period beginning on the date of approval by the Food and Drug Administration of a drug in schedule III, IV, or V, a State may not preclude a practitioner from dispensing or prescribing such drug, or combination of such drugs, to patients for maintenance or detoxification treatment in accordance with this paragraph unless, before the expiration of that 3-year period, the State enacts a law prohibiting a practitioner from dispensing such drugs or combinations of drug.

(J)(i) This paragraph takes effect on the date referred to in subparagraph (I), and remains in effect thereafter.

(ii) For purposes relating to clause (iii), the Secretary and the Attorney General may, during the 3-year period beginning on December 29, 2006, make determinations in accordance with the following:

(I) The Secretary may make a determination of whether treatments provided under waivers under subparagraph (A) have been effective forms of maintenance treatment and detoxification treatment in clinical settings; may make a determination of whether such waivers have significantly increased (relative to the beginning of such period) the availability of maintenance

treatment and detoxification treatment; and may make a determination of whether such waivers have adverse consequences for the public health.

(II) The Attorney General may make a determination of the extent to which there have been violations of the numerical limitations established under subparagraph (B) for the number of individuals to whom a practitioner may provide treatment; may make a determination of whether waivers under subparagraph (A) have increased (relative to the beginning of such period) the extent to which narcotic drugs in schedule III, IV, or V or combinations of such drugs are being dispensed or possessed in violation of this chapter; and may make a determination of whether such waivers have adverse consequences for the public health.

(iii) If, before the expiration of the period specified in clause (ii), the Secretary or the Attorney General publishes in the Federal Register a decision, made on the basis of determinations under such clause, that subparagraph (B)(iii) should be applied by limiting the total number of patients a practitioner may treat to 30, then the provisions in such subparagraph (B)(iii) permitting more than 30 patients shall not apply, effective 60 days after the date on which the decision is so published. The Secretary shall in making any such decision consult with the Attorney General, and shall in publishing the decision in the Federal Register include any comments received from the Attorney General for inclusion in the publication. The Attorney General shall in making any such decision consult with the Secretary, and shall in publishing the decision in the Federal Register include any comments received from the Secretary for inclusion in the publication.

19. Health and Safety Code section 123110, subdivisions (a) and (b) states, among other things, that a patient "shall be entitled to inspect patient records upon presenting to the health care provider a written request for those records and upon payment of reasonable clerical costs incurred in locating and making the records available" and that a patient "shall be entitled to copies of all or any portion of the patient records that he or she has a right to inspect, upon presenting a written request to the health care provider specifying the records to be copied, together with a fee to defray the cost of copying, that shall not exceed twenty-five cents ($0.25) per page or fifty cents ($0.50) per page for records that are copied from microfilm and any

additional reasonable clerical costs incurred in making the records available." The records must be transmitted within 15 days of receiving the request.

20. Health and Safety Code section 123110, subdivision (i) provides that "[a]ny health care provider described in paragraphs (4) to (10), inclusive, of subdivision (a) of Section 123105 who willfully violates this chapter is guilty of unprofessional conduct. . . . The state agency, board, or commission that issued the health care provider's professional or institutional license shall consider a violation as grounds for disciplinary action with respect to the licensure, including suspension or revocation of the license or certificate."

21. Welfare and Institutions Code section 15630, subdivision (a) provides: "Any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter."

22. Welfare and Institutions Code section 15630, subdivision (b)(1) provides: "Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, as defined in Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he or she has experienced behavior, including an act or omission, constituting physical abuse, as defined in Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse by telephone or through a confidential Internet reporting tool, as authorized by Section 15658, immediately or as soon as practicably possible. If reported by telephone, a written report shall be sent, or an Internet report shall be made through the confidential Internet reporting tool established in Section 15658, within two working days."

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PERTINENT DRUGS

23. The following drugs are classified as follows:

A. **Adderall** contains a combination of amphetamine and dextroamphetamine. Amphetamine and dextroamphetamine are central nervous system (nerves and brain) ("CNS") stimulants that affect chemicals in the brain and nerves that contribute to hyperactivity and impulse control. Adderall is a Schedule II controlled substance as defined by section 1308.12(d)(1) of Title 21 of the Code of Federal Regulations and Health and Safety Code section 11055, subdivision (d)(1). It is a dangerous drug as defined in Business and Professions Code section 4022.

B. **Amphetamine** is a stimulant and appetite suppressant. Amphetamine is used to treat narcolepsy and Attention Deficit Hyperactivity Disorder ("ADHD"). It is classified as a Schedule II controlled substance as defined by section 1308.12(d)(1) of Title 21 of the Code of Federal Regulations and Health and Safety Code section 11055, subdivision (d)(1). It is a dangerous drug as defined in Business and Professions Code section 4022.

C. **Benzodiazepines** are a class of drugs that produce CNS depression and are most commonly used to treat insomnia and anxiety. Examples of benzodiazepines include **alprazolam** (e.g., Xanax), **lorazepam** (e.g., Ativan), **clonazapem** (e.g., Klonopin), **diazepam** (e.g., Valium), **temazepam** (e.g., Restoril), **clorazepate** (Tranxene), **nordazepam** (e.g., Nordaz), and **oxazepam** (e.g., Serax). They are classified as Schedule IV controlled substances as defined by section 1308.14(c) of Title 21 of the Code of Federal Regulations and Health and Safety Code section 11057, subdivision (d). They are dangerous drugs as defined in Business and Professions Code section 4022.

D. **Buprenorphine** (Suboxone) is an opioid.[2] It is used for treatment of pain or opioid dependence. It is a Schedule III controlled substance as defined by section 1308.13(e)(2)(i) of

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[2] Opiates are a group of drugs that are used for treating pain. They are derived from opium which comes from the poppy plant. Opiates go by a variety of names including opiates, opioids, and narcotics. The term opiates is sometimes used for close relatives of opium such as codeine, morphine and heroin, while the term opioids is used for the entire class of drugs including synthetic opiates such as Oxycontin. But the most commonly used term is opiates.

Title 21 of the Code of Federal Regulations. It is a Schedule V controlled substance as defined by Health and Safety Code section 11058, subdivision (d). It is a dangerous drug as defined in Business and Professions Code section 4022.

E. **Cannabinoid** is a chemical compound in cannabis or marijuana. Tetrahydrocannabinol ("THC") is a cannabinoid. It is found in dronabinol (Marinol) and nabilone (Cesamet), which are synthetic medicines for nausea and vomiting. Tetrahydrocannabinol is a Schedule I controlled substance as defined by section 1308.11(d)(31) of Title 21 of the Code of Federal Regulations and Health and Safety Code section 11054, subdivision (d)(20). It is a dangerous drug as defined in Business and Professions Code section 4022.

F. **Chloral hydrate** is a sedative. It is a Schedule IV controlled substance as defined by section 1308.14(c)(8) of Title 21 of the Code of Federal Regulations and Health and Safety Code section 11057, subdivision (d)(4). It is a dangerous drug as defined in Business and Professions Code section 4022.

G. **Dronabinol** (Marinol) is a man-made form of the active natural substance in marijuana. It is used to treat anorexia associated with weight loss in patients with AIDS and nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional antiemetic treatments. It is classified as a Schedule III controlled substance as defined by section 1308.13(g)(1) of Title 21 of the Code of Federal Regulations and Health and Safety Code section 11056, subdivision (h). It is a dangerous drug as defined in Business and Professions Code section 4022.

H. **Lisdexamfetamine** (Vyvanse) is a stimulant. It is classified as a Schedule II controlled substance as defined by section 1308.12(d)(5) of Title 21 of the Code of Federal Regulations. It is a dangerous drug as defined in Business and Professions Code section 4022.

I. **Meprobamate** (Miltown) is in a class of medications called tranquilizers. It is used to treat anxiety disorders or for short-term relief of the symptoms of anxiety. It is a Schedule IV controlled substance as defined by section 1308.14(c)(34) of Title 21 of the Code of Federal Regulations and Health and Safety Code section 11057, subdivision (d)(18). It is a dangerous drug as defined in Business and Professions Code section 4022.

J. **MS-Contin** is an extended release formulation of morphine for chronic pain. **Morphine** is a Schedule II controlled substance as defined by section 1308.12(b)(1)(ix) of Title 21 of the Code of Federal Regulations and Health and Safety Code section 11055, subdivision (b)(1)(L). It is a dangerous drug as defined in Business and Professions Code section 4022.

K. **Oxycodone** (OxyContin) is an opioid pain medication. It is a Schedule II controlled substance as defined by section 1308.12(b)(1)(xiii) of Title 21 of the Code of Federal Regulations and Health and Safety Code section 11055, subdivision (b)(1)(M). It is a dangerous drug as defined in Business and Professions Code section 4022.

L. **Soma** is a trade name for **Carisoprodol** tablets. Carisoprodol is a muscle-relaxant and sedative. Effective January 11, 2012, Carisoprodol is classified as a Schedule IV controlled substance as defined by section 1308.14(c)(6) of Title 21 of the Code of Federal Regulations. It is a dangerous drug as defined in Business and Professions Code section 4022.

M. **Tapentadol** (Nucynta) is an opioid pain medication. It is a Schedule II controlled substance as defined by section 1308.12(c)(28) of Title 21 of the Code of Federal Regulations. It is a dangerous drug as defined in Business and Professions Code section 4022.

N. **Tramadol** (Ultram) is a narcotic-like pain reliever. It is a Schedule IV controlled substance as defined by section 1308.14(b)(3) of Title 21 of the Code of Federal Regulations. It is a dangerous drug as defined in Business and Professions Code section 4022.

O. **Zolpidem** (Ambien) is a sedative. It is a Schedule IV controlled substance as defined by section 1308.14(c)(54) of Title 21 of the Code of Federal Regulations and Health and Safety Code section 11057, subdivision (c)(32). It is a dangerous drug as defined in Business and Professions Code section 4022.

CAUSES FOR DISCIPLINE

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence-Patients B.C., N.B., P.R., S.N., M.P.)

24. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code in that he was grossly negligent in the care and treatment of patients B.C., N.B., P.R., S.N.,

and M.P.[3] The circumstances are as follows:

Patient B.C.

25. Patient B.C. was eighty-six years old and suffered from advanced dementia, possibly of the Lewy Body type. He had a valid Advanced Health Care Directive dated February 24, 2011. His daughter, Ms. D.C., was the designated agent. His son, Mr. B.C., was the designated alternate agent in case Patient B.C. revoked his daughter's authority or if his daughter was not willing, able, or reasonably available to make health care decisions for him. The Advanced Health Care Directive gave Patient B.C.'s children authority to make medical decisions on his behalf. It also gave them authority to receive or consent to the release of medical information and records.

26. On or about December 2012, Patient B.C.'s daughter hired two caregivers from Craigslist to care for her father: Mr. R.B. and Ms. R.S. At the time, Patient B.C. was rehabilitating from a fractured femur. He also had hypertension.

27. Unbeknownst to Ms. D.C., on February 25, 2013, Patient B.C. signed a health care power of attorney giving the caregivers Mr. R.B. and Ms. R.S. (relative strangers) the authority to make medical decisions on his behalf. He also signed a power of attorney giving Mr. R.B. the authority to make financial decisions on his behalf.

28. On March 5, 2013, Mr. R.B. took Patient B.C. to see Respondent, a geriatric psychiatrist, for a psychiatric evaluation to determine Patient B.C.'s "ability to make a free decision." Mr. R.B. took him to see Respondent without the knowledge or consent of Ms. D.C. Patient B.C. already had a regular psychiatrist. According to Respondent, ". . . [Respondent] was asked specifically about Patient B.C.'s medical care, and [Patient B.C.] said his daughter was very mean to him, and she had the Power of Attorney, and [Patient B.C.] didn't want [her] to have that because she was not very nice."

29. Respondent evaluated Patient B.C. and conducted a mental status examination. However, Respondent's assessment of Patient B.C.'s ability to make medical decisions or to enter into contracts was extremely superficial. In addition, Respondent performed nearly no inquiry

[3] The initials of patients' names are used to protect their right of privacy.

into Patient B.C.'s mental capacity to enter into the extensive financial contract with Mr. R.B. Patient B.C.'s mental capacity was diminished. For example, Patient B.C. did not know the year. He did not know the correct day of the week. He was not able to remember anything new after a few minutes. This should have suggested to Respondent that Patient B.C. may not have been mentally competent to revoke the prior power of attorney for health care or to make the financial power of attorney. Nevertheless, Respondent concluded that Patient B.C. was mentally competent to make medical decisions.

30. Respondent's inquiry into the validity of the health care and financial powers of attorney to Mr. R.B. was minimal, while at the same time he was presented with significant evidence of moderately severe dementia in Patient B.C. and impaired decision-making ability. He did not inquire whether a valid revocation was reported to Ms. D.C. Respondent did not notify Ms. D.C. that her father was brought to him for treatment.

31. Respondent should have had a reasonable suspicion that Patient B.C. was unaware of the terms of the financial power of attorney and should have done a more thorough psychiatric evaluation regarding Patient B.C.'s knowledge of his finances and his wish to allow full access to all his finances to Mr. R.B. Respondent should have had reasonable suspicion of impending or on-going financial abuse by Mr. R.B. and should have filed a report with Adult Protection. Respondent is a mandated reporter of elder abuse.

32. Respondent did not ask Patient B.C. about a prior existing durable power for health care, what the terms were and whether he understood the terms, how his disorder affected his functioning, what he knew about his financial assets, what he understood his medical condition to be, what the terms of the financial power of attorney he had entered into were, or even if he had an attorney to advise him. If Respondent had inquired adequately about the terms of the power of attorney, and found that Patient B.C. did not understand them, he should have contacted Adult Protection regarding suspected fraud by Mr. R.B. or abuse by Ms. D.C.

33. Respondent wrote in his progress note that Patient B.C. had two sons. He did not ask Patient B.C. why his sons were not nominated as the financial or health care agent, if Patient B.C. was dissatisfied with his daughter. Respondent does not state that he made any effort to contact

Ms. D.C. or either of Patient B.C.'s sons.

34. Respondent should have asked Mr. R.B. for authorization to contact Patient B.C.'s daughter or sons. If Mr. R.B. refused permission, Respondent should have reported suspected elder abuse by Mr. R.B. to Adult Protection. Similarly, if Ms. D.C. was allegedly abusive to her father, he should have reported her to Adult Protection.

35. Respondent did not ask Patient B.C. why he was not going to his regular psychiatrist. Respondent claims that he called Patient B.C.'s psychiatrist and primary care physician, but it is not documented in Patient B.C.'s medical records. There is no documentation showing that he requested records from those providers.

36. After the evaluation, at the request of Mr. R.B., Respondent prepared a letter dated March 19, 2013 and directed generally "To Whom It May Concern." The letter contained confidential health care information on Patient B.C. Respondent indicated that Patient B.C. possessed the capacity to make a decision about his caregiving and wished to have Mr. R.B. be his caregiver. He stated that it appeared to him that Patient B.C. understood the purpose of the power of attorney and that he wanted Mr. R.B. to be his power of attorney. He indicated that Patient B.C. verified that he did not get along with his daughter and that she was verbally abusive to him.

37. Respondent did not place any limits on the use of the letter. Respondent signed the letter indicating that he was a Board Certified Geriatric Psychiatrist. Respondent provided the letter to Mr. R.B.

38. There is no indication in Patient B.C.'s medical records that between the March 5, 2013, office visit and date of the letter, Respondent conducted further investigation into Patient B.C.'s mental state or medical condition. Respondent did not inquire about the reason for the letter he prepared for Mr. R.B. There is no written release for information to be published to the world at large. Respondent failed to protect Patient B.C.'s right of privacy when he provided the letter to Mr. R.B. to be used without limitation.

39. The caretakers subsequently withdrew $5,000 from Patient B.C.'s savings account.

40. On April 1, 2013, Ms. D.C. went to Respondent's office and requested copies of her

father's medical records. She completed an Authorization for Use and Disclosure of Personal and Health Information. She provided the Advanced Health Care Directive dated February 24, 2011. She was told it was not applicable to medical records and was not given copies of her father's medical records.

41. The next day, Ms. D.C. went back to Respondent's office with her father. Patient B.C. signed an Authorization for Use and Disclosure of Personal and Health Information authorizing release of his medical records to himself and his daughter. Respondent did not provide the records, either in person or by mail, to either Patient B.C. or his daughter.

42. In sum, Respondent was grossly negligent when (1) he conducted an inadequate psychiatric evaluation of Patient B.C.; (2) he conducted an inadequate inquiry into the validity of the financial or health care powers of attorney in favor of Mr. R.B.; (3) he failed to report suspected elder abuse by Mr. R.B. and/or Ms. D.C. to Adult Protection; (4) he failed to protect Patient B.C.'s right of privacy when he provided a letter to Mr. R.B. containing Patient B.C.'s confidential health information to be used without limitation; and (5) he failed to provide Patient B.C.'s medical records to either Patient B.C. or his daughter in response to their request for the records and despite a valid consent.

Patient N.B.

43. Patient N.B. was a twenty-nine year old male who died on December 31, 2012, from multiple drug toxicities. Respondent was a Board Certified Addiction Psychiatrist from March 31, 1993 through December 31, 2003 and April 27, 2004 through December 23, 2011. Respondent treated Patient N.B. from approximately June 2003 until the date of his death. Of particular relevance are Respondent's diagnoses of disorders that he believed would be appropriately treated with abusable controlled substances. These disorders include alleged Panic Disorder, ADHD, musculoskeletal pain, Generalized Anxiety Disorder, and the variety of substance misuse disorders.

44. As early as approximately 2003, Respondent knew that Patient N.B. abused drugs, abused alcohol, and distributed amphetamines illegally. In approximately 2007, Respondent knew that Patient N.B. was noncompliant with treatment, including prescription medications.

45. From approximately 2003 to approximately 2008, Respondent prescribed various medications to Patient N.B., including Gabitril, Adderall, Zoloft, Trileptal, Vistaril, Seroquel, Lexapro, clonazepam 2 mg #120, Ambien CR 12.5 mg, Robaxin 750 mg #120, and temazepam 15 mg #30.[4]

46. On March 13, 2009, Patient N.B. told Respondent he wanted Vyvanse instead of Adderall.

47. On April 17, 2009, Respondent prescribed Tranxene 7.5 mg b.i.d.[5] #14.

48. On May 11, 2009, Respondent prescribed meprobamate and Tranxene 15 mg for b.i.d. use. Respondent's flow sheet for medications only records a prescription for Tranxene 15 mg b.i.d.

49. On May 28, 2009, Respondent noted that Patient N.B. was taking Xanax illegally and prescribed Xanax 2 mg for q.i.d.[6] dosing.

50. On June 8, 2009, Respondent suggested that Patient N.B. take 60 mg q.i.d. of clorazepate.

51. On June 11, 2009, Respondent prescribed Klonopin 4 mg #240 and clorazepate 15 mg #240.

52. On July 27, 2009, Patient N.B.'s mother called Respondent and told him that Patient N.B. was acting crazy and was over-medicated.

53. On July 28, 2009, Respondent prescribed Valium 10 mg #180; clorazepate 15 mg #240; Klonopin 2 mg #360; Meprobamate 400 mg #60; and Seroquel 300 mg #90.

54. On August 26, 2009, Respondent prescribed clorazepate 15 mg #360, Valium 10 mg #180, and meprobamate 400 mg (no amount was noted except for 2000 mg per day).

55. On September 16, 2009, Patient N.B. reported he was taking thirty pills of various benzodiazepines per night to counter the Vyvanse. This was 150 mg per night of clorazepate, 100

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[4] Gabitril and Trileptal are anti-epileptic medications. Zoloft and Lexapro are anti-depressants. Vistaril reduces activity in the CNS. It also acts as an antihistamine that reduces the natural chemical histamine in the body. Seroquel (quetiapine) is an antipsychotic medicine. Robaxin (methocarbamol) is a muscle relaxant.

[5] b.i.d. means twice per day.

[6] q.i.d. means four times per day.

mg of Valium, and 20 mg of Klonopin.

56. On October 5, 2009, Patient N.B. was evaluated by Dr. S.S. on referral from Respondent for consultation on psychopharmacology.[7] Dr. S.S. noted that stimulants had not been particularly effective in the past for Patient N.B. Dr. S.S. noted serious substance abuse problems with Patient N.B. Dr. S.S. reported "In retrospect, it appears that this patient had a diagnosis of ADHD since the 2nd grade and was on stimulants throughout high school which did not work particularly well. He also complained of terrible social anxiety throughout grade school and high school, began to smoke marijuana and drank alcohol in high school and actually was diagnosed as bipolar in high school and even went to rehab as a senior in high school for his drug abuse. Over the years he has had problems with depression and paranoia and has more recently been diagnosed as unipolar depression and has had serious substance abuse requiring numerous rehabs over time. Current Medications: Klonopin 8 mg 4 times per day; clorazapate (sic) 45 mg four times per day; valium 60 mg at night; hydroxyzine 400 mg at night; Robaxin 1500 mg three times per day; Relafen 1500 mg twice per day; Vyvanse 280 mg per day; Meprobamate 2000 mg at night; Klonopin 1 mg at night; Invega 18 mg per day; Seroquel 900 mg per day and Pristiq 100 mg per day. In addition the patient also smokes medical marijuana which is prescribed to him by a physician for insomnia. He also drinks intermittently but he denies getting intoxicated."

57. Dr. S.S. noted Patient N.B.'s tolerance for the "heroic" doses of sedative hypnotics, and diagnosed Patient N.B. with sedative hypnotic dependence. Dr. S.S. suggested getting plasma levels of medications to see if malabsorption was an issue. If it was not an issue, Dr. S.S. recommended inpatient detoxification. Dr. S.S. stated that Patient N.B. was on dangerous levels of medications.

58. On October 14, 2009, Respondent sent Patient N.B.'s blood to a laboratory for genetic and metabolism analysis. The laboratory results did not provide any evidence of malabsorption of medication. The laboratory studies showed that Patient N.B. did not have any biological reason to need massive doses, other than tolerance as part of physical dependence.

[7] Psychopharmacology is the scientific study of the effects drugs have on mood, sensation, thinking, and behavior.

59. Genetically, Patient N.B. was identified as a poor metabolizer for CYP2D6 and an extensive metabolizer for CYP2Cl9. Respondent's handwritten note shows that he believed Vyvanse was a prodrug that the lab results indicated Patient N.B. would require a higher dose. This is inaccurate. Vyvanse is not dependent on the CYP2C19 system for activation. Excessive doses of Vyvanse were not justified by Patient N.B.'s genetics. Patient N.B.'s extensive metabolism in his CYP2C19 system did not justify ultra-high doses of any of the prescribed medications.

60. There is no documentation in Respondent's medical records on Patient N.B. that Respondent and Dr. S.S. discussed the laboratory studies. Respondent did not institute any of Dr. S.S.'s recommendations, other than performing the laboratory studies. Respondent did not take any steps to address Patient N.B.'s substance dependence and abuse following the consultation.

61. A memo dated October 11, 2009 indicated that Patient N.B. was in a car accident and wanted Vicodin.[8] Respondent noted that he does not prescribe narcotics.

62. In December 2009, Patient N.B. was taken to St. Joseph Hospital Emergency Room for sedative intoxication.

63. On January 6, 2010, Respondent prescribed Tramadol because Patient N.B. was taking extra Soma. It appears Respondent was prescribing eight Soma 350 mg per day.

64. A note dated March 17, 2010 indicated that Respondent was aware of Dr. A.Z. prescribing opiates to Patient N.B.

65. On March 18, 2010, Patient N.B.'s parents reported to Respondent that Patient N.B. was drugged and had a drawer full of pills.

66. On May 13, 2010, Respondent was notified by Express Scripts that Patient N.B. received oxymorphone[9] 20 mg from Dr. A.Z. on Apri1 15, 2010.

67. A note dated June 9, 2010 indicated that Respondent was aware of Patient N.B. using alcohol to excess. Respondent told Patient N.B. not to drink alcohol.

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[8] Vicodin contains a combination of acetaminophen and hydrocodone. Both medicines are pain killers.

[9] Oxymorphone is an opioid pain medication.

68. On June 11, 2010, Patient N.B. was seen at AHMC-Anaheim Regional Medical Center. Patient N.B. complained of back pain. He requested pain medication. He was reported to be taking Fentanyl patches, Klonopin, Chloral hydrate, Seroquel, Invega, Pristiq, and Soma.[10] Patient N.B. was seen again with the same complaint on June 16, 2010.

69. On June 15, 2010, Respondent had a telephone call with Dr. A.Z. about pain medications. Respondent said that he does not prescribe for Patient N.B.'s pain.

70. In June 2010, Patient N.B. received fentanyl patches from Dr. A.Z. and Dr. J.P, Dilaudid[11] from Dr. J.P, and oxycodone from his emergency room visits.

71. Patient N.B. had a brief hospital stay in August 2010 following a dog bite. He reported his medications at that time as Klonopin, morphine sulfate extended release (MS Contin), Seroquel, Invega, Pristiq, Vyvanse, Robaxin, Dilaudid, and Soma. There was no description of dog teeth marks, so the cellulitis and abscess may have been from injection drug use.

72. On October 1, 2010, Respondent prescribed Ativan 2 mg #180 and Klonopin 2 mg #120.

73. A patient profile for Patient N.B. in Respondent's records indicated that Dr. J.P was prescribing significant amounts of opioids to Patient N.B.

74. On January 11, 2011, Respondent prescribed Xanax 2 mg #600 and choral hydrate four pints.

75. On June 22, 2011, Respondent prescribed Soma 350 mg #900.

76. On June 27, 2011, Respondent prescribed Xanax 2 mg #720 and Vyvanse 70 mg #270. He wrote that Patient N.B. had a high tolerance and was a rapid metabolizer.

77. Respondent wrote a prescription dated October 6, 2011 for Xanax 2 mg #540, temazepam 30 mg #180, and Vyvanse 70 mg #270.

78. Respondent wrote a note dated December 9, 2011 which states "He's on a ton of

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[10] Fentanyl patch is a narcotic (opioid) pain medicine. Invega (paliperidone) is an antipsychotic medicine. Pristiq (desvenlafaxine) is an antidepressant.

[11] Dilaudid (hydromorphone) is an opioid pain medication.

narcotics; [Patient N.B.] wants to come off them; if misses a pill, he gets ill." Patient N.B. reported that Dr. J.P refuses to stop prescribing the narcotics. Respondent noted prescriptions for oxycodone, Nucynta, and MS-Contin.

79. On December 10, 2010, Respondent sketched out a plan for withdrawal from opioids. It appears the plan was to reduce the Oxycontin first.

80. On December 20, 2011, Respondent prescribed Nucynta 50 mg #120 and Nucynta 25 mg #120.

81. On December 29, 2011, Respondent prescribed Soma 350 mg #720.

82. On January 31, 2012, Respondent prescribed meprobamate 400 mg #540; oxycodone 15 mg #120; MS-Contin 60 mg #120; and MS-Contin 30 mg #120. Respondent reported in his notes that he was continuing to do an outpatient opioid withdrawal.

83. On March 8, 2012, Respondent prescribed Xanax 2 mg #540. The instruction was to take 3 mg four times per day.

84. On March 26, 2012, Respondent prescribed MS-Contin 15 mg #120 and Soma 350 mg #720.

85. On April 2, 2012, Respondent prescribed Vyvanse 70 mg #270.

86. Respondent wrote a note dated April 17, 2012 indicating that he spoke with Patient N.B. on the telephone and Patient N.B. hoped to be off all opiates in the next two weeks. Respondent prescribed Suboxone.

87. On April 25, 2012, Respondent prescribed meprobamate 400 mg #270.

88. On May 25, 2012, Respondent prescribed Xanax 2 mg #360; Soma 350 mg #720; and Marinol 10 mg #540 (90 day supplies).

89. On June 1, 2012, Respondent prescribed Dronabinol 10 mg #540.

90. On July 10, 2012, Respondent prescribed Vyvanse 70 mg #270 (90 day supply) with instructions to take three in the morning.

91. On August 13, 2012, Respondent prescribed Xanax 2 mg #360, Soma 350 mg #720 and Marinol 60 mg #540 (90 day supplies).

92. On October 24, 2012, Respondent prescribed Vyvanse 70 mg #270 (90 day supply)

with instructions to take three in the morning. In the last progress note, dated November 14, 2012, Respondent wrote that Patient N.B. was only taking Soma and Robaxin.

93. On November 14, 2012, Respondent prescribed Soma 350 mg #360, with the instruction to take four at bedtime.

94. Patient N.B. died on the morning of December 31, 2012. An autopsy revealed that he died from multiple drug toxicities. Morphine, cannabinoids, nordiazepam, and 7-aminoclonazepam[12] were detected in post-mortem blood.

95. Missing from Respondent's records on Patient N.B. are: school records; requests for records from prior treating psychiatrists or pediatricians regarding Patient N.B.'s testing and/or treatment for ADHD; records, calls or communications with contemporary collateral treating psychologists and physicians; orthopedic records related to examination or diagnosis of Patient N.B.'s alleged orthopedic spine related disorder; records or requests for records related to Patient N.B.'s alleged pain disorder; records from Sierra Tucson drug rehabilitation program; referrals to substance abuse treatment programs after 2004; or any random drug toxicologies on Patient N.B.

96. Respondent's psychiatric diagnoses and treatment of Patient N.B. failed to comply with the standard of care. Respondent's medical records reflect minimal treatment of Patient N.B.'s substance abuse, which consisted of telling him not to drink alcohol or to stop using marijuana. There are no referrals to substance abuse programs after 2004. There are no records of random urine or blood toxicologies or hair toxicologies for monitoring Patient N.B.'s substance abuse. Respondent claimed that he was treating Patient N.B. for opioid withdrawal. The standard of care would have required Respondent doing toxicology testing following the alleged detoxification treatment.

97. Respondent failed to objectively verify Patient N.B.'s alleged spinal pain disorder.

98. Respondent's records provide no medically valid justification for the diagnosis of an anxiety disorder separate and apart from the concurrent misuse of stimulants and sedatives and other abusable substances and Patient N.B.'s self reports. The treatment of benzodiazepine and

[12] A major metabolite that may be used to monitor use of the parent drug, clonazepam.

other sedative hypnotic abusers with ultra high doses of sedative hypnotics, without meaningful substance abuse treatment and supervision is not supported in the medical literature.

99. Respondent did not document the existence of any severe anxiety disorder in Patient N.B. requiring ultra high doses of sedative hypnotic medications at times when Patient N.B. was off abusable medications. It is nearly impossible to establish the existence of an anxiety disorder while patients are using stimulant medications and drugs, which can cause nearly all the symptoms of a panic attack or an anxiety disorder. It is nearly impossible to establish the existence of an anxiety disorder while patients are withdrawing from sedative hypnotic medications and drugs, which can cause nearly all the symptoms of a panic attack or an anxiety disorder.

100. Respondent did not document symptoms to support the existence of ADHD that continued from childhood into adulthood in Patient N.B. There is no referral for psychological testing to test for impaired continuous attention, impulsive responding, or other objective test findings. There is no objective testing that amphetamines improved Patient N.B.'s symptoms, if he had any symptoms suggestive of ADHD. Respondent did not obtain Patient N.B.'s records from Sierra Tucson Hospital to check if, while sober, Patient N.B. had symptoms suggestive of ADHD.

101. Respondent does not establish any need to treat Patient N.B. with ultra high doses of abusable stimulant medications. His consultation with Dr. S.S. on or about October 2009 suggested that stimulant medications were not effective. Respondent's records do not provide any evidence that Patient N.B. functioned at a more effective level on ultra high doses of amphetamines. Respondent appears to have relied solely on Patient N.B.'s statements that he needed ever increasing amounts of abusable stimulant medication. Respondent knew that Patient N.B. was distributing amphetamines to others in the past. He never obtained a blood level of amphetamines to check if Patient N.B. was even taking the prescribed medications.

102. Respondent provides no evidence that Patient N.B. suffered from symptoms of Bipolar Disorder during a time when Patient N.B. was without co-occurring substance abuse. The differentiation of Borderline Personality Disorder with unstable moods from Bipolar Disorder

requires reviewing a patient's symptoms over a long period of time. There is no mention in his records how Respondent reached the diagnosis of Bipolar Disorder, how it was established by others, or whether he ever requested records from other clinicians who made this diagnosis, particularly given that Patient N.B. was abusing drugs at such an early age (at approximately age 14) and had symptoms of a personality disorder. The prescription of CNS stimulant medications, particularly amphetamines, to a patient with possible Bipolar Disorder carries a significant risk of "switching" or precipitating a manic episode.

103. There is no documentation of any informed consent discussion with Patient N.B. about the risks of taking amphetamines or ultra high doses of amphetamines.

104. There is no documentation other than Cannabis Dependence to justify the prescribing of cannabinoids to Patient N.B. There is no establishment of a pain disorder in the records to justify prescriptions of abusable and distributable medications.

105. Respondent's claim that Patient N.B. required ultra high doses of abusable medications is without any scientific basis. Respondent's testing showing that Patient N.B. had a genotype for low activity of the CYP2D6 should have made him more cautious about even using normal doses of medications dependent on that system for detoxification to inactive metabolites. Respondent's claim that Vyvanse is a prodrug and therefore required ultra high doses is without any medical substantiation.

106. Respondent failed to comply with the standard of care for assessing and treating the existence of somatic pain requiring prescription sedative-hypnotics or opioid medication on a chronic basis. Respondent prescribed carisoprodol and meprobamate over many years for Patient N.B.'s subjective report of chronic and acute spinal pain. Respondent provided no records to indicate that he documented the basis of Patient N.B.'s pain symptoms or medical conditions that were the basis for his claimed need for "treatment" with either carisoprodol, meprobamate, or opioids.

107. There is no record of a physical examination by Respondent or records of a physical examination by other providers that support the need for chronic treatment of spinal pain with abusable medications. No spinal pathology was found on autopsy. There were no imaging

studies, or EMG[13] studies referenced in Respondent's file. Respondent does not provide information about a coordinated approach with Patient N.B.'s "pain specialist" for his claimed pain disorder. There is no record of communication between Respondent and Dr. J.P coordinating pain treatment of Patient N.B. There are no medical records from Dr. J.P. in Respondent's file, or progress notes that he reviewed any such records.

108. Respondent appears to have done little investigation into Patient N.B.'s alleged medical indications for controlled substances for chronic pain. Respondent does not detail Patient N.B.'s symptom reports, or the history of any orthopedic injury or defect. Respondent does not suggest any supplemental treatments for claimed orthopedic pain other than high dose sedative hypnotics or opioids. There is no indication in his records exactly how he believed that carisoprodol and meprobamate would offer any improved efficacy over Fentanyl, morphine and Dilaudid, even if Patient N.B. had severe back pathology.

109. There is no justification in the records for the prescribing of massive amounts of sedative hypnotics for the treatment of chronic back pain. Respondent's records indicate he was aware of Patient N.B.'s history of abusing prescription medications in the past. There is no benefit to harm consideration in the records about chronic sedative hypnotic prescribing in a known substance abuser. There is no indication that Respondent was concerned about diversion or misuse of the sedative hypnotics or the opioids, despite his knowledge that Patient N.B. had diverted drugs in the past.

110. Respondent failed to comply with the standard of care for prescribing controlled and/or abusable substances to a patient requesting a prescription for drugs of abuse with an active addiction, separate from treatment of pain. Respondent engaged in excessive prescribing to Patient N.B. Respondent did not obtain any prior treatment records on Patient N.B. to establish that Patient N.B. had ADHD in the past. Respondent did no objective testing to establish whether Patient N.B. continued to have ADHD as an adult while under his care. Respondent increased the provision of amphetamines over the years of his treatment from 80 or 90 mg per day of

[13] Electromyography (EMG) is a diagnostic procedure to assess the health of muscles and the nerve cells that control them (motor neurons).

1 amphetamine salts in 2004 to 210 mg of lisdexamfetamine in 2009. Respondent had
2 considerable information that Patient N.B. was a stimulant abuser in the past. Vyvanse has
3 nearly the same abuse potential as other amphetamines, with the exception that it cannot be
4 injected or snorted.

5 111. Respondent's explanations for providing a known stimulant abuser and distributor
6 with large quantities of stimulant is not accurate, i.e., that he had a metabolic defect that required
7 extraordinary amounts. Respondent had knowledge that Patient N.B. was a poor metabolizer of
8 drugs like opioids that are dependent on detoxification by the CYP2D6 system, and therefore this
9 would increase the toxicity of opioids. Respondent had ample information prior to treating him,
10 that Patient N.B. was a very severe hypnotic sedative abuser.

11 112. It does not appear that Respondent ever referred Patient N.B. for treatment of his
12 sedative hypnotic abuse after 2004, or provided treatment himself. Though Respondent
13 prescribed some psychotropic medications with little potential for abuse, by 2009, Respondent
14 was providing very large amounts of sedative hypnotic medications to Patient N.B. without
15 medical justification. The doses were far in excess of maximum recommended doses by the
16 Federal Drug Administration for either anxiety or insomnia.

17 113. Respondent assisted Patient N.B. in diverting abusable drugs to the public.
18 Respondent had knowledge that Patient N.B. diverted drugs in the past. Respondent had
19 knowledge from Patient N.B.'s parents that he was in possession of bottles of medications, in
20 addition to those prescribed. Respondent asserted a pretext explanation for prescribing large
21 amounts of controlled abusable medications to Patient N.B. Respondent asserted that Patient
22 N.B. had an enzyme deficiency that made it necessary for Patient N.B. to take far above
23 recommended doses of abusable drugs in order to achieve any beneficial effect. Respondent
24 claims that he sent Patient N.B. for a consultation with psychopharmacologist Dr. S.S. to
25 characterize the biochemical reasons that Patient N.B. was claiming to need large doses of
26 medications. Dr. S.S., inter alia, particularly noted that Patient N.B. was a severe
27 substance abuser, with little or no interest in treatment, only in receiving large amounts of drugs.

28 114. Respondent had Patient N.B. tested by a laboratory, which indicated that Patient N.B.

1 was a "poor metabolizer" of medications that use the CYP219 system in the liver. Respondent
2 claims this was the reason for the very extreme doses of Vyvanse, roughly three times the
3 maximum Federal Drug Administration recommended dose (assuming arguendo that Patient N.B.
4 even had ADHD). Vyvanse does not need the liver for its conversion to active amphetamine.

5 115. The argument put forth by Respondent has no merit. Carisoprodol is metabolized by
6 the CYP2C19 liver system into meprobamate, the primary active metabolite. The sensible
7 solution in a person with impaired CYP2C19 conversion is to use meprobamate instead of
8 carisoprodol. Respondent was prescribing large amounts of both carisoprodol and meprobamate
9 to Patient N.B. Respondent's records do not justify that Patient N.B. had a medical condition
10 requiring either of these drugs. It appears very likely that these drugs were prescribed for
11 diversion purposes.

12 116. Respondent violated the Federal Drug Addiction Treatment Act. Respondent stated
13 in the interview with the Medical Board of California that he furnished opioid prescriptions to
14 Patient N.B. to assist in his withdrawal from opioids. One prescription was for Suboxone 8
15 mg/2mg # 15 on May 1, 2012. However, Respondent acknowledged providing prescriptions to
16 Patient N.B. for morphine sulfate, oxycodone, and Nucynta beginning in January 2012.
17 Specifically, Respondent provided Nucynta 50 mg #120 on January 4, 2012; oxycodone 15 mg
18 #120 on February 17, 2012; morphine sulfate 60 mg #120 on February 17, 2012; morphine sulfate
19 30 mg # 120 on March 6, 2012; and morphine sulfate 15 mg # 120 on April 14, 2012.

20 117. There is no indication that Respondent had Patient N.B. receive any supplementary
21 rehabilitation services or counseling. The high levels of opioid medications suggests this was not
22 actually a program for withdrawal, but a pretext for supplying large amounts of abusable opioids
23 to be diverted.

24 118. In sum, Respondent was grossly negligent as follows:

25 a. There is nothing in the medical records, other than Patient N.B.'s self-report, to
26 support the need for long term doses of carisoprodol. Respondent prescribed abusable and/or
27 controlled medications to Patient N.B., a known severe substance abuser, for alleged pain
28 disorders, without any physical examination, imaging studies, or objective verification of the need

for abusable medications;

b. Respondent supplied Patient N.B. with extremely large amounts of carisoprodol over many months without any medical re-evaluation. The provision of sedative-hypnotic medications to a sedative-hypnotic misuser, and known drug distributor, with no medical justification except unsupportable pretext diagnoses is an extreme departure;

c. Respondent does not establish in the medical records that Patient N.B. had an anxiety disorder other than possibly anxiety related to substance misuse. Benzodiazepines and related sedative hypnotics are used for the brief treatment of anxiety symptoms because of their addictive qualities. The provision of sedative-hypnotic medications to a sedative-hypnotic misuser, over many years and in ultrahigh doses, with no medical justification except unsupportable pretext diagnoses is an extreme departure;

d. Respondent did not provide any legitimate treatment for Patient N.B.'s properly diagnosed substance misuse, and appears in fact to have worsened Patient N.B.'s earlier benzodiazepine misuse into ultra high dose benzodiazepine dependence;

e. The provision of ultra high doses and very large amounts of amphetamines to a known substance abuser with a history of illegal distribution of amphetamines, without clearly established medical need, is an extreme departure;

f. The provision of abusable opioid medications to a known opioid dependent individual to provide comfort against possible withdrawal symptoms is an extreme departure, and also illegal;

g. Respondent's prescribing of cannabinoids to Patient N.B. given his very low levels of functioning, his need to achieve sobriety, and his lack of medical justification for the use of cannabinoids is an extreme departure. This is particularly so in a known distributor of controlled substances;

h. Respondent provided minimal assessment of Patient N.B.'s pain disorders. Respondent's records do not suggest he attempted to comply with The American Pain Society-American Academy Of Pain Medicine Guidelines, the California Medical Board's guidelines, or with community standards. There is no physical examination or meaningful history;

i. There is no evidence of any consideration of a multimodal approach to Patient N.B.'s chronic pain;

j. There is no periodic review of efficacy of treatment;

k. There is no indication of discussions with other specialists in pain, psychiatry, orthopedics or addictions. Respondent provided no detail to justify the amounts and chronicity of abusable medications prescribed to Patient N.B. for alleged treatment of pain;

l. The CURES[14] tracking shows massive amounts of hypnotic sedatives, and CNS stimulants being prescribed to Patient N.B. Respondent's excessive prescribing of stimulants without any justification was an extreme departure;

m. Respondent willfully avoided the obvious diagnoses of active stimulant, sedative, and opioid misuse with pretext medical or metabolic conditions. His prescribing of large quantities of abusable medications, without adequate documentation or any justification of the basis for the prescriptions, is an extreme departure;

n. Respondent did not impede Patient N.B.'s distribution of prescription drugs to others. Respondent did not limit Patient N.B.'s access to large amounts of abusable drugs, far in excess of what an individual patient might need for a medical condition;

o. Respondent violated the clear Federal laws prohibiting maintaining and withdrawing opioid dependent individuals, except through a licensed program with buprenorphine, methadone or LAAM; and

p. Respondent failed to obtain collateral records (such as records from contemporary prescribers and therapists), which were necessary for the safe treatment of Patient N.B. Respondent's failure to obtain those records is an extreme departure.

Patient P.R.

119. Patient P.R. was a seventy-three year-old female who died on January 26, 2013. An autopsy revealed that she died from gabapentin and memantine intoxication.[15] Respondent

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[14] CURES refers to the Controlled Substance Utilization Review and Evaluation System is a database containing information on Schedule II through IV controlled substances dispensed in California.

[15] Gabapentin is an anti-epileptic medication. Memantine reduces the actions of chemicals

(continued...)

treated Patient P.R. from approximately May 22, 2008 until the date of her death. Patient P.R. had interstitial cystitis which apparently caused chronic severe pain. She also had a dementing process.

120. On May 26, 2009, Respondent prescribed Xanax-XR 2mg #30 and Ambien CR 2.5 #30. On June 8, 2009, Patient P.R. reported her Xanax was stolen. Respondent then prescribed Xanax 0.5 mg #120.

121. Patient P.R. continued on Xanax and Ambien until March 2012 when Respondent substituted temazepam 30 mg for Ambien. Respondent prescribed temazepam 30 mg per day from March 29, 2012 until Patient P.R.'s death.

122. The last CURES prescription record for alprazolam was for 0.5 mg #60 on June 20, 2012. Respondent's note of December 20, 2012 is indicated as late. It recorded that Patient P.R. was then taking temazepam, Keppra, Namenda (memantine), Gabapentin, Risperdal, Razadyne (galantamine) and Tramadol.[16] It does not list doses.

123. In sum, Respondent was grossly negligent as follows:

a. Respondent prescribed an excessive dose of benzodiazepine temazepam to Patient P.R. Inappropriate medication use for older adults is defined as medication use for which the potential harm outweighs the potential benefit and for which a good alternative is available. Use of temazepam above a daily dose of 15 mg per day has high adverse effects and is inappropriate. Longer duration of use (greater than 14 days) is also inappropriate. Benzodiazepines cause a variety of cognitive impairments particularly in the elderly. The concurrent prescribing of tramadol, gabapentin, and Risperdal increases CNS impairment; and

b. Respondent provided no explanation or justification for the long term use of an inappropriately high dose of temazepam in Patient P.R., an already cognitively-impaired elderly woman.

(...continued)
in the brain that may contribute to the symptoms of Alzheimer's disease. Memantine is used to treat moderate to severe dementia of the Alzheimer's type.

[16] Keppra is an anti-epileptic drug. Risperdal is an antipsychotic medicine. Razadyne improves the function of nerve cells in the brain. It is used to treat mild to moderate dementia caused by Alzheimer's disease.

Patient S.N.

124. Patient S.N. was a fifty-three year old male who died on January 26, 2012, of a mixed drug overdose. Respondent treated Patient S.N. from approximately September 2004 until the date of his death. In September 2004, Respondent diagnosed Patient S.N. with Obsessive Compulsive Disorder or Major Depressive Disorder, Mixed Personality Disorder, along with disc disease of the spine. That same month, Respondent became aware that Patient S.N. had a history of substance abuse.

125. On July 12, 2006, Patient S.N. informed Respondent that he had been abusing Vicodin. Respondent prescribed Suboxone 4 mg b.i.d. On July 24, 2006, Patient S.N. reported taking extra Suboxone and demanded more. The last Suboxone prescription noted in Patient S.N.'s medical records was on July 7, 2010.

126. There is an unclear note dated February 4, 2009 in Patient S.N.'s medical records about Klonopin use or abuse. It appears Respondent was concerned that Patient S.N. was calling in refills for himself. There is another unclear note dated August 18, 2009 about Patient S.N. abusing "benzos." Respondent prescribed Klonopin 0.5 mg t.i.d. The quantity was not noted.

127. Respondent hospitalized Patient S.N. at Mission Hospital RMC in March 2010, and again in May 2011, for severe depression and Obsessive Compulsive Disorder. In the discharge summary dictated April 10, 2010, for the discharge on March 18, 2010, Respondent diagnosed Patient S.N. with history of Opiate Abuse and Benzodiazepine Abuse in addition to Major Depressive Disorder, recurrent, and Obsessive Compulsive Disorder. Respondent discharged Patient S.N. with prescriptions for Klonopin, Ambien (zolpidem), Suboxone, Lexapro and Seroquel.

128. On July 7, 2010, Patient S.N. reported to Respondent that he was abusing oxycontin, averaging 325 mg per day.

129. Pharmacy records indicate that a prescription for clonazepam 0.5 mg #270 was filled on October 11, 2010.

130. In the discharge summary dictated June 17, 2011, for the discharge on May 20, 2011, Respondent diagnosed Patient S.N. with Opiate Abuse and Benzodiazepine Abuse in addition

to Major Depressive Disorder, recurrent, psychotic and Obsessive Compulsive Disorder.

131. On July 10, 2011, Patient S.N. asked Respondent to change Klonopin to Xanax-XR (alprazolam) 2 mg. Respondent prescribed the Xanax, quantity #30. On November 3, 2011, Patient S.N. went to Mission Hospital for chest pain.

132. The last progress note is dated January 3, 2012. Respondent prescribed Patient S.N. Lexapro 40 mg, Xanax XR 2 mg, and Zyprexa[17] (olanzapine) 20 mg per day.

133. On January 26, 2012, Patient S.N. died of a mixed drug overdose including methadone, methamphetamine, amphetamine, olanzapine, citalopram, and alprazolam.[18]

134. Respondent's medication flow sheet is barely legible, missing years on the dates and missing years of treatment. There is no evidence that Respondent ever ordered toxicology studies during the entire course of his treatment of Patient S.N. There is no indication that Respondent requested the prior psychiatric records of Patient S.N.

135. Respondent's psychiatric treatment of Patient S.N. failed to comply with the standard of care. Respondent prescribed benzodiazepines to Patient S.N. nearly continuously during his course of treatment beginning in 2004. There is little evidence of efficacy of benzodiazepines in Obsessive Compulsive Disorder or Major Depressive Disorder. Patient S.N. had only the most tenuous basis for short term benzodiazepine treatment and none for long term treatment.

136. There is no evidence in Patient S.N.'s medical records that Respondent considered non-pharmacological treatments for Patient S.N.'s anxiety disorders or panic episodes. There is no evidence that Respondent addressed or treated Patient S.N.'s substance abuse disorders, other than to supply him with prescribed abusable medications.

137. Respondent's notes do not have any information to explain his treatment plan for prescribing Suboxone. There was no toxicological monitoring for illicit substance abuse, nor referrals for psychosocial treatments for Patient S.N.'s long-standing problems with polysubstance abuse. Treatment of substance misuse requires a multimodal approach, including

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[17] Zyprexa is an antipsychotic medication.

[18] Methadone is an opioid medication. Methamphetamine is a CNS stimulant. Citalopram is an antidepressant.

random testing.

138. The lack of any treatment for Patient S.N.'s substance abuse disorders, known to Respondent, but not meaningfully addressed, along with providing him with alprazolam found on autopsy, cost Patient S.N. his life.

139. In sum, Respondent was grossly negligent as follows:

a. Respondent provided sedative-hypnotic medications to a known sedative-hypnotic misuser, over many years with minimal medical justification, in nontrivial amounts;

b. Respondent prescribed long term Suboxone for a person with unproven opioid addiction or dependence, but with primarily established opioid abuse. Respondent never recorded any signs of physiological dependence from Patient S.N.'s opioid misuse;

c. Respondent failed to toxicologically monitor Patient S.N., a patient with known illicit substance abuse of prescribed medications, with relapsing disease, and a patient with well documented prescription drug abuse; and

d. Respondent failed to provide effective treatment for substance abuse, or to make referrals for effective treatment of substance abuse.

Patient M.P.

140. Patient M.P. was a twenty-seven year old male who died on October 12, 2014, from acute polydrug intoxication. Respondent treated Patient M.P. from approximately June 15, 2012 until his death. In June 2012, Respondent diagnosed him with Major Depressive Disorder and "Polydrug in recovery." Respondent prescribed Remeron 30 mg #30 and Wellbutrin-XL 150 mg #60 (to take 300 mg per day).[19]

141. A note written by Respondent in his medical records for Patient M.P., dated July 9, 2012, indicates that Patient M.P. was using heroin[20] for the past four months, half to one gram per day and that his parents were kicking him out for stealing money. Respondent prescribed Suboxone for a sixteen-day taper.

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[19] Remeron and Wellbutrin are antidepressants.

[20] Heroin (diacetylmorphine) is derived from the morphine alkaloid found in opium and is roughly 2-3 times more potent.

1 142. On July 24, 2012, Respondent started Patient M.P. on naltrexone[21] 50 mg q[22] day and
2 Ambien for insomnia (no dose or quantity in record).
3 143. On August 6, 2012, Patient M.P. told Respondent that he could not afford the
4 medications. Respondent prescribed Wellbutrin-XL 450 mg, Lunesta[23] 2 mg #6, and Remeron 45
5 mg per day.
6 144. On January 15, 2013, Patient M.P. reported to Respondent that he had used
7 methamphetamine since the last visit. Patient M.P. wanted to restart on Wellbutrin. Respondent
8 provided samples of Nuvigil[24] (armodafinil) 150 mg and prescribed Buspar[25] 15 mg for t.i.d. use.
9 145. On January 29, 2013, Respondent prescribed Wellbutrin #270 (presumably 150 mg
10 pills).
11 146. On February 12, 2013, Respondent prescribed Remeron and an unnamed medication
12 [presumably Valium] for anxiety 5 mg #30.
13 147. On April 9, 2013, Respondent prescribed Wellbutrin-XL 150 mg #270, Remeron 45
14 mg #90, Valium 5 mg #30, and propranolol[26] 20 mg.
15 148. On June 10, 2013, Respondent prescribed Valium 10 mg #30 for Patient M.P.'s
16 reported social anxiety.
17 149. On June 22, 2013, Patient M.P. was treated at Fountain Valley Regional Hospital and
18 Medical Center for heroin overdose.
19 150. On August 7, 2013, Patient M.P. was treated for opioid overdose (heroin poisoning)
20 at Hoag Hospital. He was using methamphetamine, alcohol, Vicodin, and heroin, and passed out.
21 151. On August 13, 2013, Patient M.P. was prescribed gabapentin for delayed sleep phase
22 problems by Dr. R.M.

23 [21] Naltrexone blocks the effects of opioid medication, including pain relief or feelings of
24 well-being that can lead to opioid abuse.
[22] q means every.
[23] Lunesta is a sedative, also called a hypnotic.
25 [24] Nuvigil is a medication that promotes wakefulness.
[25] Buspar is an anti-anxiety medicine that affects chemicals in the brain that may become
26 unbalanced and cause anxiety.
[26] Propranolol is a beta-blocker. It is used to treat tremors, angina (chest pain),
27 hypertension (high blood pressure), heart rhythm disorders, and other heart or circulatory
conditions.
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152. On August 15, 2013, Patient M.P. saw Respondent. Respondent reported "no change" in his medical records for Patient M.P. This is the entirety of the note other than prescriptions. Respondent prescribed Valium #30 (no dosage in records).

153. On October 1, 2013, Respondent recorded "deny symptoms" as the entirety of the note other than prescriptions. He prescribed Valium #90 (no dosage in records).

154. On December 14, 2013, Patient M.P. was arrested with heroin and syringes.

155. On January 9, 2014, Respondent recorded that Patient M.P. denied using drugs. He prescribed Valium 5 mg #90 in addition to Wellbutrin and Remeron. On March 31, 2014, Ambien is mentioned in the note without dose or quantity.

156. On April 3, 2014, Patient M.P. called Respondent, stating that the Valium should have been for 10 mg pills.

157. On July 10, 2014, Respondent prescribed Valium 10 mg #30.

158. On August 27, 2014, Respondent recorded that Patient M.P. was having panic attacks and chronic anxiety. Respondent increased the Valium to b.i.d., and prescribed #60 (no dose in record, presumably 10 mg pills).

159. On September 30, 2014, Respondent recorded that Patient M.P. was "doing well." A prescription for Valium 10 mg is reported, but no quantity.

160. On October 12, 2014, Patient M.P. died. Drugs detected on post-mortem testing included fentanyl, morphine, oxazepam, temazepam, diazepam, alprazolam, and THC. A coroner's office investigator spoke with Respondent who said that Patient M.P. had been drug free for the past two years.

161. Respondent's records for Patient M.P. contain no collateral records, requests for medical records, or any discussion or referrals for Patient M.P. to seek treatment for his substance misuse.

162. The CURES report for Patient M.P. has the actual dosages and quantities that are missing from Respondent's records. In the year before Patient M.P.'s death, beginning October 1, 2013, Respondent prescribed Valium 10 mg for a total of 525 pills.

163. Respondent's psychiatric diagnoses and treatment of Patient M.P. failed to comply

1 with the standard of care. When informed of Patient M.P.'s death by the coroner's office,
2 Respondent reported that he believed Patient M.P. had been drug free for the past two years. At
3 the earliest meetings (July 2012) with Patient M.P., Respondent knew that Patient M.P.'s reports
4 of being "drug free" were deceitful. If Respondent had obtained the records from Mission
5 Hospital Regional Medical Center, he would have known that Patient M.P. abused both heroin
6 and prescription medications (both opioids and benzodiazepines) comprising his "polydrug"
7 disorder.

8 164. Six months after Patient M.P. admitted his relapse on heroin, Respondent had been
9 told by Patient M.P. that he had relapsed using methamphetamine. Respondent did not make any
10 inquiry about other substance abuse during that relapse. Respondent had no basis for believing
11 that Patient M.P. had achieved sobriety in 2013.

12 165. Respondent provided no referrals for psychosocial treatments for Patient M.P.'s
13 relapses from his long-standing problems with polysubstance abuse. Substance misuse requires a
14 multimodal approach.

15 166. Further, in February 2013, Respondent began prescribing Valium, a benzodiazepine,
16 similar to the Xanax that Patient M.P. had reported abusing since age 21. Respondent began
17 prescribing Valium on a long term basis, for what appears to be insomnia, "stress," and later
18 Patient M.P.'s reports of panic attacks and social anxiety when going to job interviews. None of
19 these are supportable bases for long term prescription of a benzodiazepine.

20 167. The prescription of dependence causing medications in patients with known substance
21 abuse disorders, is controversial, but at a minimum requires very careful monitoring and
22 avoidance of creating further dependency. Respondent's notes do not reflect any concerns about
23 the long term prescribing of Valium for conditions in which it is rarely indicated for more than
24 short term use. Valium can be justified for panic episodes, but the sudden appearance of so-called
25 panic attacks appears more likely to be Respondent's attempt to create a pretext diagnosis to
26 justify his prescribing practices.

27 168. At the time of his death, apparently Patient M.P. was abusing multiple different
28 benzodiazepines. As an expert in addiction psychiatry, Respondent would know that patients

with substance abuse histories are frequently deceitful about their substance misuse history, and efforts to obtain objective information is essential, particularly if prescribing medications that had been drugs of choice. Respondent never asked for a random toxicology or hair toxicology to determine if Patient M.P. had again relapsed.

169. There is no evidence of any serious inquiry by Respondent to determine if Patient M.P. was using illicit drugs beyond accepting superficial denials of relapse.

170. Respondent may not have had an easy way to know that Patient M.P. had overdosed in June or August of 2013, requiring hospitalization, but those events were only the tip of the iceberg. Patient M.P. was using and abusing drugs on a regular basis. Respondent continued to prescribe Valium, continued to ignore the need to monitor Patient M.P. for substance abuse, and approached Patient M.P.'s treatment for depression with no effort to engage Patient M.P. in substance recovery treatment.

171. Respondent was grossly negligent as follows:

a. Respondent provided sedative-hypnotic medications to a known sedative-hypnotic misuser, for over a year with minimal medical justification, in nontrivial amounts;

b. Respondent failed to toxicologically monitor a patient with known illicit substance abuse of prescribed medications, with relapsing disease, while prescribing a drug of choice. Also, Patient M.P.'s prescription drug abuse was well documented; and

c. Respondent failed to provide effective treatment for substance abuse, or to make referrals for effective treatment of substance abuse.

172. Respondent's acts and/or omissions as set forth in paragraphs 25 through 171, 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

(Repeated Negligent Acts-Patients B.C., N.B., P.R., S.N., and M.P.)

173. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code for repeated negligent acts. The circumstances are as follows:

Patient B.C.

174. The facts and allegations in Paragraphs 25 through 42, above, are incorporated by reference and re-alleged as if fully set forth herein.

Patient N.B.

175. The facts and allegations in Paragraphs 43 through 118, above, are incorporated by reference and re-alleged as if fully set forth herein.

176. Respondent provided amphetamines to a possibly Bipolar patient without documentation of informed consent.

177. Respondent treated Patient N.B., a patient with suspected ADHD, with stimulant drugs without any attempt at objective testing.

Patient P.R.

178. The facts and allegations in Paragraphs 119 through 123, above, are incorporated by reference and re-alleged as if fully set forth herein.

Patient S.N.

179. The facts and allegations in Paragraphs 124 through 139, above, are incorporated by reference and re-alleged as if fully set forth herein.

180. Respondent's record keeping explaining the basis for his treatments of Patient S.N. is deficient.

181. Respondent failed to obtain prior treatment records.

Patient M.P.

182. The facts and allegations in Paragraphs 140 through 171, above, are incorporated by reference and re-alleged as if fully set forth herein.

183. Respondent's acts and/or omissions as set forth in paragraphs 174 through 182, inclusive above, whether proven individually, jointly, or in any combination therefore, constitute repeated negligent acts pursuant to section 2234, subdivision (c) of the Code. Therefore, cause for discipline exists.

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THIRD CAUSE FOR DISCIPLINE

(Excessive Prescribing-Patients N.B., P.R., S.N., and M.P.)

184. Respondent is subject to disciplinary action for unprofessional conduct under section 725 of the Code for repeated acts of clearly excessive prescribing of controlled substances. The circumstances are as follows:

185. The facts and allegations in Paragraphs 43 through 171, above, are incorporated by reference and re-alleged as if fully set forth herein.

186. Respondent's acts and/or omissions as set forth in paragraph 185, inclusive above, whether proven individually, jointly, or in any combination therefore, constitute repeated acts of clearly excessive prescribing pursuant to section 725 of the Code. Therefore, cause for discipline exists.

FOURTH CAUSE FOR DISCIPLINE

(Improper Prescribing to an Addict-Patients N.B., S.N. and M.P.)

187. Respondent is subject to disciplinary action under sections 2241, subdivision (b), and 2234, subdivision (a), of the Code for improper prescribing to an addict without complying with section 2241, subdivision (a) of the Code or Health and Safety Code sections 11215, 11217, 11217.5, 11218, 11219, and 11220. Respondent prescribed, dispensed, or administered controlled substances to a person he knew or reasonably believed was using the drugs or substances for nonmedical purposes. The circumstances are as follows:

188. The facts and allegations in Paragraphs 43 through 118 and 124 through 171, above, are incorporated by reference and re-alleged as if fully set forth herein.

189. Respondent's acts and/or omissions as set forth in paragraph 188, inclusive above, whether proven individually, jointly, or in any combination therefore, constitute improper prescribing to an addict pursuant to sections 2241, subdivision (b), and 2234, subdivision (a), of the Code. Therefore, cause for discipline exists.

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FIFTH CAUSE FOR DISCIPLINE

(Prescribing Without an Appropriate Prior Examination and Medical Indication-Patients N.B., S.N., and M.P.)

190. Respondent is subject to disciplinary action under section 2242, subdivision (a), of the Code for prescribing, dispensing, or furnishing dangerous drugs without an appropriate prior examination and medical indication. The circumstances are as follows:

191. The facts and allegations in Paragraphs 43 through 118 and 124 through 171, above, are incorporated by reference and re-alleged as if fully set forth herein.

192. Respondent's acts and/or omissions as set forth in paragraph 191, inclusive above, whether proven individually, jointly, or in any combination therefore, constitute prescribing without an appropriate prior examination and medical indication pursuant to section 2242, subdivision (a), of the Code. Therefore, cause for discipline exists.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Exercise Reasonable Care-Patients N.B., S.N., and M.P.)

193. Respondent is subject to disciplinary action under sections 2241.5, subdivision (d) and 2234, subdivision (a) of the Code for failure to exercise reasonable care in determining whether the patient or condition, or complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, required consultation with, or referral to, a more qualified specialist. The circumstances are as follows:

194. The facts and allegations in Paragraphs 43 through 118 and 124 through 171, above, are incorporated by reference and re-alleged as if fully set forth herein.

195. Respondent's acts and/or omissions as set forth in paragraph 194, inclusive above, whether proven individually, jointly, or in any combination therefore, constitute failure to exercise reasonable care pursuant to sections 2241.5, subdivision (d) and 2234, subdivision (a) of the Code. Therefore, cause for discipline exists.

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SEVENTH CAUSE FOR DISCIPLINE

(Violation of State and Federal Laws and

Regulations-Patients N.B., P.R., S.N., and M.P.)

196. Respondent is subject to disciplinary action under section 2238 of the Code in conjunction with Article 2, of Chapter 5, of Division 10 of the Health and Safety Code, Health and Safety Code sections 11210, 11153, subdivision (a), and 11156, 11215 to 11222, and Section 823(g) of Title 21 of the United States Code for violating state and federal laws and regulations. The circumstances are as follows:

197. The facts and allegations in Paragraphs 43 through 171 above, are incorporated by reference and re-alleged as if fully set forth herein.

198. Respondent's conduct constitutes the prescribing of controlled substances in such excess of such quantity and length of time as is reasonably necessary.

199. Respondent's conduct constitutes prescribing, dispensing, and furnishing controlled substances without legitimate medical purpose.

200. Respondent's conduct constitutes the prescribing of controlled substances to an addict.

201. Respondent's conduct constitutes the failure to follow the protocol set forth in Article 2, of Chapter 5, of Division 10 of the Health and Safety Code and Section 823(g) of Title 21 of the United States Code.

202. Respondent's acts and/or omissions as set forth in paragraphs 197 to 201, inclusive above, whether proven individually, jointly, or in any combination therefore, constitute violations of state and federal laws and regulations pursuant to section 2238 of the Code in conjunction with Article 2, of Chapter 5, of Division 10 of the Health and Safety Code, Health and Safety Code sections 11210, 11153, subdivision (a), and 11156, 11215 to 11222, and Section 823(g) of Title 21 of the United States Code. Therefore, cause for discipline exists.

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EIGHTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct-Patients B.C., N.B., P.R., S.N., and M.P.)

203. Respondent is subject to disciplinary action under section 2234 of the Code for unprofessional conduct. The circumstances are as follows:

204. The facts and allegations in Paragraphs 25 through 171, above, are incorporated by reference and re-alleged as if fully set forth herein.

205. Respondent's acts and/or omissions as set forth in paragraph 204, 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.

NINTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and
Accurate Records-Patients B.C., N.B., S.N., and M.P.)

206. Respondent is subject to disciplinary action under section 2266 of the Code, in that he failed to maintain adequate and accurate medical records. The circumstances are as follows:

Patient B.C.

207. The facts and allegations in Paragraphs 25 through 42, above, are incorporated by reference and re-alleged as if fully set forth herein.

208. Respondent claims that he called Patient B.C.'s psychiatrist and primary care physician, but it is not documented in Patient B.C.'s medical records. In addition, there is no documentation showing that he requested records from those providers.

Patients N.B. and M.P.

209. The facts and allegations in Paragraphs 43 through 118 and 140 through 171, above, are incorporated by reference and re-alleged as if fully set forth herein.

Patient S.N.

210. The facts and allegations in Paragraphs 124 through 139, above, are incorporated by reference and re-alleged as if fully set forth herein.

211. Respondent's record keeping explaining the basis for his treatments of Patient S.N. is deficient.

212. Respondent's acts and/or omissions as set forth in paragraphs 207 through 211, inclusive above, whether proven individually, jointly, or in any combination therefore, constitute inadequate record keeping pursuant to section 2266 of the Code. Therefore, cause for discipline exists.

CAUSES TO REVOKE PROBATION

FIRST CAUSE TO REVOKE PROBATION

(Obey All Laws)

213. Condition (17) of the November 23, 2011 Decision and Order states:

"Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in California. Respondent shall remain in full compliance with any court ordered criminal probation, payments, and other orders."

214. Condition (34) of the November 23, 2011, Decision and Order states:

"Failure to fully comply with any condition of probation is a violation of probation. If respondent violates probation in any respect, the board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation, a petition to revoke probation, or an interim suspension order is filed against respondent during probation, the board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final."

215. Respondent's probation is subject to revocation because he failed to comply with Probation Condition (17) of the November 23, 2011, Decision and Order, referenced above. The facts and circumstances regarding this violation are as follows:

216. The facts and allegations in Paragraphs 24 through 212, above, are incorporated by reference and re-alleged as if fully set forth herein.

217. Respondent violated probation in that he violated the Medical Practice Act, as more fully set forth in the First through Ninth Causes for Discipline.

218. Respondent violated Welfare and Institutions Code section 15630, subdivision (b)(1), insofar as he failed to report suspected elder abuse to the proper authorities as a mandated reporter, as more fully set forth in the First Cause for Discipline.

DISCIPLINARY CONSIDERATIONS

219. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about December 23, 2011, in a prior disciplinary action entitled *In the Matter of the Accusation Against Irwin Ira Rosenfeld, M.D.* before the Medical Board of California, in Case Number 09-2008-193536, Respondent's license was revoked after a contested hearing. However, the revocation was stayed and Respondent's license was placed on probation for five years with certain terms and conditions.

220. Respondent's license was disciplined in the above-entitled action on the following grounds: engaging in gross negligence and repeated negligent acts in violation of Business and Professions Code sections 2227, 2234, subdivisions (b) and (c); failing to maintain adequate and accurate records in violation of Business and Professions Code sections 2227, 2234, and 2266; violating labeling requirements of the Pharmacy Law in violation of Business and Professions Code sections 2227, 2234, 4076, subdivision (a), and 4170, (a)(4); violating statutes that regulate dangerous drugs and controlled substances in violation of Business and Professions Code sections 2227, 2234, and 2238; and engaging in unprofessional conduct in violation of Business and Professions Code sections 2227 and 2234. That decision is now final and is incorporated by reference as if fully set forth herein.

221. Complainant further alleges that on or about September 11, 1999, in a prior disciplinary action entitled *In the Matter of the Accusation Against Irwin I. Rosenfeld, M.D.* before the Medical Board of California, in Case Number 04-1995-45486, Respondent's license was revoked pursuant to a settlement agreement with the Board. However, the revocation was stayed and Respondent's license was placed on probation for five years with certain terms and conditions, including a thirty-day suspension of his Physician's and Surgeon's Certificate. Respondent did not contest the allegation that he had been grossly negligent by engaging in repeated and excessive prescribing. His license was disciplined for violating section 2234, subdivision (b) of the Code. That decision is now final and is incorporated by reference as if fully set forth herein.

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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 G 34731, issued to Respondent;

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: December 21, 2015

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

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22 **EXHIBIT A**
23 **Decision and Order**
24 **Medical Board of California Case No. 09-2008-193536**
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

MEDICAL BOARD OF CALIFORNIA
I do hereby certify that this document is a true and correct copy of the original on file in this office.
Signature Cliff Hamilton
Title For the Custodian of Records
Date June 17, 2015

In the Matter of the Accusation Against:	)	
Irwin Ira Rosenfeld, M.D.	)	Case No. 09-2008-193536
Physician's and Surgeon's Certificate No. G 34731	)	
Respondent	)	

DECISION

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 23, 2011.

IT IS SO ORDERED: November 23, 2011.

MEDICAL BOARD OF CALIFORNIA

Hedy Chang, Chair
Panel B

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

In the Matter of the Accusation Against: IRWIN IRA ROSENFELD, M.D. Laguna Hills, California Physician and Surgeon's Certificate No. G 34731 Respondent.	Case No. 09-2008-193536 OAH No. 2010080632

PROPOSED DECISION

Robert Walker, Administrative Law Judge, State of California, Office of Administrative Hearings, heard this matter in Santa Ana, California, on May 31; June 1; June 2; and June 6 through June 10, 2011.

Alexandra M. Alvarez, Deputy Attorney General, represented the complainant Linda Whitney, Executive Director of the Medical Board of California.

David L. Rosner, Attorney at Law, and Marc R. Rosner, Attorney at Law, represented the respondent, Irwin Ira Rosenfeld, M.D.

POST-HEARING PROCEEDINGS AND BRIEFS

The record was held open to provide the parties with an opportunity to submit closing briefs and to address issues concerning the admissibility of certain exhibits.

By a letter dated June 24, 2011, from Ms. Alvarez and Mr. David Rosner to the undersigned administrative law judge, counsel advised that they had reached certain stipulations. The letter was marked as exhibit BB and was received in evidence. Counsel stipulated that, regarding exhibit 4, the following pages should be received in evidence as administrative hearsay: 56, 57, 59-61, 114, 116, 118, 120, 122, 124, 125, and 234. The remaining pages of exhibit 4 are withdrawn. Counsel stipulated that, regarding exhibit H, the

following pages should be received in evidence as administrative hearsay: 3-6, 18, 54, 94, 98, 106, 123, 125-127, 132 and 133. The remaining pages of exhibit H are withdrawn. Those stipulations are accepted.

On July 8, 2011, a hearing was held by telephone conference call. Ms. Alvarez, Mr. David Rosner, and the undersigned administrative law judge participated. Ms. Alvarez moved to reopen the record to allow her to offer three additional exhibits concerning patient DB. That motion was granted. A record of minute orders in criminal case number 07HM06085 M A in the Superior Court of the State of California for the County of Orange was marked as exhibit 53. A police report written by Officer Cota of the Laguna Beach Police Department on June 27, 2007, was marked for identification as exhibit 54. A supplemental police report written by Officer Bixby of the Laguna Beach Police Department on June 27, 2007, was marked for identification as exhibit 55. Ms. Alvarez offered the three exhibits as rebuttal evidence. Mr. Rosner objected to the exhibits being received in evidence. He contended, among other things, that the exhibits were not in the nature of rebuttal but were items that, if they were to be offered, should have been offered as part of the complainant's case in chief. Good cause appearing, respondent's objections to exhibits 53 through 55 are sustained.

The parties submitted simultaneous closing briefs. Complainant's brief was marked as exhibit 56 for identification. Respondent's brief was marked as exhibit CC for identification. Complainant submitted a rebuttal brief that was marked as exhibit 57 for identification. Respondent submitted a reply brief that was marked as exhibit DD for identification.

Complainant's rebuttal brief and respondent's reply brief were received on August 8, 2011, and the record was closed on August 8, 2011.

FACTUAL FINDINGS

Licensure

1. On July 1, 1977, the Medical Board of California issued Physician and Surgeon's Certificate No. G 34731 to the respondent, Irwin Ira Rosenfeld.

Respondent's Education, Training, and Practice

2. Respondent obtained his medical degree in 1976 from The Medical College of Wisconsin. He did his internship at Mercy Hospital and Medical Center in San Diego, California, in 1976 through 1977. He did his residency in psychiatry at the University of California at Irvine (UCI) from 1977 to 1980 and was an Inpatient Psychiatry Fellow at UCI from 1980 to 1981. Respondent has been licensed in California since 1977. He has had a full-time private practice in psychiatry since 1980.

Respondent has been board certified in psychiatry since 1982. He is a diplomate of the American Board of Psychiatry & Neurology with additional qualifications in geriatric psychiatry and in addiction psychiatry. Respondent also is certified in advanced clinical pharmacology.

3. Respondent has been a long-time member of the medical staff of South Coast Medical Center (SCMC),[1] a psychiatric hospital in South Laguna Beach, California. Except for two years, respondent has been on staff at SCMC since 1980. Respondent was suspended from hospital privileges for two years while the SCMC Medical Executive Committee did a peer review of charges brought by Andrew Sassani, M.D., who was the medical director of the psychiatric unit at SCMC from 2006 through 2008. In 2008, SCMC was sold. The committee's peer review terminated without findings, and respondent's privileges were reinstated.

4. Respondent is an active member of the medical staff of Saddleback Memorial Medical Center in Laguna Hills and an active member of the medical staff of San Clemente Medical Center in San Clemente. From April of 1992 to June of 1995, respondent served as the Service Director of Partial Hospitalization Programs and Older Adult Programs at Charter Hospital Mission Viejo, in Mission Viejo, California, an 80-bed acute psychiatric and substance abuse facility in Orange County.

5. Since 1994, respondent has been a clinical instructor in psychiatry at Western University of Health Sciences in Pomona. Additionally, from 1983 to 1996, he was an assistant clinical professor of psychiatry in the Department of Psychiatry at the California College of Medicine at UCI.

6. Respondent has been active in a number of professional organizations. From 1988 to 1990, he was president of the Orange County Psychiatric Society, and he has served on a number of committees of that society. He has been a frequent lecturer at meetings of professional organizations.

Summary of Allegations.

7. All of the allegations concern respondent's work at SCMC.

8. The allegations concern respondent's care and treatment of eight patients. Regarding each patient, there are multiple allegations of misconduct.

9. Complainant alleges that respondent engaged in conduct that fell below the standard of care in a number of ways. Complainant alleges that, in administering electroconvulsive therapy (ECT), respondent engaged in conduct that fell below the standard of care. Complainant alleges that respondent failed to respond to pages, failed to provide discharge planning, failed to initiate withdrawal protocol, and failed to comply with the

[1] South Coast Medical Center became Mission Hospital - Laguna in 2009.

Pharmacy Law, which begins at Business and Professions Code section 4000. Complainant alleges that respondent improperly permitted a pharmaceutical representative to observe a patient interview. Finally, complainant alleges that respondent improperly discharged patients whom he should have placed on 5150 holds and improperly released patients from 5150 holds.

10. Complainant charges respondent with gross negligence, repeated negligent acts, failure to maintain records, violation of the Pharmacy Law, violation of statutes regulating dangerous drugs and controlled substances, and unprofessional conduct.

11. Respondent acknowledges that, on one occasion, he failed to comply with the Pharmacy Law, and he acknowledges that his failure to comply constituted a departure from the standard of care. He denies all of the remaining allegations.

Complainant's Experts

12. Complainant called two physicians to testify regarding the standard of care. Peter J. Weingold, M.D., testified concerning respondent's care and treatment of patient AM. Alan L. Schneider, M.D., testified concerning respondent's care and treatment of seven other patients.

13. Dr. Schneider obtained his medical degree in 1983 from the University of Southern California School of Medicine in Los Angeles. He did an internship in internal medicine at the University of California Los Angeles (UCLA) Cedars Sinai Medical Center, which he completed in 1984. He was licensed in California in 1984. Dr. Schneider then did an internship in psychiatry, also at UCLA Cedars Sinai Medical Center, which he completed in 1987.

14. Dr. Schneider is board certified in psychiatry. He has been a diplomate of the American Board of Psychiatry & Neurology since 1989 and has an additional qualification in geriatric psychiatry. He has also been board certified by the American Society of Clinical Psychopharmacology and has an American Psychiatric Association certification in administrative psychiatry. Dr. Schneider has received numerous honors and awards.

15. From 1988 to the present, Dr. Schneider has served as Associate Professor of Psychiatry at UCLA School of Medicine. From 2008 to the present, he has served as Associate professor of Psychiatry and Behavioral Sciences at the University of Southern California School of Medicine. From 1994 through 1998, he was Chairman of the Department of Psychiatry at Valley Presbyterian Hospital in Van Nuys, California.

16. Dr. Schneider has taught and lectured extensively. He has had hospital affiliations with 11 hospitals in the Los Angeles area. He has done research and published numerous abstracts.

17. As noted above, Dr. Weingold testified concerning patient AM. In 1977, Dr. Weingold was graduated with a degree in medicine from Mount Sinai School of Medicine in New York. From 1977 to 1980, he did an internship and residency in psychiatry at Cedars Sinai Medical Center, and in 1980 through 1981, he was Chief Resident in Psychiatry at Cedars Sinai Medical Center. Dr. Weingold is licensed in California.

18. Dr. Weingold is board certified in psychiatry. He is a diplomate of the American Board of Psychiatry & Neurology.

19. From 1999 to 2001, Dr. Weingold was Clinical Chief, Department of Psychiatry, Cedars Sinai Medical Center. From 1982 to the present he has been Assistant Clinical Professor of Psychiatry at the Geffen School of Medicine UCLA. From 1982 to the present, he has been on the attending staff at Cedars Sinai Medical Center. Dr. Weingold has had a private practice in psychiatry since 1981.

Respondent's Experts

20. Respondent called two physicians to testify regarding the standard of care. Jody Mark Rawles, M.D., testified concerning respondent's care and treatment of patient SK. Dominich Addario, M.D., testified concerning respondent's care and treatment of six other patients.

21. In 1969, Dr. Addario was graduated with a medical degree from Wake Forest University, North Carolina. In 1970, he completed an internship at Albany Medical Center and Albany Medical College, Albany, New York. In 1975, he completed a residency in psychiatry at the University of California, San Diego, School of Medicine. Dr. Addario is licensed in California.

22. Dr. Addario is board certified in psychiatry. He is a diplomate of the American Board of Psychiatry & Neurology and has an additional qualification in geriatric psychiatry. He is a distinguished life fellow of the American Psychiatric Association.

23. Dr. Addario has received a number of awards and scholarships. He has served in various positions in numerous professional societies and organizations. He has published and lectured extensively.

24. Dr. Addario has been on staff at many psychiatric hospitals in the San Diego area, and from 1989 to 1995, he was Medical Director of Scripps Mercy Hospital & Medical Center, San Diego. Dr. Addario is Health Sciences Clinical Professor, Voluntary, UCSD Department of Psychiatry, and he is Staff Psychiatrist, Scripps Mercy Hospital & Medical Center. From 1995 to 2010, he was Chairman, Physician Well Being Committee, Scripps Mercy Hospital. He has a private practice in psychiatry.

25. As noted above, Dr. Rawles testified concerning patient SK. In 1998, Dr. Rawles was graduated with a medical degree from Albany Medical College, Union University. He completed a rotating internship at UCI in 1999, and he completed a psychiatric residency at UCI in 2002. Dr. Rawles is licensed in California.

26. Dr. Rawles is board certified in psychiatry. He is a diplomate of the American Board of Psychiatry & Neurology.

27. Dr. Rawles is Associate Clinical Professor of Psychiatry and Behavioral Medicine at UCI; Director of Hospital Services, Department of Psychiatry, UCI Medical Center; and Director of the ECT Treatment Program, UCI Medical Center. Dr. Rawles has a private practice in psychiatry.

28. Dr. Rawles has published and lectured.

Overview of the Testimony of Dr. Schneider and Dr. Addario

29. As noted above, Dr. Addario testified regarding six patients. He testified regarding all of the patients except SK and AM. Dr. Schneider testified regarding seven patients. He testified regarding all of the patients except AM.

30. Both Dr. Addario and Dr. Schneider were impressive witnesses, exhibiting vast knowledge and experience in psychiatry and the standard of care expected of psychiatrists. There were times, however, when each was unjustifiably eager to support the position of the party who called him. That is, at times, each testified to conclusions and opinions that appeared to be at odds with the evidence concerning the facts of the case.

Five Medical Directors Testified Concerning Respondent's Practice

31. As noted above, Dr. Sassani, also a psychiatrist, was the medical director of the psychiatric unit at SCMC from 2006 through 2008. Dr. Sassani testified that he received complaints regarding respondent. As noted above he initiated a peer review of respondent's work. As will be explained below, there was one occasion when Dr. Sassani overruled respondent's decision to release a patient from a 5150 involuntary hold.

32. Three other former SCMC medical directors and the current medical director testified. All four are psychiatrists. They testified as to their observations of respondent. All four had very positive things to say about him.

Dr. Rawles's Explanation of ECT

33. Dr. Rawles gave a basic explanation of ECT. The following is a paraphrased summary of part of his testimony.

34. ECT involves electronic stimulus to the head in order to induce seizure. Physicians are not sure why it works, but it is effective in many patients. ECT is the most efficacious treatment for severe depression, bipolar depression, and major depressive disorders.

35. Side effects and risks include headache, vomiting, confusion, short term memory problems, elevated blood pressure, bitten tongue, and chipped teeth. Less common but more serious risks include heart attack, stroke, and death.

36. The standard of care requires a doctor to do a formal consultation with a patient before administering ECT. The discussion should include a review of the side effects and risks, the potential benefits, why the treatment is indicated for the patient, the alternatives that are available, and the proposed number of treatments. The standard of care also requires a doctor to document the fact that he or she did a formal consultation.

37. A special informed consent is required, and a second opinion is required. If a patient has been treated with drug therapy and the physician switches to ECT, the standard of care requires that the doctor document the rationale for switching.

38. The usual course of treatment is 12 treatments, with maintenance treatments as necessary.

39. The standard of care requires a doctor to plan maintenance treatment after a course of ECT has been concluded. For patients who respond to nothing but ECT, the maintenance may need to be ECT once a month for a few months or indefinitely. For some patients, follow-up care without ECT may be sufficient.

Involuntary Holds

40. Welfare and Institutions Code section 5150 provides for the involuntary detention of a person who has been determined to be, as a result of mental disorder, a danger to self or others. A peace officer or specified medical professional may take the person into custody. The person may be detained in a mental health facility for a 72 hour involuntary hold. The code also provides for longer periods of detention if a psychiatrist concludes that the person continues to be a danger to self or others.

41. Welfare and Institutions Code section 5151 provides that, when a person is brought to a mental health facility for a 5150 hold, the professional person in charge of the facility or his or her designee shall assess the individual to determine the appropriateness of an involuntary, 72 hour detention.

42. Section 5152 requires prompt treatment and evaluation and specifies the conditions for early release. The section provides, in part:

> Each person admitted to a facility for 72-hour treatment and evaluation . . . shall receive an evaluation as soon as possible after he or she is admitted and shall receive whatever treatment and care his or her condition requires for the full period that he or she is held. The person shall be released before 72 hours have elapsed *only if the psychiatrist directly responsible for the person's treatment believes*, as a result of the psychiatrist's *personal observations*, that the person no longer requires evaluation or treatment. (Italics added.)

43. There are additional provisions concerning early release in the circumstance in which a psychiatrist and psychologist are collaborating in a patient's treatment.

44. Being held pursuant to section 5150 constitutes a complete deprivation of one's liberty. Therefore, placing a person on a hold when he or she is not a danger is a very serious deprivation. And continuing a person on a hold after he or she no longer is a danger is a very serious deprivation. Psychiatrists who are placed in a position of having to make these decisions often are confronted with a difficult task. The psychiatrist does not want to expose the person or other people to danger, but the psychiatrist, also, does not want to deprive a person of his or her liberty unnecessarily.

Corroboration as Part of an Early Release Evaluation

45. Witnesses testified as to the character of the evaluation a psychiatrist should do in determining whether to order an early release from a 5150 hold. Talking with a patient's family and friends to corroborate a patient's statements can be appropriate. For example, if a patient relates a number of things that are counter indicative of suicide risk factors, a psychiatrist might want to corroborate the patient's statements before relying on them in deciding to order an early release.

46. Respondent testified that corroboration with a patient's family is part of a proper evaluation. Dr. Sassani testified about gathering collateral information from family and friends in order to have an adequate psychiatric evaluation. He testified that it is a standard practice because some patients cannot be trusted to provide truthful information.

47. Dr. Schneider was critical of respondent for ordering early releases based on patients' statements without obtaining corroboration.

48. In connection with discussing corroboration, only one witnesses alluded to the matter of confidentiality and psychiatrist-patient privilege. Dr. Addario testified that, *if a patient gives permission*, one should seek corroborating information.

49. In *Scull v. Superior Court* (1988) 206 Cal.App.3d 784, at pages 789 through 190, the court said:

> It is well settled in California that the mere disclosure of the patient's identity violates the psychotherapist-patient privilege. [Citations.] The rationale for this rule is that the harm to the patient's interest of privacy is exacerbated by the stigma that society often attaches to mental illness. [Citations.] As noted by one commentator: "a person in psychotherapy, by and large, visits his psychiatrist with the same secrecy that a man goes to a bawdy house." [Citation.] In short, the disclosure that an individual is seeing a therapist may well serve to discourage any treatment and thereby interfere with the patient's freedom to seek and derive the benefits of psychotherapy. "When a patient seeks out the counsel of a psychotherapist, he wants privacy and sanctuary from the world and its pressures . . . . The patient's purpose would be inhibited and frustrated if his psychotherapist could be compelled to give up his identity without his consent. Public knowledge of treatment by a psychotherapist reveals the existence and, in a general sense, the nature of the malady." [Citation.]

50. Thus, while neither party presented evidence on this point, it would appear that consulting a patient's family or friends is permissible only if the patient consents and waives the privilege.[2] And Dr. Schneider's criticism must be considered with that in mind. The criticism cannot be that respondent failed to talk with a patient's family and friends. The criticism must be that respondent relied on a patient's representations without corroboration. A lack of corroboration might result from a patient's refusing to waive the privilege, or it might result from a psychiatrist's not seeking a waiver, i.e., not asking for permission to speak with family or friends.

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[2] Gwynneth F. Smith wrote an article entitled *Ewing v. Goldstein and the Therapist's Duty to Warn in California*, which was published in 2006 in volume 36 of the Golden Gate University Law Review, beginning at page, 293. The author, referring to psychiatrists who release patients from 5150 holds, says, "Welfare and Institutions Code section 5259.3, subdivisions (a) and (b), unambiguously protect a therapist from liability for breaking confidentiality." (Id. at p. 318.) Those subdivisions, however, do not support that proposition. Those subdivisions concern a therapist's immunity from liability to third persons who are injured by a person who has been released from a hold. Those subdivisions do not concern a therapist's liability or immunity from liability to a patient for a breach of confidentiality.

Importance of Documentation

51. Dr. Rawles testified that thorough and accurate documentation is important so that a subsequent treating physician can determine what has transpired in the past, including what treatment a patient has had. Other witnesses, including the respondent, also testified regarding the importance of careful documentation in patient files.

Care and Treatment of SK.

52. Before August of 2004, SK had been diagnosed with bipolar depression and had been treated by a psychiatrist in Northern California. She was taking Valium, a benzodiazepine, and had developed a substance abuse problem with respect to overuse of benzodiazepines. SK had been unsuccessful with previous trials of psychotropic drugs. She also had been treated with multiple antidepressant drugs.

53. From August 6, 2004, to June 21, 2005, SK was admitted to SCMC on four occasions.

54. On August 6, 2004, respondent interviewed SK and documented an initial diagnosis and a brief medication history. On August 7, 2004, he documented additional information regarding SK's medication history. The initial diagnosis included bipolar disorder, depressed phase; benzodiazepine dependence; and benzodiazepine withdrawal. Subsequently, respondent added migraine headaches and marital discord.

55. Respondent treated SK with drugs for mood stabilization. During SK's hospitalization, she expressed suicidal ideation.

56. On August 21, 2004, SK told respondent that her mother had had ECT and had responded well to it. SK wanted to try it.

57. On August 25, 2004, SK's husband spoke with respondent and objected to SK's having ECT.

58. On August 26, 2004, SK told respondent that her husband was over-controlling. She said he told her to refuse ECT.

59. On August 28, 2004, respondent met with SK's husband, who demanded that they try intensive psychotherapy before trying ECT.

60. On August 29, 2004, SK again told respondent that her mother had a very positive response to ECT.

61. Before administering ECT, a doctor must do three things. A doctor must do a formal consultation with a patient. A doctor must obtain the patient's signed, written consent. And a doctor must obtain a second opinion consultation from another doctor. On August 29, 2004, SK executed an informed consent form. The standard practice in hospitals is to obtain one informed consent for an entire course of ECT treatments. At SCMC, however, there was a policy that required the execution of an informed consent for each administration of ECT.

62. Respondent also obtained a second opinion consultation. The physician who provided the second opinion reviewed SK's records, examined her, and concluded that other treatments had been considered, that ECT was the least drastic treatment indicated, and that SK was capable of giving her informed consent. Each time respondent administered ECT to SK, he obtained a second opinion consultation from either Dr. Hockenbury or Dr. Speare.

63. On August 30, 2004, respondent administered ECT to SK.

64. There is no record of respondent's having done a formal ECT consultation. August 21, 2004, was the first time SK mentioned ECT. Between then and August 30, 2004, there is no record of a formal ECT consultation. There is no record of respondent's having discussed with SK the indication for ECT, the risks, the potential benefits, or the number of sessions he anticipated.

65. Between August 30, 2004, and September 4, 2004, respondent administered two more ECT treatments. Respondent then discharged SK with a regimen of medications and a note that she was to follow up with his office. SK agreed that she would follow up with respondent in his private office, but she did not do that.

66. As noted above, the usual course of treatment is 12 treatments. It is unusual to administer only three ECT treatments.

67. Also as noted above, for patients who respond to nothing but ECT, maintenance ECT may be needed once a month for a few months or indefinitely. Respondent did not provide for maintenance ECT.

68. There is no record of respondent's providing a discharge plan that dealt with SK's need for a substance abuse relapse prevention program.

69. SK returned to Northern California, and again obtained a prescription for Valium.

70. After being out of the hospital for six months, SK was again hospitalized at SCMC. This stay was from March 9, 2005 to March 18, 2005. SK presented with increasing agitation. She said she had been off of her medications since her last ECT treatment, but toxicology reports were positive for marijuana, benzodiazepines, and barbiturates.

71. On March 14, 2005, respondent obtained a second opinion consultation for ECT. On March 14 and March 15, 2005, SK executed informed consent forms. Respondent administered ECT on March 14 and March 15, 2005. When respondent discharged SK he did not provide for subsequent, maintenance ECT. SK agreed that she would follow up with respondent in his private office, but there is no record of her having done that.

72. After being out of the hospital for only three days, SK was again hospitalized at SCMC. This stay was a brief stay – from March 22, 2005 to March 24, 2005. There is no record of her availing herself of any follow up. SK agreed that she would follow up with respondent in his private office, but there is no record of her having done that.

73. Three months later, on June 21, 2005, SK was admitted to SCMC on a 5150, involuntary 72 hour hold. SK had made a superficial laceration to her left wrist. On July 5, 2005, respondent discharged SK on a regimen of drugs.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of SK in that he Failed to Document Whether SK Should Continue to have ECT after September 4, 2004

74. Dr. Schneider testified that respondent should have documented his opinion as to whether the ECT should be continued beyond the three treatments. He said the failure to do that was a matter of simple negligence.

75. Dr. Rawles testified that respondent's discharge summaries concerning SK are very well written. In them, respondent provided that SK should follow up with him, and that was an appropriate plan for maintenance. "Follow up with me," is adequate. Maintenance can mean simply follow-up care.

76. Dr. Schneider's testimony regarding this allegation was no more persuasive than was Dr. Rawles's.

77. It is found that complainant failed to prove by clear and convincing evidence that respondent's failure to document whether SK should have further ECT constituted a departure from the standard of care.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of SK in that he Failed to Document Whether he discussed with SK the need for maintenance ECT

78. Dr. Schneider testified that respondent should have documented the matter of whether he did or did not recommend to SK that she have maintenance ECT after she was discharged. Dr. Schneider said respondent's failure to document that was a matter of simple negligence.

79. It is found that respondent failed to document whether he discussed a need for maintenance ECT with SK and that his failure to document that constituted a departure from the standard of care.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of SK in that he Failed to Provide for a Substance Abuse Relapse Prevention Program Plan in connection with the September 4, 2004, Discharge

80. Dr. Schneider testified that, on SK's discharge, respondent should have recommended a substance abuse relapse prevention program. Dr. Schneider said respondent's failure to do that constituted an extreme departure from the standard of care.

81. Dr. Rawles testified that, in respondent's discharge summary, there was no special plan for substance abuse relapse prevention but that no express plan is necessary. He said it is adequate to provide simply, as respondent did, that the patient is to follow up with the attending physician.

82. Respondent testified that his plan for avoiding relapse was to have SK follow up with him.

83. In spite of the fact that SK said she would follow up with respondent's office, it was not certain that she would. And she did not. She went back to Northern California and got another prescription for Valium. In view of respondent's diagnosis of benzodiazepine dependence and withdrawal, Dr. Schneider's opinion that respondent should have recommended a relapse prevention program is more convincing than is Dr. Rawles's opinion that that was not necessary. It is possible that SK would have benefitted from a recommendation of a relapse prevention program.

84. However, Dr. Schneider's testimony that this was an extreme departure is at odds with his written report concerning patient LM. In Dr. Schneider's report concerning LM, he wrote that respondent's failure to provide discharge planning and follow up for LM's chemical dependency problem was a *simple* departure from the standard of care. The two cases were different in some respects, but none of the differences would explain why the same departure would be a simple departure in one case but an extreme departure in the other. Because of the conflict in Dr. Schneider's testimony and report, it is found that the evidence does not support a finding that this was an extreme departure.

85. It is found that respondent's failure to recommend a substance abuse relapse prevention program for SK constituted a simple departure from the standard of care.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of SK in that he Failed to Provide for a Substance Abuse Relapse Prevention Program Plan in Connection with the March 18, 2005, Discharge

86. The evidence and findings concerning the failure to provide for a substance abuse relapse prevention program plan in connection with the March 18, 2005, discharge are similar to the evidence and findings on that allegation concerning the September 4, 2004, discharge.

87. It is found that respondent's failure to recommend a substance abuse relapse prevention program constituted a simple departure from the standard of care.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of SK in that on June 24, 27, and 29, 2005, and on July 1, 2005, he administered ECT to SK Without having First Performed a Formal ECT consultation with her

88. On August 27, 2004, respondent arranged for SK to watch an educational video regarding ECT. He gave her educational material that SCMC provided. He provided her with a form for informed consent, which she signed. Also, respondent obtained a second opinion consultation by Dr. Hockenbury.

89. Before subsequent administrations of ECT, respondent obtained SK's signed informed consent and a second opinion consultation.

90. There is no documentation showing that respondent did a formal consultation with SK regarding the risks and possible benefits of ECT.

91. Respondent contends that the second opinion consultations satisfy the requirement of a formal consultation. But the records of the second opinion consultations do not support that contention. As noted above, the records show that the doctor who did the second opinion consultation concluded that other treatments had been considered, that ECT was the least drastic treatment indicated, and that SK was capable of giving her informed consent. The records do not show that the doctors who did the second opinion consultations reviewed side effects and risks, potential benefits, why the treatment is indicated, alternatives that are available, and the proposed number of treatments.

92. Respondent also contends that the informed consent forms that SK executed contained all of the information required in a formal consultation and satisfy the consultation requirement. The informed consent form contains spaces for a doctor or other staff person to fill in information regarding the number of treatments per week, the number of weeks, the maximum number of treatments, the reason alternative treatments are not being recommended, and conditions the patient may have that would increase the risks ECT presents. On some of the forms SK signed, some of those blanks were filled. For example, the form she signed on March 13, 2005, provides that there would be three treatments during one week, with a maximum of three treatments. On most of the forms SK signed, however,

the blanks were left blank. There is no allegation that respondent failed to obtain informed consent. However, since he claims that the informed consent forms are a substitute for a patient consultation, the fact that the spaces were left blank is relevant.

93. Dr. Rawles concluded that respondent "adequately consulted with the patient."

94. Respondent acknowledged that he did not document a formal consultation in SK's progress notes, but he testified that he did, in fact, conduct a formal consultation. He said he always discusses the matters covered in the consent form. He said he does that with every patient. Respondent was a very credible witness.

95. In Dr. Schneider's report, he wrote:

> [T]here are multiple references in the chart to indicate that the patient knew why she was receiving ECT, was positive about the experience, felt that it was immediately helping her, understood the side effect profile of ECT, and wished to proceed with the treatment during this course. These remarks were documented in staff notes both before and after each treatment.

96. It is found that complainant failed to prove by clear and convincing evidence that respondent did not provide SK with a formal consultation concerning ECT.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of SK in that he Failed to Provide for a Substance Abuse Relapse Prevention Program Plan in connection with the September 4, 2004 Discharge

97. For the hospitalization that ended on September 4, 2004, Dr. Hockenbury wrote the aftercare plan, and it was his responsibility to provide for a substance abuse relapse prevention program plan if one was needed.

98. It is found that complainant failed to prove by clear and convincing evidence that, in connection with the hospitalization that ended on September 4, 2004, respondent had a responsibility to provide for a substance abuse relapse prevention program.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of SK in that he Failed to Identify Specifically SK's Illicit Use of Marijuana and Benzodiazepines

99. Dr. Hockenbury was SK's attending physician. If there was an obligation to identify SK's illicit use of marijuana and benzodiazepines, it was Dr. Hockenbury's responsibility to do that.

100. It is found that complainant failed to prove by clear and convincing evidence that respondent had a responsibility to identify specifically SK's illicit use of marijuana and benzodiazepines.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of SK in that he Failed to Identify a Treatment Plan in Regard to Maintaining Abstinence

101. This allegation is duplicative of the allegations that respondent failed to recommend a substance abuse relapse prevention program.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of SK in that he Failed to Educate SK about the Possible Interference that Marijuana and Benzodiazepines Could Produce with her Prescribed Drug Regimes

102. Dr. Schneider testified that the records contain no documentation as to whether SK's use of marijuana in connection with other drugs she was taking would pose a risk. He said her use of benzodiazepine would increase her seizure threshold and make it more difficult to induce an ECT seizure. Dr. Schneider did not testify that respondent had an obligation to educate SK about these matters and did not testify as to what would be required in order to "educate" a patient about such matters.

103. Dr. Rawles testified that he did not have an opinion on the standard of care regarding a failure to educate a patient about drug interference. He observed that there was no documentation that respondent had talked with SK about the risk of marijuana and Valium interfering with the drugs respondent prescribed. Dr. Rawles said it would be good to talk with a patient about those things and good to document the fact that the discussion took place.

104. Respondent testified that he did tell SK that she was not to use alcohol or marijuana while she was using the drugs he prescribed. He acknowledged that he did not document his discussions in the progress notes. But respondent pointed to drug consent forms that SK signed as tending to show that she had been informed of drug interference. Most of those forms warn about possible side effects but do not advise about drug interference, but a few do warn about drug interference.

105. Complainant stipulated that there are drug consent forms for each of SK's hospitalizations but disputed that they document an appropriate discussion.

106. It is found that complainant failed to prove by clear and convincing evidence that respondent failed to educate SK about the possible interference that marijuana and benzodiazepines could produce with her prescribed drug regimes.

Complainant Alleges that Respondent Engaged in Simple Negligence in his Care and Treatment of SK in that he Failed to Document a Rationale for Switching from Medication to a Course of ECT

107. When SK was first admitted to SCMC, respondent treated her with drug therapy. Dr. Schneider testified that there is no documentation of respondent's reason for changing from drug therapy to ECT. He said the failure to document the reason constituted a simple departure from the standard of care.

108. Dr. Rawles acknowledged that respondent's progress notes for the period before he began ECT contained no such documentation. Dr. Rawles, however, concluded that the documentation met the standard of care. He pointed to respondent's documentation of the fact that SK had been on various drug therapy regimes without much success and to the fact that SK continued to be very depressed. Dr. Rawles pointed to SK's advising respondent that her mother had had ECT and had responded well to it. And Dr. Rawles pointed to Dr. Hockenbury's August 29, 2004, progress note in which he wrote, "ECT . . . patient has been cycling [with] poor response to meds. [¶] . . . [¶] Patient has not had ECT, but mother did with good response."

109. In contending that the file contained adequate documentation of the reason for switching to ECT, respondent emphasized his documentation of the medication therapies SK had tried before her hospitalization, his documentation of the medication therapies she tried under his care from August 6 through August 29, 2004, and the documentation of the fact that she was not progressing satisfactorily.

110. The documentation was such that a subsequently treating physician would have been able to determine the reason for switching to ECT therapy.

111. It is found that complainant failed to prove by clear and convincing evidence that respondent's documentation concerning the reason for switching constituted a departure from the standard of care.

Complainant Alleges that Respondent Engaged in Simple Negligence in his Care and Treatment of SK in that he failed to document the anticipated length of the ECT course

112. Dr. Schneider testified that it is not necessary to document the anticipated number of sessions. He said the failure to document the anticipated length of treatment is less than ideal but does not constitute a departure from the standard of care.

113. Dr. Rawles testified that he is not aware of any standard of care requirement concerning the documentation of the anticipated length of treatment.

114. It is found that complainant failed to prove by clear and convincing evidence that respondent's failure to document the anticipated length of the ECT course constituted a departure from the standard of care.

Complainant Alleges that Respondent Engaged in Simple Negligence in his Care and Treatment of SK in that he Failed to Document the Reason for Truncating the ECT After Only Three Sessions

115. This allegation is duplicative of the allegation addressed in findings 74 through 77, above. There the allegation is worded in terms of a failure to document whether SK was to continue with ECT. Here the allegation is worded in terms of a failure to document the reason for truncating after only three sessions.

Complainant Alleges that Respondent Engaged in Simple Negligence in his Care and Treatment of SK in that he Failed to Provide for Maintenance Treatment after the ECT

116. As noted above, Dr. Rawles testified that respondent's discharge summaries concerning SK are very well written. Dr. Rawles said respondent provided that SK should follow up with him, and that was an appropriate plan for maintenance. "Follow up with me," is adequate. Maintenance can mean simply follow-up care.

117. Complainant presented no evidence on this point that was more convincing than was Dr. Rawles's testimony.

118. It is found that complainant failed to prove by clear and convincing evidence that respondent failed to provide for maintenance treatment after ECT.

Complainant Alleges that Respondent Engaged in Simple Negligence in his Care and Treatment of SK in that he Failed to Inform SK about the Risk of Relapse in the Absence of Medication Plus Maintenance

119. In Dr. Schneider's report, he wrote:

> [T]here was inadequate documentation . . . regarding the switch over from medication to a course of ECT, the length of the anticipated ECT course, the reason for truncation of ECT treatments after only 3 sessions, the lack of provision for any maintenance treatment, the lack of information to the patient about the risk of relapse in the absence of medications plus maintenance ECT. Overall, these features represent a <u>simple departure</u> from the usual standard of care.

120. Thus, the evidence the complainant presented was that, taken together, as a whole, the failure to do five things constituted a departure from the standard of care. The five are a failure to document the reason for switching to ECT, a failure to document the length of the anticipated course of ECT, a failure to document the reason for not providing more than three sessions of ECT, a failure to provide for maintenance, and a failure to inform SK of the risk of relapse in the absence of maintenance. Dr. Schneider did not write and did

not testify that any of these matters, by itself, constituted a departure from the standard of care.

121. With regard to the first four of these matters, it has been found that complainant failed to prove by clear and convincing evidence that respondent's conduct fell below the standard of care. Because Dr. Schneider did not express an opinion regarding the fifth matter independent of his opinion regarding the five matters as a whole, it is found that complainant failed to prove the allegation concerning the fifth matter.

122. Complainant failed to prove by clear and convincing evidence that respondent engaged in a departure from the standard of care by failing to inform SK about the risk of relapse in the absence of medication plus maintenance.

Complainant Alleges that Respondent Engaged in Simple Negligence in his Care and Treatment of SK in that he Failed to Provide one or two Additional ECT Sessions Beyond the Point at which SK Felt she was Fully Recovered

123. In Dr. Schneider's report, he wrote, "[I]t is the usual standard of care to deliver at least 1 - 2 treatments beyond a point at which the patient feels that they are fully recovered."

124. Dr. Rawles testified that respondent exercised his clinical judgment on this matter, and there was no evidence that it was below the standard of care.

125. Dr. Schneider's report regarding this allegation was no more persuasive than was Dr. Rawles's testimony.

126. It is found that complainant failed to prove by clear and convincing evidence that respondent's conduct fell below the standard of care by his failing to provide one or two ECT sessions beyond the point at which SK felt she was recovered.

Care and Treatment of LM

127. LM was admitted to SCMC on November 17, 2006, after going there voluntarily. She was in a manic state and said she wanted to die. She said, "I had a long-term plan to commit suicide if I did not find my cat." She suffered from bipolar disorder and fibromyalgia and was dependent on Vicodin. At the time of her admission to SCMC, respondent had been treating her for several years, and after she was discharged, she continued to treat with him on an outpatient basis until moving out of the state in 2009.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of LM in that Respondent, who was on Call to the Emergency Room, Failed to Respond to a Page at 3:00 a.m. on November 17, 2006

128. Concerning LM and other patients, complainant makes a number of allegations having to do with respondent's failing to respond to pages and phone calls. The evidence concerning all of those allegations – not merely the evidence concerning November 17, 2006 – will be discussed at this point.

129. Dr. Rosenfeld testified that he did not fail to respond to pages or calls that he received. He said his pager and cell phone frequently failed to operate in the area where he lives and that he had given his land line number to the hospital staff and asked them to use it when he failed to respond to a page. He testified that he had provided his land line number to the emergency room and to the psychiatric unit. Respondent testified that there were times when the ER staff did call on his land line. He said he received no phone call from the ER staff concerning LM.

130. Dr. Schneider testified that, when a physician is on call to the emergency room, a failure to respond to a page constitutes an extreme departure from the standard of care.

131. Dr. Schneider testified that he did not believe respondent's pager did not work. He concluded that respondent's contentions that his pager did not work "are specious, at best." He said it is a doctor's duty to find a pager that works. Dr. Schneider acknowledged, however, that if hospital staff have a land line number, they should use it when a doctor fails to respond to a page. When asked about the allegation that respondent failed to respond to emergency phone calls concerning LM, Dr. Schneider acknowledged, also, that the records did not show that the ER staff made phone calls to respondent.

132. Richard Granese, M.D., is the current medical director of the psychiatric unit at SCMC. He testified that his pager often does not work in the area where he lives.

133. Dr. Addario agreed that, if a physician received a page but failed to respond, that would constitute an extreme departure from the standard of care. He said, however, that it is a hospital's responsibility to pursue measures to communicate with a physician. If the hospital staff has a land line number for a doctor but relies only on a pager, it is the staff's fault that the doctor fails to receive a communication. He testified that, therefore, one cannot conclude that respondent engaged in conduct that constituted a departure from the standard of care.

134. Respondent was a credible witness. His testimony that he never ignored a page, while self serving, was believable. There was no evidence to contradict respondent's testimony that he provided the staff with a land line number, and there was no evidence that, on the occasions in question, the staff used a land line number.

135. It is found that complainant failed to prove by clear and convincing evidence that respondent received but failed to respond to pages and calls.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of LM in that, on November 17, 2006, between 3:00 a.m. and 7:30 a.m., the ER Physician Paged Respondent Every 20 Minutes, but Respondent Failed to Respond Until 7:30 a.m.

136. Based on the evidence reviewed in findings 128 through 134, it is found that complainant failed to prove by clear and convincing evidence that respondent received but failed to respond to pages and calls.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of LM in that there is no Documentation in LM's Chart that, when Respondent Discharged her on November 22, 2006, Respondent Referred her for Substance Abuse Counseling or a Drug Treatment Program

137. Dr. Schneider testified that the record shows that LM had a serious problem with chemical dependency but that respondent's discharge summary does not provide for a plan to deal with chemical dependency. There is no record of respondent's referring LM to Narcotics Anonymous (NA) or Alcoholics Anonymous (AA). There is no record of respondent's recommending an intensive, hospital based outpatient program. The only follow up the record reflects is, "With Myself."

138. Dr. Schneider testified that the failure to document a plan to deal with LM's chemical dependency constituted an extreme departure from the standard of care.

139. Dr. Schneider said that, if respondent had been treating LM from 2002 to 2009, it would have been helpful for him to have stated that in the discharge summary and for him to have stated whether he had already recommended a 12-step program or an intensive out patient program. Dr. Schneider testified that, if respondent had recommended those things recently and if he had documented that in the discharge summary, that would have satisfied the standard of care.

140. Respondent testified that LM had been his patient for many years and that he had recommended substance abuse programs to her many times. He said she refused to take his advice because she was convinced she needed narcotics. Respondent said he is a chemical dependence specialist and was dealing with LM's chemical dependence problems.

141. Dr. Addario testified that respondent adequately documented a discharge plan when he wrote that follow up would be with him. LM's immediate problem was that she was manic, and it was appropriate for respondent to focus on that. Referring such a patient to NA or AA is futile; they do not follow through.

142. Dr. Schneider's testimony that the failure to document a referral to a chemical dependency program constituted a departure from the standard of care is not convincing. Any subsequently treating physician who looked at LM's records would know immediately that she needed to be involved in a chemical dependency program. Whether respondent had recommended one would add very little to what a subsequently treating physician needed to know. The important questions would have been things respondent could not have predicted. Did she go into a program? If so, to what extent was it helpful? It is found that Dr. Addario's testimony that respondent's failure to document a referral to a chemical dependency program did not constitute a departure from the standard of care was more convincing than was Dr. Schneider's testimony on this point.

143. It is found that complainant failed to prove by clear and convincing evidence that respondent's failure to document a plan to deal with LM's chemical dependency constituted a departure from the standard of care.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of LM in that there is no Documentation in LM's Chart that Respondent Attempted to Communicate with the Physicians Who had Prescribed a Benzodiazepine and Vicodin for LM

144. In Dr. Schneider's report, he wrote that there was no documentation in the chart that, "Dr. Rosenfeld attempted to contact the prescribing physicians (e.g. rheumatologists) who were providing her with these medications." Dr. Schneider, however, did not write that this constituted a departure from the standard of care, and neither did he testify to that effect.

145. Complainant presented no evidence that respondent's failure to document an attempt to communicate with the physicians who prescribed benzodiazepine and Vicodin constituted a departure from the standard of care.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of LM in that he Failed to Respond to Emergency Phone Calls Regarding LM

146. Based on the evidence reviewed in findings 128 through 134, it is found that complainant failed to prove by clear and convincing evidence that respondent received but failed to respond to pages and calls.

Complainant Alleges that Respondent Engaged in Simple Negligence in his Care and Treatment of LM in that he Discharged her Without Providing Adequate Planning or Follow Up Regarding her Chemical Dependency Problem

147. In Dr. Schneider's report, he wrote that respondent's failure to provide discharge planning and follow up for LM's chemical dependency problem was a simple departure from the standard of care.

148. As noted above, Dr. Addario testified that respondent adequately documented a discharge plan when he wrote that follow up would be with him. LM was well known to respondent. Her immediate problem was that she was manic, and it was appropriate for respondent to focus on that.

149. This is very different from respondent's failure to recommend a substance abuse relapse prevention program for SK. Respondent had not treated SK before she came to SCMC. Also, at the time he discharged her, he should have anticipated the very real possibility that she would not follow up with him, and she did not follow up with him. He failed to take advantage of an opportunity to recommend a substance abuse relapse prevention program to her.

150. LM, on the other hand, had been respondent's patient for many years. As noted above, respondent testified that he had recommended substance abuse programs to LM many times, but she refused to take his advice because she was convinced she needed narcotics. Respondent is a chemical dependence specialist, and he testified that he was dealing with LM's chemical dependence problems.

151. In view of the fact that LM had been respondent's patient and the fact that he had recommend substance abuse relapse prevention programs to her, Dr. Adderao's testimony regarding this allegation is more convincing than was Dr. Schneider's testimony.

152. It is found that complainant failed to prove by clear and convincing evidence that respondent's failure to provide discharge planning for LM's chemical dependency problem was a departure from the standard of care.

Care and Treatment of BM

153. BM was a 38-year-old woman who was brought to the SCMC intensive care unit on March 11, 2007, on a 5150 hold after having told a neighbor she had taken pills and wanted to die. She suffered from chronic back pain and had a history of dependence on Klonopin and OxyContin. She was in the intensive care unit from March 11, 2007, at 9:28 p.m., to March 12, 2007, at approximately 3:07 p.m. Thus, she was in the intensive care unit for five and one-half hours. She was observed closely and medically cleared.

154. On March 12, 2007, at 3:07 p.m., respondent, through a telephone order, admitted BM to the psychiatric unit. Respondent made a provisional diagnosis of major depression with suicidal ideation. In his telephone admission order, he directed the staff to take BM's vital signs every four hours and to call respondent if BM began having withdrawal symptoms. He said that, if she began having withdrawal symptoms, he would assess for detoxification protocol.

155. At the time respondent admitted BM, laboratory studies had been completed and showed that BM had not taken any drugs for at least a few days. Thus, her report to the neighbor that she had taken pills must have been false. Respondent, however, did not know the results of the laboratory studies.

156. On March 12, 2007, at 4:00 p.m., respondent called in a telephone order for medications. He prescribed Zyprexa for acute agitation; Cynbalta, an antidepressant; and Neuronten, an anti seizure medication that also reduces anxiety. Respondent also ordered that BM be restrained for four hours due to her combative behavior and that, after four hours, a nurse assess whether the restraint needed to be continued.

157. On March 12, 2007, at sometime after 4:45 p.m., the nursing staff tried to reach respondent but could not reach him. At 6:35 p.m., one of the nurses called Dr. Sassani and told him BM needed something to deal with her increased agitation. Dr. Sassani prescribed Ativan for "continued agitation."

158. On March 12, 2007, at 6:40 p.m., respondent called in a telephone order for an additional medication. He prescribed one dose of Haldol for agitation to be administered in addition to the Ativan that Dr. Sassani had ordered.

159. Respondent first saw BM on March 13, 2007, at 10:30 a.m. His progress note says, in part, that BM's vital signs are stable and that, therefore, she was not in withdrawals. The note says, further, that BM was oriented as to three out of four matters and that respondent's plan was to transfer her to ETS, a county facility for patients who have no insurance or other means to pay for their care. Respondent testified that a patient can be transferred if he or she is medically stable.

160. On March 13, 2007, at 1:55 p.m., Dr. Sassani wrote a progress note indicating that respondent was unavailable and that he, Dr. Sassani, "came instead to see if the patient still needs to be on a 5150 hold."

161. Later in the day on March 13, 2007, a bed became available at ETS, and BM was transferred to ETS. Dr. Dismalchi Desmalche signed an order saying that BM was medically stable for a transfer to ETS.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of BM in that, in his Admitting Orders, he Failed to Account for BM's Use of OxyContin

162. Dr. Schneider testified that respondent failed to document how long BM had been taking Klonopin and failed to document how long she had been taking OxyContin. He, however did not testify that the failure to document constituted a departure from the standard of care.

163. Complainant failed to prove by clear and convincing evidence that respondent engaged in negligence by failing to account for BM's use of OxyContin.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of BM in that, for Several Hours After he Admitted her, he Failed to Respond to Pages

164. Based on the evidence reviewed in findings 128 through 134, it is found that complainant failed to prove by clear and convincing evidence that respondent received but failed to respond to pages and calls.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of BM in that, After he Admitted her, More than 24 Hours Passed Before Respondent Instituted "the Standard Opiate Withdrawal Protocol."

165. From the allegation, one could infer that, sometime beyond 24 hours after admitting BM, respondent instituted a standard opiate withdrawal protocol. That inference would be incorrect. Respondent did not initiate a withdrawal protocol, and he contends there was no reason to initiate one.

166. Dr. Schneider testified there was a potential for withdrawal, and the standard of care required that respondent either provide a prophylactic opiate withdrawal protocol or write an order that the nursing staff observe BM for symptoms of withdrawal. Dr. Schneider testified that respondent's failure to do either of these things constituted an extreme departure from the standard of care. Dr. Schneider was asked about respondent's March 12, 2007, telephone order, which he gave at 3:07 p.m. As noted above, respondent ordered the nursing staff to call him if BM began having withdrawal symptoms – in which event, respondent would assess for detoxification protocol. Dr. Schneider was asked whether this satisfied the second of the alternatives he listed as satisfying the standard of care. He said, "No," because, in order to satisfy the second alternative, one would have to write an order to the nursing staff, in great detail, ordering them to watch the patient for signs of a seizure.

167. Dr. Schneider was asked about the fact that physicians and nurses in the intensive care unit had observed BM closely for five and one-half hours before respondent took over her care. Dr. Schneider testified that BM would have continued to be at risk for withdrawal because the risk of seizure is greater after the first day.

168. Dr. Addario testified that, if a prophylactic opiate withdrawal protocol had been indicated, the doctors who cared for BM before she was transferred to respondent's care would have initiated that. Dr. Addario testified, also, that the doctors who cared for BM before she was transferred to respondent's care must have considered her condition to have been stabilized because there was a hospital policy not to refer patients to the psychiatric unit they had been medically stabilized. Further, Dr. Addario pointed out that there was no evidence that BM was having seizures.

169. When Dr. Sassani prescribed Ativan on March 12, 2007, at 6:35 p.m., he did not prescribe it for withdrawal. He prescribed it for "continued agitation." Further, he prescribed only one dose. Dr. Addario testified that, if Dr. Sassani had been prescribing Ativan for withdrawal, he would have prescribed a continuing administration of it.

170. Respondent pointed to the fact that he had ordered the nursing staff to call him if BM began having withdrawal symptoms. He said, also, that he saw no evidence that BM needed prophylactic measures for withdrawal. He noted that neither BM's blood pressure nor heart rate went up. He noted, also, that there is no mention of withdrawal in Dr. Desmalche's notes.

171. As noted above, respondent ordered the nursing staff to call him if BM began having withdrawal symptoms. The order also alerted the nursing staff as to why this was important; in the event of withdrawal symptoms, respondent would assess for detoxification protocol. The burden of Dr. Schneider's opinion that respondent failed to meet the standard of care is that respondent's order was not sufficiently detailed regarding the nurses' duty to observe BM. Dr. Schneider testified that the order would have to be in great detail ordering the nursing staff to watch the patient for signs of a seizure. That testimony is not convincing. First, there was no evidence that nurses do not know that seizure is a symptom of withdrawal. Second, one does not have to be a medical expert to know that, when a nurse is ordered to call a doctor if a patient begins having symptoms, the order implicitly requires the nurse to observe the patient. Dr. Addario's testimony regarding this allegation was more convincing than was Dr. Schneider's testimony.

172. It is found that complainant failed to prove by clear and convincing evidence that respondent's failure to initiate withdrawal protocol constituted a departure from the standard of care.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of BM in that, he Failed to Respond to Emergency Phone Calls

173. Based on the evidence reviewed in findings 128 through 134, it is found that complainant failed to prove by clear and convincing evidence that respondent received but failed to respond to pages and calls.

Care and Treatment of DA

174. DA was a 43-year-old woman who was brought to SCMC after a week of drinking. She was admitted at 1:25 p.m. on May 4, 2007. DA had a long history of alcohol dependence and had recently been asked to leave an in-patient rehabilitation facility because of her noncompliance. An SCMC emergency department record says, in part, "Chief Complaint: Alcohol – possible drug overdose? History of vodka and Xanax." But an intake evaluation form states, among other things, that DA said she had been off of Xanax for eight days.

175. An emergency department record for May 4, 2007, at 1:40 p.m., says that DA was "found poorly responsive with empty bottles of vodka and Xanax (indecipherable) per ex boyfriend. Patient has slurred speech/mumbles and no history obtainable from her."

176. On May 4, 2007, at 1:55 p.m., a laboratory result for benzodiazepines was negative. Xanax is a benzodiazepine. That, however, would not necessarily mean DA had not taken Xanax. For the first 12 hour after a person has taken Xanax, it may not show up in a drug test.

177. A nursing note for May 4, 2007, at 3:30 p.m., said that DA was alert and answering questions and that her vital signs remained stable.

178. On May 4, 2007, at 3:50 p.m., a test result showed a blood alcohol level of 0.446.

179. At 5:10 p.m. on May 4, 2007, Bill Khoury, M.D., an emergency room doctor, placed DA on a 5150 hold. In the application form, Dr. Khoury wrote, "She presents to the emergency room after admitting to taking an overdose of Xanax and drinking alcohol. She has a history of substance abuse and is depressed." Dr. Khoury found that there was probable cause to believe that, as a result of mental disorder, DA was a danger to herself. An involuntary advisement form given to DA at the time Dr. Khoury placed her on the 5150 hold said, "You were brought to the emergency room after admitting to taking an overdose of Xanax and drinking alcohol."

180. On May 4, 2007, at 9:12 p.m., a laboratory result for benzodiazepines was negative. Again, that would not necessarily mean DA had not taken Xanax. As of 9:12 she had been in the hospital for only seven hours and 47 minutes, and as noted above, it can take as long as 12 hour for Xanax to show up in a test.

181. George Shahinian, M.D., performed an intake assessment and wrote a report, which he dictated at 9:50 p.m. on May 4, 2007. Dr. Shahinian wrote, "[DA] comes from an alcoholic recovery program . . . . She is attempting to take an overdose of Xanax and drinking alcohol. She had a history of substance abuse and depression in the past." He noted that DA denied any recent drug use. Dr. Shahinian noted that DA had an extremely high blood alcohol level of 0.446. Dr. Shahinian wrote, "She is, remarkably, still coherent enough to talk in full sentences." Dr. Shahinian recorded his impressions as "Critical Alcoholism, Anxiety, Depression, and Critically ill secondary to the above." His plan included "IV fluid, watch for alcohol withdrawal symptoms, and a psychiatric evaluation." The laboratory results were negative for benzodiazepines, which includes Xanax.

182. A nurse's note for May 5, 2007, at 6:00 a.m. says, in part, "never had seizure . . . denies suicidal thoughts . . . ."

183. On May 5, 2007, at 3:30 p.m., Dr. Shahinian wrote an order discharging DA from the hospital subject to a psychiatrist's discharging her from the 5150 hold. He wrote, "Patient doing well. No complaint. Vitals stable. [¶] . . . [¶] Ready to be discharged medically. Patient wants to go to College Hospital to help her stop drinking. OK to be discharged when cleared by psychiatry."

184. As of May 5, 2007, at 5:15 p.m., a laboratory result showed that DA's blood alcohol level had dropped from 0.446 to 0.35.

185. A nurse's note for May 5, 2007, at 7:00 p.m., says, "Dr. Rosenfeld here to see patient and discuss plan of care."

186. On May 5, 2007, at 7:35 p.m., respondent released the 5150 hold. In respondent's consultation notes, he wrote that DA had a "History of anxiety attacks, and she was treating it with alcohol. And also panic and agoraphobia.[3] [¶] . . . [¶] Patient denies suicidal ideation. [¶] . . . [¶] Had been in sober living home, kicked out for using benzodiazepines. Went to a motel with alcoholic friend. [¶] . . . [¶] Husband doesn't want her home."

187. In respondent's order, he wrote, "Patient can go to College Hospital (where insurance covers) when they have a bed available – as a voluntary patient."

188. At the time respondent released the 5150 hold, DA had been in the hospital 30 hours.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of DA in that, When Respondent Released her from a 5150 hold, Respondent Failed to Appreciate the Risk Factors that Predispose People to Suicide. For Example, he Failed to Appreciate Substance Abuse and Psychic Anxiety as Risk Factors in a Patient with a 0.446 Blood Alcohol Level who is Sentient Enough to Carry on a Conversation

189. Alcohol abuse is a risk factor for suicide. The evidence, however, did not support a finding that DA carried on a conversation while having a blood alcohol level of 0.446. On May 4, 2007, at 1:40 p.m., the nursing staff was unable to obtain a history from DA because her speech was slurred, and she mumbled. Two hours later, test results showed a blood alcohol level of 0.446. Six hours after that, she was coherent enough to talk in full sentences. There was no evidence as to exactly what her blood alcohol level was at the time she was coherent enough to talk in full sentences. Nineteen hours after that, test results showed a blood alcohol level of 0.35, so at the time DA was talking in full sentences, her blood alcohol level was somewhere between 0.446 and 0.35.

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[3] Agoraphobia is an abnormal fear of being helpless in a situation from which escape may be difficult or embarrassing. Agoraphobia often is characterized by panic or anticipatory anxiety and finally by avoidance of open or public places.

190. Respondent has practiced psychiatry for over 30 years. He has done thousands of suicide assessments. He testified about numerous risk factors – including substance abuse and anxiety. His testimony was consistent with the testimony of the expert witnesses regarding risk factors.

191. Respondent testified about risk factors in *DA*'s life. He concluded that he did not have grounds to continue *DA* on a 5150 hold and to continue to keep her against her will. That conclusion may have been wrong, but if it was, it was not because respondent did not appreciate risk factors.

192. Complainant failed to prove by clear and convincing evidence that respondent did not appreciate the risk factors that might predispose *DA* to suicide.

193. Complainant failed to prove by clear and convincing evidence that respondent did not appreciate substance abuse or psychic anxiety.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of DA in that he Failed to Inform DA of her Imminent Risk for Seizures and Delirium Tremens

194. Dr. Addario testified that Dr. Jamali was DA's treating physician. He and the critical care staff were dealing with DA's detoxification, withdrawal, and seizure issues. As noted above, on May 5, 2007, at 3:30 p.m., Dr. Shahinian wrote an order discharging DA from the hospital subject to a psychiatrist's releasing the 5150 hold. Thus, Dr. Shahinian must have concluded that there was no imminent risk for seizures or delirium tremens. Dr. Addario testified that respondent, then, did a consultation for Dr. Jamali by dealing with the 5150 hold issues.

195. Dr. Schneider did not testify that respondent had a duty to inform DA of her imminent risk for seizures and delirium tremens. Dr. Schneider did not testify that respondent's failure to inform DA of her imminent risk for seizures and delirium tremens constituted a departure from the standard of care. In Dr. Schneider's report, however, he wrote:

> [E]ven if the primary care physician/internist had elected to allow the patient to leave the hospital, *it was Dr. Rosenfeld's responsibility to inform the patient of her risk for imminent seizures and delirium tremens* and to insure that she remained at the highest level of medial care setting (such as a medical center) where resuscitation equipment was immediately available. (Italics added.)

196. But in Dr. Schneider's report, he did not say that respondent's conduct in that regard amounted to a departure from the standard of care.

197. It is found that complainant failed to prove by clear and convincing evidence that respondent engaged in negligence by failing to inform DA of her imminent risk for seizures and delirium tremens.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of DA in that he Failed to Ensure that she Remained at the Highest Level of Medial Care Setting Available

198. As noted above, Dr. Schneider wrote in his report:

> [E]ven if the primary care physician/internist had elected to allow the patient to leave the hospital, it was Dr. Rosenfeld's responsibility . . . to *insure that she remained at the highest level of medial care setting* (such as a medical center) where resuscitation equipment was immediately available. (Italics added.)

199. But in Dr. Schneider's report, he did not say that respondent's conduct in that regard amounted to a departure from the standard of care, and neither did he testify that it did.

200. It is found that complainant failed to prove that respondent engaged in negligence by failing to ensure that DA "remained at the highest level of medial care setting available."

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of DA in that he Failed to Perform a Complete Suicide Risk Assessment on DA to Ensure that she was Sufficiently Psychiatrically Stable to be Released From a 5150 Hold

201. Dr. Schneider testified that a blood alcohol level of 0.446 indicates that a person has a very high tolerance to alcohol. That alcohol level would mean death for most people. To be alert and able to answer questions with that level of alcohol is extraordinary. As noted above, the evidence did not support a finding that DA carried on a conversation while having a blood alcohol level of 0.446.

202. Dr. Schneider said the negative laboratory result for benzodiazepines does not necessarily mean DA had not taken Xanax because test results can be negative for up to 12 hours after one has taken Xanax.

203. As noted above, Dr. Rosenfeld released the 5150 hold at 7:35. Dr. Schneider testified that respondent spent only 35 minutes with DA in assessing whether he should discharge the 5150. Dr. Schneider arrived at that conclusion by assuming that the nurse's note for May 5, 2007, at 7:00 p.m., which says, "Dr. Rosenfeld here to see patient and discuss plan of care," means that respondent had just arrived at 7:00 p.m. But that is not a

fair assumption; respondent may have arrived before that. He testified that he interviewed DA from 6:30 to 7:35.

204. Dr. Schneider testified that there are factors that caused the release of the hold on DA to be a very serious matter. She had a history of substance abuse. It appeared she made an acute overdose attempt. She had a heightened blood alcohol level. She had a history of depression. And when Dr. Shahinian performed his intake assessment, DA told him she was anxious. Dr. Schneider testified that a combination of things indicated that the risk of DA's attempting suicide was high. She recently was dismissed from a sober living house and went with an alcoholic friend to a motel room to drink. Her husband did not want her to return home. The record indicated that DA had admitted taking an overdose of Xanax.

205. Dr. Schneider said that, under theses circumstances, a psychiatrist would be obligated to keep a patient for as long as necessary – probably at least seven days. And a psychiatrist would be obligated to communicate with as many corroborating sources as possible, including the patient's spouse. In this case, respondent had a duty to keep DA in a supervised setting in order to take a complete psychiatric history and in order to communicate with the patient's family and others to corroborate things the patient said. Dr. Schneider testified that respondent, by discharging the 5150 hold before doing those things, engaged in an extreme departure from the standard of care. Dr. Schneider testified that respondent failed to do a complete suicide assessment and that his failure in that regard constituted an extreme departure from the standard of care.

206. Dr. Addario testified that respondent's assessment of DA was within the standard of care. The following is a paraphrased summary of part of Dr. Addario's testimony. By the time respondent saw DA, her blood alcohol level had dropped from 0.446 to 0.35. Laboratory tests were negative for Xanax, but it can take as long as 24 hour for Xanax to show up in a test. There is no reference to suicide in the emergency department records, the pre-hospital care report, or Dr. Jamali's diagnosis. There was no record of suicidal ideation. An emergency room record shows a plan for a voluntary admission to College Hospital. DA needed a program to treat her alcohol addiction. She just drank herself into a stupor, and there was no evidence that, in this case, this was a risk factor for suicide.

207. In spite of having testified that the negative laboratory results for benzodiazepines did not necessarily mean DA had not taken Xanax because it can take as long as 24 hour for Xanax to show up in a test, Dr. Addario testified twice that the tests showed that DA had not taken Xanax. Once, Dr. Addario called attention to the results reported seven hours and 47 minutes after DA was admitted and said, "So she had not taken Xanax." Later, Dr. Addario called attention to that same test result and said, "By this time, it definitely would have shown up in the screen." He did not explain this inconsistency in his testimony.

208. Dr. Addario acknowledged that a history of substance abuse is a risk factor for suicide. He did not explain what it was that caused SA's drinking "herself into a stupor" not to be a risk factor for suicide "in this case."

209. Dr. Addario was asked about the things Dr. Shahinian wrote in his intake assessment report – that DA was attempting to take an overdose of Xanax and drinking alcohol and that she had a history of substance abuse and depression. Dr. Addario acknowledged that those things are risk factors for suicide.

210. Respondent testified that his assessment was within the standard of care. He pointed to the fact that none of the doctors' notes or nursing notes indicated that DA had suicidal thoughts. He pointed to the laboratory results that were negative for benzodiazepines. Respondent said, "When I interviewed her, there was no indication of a risk that she was a danger to herself or others."

211. Dr. Addario's explanation as to why he concluded that respondent's assessment of DA was within the standard of care was not convincing. There were a few references in the record that suggested it was possible that DA had taken an overdose of Xanax. One record said she had admitted to having taken an overdose. It is true that that was inconsistent with the record of her having said she had been off of Xanax for eight days. But the record was such that respondent should have been very concerned about the possibility that she had taken an overdose of Xanax. And if she had done that, that would have been a particularly strong risk factor for suicide. Dr. Addario testified that Xanax might not show up on a drug screen for 24 hours after it was taken. Dr. Schneider said 12 hours. Thus, the two drug screens that were done did not rule out the possibility that DA had taken an overdose of Xanax. And there is no record of a drug screen having been done 12 hours or more after DA was admitted.

212. Respondent was faced with the references in the record that suggested that DA had taken an overdose of Xanax, and he had no laboratory results that ruled out her having done that. He should have done something to try to resolve the conflict in the record. There is no evidence that he was justified in assuming that DA had not taken an overdose of Xanax. He could have had a drug test done at a time more than 12 hours after DA was admitted. He could have made an effort to speak with people who knew something about DA's behavior before she entered the hospital. Before discharging the 5150 hold, he should have done something to gain more information as to whether DA had taken an overdose of Xanax.

213. In addition to the possibility that DA had taken an overdose of Xanax, there were a number of other serious risk factors. When she was admitted to the hospital, she had consumed a large quantity of alcohol. DA had a long history of alcohol dependence. She was depressed. She had a history of substance abuse and depression. She had a history of anxiety attacks, panic attacks, and agoraphobia. She had been in a sober living home but had been asked to leave because she used benzodiazepines. Her husband did not want her in their home.

214. Dr. Schneider's testimony and opinion logically accounted for the facts. Dr. Addario's testimony and opinion did not. Dr. Schneider's testimony was convincing.

215. It is found that respondent failed to do a complete suicide assessment of DA and that his failure in that regard constituted an extreme departure from the standard of care.

Care and Treatment of JP

216. JP was a 29 year-old woman who presented to SCMC voluntarily with suicidal ideation following an incident of finding her boyfriend in bed with another woman. She also had a history of crystal methamphetamine use.

217. On May 15, 2007, at a few minutes before 1:00 o'clock in the afternoon, JP came to the emergency room. Her chief complaints were "multiple stressors, overwhelmed, and methamphetamine abuse." She admitted suicidal ideation. An emergency room record for May 15, 2007, at 1:30 p.m., shows that, when JP was asked whether she had a plan for suicide, she said, "pills, running in front of a train."

218. On May 15, 2007, at 3:58 p.m., JP was transferred to the psychiatric ward.

219. At some time before 9:00 a.m. on May 16, 2007, Greg Brown, M.D., saw JP and did a physical examination. The following is a paraphrased summary of part of Dr. Brown's report. JP has a history of methamphetamine use on and off for several years. She has been using methamphetamine almost daily for the past four months. She has suffered from depression for several years. Her mother has a history of bipolar disorder. JP has had several suicide attempts, cutting her wrists. She has stressors at home because of an unfaithful boyfriend and stressors at work because of multiple responsibilities – including scheduling 290 Costco employees. Past medical history includes a diagnosis of attention deficit disorder and possible bipolar depressive disorder.

220. On May 16, 2007, beginning at 9:00 a.m., respondent interviewed JP for one hour. At 10:00 a.m., respondent released the 5150 hold. In his discharge summary, he wrote, "I did not feel the patient needed to stay in the hospital after I performed the initial interview . . . ." The following is a paraphrased summary of part of respondent's discharge summary. JP was admitted with depression, amphetamine abuse, and suicidal ideation after having found her boyfriend in bed with another woman two days prior to the admission. JP's therapist feels that JP may have attention deficit disorder, but JP has never had medication for attention deficit disorder. JP has been crying a lot in the past few days. On the day of admission, she had thoughts of shooting herself in the head with a gun.

221. At the time respondent interviewed JP, he concluded she was not terribly depressed. At the time of the interview, JP did not express suicidal ideation. She was able to contract for safety.[4] Respondent diagnosed depression, attention deficit disorder with hyperactivity, amphetamine abuse, histrionic personality disorder with borderline traits, and acute stressors with mild chronic stressors.

222. During the interview, respondent prescribed Strattera for attention deficit disorder and explained to JP that it could help her.

223. Respondent concluded that he did not have grounds to place JP on a 5150 hold and keep her against her will. Thus, 23 hours after JP arrived at the emergency room, respondent discharged her from the hospital.

224. Respondent testified that, while a contract for safety does not guarantee that a patient will not attempt suicide, it is useful because, if a patient refused to contract for safety, one would not discharge him or her.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of JP in that he Prescribed Strattera for Attention Deficit/Hyperactivity Disorder (ADD) Without Performing or Documenting that he had Performed a Standard ADD Review

225. Dr. Schneider did not testify that prescribing Strattera without performing or documenting the performance of a standard ADD review constituted a departure from the standard of care.

226. Also, in Dr. Schneider's report, he did not criticize respondent for prescribing Strattera without performing or documenting the performance of a standard ADD review. He did criticize respondent for starting JP on Strattera without ascertaining "its tolerability prior to her discharge." But the focus of Dr. Schneider's report concerning JP has to do with his opinion that respondent did not observe and evaluate JP sufficiently before releasing the 5150 hold. He did not opine that, by prescribing Strattera, respondent engaged in conduct that fell below the standard of care.

227. It is found that complainant failed to prove by clear and convincing evidence that respondent's prescribing Strattera without performing or documenting the performance of a standard ADD review constituted conduct that fell below the standard of care.

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[4] A patient contracts for safety when he or she promises not to harm himself or herself.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of JP in that he Discharged her Without Understanding the Risk Factors that Predisposed her to Suicide. For Example, he Failed to Understand Substance Abuse and Psychic Anxiety

228. As noted above, respondent has practiced psychiatry for over 30 years. He has done thousands of suicide assessments. He testified about numerous risk factors – including substance abuse and anxiety.

229. Respondent testified about risk factors in JP's life. He concluded that he did not have grounds to place JP on a 5150 hold and keep her against her will. That conclusion may have been wrong, but if it was, it was not because respondent did not understand risk factors.

230. Complainant failed to prove by clear and convincing evidence that respondent did not understand the risk factors that might predisposed JP to suicide.

231. Complainant failed to prove by clear and convincing evidence that respondent did not understand substance abuse or psychic anxiety.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of JP in that he Discharged her Without Having Observed and Evaluated her Sufficiently

232. Dr. Schneider testified that respondent discharged JP without having observed and evaluated her sufficiently. He said JP's behaviors warranted hospital admission rather than out-patient treatment. Dr. Schneider pointed to a number of suicide risk factors. JP admitted feeling overwhelmed and having suicidal ideations. According to an emergency room record, when JP was asked whether she had a plan for suicide, she said, "pills, running in front of a train." Dr. Schneider said it is significant that the patient identified more than one means of committing suicide. Dr. Schneider pointed to Dr. Brown's note that JP had a history of methamphetamine use "on and off for several years," and that, "She has been using methamphetamine almost daily for the past four months." JP had suffered from depression for several years. Her mother had a history of bipolar disorder. JP had had several suicide attempts, cutting her wrists. She had stressors at home because of an unfaithful boyfriend and stressors at work because of multiple responsibilities. Dr. Schneider pointed to respondent's note that, on the day before respondent saw JP, she had thoughts of shooting herself in the head with a gun.

233. Dr. Schneider testified that, in addition to JP's having this combination of risk factors, there is the matter of no documentation of corroboration from family or friends that might have justified relying on contra indicators and no documentation of determining who would be taking care of JP.

234. Dr. Schneider said a so called "contract for safety" is totally invalid for preventing suicide and should not be considered in determining whether a patient should be placed on a 5150 hold.

235. Dr. Schneider testified that, when risk factors for suicide are high, one should place a hold on a patient, and respondent should have placed JP on a 72 hour hold. Dr. Schneider testified that respondent's failure to observe and evaluate JP sufficiently constituted a departure from the standard of care. In Dr. Schneider's report, he wrote that respondent's actions constituted an extreme departure from the standard of care.

236. Dr. Addario testified that the fact that JP had thought of a suicide plan – taking pills or running in front of a train – was a significant risk factor for suicide. He testified that a history of drug use and anxiety also are risk factors.

237. Dr. Addario pointed to certain things that he characterized as contra risk factors. One was that JP has close relationships with friends and family. In support of that proposition, Dr. Addario pointed to respondent's discharge summary. But the discharge summary does not mention friends, and while it does mention family, there is no indication of what kind of a relationship JP had with her family.

238. Dr. Addario testified that respondent considered all of the risk factors and was not negligent in concluding that he should not place JP on a 5150 hold. Dr. Addario testified that JP was not suicidal. It is not clear what he meant by that. It is true that respondent recorded that, at the time he interviewed JP, she did not express suicidal ideation. Just 23 hours before that, however, she had expressed suicidal ideation and had ideas as how one might commit suicide.

239. As other contra risk factors, Dr. Addario pointed to the fact that JP had plans for the future. But the record contains no information about plans for the future.

240. Respondent testified that he concluded he did not have grounds to place JP on a 5150 hold. He said that, during the time she was in the hospital, she began to feel better. Also, in his interview with her, he prescribed Strattera and explained to her that it could help with her attention deficit disorder. She felt good about having a new medication to try. Respondent testified that JP was looking forward to going back to work. There is, however, no documentation in respondent's notes or anywhere else in JP's records that she was looking forward to going back to work.

241. Dr. Schneider's testimony and opinion logically accounted for the facts. Dr. Addario's testimony and opinion did not. Dr. Schneider's testimony was convincing. JP's history and behaviors warranted hospital admission rather than out-patient treatment.

242. It is found that respondent discharged JP without having observed and evaluated her sufficiently. Respondent's discharging JP constituted an extreme departure from the standard of care.

Care and Treatment of RR

243. In May of 2007, RR was 21 years old. His girlfriend ended their relationship. RR felt suicidal and overdosed on Advil. Coincidentally, the former girlfriend's mother had become concerned about RR and had called his father to tell him about her concern. RR's father called RR on his cell phone and located him at a coffee shop. RR was despondent and told his father he had taken a lot of pills.

244. On May 16, 2007, at 22 minutes after midnight, RR's father brought him to SCMC.

245. An emergency room physician recorded an "initial diagnosis impression" of "major depression suicide attempt."

246. RR's father testified that RR was upset about being taken to the hospital; RR just wanted to go home.

247. On the morning of May 16, 2007, the staff did a suicide assessment on a preprinted form. One question was, "Do you think about suicide or want your life to be over?" RR checked "yes" and wrote, "Sometimes but not all the time." One question was, "Do you intend to commit suicide?" RR checked "no" and wrote, "Not after last night." He denied having a suicide plan or a history of suicide attempts. He said he had had a recent loss in that he broke up with his girlfriend after about three and one-half years. He denied that he made decisions impulsively. One question was, "Do you have feelings of hopelessness?" RR checked "yes" and wrote, "Sometimes it doesn't feel like I can do anything right." One question was, "Do you have feelings of isolation?" he checked "yes" and wrote, "I guess so. I usually keep to myself about most things." He described his relationship with both family and friends as "close" and said he liked where he lives. One question was, "How would you like to see your life one year from today?" He wrote, "Having graduated & starting a small job starting at a game company." One question was, "How would you like to see your life five years from today?" He wrote, "In a higher ranking position in the game industry somewhere." He said he did not want to die, and he contracted for safety. In a narrative, RR wrote: "I recently broke up with my girlfriend after 3½ years, and I was having a hard time accepting that she has moved on while I haven't. I became depressed to the point I thought I had no reason to live anymore and made a stupid, regrettable decision rather than talking to someone else close to me."

248. On May 16, 2007, at 9:45 a.m., respondent, who was RR's attending physician, did a psychiatric admission evaluation and wrote progress notes. His diagnosis was adjustment disorder with depressed mood, overdose of Ibuprofen, acute stressor – breaking up with girlfriend . . . ." The following is a paraphrased summary of the admission evaluation notes. Twenty-one-year-old admitted with depression after breakup with girlfriend. Process began two months ago; breakup occurred five weeks ago. She broke with him because she was paying for things while he was in college. He had had trouble finding a

pert time job to pay for dating. RR lives with his parents. He felt suicidal yesterday. Overdosed on Advil. Sleeps OK most of the time. No prior psychiatric history. Due to graduate December of 2007. Oriented as to person, place, time, and situation. Depressed yesterday; [indecipherable] today. Insight and judgment are fair to good. Follow up with psychotherapist.

249. On May 16, 2007, at 10:15 a.m., respondent wrote an admitting diagnosis of "depression." The intake order also said, "After history and physical (Dr. Brown to do today if possible) patient may be discharged home."

250. RR was discharged from the hospital on May 16, 2007, at 2:30 p.m., which was approximately 14 hours after his admission.

251. In respondent's discharge summary, he diagnosed adjustment disorder with depressed mood, status post Ibuprofen overdose, and severe acute stressor: breakup with girlfriend.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of RR in that Respondent Discharged RR Without having Observed and Evaluated him Sufficiently

252. Dr. Schneider, testifying about respondent's admission evaluation notes, said respondent provided inadequate documentation of risk factors. For example, respondent did not discuss whether RR had a history of impulsivity. In Dr. Schneider's report, he wrote, "There is no discussion in the note of long term or short term suicide risk factors, or suicide preventative factors as is considered standard when assessing a patient after a suicide attempt." The record is not adequate with regard to what is to happen when RR is discharged. Who will take care of him? What will be done concerning his depression? The only plan in respondent's records is his referral to a therapist, Dr. Karen Rabin, in Laguna Hills.

253. Respondent discharged RR from the hospital approximately 14 hours after he was admitted. The following is a paraphrased summary of part of Dr. Schneider's testimony. RR's taking an overdose of Advil was a suicide attempt. Most patients who attempt suicide want to get out of the hospital as soon as possible. Eleven hours was not an adequate amount of time to observe a patient who had made a suicide attempt a few hours before he was admitted. Overdosing on a drug is a very impulsive act, and impulsivity is the highest risk factor for suicide. One should observe such a patient for at least two days. Also, one should seek corroboration from family and friends that there is reason to believe that, if the patient is released, he or she will be safe.

254. Dr. Schneider testified that respondent's failure to observe RR adequately constituted a departure from the standard of care. In Dr. Schneider's report, he wrote: "Dr. Rosenfeld's judgment . . . comes into question in the discharge of a patient immediately after an overdose. While the patient's risk factors were limited for imminent suicidality, [Dr.

Rosenfeld's] lack of knowledge of the patient, lack of interface with the patient's parents, and failure to observe and evaluate the patient more than one time shows a seriously careless approach in the management of this patient. [¶] . . . [¶] As such, I find that Dr. Rosenfeld's actions . . . represent an extreme departure from the usual standard of care."

255. Dr. Addario testified that that RR's overdosing on Advil was not a serious suicide attempt but only a cry for help. He concluded that, in part, because he understood that RR called his father after taking the Advil. But Dr. Addario's understanding regarding that was mistaken. RR did not call his father. The mother of RR's former girlfriend called RR's father and told him she was concerned about RR.

256. Dr. Addario testified that overdosing on a drug is an impulsive act and that impulsivity is a risk factor for suicide. He testified, however, that a single act of impulsivity is not a risk factor for suicide. That testimony was not believable. It is not believable that overdosing on a drug on May 15 is not a risk factor for suicide on May 16.

257. The following is a paraphrased summary of part of respondent's testimony. Respondent said that, in evaluating RR, he considered the following: There was no evidence that RR used alcohol or drugs. There was no prior history of RR's having had psychiatric treatment or problems. There was no family history of psychiatric problems. RR's use of caffeine was limited. He was oriented as to person, place, time, and situation. The day before I met with him, he had been depressed, but the day I met with him, he was not. His thought processes were intact without suicidal or homicidal ideation. His sense of abstraction was good, and his insight and judgment were fair to good. There was a plan for him to follow up with a psychotherapist. Respondent referred to the staff's suicide assessment and noted that RR had hopes for a career, was thinking five years into the future, said he did not want to die, said he could contract for safety, said he liked where he lived, and realized that he could talk with someone close to him. The emergency room doctor did not place RR on a 5150 hold; thus, the emergency room doctor must have concluded that RR did not present a risk to himself or others. Respondent testified, "I concluded he was psychologically stable."

258. Dr. Schneider's testimony that respondent's evaluation was inadequate comported with the facts and was very convincing. No doubt respondent observed RR and concluded that he was telling the truth. But under the circumstances it behooved respondent to consider the possibility that RR was being manipulative. Respondent did have a drug screen that showed that RR was not currently using alcohol or drugs, but respondent had almost nothing else to corroborate the things RR told him. Respondent should have sought RR's permission to talk with RR's family to determine whether they would confirm that RR did not use alcohol or drugs, that he had no prior history of psychiatric problems, that there was no family history of psychiatric problems, and that he was expected to graduate in December. If it turned out that most of that was not true, respondent would have been confronted with a very different situation. And the fact that RR was not depressed on the day respondent evaluated him and had no suicidal ideation, needed to be considered in view of the fact that the emergency room physician concluded that, just the night before, RR suffered

a "major depression" and made a "suicide attempt." These circumstances, as Dr. Schneider opined, gave rise to a need to observe RR for a while to see whether he would fall back into a depression and to see whether he would revert to suicidal ideation.

259. Dr. Schneider's testimony and opinion logically accounted for the facts. Dr. Addario's testimony and opinion did not. Dr. Schneider's testimony was convincing. RR's behaviors warranted hospital admission.

260. It is found that respondent discharged RR without having observed and evaluated him sufficiently. Respondent's discharging RR constituted an extreme departure from the standard of care.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of RR in that Respondent Failed to Document Long Term or Short Term Suicide Risk Factors for RR and Failed to Document Suicide Preventive Factors for RR

261. In Dr. Schneider's report, he was critical of respondent's admission evaluation note concerning RR. As noted above, Dr. Schneider wrote that respondent failed to discuss, "long term or short term suicide risk factors, or suicide preventative factors as is considered standard when assessing a patient after a suicide attempt."

262. Dr. Schneider, however, did not testify that respondent's failure to discuss risk factors or preventive factors in his admission evaluation note constituted a departure from the standard of care. Also, in his report, he did not write that respondent's failure to discuss risk factors or preventive factors in his admission evaluation note constituted a departure from the standard of care.

263. It is found that complainant failed to prove by clear and convincing evidence that respondent's failure to discuss *risk factors* in his admission evaluation note constituted a departure from the standard of care.

264. It is found that complainant failed to prove by clear and convincing evidence that respondent's failure to discuss *preventive factors* in his admission evaluation note constituted a departure from the standard of care.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of RR in that Respondent Improperly Allowed a Pharmaceutical Representative to Observe his Observation of RR

265. When respondent performed his admission evaluation of RR, respondent permitted a pharmaceutical sales representative to be present and observe the evaluation. The pharmaceutical representative asked respondent whether he could sit in on an evaluation. Respondent, in the presence of RR's father, asked RR whether it would be okay to have a pharmaceutical representative present at his evaluation. RR said it would be okay.

Respondent did not chart the fact that RR gave his consent to having the pharmaceutical representative present in the evaluation, but RR did consent.

266. At the time respondent decided to ask RR whether it would be okay for the pharmaceutical representative to sit in on the evaluation, respondent had just met RR and had not yet evaluated him. At the time respondent concluded that RR seemed to be competent to give his consent, respondent had just met RR and had not yet evaluated him.

267. Dr. Schneider testified that there is no justification for having a pharmaceutical representative present in an evaluation of a psychiatric patient – especially when the patient is a new patient who may be unstable. He said it does not matter that the patient consented. Dr. Schneider testified that it might be appropriate to allow a medical student, nurse, social worker, or colleague to be present, but there is no reason to allow a pharmaceutical representative to be present.

268. In Dr. Schneider's report, he referred to the American Medical Association Principles of Medical Ethics with annotations applicable to psychiatry (2009) Section 8, which provides, in part: "A physician shall, while caring for a patient, regard responsibility to the patient as paramount." The following is a paraphrased summary of part of Dr. Schneider's report. Permitting a pharmaceutical representative to be present during an initial evaluation is beyond the realm of what could be considered teaching as one would see in a training program for residents or medical students. When a person in crisis is being interviewed, a psychiatrist should not have an observer present unless it is necessary.

269. Dr. Schneider testified that respondent's permitting a pharmaceutical representative to be present during RR's evaluation constituted an extreme departure from the standard of care

270. Dr. Addario testified that pharmacy representatives are adjuncts to hospitals. They support educational programs. They attend rounds and grand rounds. They understand the requirements of confidentiality. He said nothing indicates that RR was not competent to give his consent. Dr. Addario testified that respondent's permitting the pharmacy representative to sit in on the evaluation did not constitute a departure from the standard of care.

271. Respondent testified that RR seemed to be competent to give his consent.

272. Dr. Schneider's testimony and opinion logically accounted for the facts. Dr. Addario's testimony and opinion did not. Dr. Schneider's testimony was convincing.

273. It is difficult to imagine a justification for permitting a salesperson to observe a psychiatrist's evaluation of a patient. Psychiatrists have no particular role in educating or training sales people. Psychiatrists do have a role in educating the public, generally, and it is appropriate for psychiatrists to use clinical materials in teaching and writing so long as the materials are adequately disguised to preserve the anonymity of the clients involved. But it

is difficult to imagine a justification for permitting a salesperson to observe a session with a patient. Many people may be "adjuncts to hospitals," but that does not make them appropriate candidates to observe a psychiatrist's observation of a patient.

274. Moreover, it is highly questionable as to whether it would have been appropriate for respondent to have permitted anyone to observe his initial evaluation of RR under these circumstances. Respondent had never met RR before, and at the time he permitted the pharmaceutical representative to sit in on the evaluation, respondent knew very little about RR. What he did know should have cautioned against having a third party present. Respondent knew that, when RR arrived at the hospital the previous night, an emergency room physician recorded an "initial diagnosis impression" of "major depression suicide attempt." Respondent knew that that morning the staff had done a suicide assessment in which RR acknowledged that he thought about suicide and wanted his life to be over sometimes but not all of the time. Respondent knew that RR had reported that he recently broke up with his girlfriend of three and one-half years and that he had been having a hard time accepting that she had moved on while he had not. Respondent knew that, the previous night – just a few hours before respondent met with RR – the patient became so depressed that he came to think he had no reason to live anymore. It is true that the staff's suicide assessment also contained a number of more encouraging things, which, if true, suggested that RR might not be in crisis. But with what respondent knew, he had reason to conduct his initial interview with great care.

275. It is found that respondent improperly allowed a pharmaceutical representative to observe his observation of RR and that respondent's conduct constituted an extreme departure from the standard of care.

Care and Treatment of DB

276. DB was a 57 year-old man who was admitted to SCMC on a 5150 hold after getting into a drunken dispute with his former wife, who also was his business partner. The dispute escalated into a physical assault. DB told the police he wanted to kill himself.

277. On June 25, 2007, at 8:51 p.m., Officer Bixby, who was with the Laguna Beach Police Department, placed DB on a 5150 hold. In completing an application for a 72-hour detention for evaluation and treatment, Officer Bixby wrote the following:

> [B's] ex-wife & business partner called LBPD after [B] struck her and said that he was going to kill her and then kill himself.
>
> [¶] . . . [¶]
>
> Upon contact at his residence, [B] admitted that he was prepared to kill himself because he was depressed. He said that he was

going to use the loaded revolver that had just been in his hand and was next to the front door. A loaded revolver was confiscated from that location.

> On the form, Office Bixby checked boxes for the following: "Based on the above information, it appears that there is probable cause to believe that said person is, as a result of mental disorder, a danger to himself . . . [and] a danger to others."

278. In a section of the form entitled "notification to be provided to law enforcement agency," Office Bixby checked boxes for the following:

> Notification of person's release from an evaluation and treatment facility is requested by the referring peace officer because; [1.] [the] person had been referred under circumstances in which criminal charges might be filed pursuant to W & I Code Sections 5152 1 and 5152 2, and [2.] Weapon was confiscated pursuant to W & I Code 8102.

279. Officer Bixby wrote that the person to be notified was the Laguna Beach Police Department Watch Commander, and he gave a phone number.

280. DB completed an admission form with preprinted questions. One question was, "What sets you off?" DB responded, "My ex-wife."

281. A nurse had DB complete a preprinted "Suicide Assessment" form. DB denied suicidal ideation. He denied any suicidal intent, plan, or history. One question was, "Do you tend to make decisions impulsively?" He checked, "Yes." Regarding his relationship with his family, he checked "distant," and regarding his relationship with his friends, he checked "distant."

282. On June 25, 2007, at 8:50 p.m., a drug and alcohol screen showed an alcohol level of 94, which is slightly above the level at which it is statutorily presumed that one is too intoxicated to drive. The scan was positive for cannabis.

283. On June 25, 2007, at 8:51 p.m., DB was admitted to the SCMC emergency room. An emergency room doctor wrote an "initial diagnosis impressions" of "major depression with suicidal ideation." Respondent was listed as the attending physician. A nurse gave DB an advisement as to why he was being held and as to when the hold began. It said the staff had concluded that DB was dangerous to himself and to others. It said the staff had reached that conclusion because, "You admitted that you were prepared to kill yourself because you were depressed. You said you were going to use the loaded revolver that was next to your front door." The advisement said, further, "[Y]our 72-hour period will begin [at] 8:51 p.m. [on] 6-25-07."

284. A June 25, 2007, "treatment plan problem list," specifies "depression" and "anxiety."

285. A June 26, 2007, "treatment assessment and review plan," says, "Patient less anxious now that he is sober. He is not being treated medically for anxiety."

286. On June 26, 2007, respondent did a psychiatric admission evaluation. The following is a paraphrased summary of part of respondent's admission notes. DB admitted on a 5150. He threatened to kill himself. He had an argument with his ex-wife who is the designer for his business. He "pushed her." (Report says he hit her.) Consumes four ounces of alcohol daily and uses marijuana two times a week. No children. No religion. He threatened to kill himself with a gun. Angry about being here. Evasive. Plan: possible discharge.

287. Respondent testified that DB said he was sorry he had said he was going to kill himself. Respondent acknowledged that he should have documented the fact that DB told him that.

288. Respondent testified that DB told him a few things about DB's former wife. Respondent acknowledged that he should have documented the fact that DB told him things about DB's former wife.

289. On the morning of June 26, 2007, the doctors, nurses, and social workers who worked in the psychiatric unit met for their weekly case review. Respondent presented DB's case. There is a conflict in the evidence as to whether he mentioned his plan to release DB from the 5150 hold. Respondent testified that, in presenting cases, he always talks about discharge plans. He testified that, regarding DB, he said he was considering releasing him and asked whether anyone thought release sounded contra-indicated. Respondent said that no one objected. Respondent testified , "If anyone had expressed concerns, I would have taken that into account." Dr. Sassani testified that respondent did not mention that he intended to order an early release. After respondent presented DB's case, respondent left the case review meeting.

290. Respondent testified that, after leaving the meeting, he returned to the ward and met with DB again and decided to do an early release of the hold. Respondent acknowledged that he failed to document the fact that he met with DB again and failed to document why his opinion changed from possible release to release.

291. On June 26, 2007, at 9:15 a.m., respondent wrote a discharge note in which he released DB from the 5150 hold and wrote, "Follow up with psychotherapist. Two names and phone #s given to patient." At the time respondent signed the early release, DB had been in the hospital 12 and one-half hours.

292. When the case review meeting ended, a nurse told Dr. Sassani that respondent had released DB from the 5150 hold. Dr. Sassani testified that, when the nurse told him about the release, he recalled respondent's presentation of DB's case and was very concerned. He concluded he had to prevent the release. Dr. Sassani, as the medical director of the psychiatric unit, vetoed respondent's early release of DB. At 10:00 a.m., Dr. Sassani wrote an order saying, "Transfer care to Sassani," and he assumed responsibility as DB's attending physician.

Dr. Schneider's Testimony and Report Regarding Two Allegations Concerning DB

293. Complainant alleges that respondent committed gross negligence in his care and treatment of DB in two respects. One is that respondent released DB from the 5150 hold in spite of the fact that DB continued to have suicidal and homicidal risk factors. The second allegation is that respondent failed to notify readily identifiable potential victims of a homicidal threat. Complainant alleges these as separate matters.

294. Dr. Schneider testified that, regarding the first matter, respondent's conduct constituted a departure from the standard of care. He did not testify that it was an extreme departure.

295. Regarding the second matter, Dr. Schneider did not testify that it constituted a departure from the standard of care.

296. In Dr. Schneider's written report, he did not address these matters separately. He expressed an opinion about the two combined. He wrote that they would be considered an extreme departure. He wrote:

> In removing an imminently dangerous patient from a 5150 hold, failing to notify readily identifiable potential victims of a homicidal threat, [failing to have] corroborating patient information with supplemental data obtained from the patient's ex-wife, police officers, etc., Dr. Rosenfeld showed grievous errors of judgment which would be considered to be an extreme departure from the standard of care in this case.

297. Thus, from the combination of Dr. Schneider's testimony and written report, we have his opinion that the conduct alleged in the two matters, taken together, constitutes an *extreme* departure.

298. In testifying about and writing about respondent's care and treatment of DB, Dr. Schneider did not express an opinion that the conduct alleged in either of the allegations, *taken by itself*, constituted an *extreme* departure.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of DB in that Respondent Released DB from the 5150 Hold in Spite of the Fact that DB Continued to Have Suicidal and Homicidal Risk Factors

299. Dr. Schneider testified that DB's chart indicated a serious presence of suicidal and homicidal risk factors. The chart indicated the following: DB's former wife claimed he struck her and told her he was going to kill her and then kill himself. When the police arrived at DB's home, he had a loaded gun. DB admitted to the police that he was prepared to kill himself because he was depressed, and he told the police he was going to use the loaded revolver.

300. Dr. Schneider testified that respondent's admission evaluation note is very sketchy. Also, there is no evidence that respondent made an effort to contact anyone to determine whether DB's statements to him could be corroborated. Dr. Schneider testified that respondent failed to determine whether DB was dangerous.

301. Dr. Schneider said respondent failed to do an adequate observation before releasing the 5150 hold on DB and that his failure to do that constituted a departure from the standard of care. He said this was an extremely serious business. Dr. Schneider emphasized Officer Bixby's application for a 72-hour hold, which respondent read. From that, respondent knew the following: DB's former wife had called the police and claimed that DB struck her and said he was going to kill her and then kill himself. When Officer Bixby went to DB's residence, DB admitted that he was prepared to kill himself because he was depressed, and DB said he was going to use the loaded revolver that had just been in his hand and was next to the front door.

302. As noted above, Dr. Schneider did not testify or write that respondent's failure to do an adequate observation before releasing the 5150 hold, taken by itself, constituted an *extreme* departure. Nevertheless, from Dr. Schneider's testimony and report concerning a different patient, patient DA, it is clear that it is Dr. Schneider's opinion that authorizing an early release of a 5150 hold when that is not warranted constitutes an *extreme* departure from the standard of care. With regard to patient DA, Dr. Schneider testified that respondent's failure to do a complete suicide assessment constituted an extreme departure from the standard of care.

303. Dr. Addario testified that respondent was not negligent in removing the hold regarding DB. Dr. Addario emphasized the following: DB told respondent he did not intend to commit suicide and did not intend to harm others, and DB had no history of violence. Also, DB denied suicidal ideation and denied any intent to harm others. Dr. Addario dismissed the June 25, 2007, "treatment plan problem list," which listed depression and anxiety. He pointed to the "treatment assessment and review plan" of the following day, which says, "Patient less anxious now that he is sober. He is not being treated medically for anxiety." The implication of Dr. Addario's testimony is that, because DB's anxiety could have resulted from intoxication, respondent was free to ignore the possibility that DB's anxiety was more deep seated and could have been a suicide risk factor.

304. Dr. Addario testified that respondent's documentation concerning DB was adequate.

305. Respondent testified that he considered the risk factors that were present. He considered that DB was a 57-year-old white male who had threatened to kill himself, had a gun, lived alone, had argued with his ex-wife, engaged in substance abuse, and had lived in the area only a short while. Respondent said he concluded DB was a low risk for suicide because, after he sobered up, he regretted having threatened suicide and said he loved his ex-wife and wanted to get back together with her. Respondent testified that, from what DB told him, it sounded as though the ex-wife was a highly manipulative person.

306. Respondent did not document what DB said about his former wife. Also, respondent did not document his impression that the former wife was a highly manipulative person.

307. Dr. Schneider's testimony and opinion logically accounted for the facts. Dr. Addario's testimony and opinion did not. Dr. Schneider's testimony was convincing.

308. Dr. Addario's testimony about DB was incredible. He based his opinion that respondent was not negligent in releasing the hold on the fact that DB denied that he intended to commit suicide, denied that he intended to harm others, and had no history of violence. It does not require expertise to know that, when one threatens to do something and, the following day, denies the intent to do it, the denial does not just erase the threat. After a person threatens to kill someone, it takes more than a simple denial of intent to set things on an even keel. Dr. Addario's testimony in this regard was particularly curious in view of respondent's having reported that DB was "evasive" and in view of DB's response to, "What sets you off? He responded, "My ex-wife." Furthermore, what did Dr. Addario mean by his testimony that respondent knew that DB had no history of violence? Respondent knew very little about DB. Did Dr. Addario mean that respondent had no evidence of a history of violence? Simply having no evidence of a history of violence is not a sound bases for concluding that a person has no history of violence. One could reach such a conclusion only after having delved into the matter.

309. It is found that respondent released DB from the 5150 hold in spite of the fact that DB continued to have suicidal and homicidal risk factors and that respondent's conduct in that regard constituted an extreme departure from the standard of care.

Complainant Alleges that Respondent Engaged in Gross Negligence in his Care and Treatment of DB in that Respondent Released DB from the 5150 Hold Without Notifying Readily Identifiable Potential Victims of a Homicidal Threat

310. As noted above, Dr. Schneider, in testifying about and writing about respondent's care and treatment of DB, did not express an opinion that respondent's failing to notify a victim, taken by itself, constituted a departure from the standard of care.

311. In addition to that, Dr. Schneider assumed that DB told the police that he had planned to use a loaded revolver to kill himself and his ex-wife. In fact, there was no evidence that DB ever told the police or anyone at the hospital that he planned to or wanted to harm his ex-wife. The only evidence about a plan to harm DB's former wife was the evidence that the former wife called the police and claimed that DB was going to kill her and then kill himself.

312. DB did not make a threat against his former wife while he was in the hospital. Indeed, while he admitted that he had threatened to kill himself, he denied that he had threatened to kill his former wife.

313. In *Tarasoff v. Regents of the University of California* (1974) 13, Cal.3d 177, 131, the California Supreme Court held that, "[w]hen a doctor or a psychotherapist, in the exercise of his professional skill and knowledge, determines, or should determine, that a warning is essential to avert danger arising from the medical or psychological condition of his patient, he incurs a legal obligation to give that warning." (Ibid.) The court agreed to rehear the case. On rehearing, the court held that, "[w]hen a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger." The court said, "The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances." (*Tarasoff v. Regents of the Univ. of Cal.* (1976) 17 Cal.3d 425, 431.) The decision on rehearing broadened the duty from one of warning a potential victim to one that called for the protection of a potential victim.

314. Seven years later, the court handed down *Hedlund v. Superior Court* (1983) 34 Cal.3d 695. In *Hedlund,* the court concluded that the therapist's duty of care extended beyond the intended victim to her minor child because it was foreseeable that the child could be near her and emotionally traumatized by an attack against his mother. The court concluded that, when a therapist evaluates the risk of harm posed and takes steps to protect the potential victim, this must include a consideration of the risk of trauma to individuals who are "in close relationship" to the object of the threat. (*Hedlund, supra,* 34 Cal.3d 695, 706.)

315. Therapists were rightly concerned about the potential conflict between the duty to provide a *Tarasoff* warning and the duty to maintain the psychotherapist-patient privilege. They were concerned that patients, knowing of a therapist's duty to disclose, would be unwilling to discuss matters that were essential to their therapy. They were concerned about their professional obligations, and they were concerned about the risk of liability for a failure to give a *Tarasoff* warning and the risk of liability of violating patient confidentiality if they gave a warning.

316. In 1985, the Legislature responded by enacting Civil Code section 43.92, which substantially limited a therapist's exposure to liability for a failure to warn. Civil code section 43.92, subdivision (a), provides:

> There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist as defined in Section 1010 of the Evidence Code in failing to warn of and protect from a patient's threatened violent behavior or failing to predict and warn of and protect from a patient's violent behavior except where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.

317. In *Ewing v. Goldstein* (2004) 120 Cal.App.4th 807, the California Court of Appeal for the Second District expanded this statutory narrowing of the duty. The court held that "[a] communication from a patient's family member to the patient's therapist" that relays a threat of violence against an identifiable victim imposes a duty to warn. (Id. at p. 814.)

318. DB did not communicate a threat to respondent. In the present case, what respondent knew was that DB's former wife had reported to the police that he had threatened to kill her. No case has been found in which a court has applied Civil Code 43.92 to allow monetary liability for a failure to warn in such a case. And no case has been found in which a court has expanded Civil Code 43.92 and found a judicially created duty in such a case.

319. Moreover, a psychiatrist who authorizes an early release from a 5150 hold is immune from liability for the consequences of the patient's conduct if the psychiatrist has complied with certain statutory requirements. Welfare and Institutions Code section 5154, subdivision (a), provides:

> Notwithstanding Section 5113, if the provisions of Section 5152 have been met, the professional person in charge of the facility providing 72-hour treatment and evaluation . . . [and] the psychiatrist directly responsible for the person's treatment . . . shall not be held civilly or criminally liable for any action by a person released before the end of 72 hours pursuant to this article.

320. The person in charge and the psychiatrist meet the provisions of section 5152 and obtain the immunity from liability if the psychiatrist, as a result of observing the patient, believes the patient no longer requires evaluation or treatment. In the event of a disagreement regarding early release, section 5152 requires that the matter be referred to the medical director of the facility. As noted above, Welfare and Institutions Code section 5152 provides, in part:

> Each person admitted to a facility for 72-hour treatment and evaluation . . . shall receive an evaluation as soon as possible after he or she is admitted and shall receive whatever treatment and care his or her condition requires . . . . The person shall be released before 72 hours have elapsed only if the psychiatrist directly responsible for the person's treatment believes, as a result of the psychiatrist's personal observations, that the person no longer requires evaluation or treatment.

321. Respondent personally observed DB and, as a result of his observation, came to believe that DB no longer required evaluation or treatment. Thus, if DB had been released pursuant to respondent's order and had harmed someone, respondent would have had the benefit of the immunity from liability provided by Welfare and Institutions Code section 5154.

322. It would be possible for the standard of care to require a psychiatrist to give notice in spite of the fact that no monetary liability could attach for the failure. As noted above, however, Dr. Schneider did not testify that respondent's failure to warn, taken by itself, constituted a departure from the standard of care.

323. It is found that complainant failed to prove by clear and convincing evidence that respondent had an obligation to notify anyone that DB posed a threat.

Complainant did not Allege that Respondent's Failure to Notify the Watch Commander was a Violation of the Standard of Care

324. As noted above, in a section of the application form entitled "notification to be provided to law enforcement agency," Office Bixby checked boxes for the following:

> Notification of person's release from an evaluation and treatment facility is requested by the referring peace officer because; [1.] [the] person had been referred under circumstances in which criminal charges might be filed pursuant to W & I Code Sections 5152 1 and 5152 2, and [2.] Weapon was confiscated pursuant to W & I Code 8102.

325. Officer Bixby wrote that the person to be notified was the Laguna Beach Police Department Watch Commander, and he gave a phone number.

326. Dr. Sassani testified that it is very unusual for these boxes to be checked. He observed, also, that the form does not state who was supposed to notify the watch commander.

327. Ultimately, it was Dr. Sassani who released DB, and he did not notify the watch commander.

328. Complainant did not allege that respondent's failure to notify the watch commander constituted a departure from the standard of care.

329. Moreover, it is the professional person in charge of the facility – not the treating psychiatrist – who is responsible for notifying a peace officer when a person is released from a hold. Welfare and Institutions Code section 5152.1 provides:

> *The professional person in charge of the facility* providing 72-hour evaluation and treatment, or his or her designee, shall notify the county mental health director or the director's designee and the peace officer who makes the written application pursuant to Section 5150 or a person who is designated by the law enforcement agency that employs the peace officer, when the person has been released after 72-hour detention, when the person is not detained, or when the person is released before the full period of allowable 72-hour detention . . . . (Italics added.)

330. It was not respondent's responsibility to notify the watch commander.

Care and Treatment of AM.

331. Respondent prescribed Trileptal for AM, a drug that she, after asking that the prescription be filled, concluded she could not afford. AM's mother, who also was respondent's patient, told respondent that AM could not afford the medication he had prescribed.

332. Respondent, intending to be generous, gave AM a container of Trileptal that another patient had opened and returned to respondent. At the time respondent gave the medication to AM, respondent tore off the label.

Complainant Alleges that Respondent Engaged in Simple Negligence in his Care and Treatment of AM in that Respondent Gave her Prescription Medication After the Date on which the Medication had Expired.

333. Complainant offered no non-hearsay evidence that the medication respondent gave AM was beyond its expiration date.

334. It is found that complainant failed to prove by clear and convincing evidence that the medication respondent gave AM was beyond its expiration date.

Complainant Alleges that Respondent Engaged in Simple Negligence in his Care and Treatment of AM in that Respondent Gave AM Prescription Medication that was Not Clearly Labeled

335. The labeling was in violation of Business and Professions Code section 4076, subdivision (a), in that it failed to include the following: The manufacturer's trade name of the drug or a generic name, directions for use, the name of the patient, a prescription number or other means of identification, the strength of the drug, the quantity of the drug dispensed, and the date of the expiration of effectiveness.

336. Peter Weingold, M.D., testified that respondent's giving AM medication that was not properly labeled constituted an act of negligence.

337. Respondent acknowledged that, by giving AM medication that was not properly labeled, he breached the Pharmacy Law, which begins at Business and Professions Code section 4000.

338. It is found that, by giving AM medication that was not properly labeled, respondent engaged in conduct that constituted a departure from the standard of care.

Complainant Alleges that Respondent Engaged in Simple Negligence in his Care and Treatment of AM in that Respondent Gave AM Prescription Medication that was Not Sealed

339. Dr. Weingold testified that it is below the standard of care to give a patient medication that another patient has returned. In that circumstance, a doctor has no way of knowing the medication is pure. The first patient may have tampered with the medication or caused it not to be sterile.

340. It is found that by giving AM medication that was not properly sealed, respondent engaged in conduct that constituted a departure from the standard of care.

Matter in Aggravation

341. Respondent's license was disciplined previously. In 1998, an accusation was filed against respondent alleging, among other things, that he violated drug statutes by engaging in repeated, clearly excessive prescribing. The allegation concerned one patient – a man respondent treated at various times from 1983 to 1994. Respondent entered into a settlement agreement with the board in which respondent agreed not to contest the allegation that he had been grossly negligent by engaging in repeated and excessive prescribing. All other allegations were dismissed. The board suspended respondent's license but stayed the suspension and placed him on probation for five years subject to certain conditions. The suspension and probation became effective on September 11, 1999. Respondent testified that, during the term of his probation, there were no charges that he failed to comply with any of the probationary conditions. Respondent successfully completed his probation, and in 2004, his license was fully restored

Mitigating Circumstances

342. In giving the Trileptal to AM, respondent was not seeking any personal gain. He was intending to be generous and to provide AM with an opportunity to try a drug that he thought might help her – but that she felt she could not afford. That in no way excuses him for violating the Pharmacy Law; nevertheless, it is important to acknowledge that his motivation in giving AM the drug was a principled one.

343. The evidence did not show that respondent, in evaluating suicide risk factors and in providing early releases from 5150 holds, acted out of some malicious or self serving motive. There was no evidence that he would gain any personal benefit from providing early releases. He testified that he released people because of their right not to be held any longer than required for evaluation or treatment. He was concerned about unnecessarily depriving people of their liberty. The evidence clearly showed that some of his decisions constituted an extreme departure from the standard of care. To some extent, however, it is possible that his decisions would have appeared to be more in line with the standard of care if he had more thoroughly documented what he did to gather information and what he learned about his patients. The point concerning mitigation is that there is no evidence that respondent is unfit to practice. What the evidence shows is that he needs to change his practice in order to conform to the standards of the profession.

Rehabilitation

344. Respondent attended a two-day continuing education course on prescribing. The course dealt with a number of Pharmacy Law issues, and respondent declared that he will never again violate the Pharmacy Law.

Letters and notes from Patients

345. Respondent submitted 12 letters and notes from patients and former patients to support and supplement his testimony that he is a careful, attentive, and effective psychiatrist. The letters and notes range in date from August of 1995 to February of 2008. They are extremely laudatory. Some of the authors speak of their gratitude to respondent for his having saved their lives. Some speak of their gratitude to respondent for his having helped them recover from miserable lives. Many relate bad experiences with former psychiatrists and praise respondent for being adept as a therapist and adept with medication management. Patients praise respondent for being respectful, attentive, generous with his time, and prompt to respond to their needs. The letters convey a sense of the trust the authors have placed in respondent and describe wonderful things they have accomplished with his help.

Letters from Mr. Thrash and Ms. Todd

346. As noted above, respondent served as the Service Director of Partial Hospitalization Programs and Older Adult Programs at Charter Hospital Mission Viejo from April of 1992 to June of 1995. During that time, Jeffrey A. Thrash was the Chief Executive Officer of Charter Behavioral Health System of Mission Viejo. Mr. Thrash wrote a letter dated August 1, 1995, addressed to "Whom it May Concern." The following is a paraphrased summary of part of Mr. Thrash's letter: Respondent is highly knowledgeable, hard working, and dedicated. He contributed solid clinical and administrative recommendations to assist in the provision of quality and efficient psychiatric care. He is the rare psychiatrist who is triple board certified in psychiatry, geriatrics, and substance abuse. He served a valuable role as supervisor and practitioner.

347. Linda K. Todd, R.N., worked as a charge nurse at SCMC and had served as the Interim Nursing Director of the Behavioral Medicine Unit. Ms. Todd wrote a letter dated May 31, 2007, addressed to "Whom it May Concern." As of the date of Ms. Todd's letter, she had worked with respondent for five years. Ms. Todd wrote:

> During the past five years, if there have been complaints regarding Dr. Rosenfeld from patients, I have spoken to him directly and have found that he will assertively address specific complaints directly with patients. If there are complaints regarding medication side effects, I have found that Dr. Rosenfeld will respond in a timely manner to work with the patients and resolve issues.

Four SCMC Medical Directors Testified on Respondent's Behalf

348. John Robert Burnham, M.D., was the founding medical director of the mental health unit at SCMC. He served as medical director from 1974 to 1989. Dr. Burnham testified that he reviewed every patient's chart. He reviewed the quality of the evaluation and the quality of the treatment plan. He said the level of psychiatric practice was very high, but some of the psychiatrists did not document as extensively as they should have. He said he often discussed inadequate noting. Dr. Burnham testified that he did not, however, recall ever having had a problem with respondent's noting. Dr. Burnham testified that respondent is expert in the performance of ECT procedures. He said respondent's clinical skills and psycho-pharmacology skills are excellent, also.

349. Russell Christopher, M.D., was board certified in psychiatry by the American Board of Psychiatry & Neurology. He met respondent in 1978 through the Orange County Psychiatric Society. Dr. Christopher became medical director of the psychiatric unit at SCMC in 1990 and served in that capacity for more than 10 years. Dr. Christopher testified that respondent is a very good educator and lecturer. Dr. Christopher testified that he often observed respondent and often reviewed his charts. He said respondent is an excellent psychiatrist, an excellent diagnostician, and an excellent psycho-pharmacologist. Dr.

Christopher frequently consulted respondent for a second opinion regarding patients who were not progressing well. Dr. Christopher said he practiced with respondent during the time respondent's license was on probation but that he never observed respondent do anything that suggested he was not safe to practice.

350. Eric Speare, M.D., is board certified in psychiatry by the American Board of Psychiatry & Neurology. Dr. Speare and respondent were in school together; they were in the same residency program. Dr. Speare was the medical director of the psychiatric unit at SCMC from 2001 to 2006. Dr. Speare testified that respondent is thorough and reliable. Dr. Speare has referred patients to respondent. Dr. Speare said he has observed respondent's work for years and has never seen a problem with it. Dr. Speare said respondent has a good reputation as a practitioner.

351. As noted above, Dr. Granese is the current medical director of the psychiatric unit at SCMC. Dr. Granese is board certified in psychiatry by the American Board of Psychiatry & Neurology. Dr. Granese testified that he has reviewed respondent's cases and observed respondent. He said respondent is an excellent psychiatrist; "he does great clinical work." Dr. Granese said that, when he needs a second opinion, respondent is the person he goes to and that respondent is a valuable resource regarding medications.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of the Medical Practice Act is to assure the high quality of medical practice. The purpose is to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.)

2. The purpose of administrative discipline is not to punish physicians but to protect the public by eliminating those practitioners who are dishonest, immoral, disreputable, or incompetent. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

The Standard of Proof

3. The standard of proof in an administrative disciplinary action seeking the suspension or revocation of a physician's and surgeon's certificate is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

4. "Clear and convincing evidence" requires a high probability. It must be so clear as to leave no substantial doubt and to command the unhesitating assent of every reasonable mind. (*Mathieu v. Norrell Corp.* (2004) 115 Cal.App.4th 1174, 1190.)

A Witness's Testimony May be Accepted in Part and Rejected in Part

5. A jury, or a judge sitting without a jury, may accept part of a witness's testimony as convincing while rejecting other parts of the witness's testimony.

6. "If a witness is knowingly false in one part of his testimony, the jury may distrust other portions of his testimony as well." [Citation.] (*People v. Cook* (1978) 22 Cal.3d 67, 86.) However, a trier of fact may accept part of a witness's testimony but reasonably disbelieve other parts of it. (*Vallbona v. Springer* (1996) 43 Cal.App.4th 1525, 1537.) "The jury may reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses, thus weaving a cloth of truth out of selected available material." [Citations.] (*Stevens v. Parke, Davis & Co.* (1973) 9 Cal. 3d 51, 67-68.) "Although impeaching evidence in the nature of contradictions or otherwise has been received, it is still the right as well as the duty of the jury to determine to what extent they believe or disbelieve the testimony. [Citations.] They may likewise give credence to a witness who has falsely testified in part [citation] or whose testimony contains contradictions or inconsistencies." (*Hansen v. Bear Film Co.* (1946) 28 Cal.2d 154, 184. Accord, Turner v. Whittel (1934) 2 Cal.App.2d 585, 588.)

7. The trier of fact may evaluate the credibility of a witness, in part, by its subjective reaction to his demeanor, attitude, and manner of testifying, which are not communicated by the record. (*Meiner v. Ford Motor Co.* (1971) 17 Cal.App.3d 127).

The Unprofessional Conduct Issues and the Standard of Care

8. Physicians are required to exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care is a matter peculiarly within the knowledge of experts. It can be proven only by expert testimony, unless the conduct required by the particular circumstance is within the common knowledge of the layman. (*Williamson v. Prida* (1999) 75 Cal.App.4th 1417, 1424.)

9. Expert opinion testimony is required to prove or disprove that a physician performed in accordance with the prevailing standard of care. (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 1001.)

10. "Gross negligence" is "the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Eastburn v. Regional Fire Protection Authority* (2003) 31 Cal.App.4th 1175, 1185-1186.

Grounds to Impose Discipline

11. By reason of the matters set forth in Findings 201 through 215, 232 through 242, 252 through 260, 265 through 275, and 299 through 309, it is determined that respondent engaged in unprofessional conduct in that he engaged in gross negligence. Thus, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b), it is determined that there are grounds to discipline respondent's license.

12. Complainant alleged repeated negligent acts as a ground to impose discipline. However, complainant alleged repeated negligent acts only with regard to SK, LM, and AM. By reason of the matters set forth in Findings 78, 79, 80 through 85, 86, and 87, it is determined that respondent engaged in unprofessional conduct in that he engaged in repeated negligent acts. Thus, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c), it is determined that there are grounds to discipline respondent's license.

13. By reason of the matters set forth in Findings 78 and 79, it is determined that respondent engaged in unprofessional conduct in that, in providing services to a patient, he failed to maintain adequate and accurate records. Thus, pursuant to Business and Professions Code sections 2227, 2234, and 2266, it is determined that there are grounds to discipline respondent's license.

14. By reason of the matters set forth in Findings 335 through 338, 339, and 340, it is determined that, in connection with dispensing Trileptal to AM, respondent violated labeling requirements of the Pharmacy Law. Thus, pursuant to Business and Professions Code sections 2227, 2234, 4076, subdivision (a), and 4170, subdivision (a)(4), it is determined that there are grounds to discipline respondent's license.

15. By reason of the matters set forth in Findings 335 through 338, 339, and 340, it is determined that, in connection with dispensing Trileptal to AM, respondent violated statutes that regulate dangerous drugs and controlled substances. Thus, pursuant to Business and Professions Code sections 2227, 2234, and 2238, it is determined that there are grounds to discipline respondent's license. While this is a ground to discipline respondent's license, it does not, in this case, concern any conduct that is separate from the conduct that gives rise to the ground stated in conclusion 14 concerning the Pharmacy Law. This charge is cumulative.

16. By reason of the matters set forth in Findings 78, 79, 80 through 85, 86, 87, 201 through 215, 232 through 242, 252 through 260, 265 through 275, 299 through 309, 335 through 338, 339, and 340, it is determined that respondent engaged in unprofessional conduct. Thus, pursuant to Business and Professions Code sections 2227 and 2234, it is determined that there are grounds to discipline respondent's license. While this is a ground to discipline respondent's license, it does not, in this case, concern any conduct that is separate from the conduct that gives rise to the grounds stated in conclusions 11 through 14. This charge is cumulative.

What Discipline Should be Imposed?

17. Business and Professions Code section 2229 provides in part:

> (a) *Protection of the public* shall be the highest priority for the Division of Medical Quality . . . and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.
>
> (b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, the division . . . shall, wherever possible, *take action that is calculated to aid in the rehabilitation of the licensee*, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence.
>
> (c) It is the intent of the Legislature that the division . . . and the enforcement program shall seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies. Where rehabilitation and protection are inconsistent, protection shall be paramount. (Italics added.)

18. The board has adopted model disciplinary guidelines. In the introduction to the guidelines, the board notes the following: Business and Professions Code section 2229 mandates that protection of the public shall be the highest priority for the board. That section further specifies that, to the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of licensees. The guidelines set forth the various disciplines the board finds appropriate for identified violations. The guidelines will protect the public. Where not inconsistent with that mandate, they will promote rehabilitation of licensees. The guidelines, also, will promote uniformity, certainty, fairness, and deterrence.

19. The introduction recognizes that departure from the guidelines may be appropriate when there are mitigating circumstances. Departure may be appropriate, also, in settlement agreements if a licensee has promptly accepted responsibility and demonstrated a willingness to undertake board-ordered rehabilitation. The introduction provides that decisions and proposed settlements containing departures from the guidelines shall identify the departures and the facts supporting them.

20. Complainant established that respondent engaged in extreme departures from the standard of care as follows: Respondent discharged DA, JP, RR, and DB without having observed and evaluated them sufficiently, and respondent improperly allowed a pharmaceutical representative to observe his observation of RR.

21. Complainant established that respondent engaged in simple departures from the standard of care as follows: Respondent failed to recommend a substance abuse relapse prevention program for SK, failed to document whether he discussed a need for maintenance ECT with SK, and gave AM medication that was not properly labeled and sealed.

22. The Medical Board's disciplinary guideline for gross negligence and for repeated negligent acts provides for a minimum penalty of a stayed revocation and five years of probation and a maximum penalty of outright revocation.

23. In this case, there are no circumstances that would support a departure from the guidelines.

24. It is disturbing that this is not the first disciplinary proceeding against respondent. Nevertheless, on balance, it is determined that the minimum penalty is the appropriate one.

25. Respondent has taken steps toward rehabilitation. Respondent acknowledged that by giving AM medication that was not properly labeled, he violated the Pharmacy Law. He attended a two-day continuing education course on prescribing and declared that he will never again violate the Pharmacy Law. While not admitting that his record keeping fell below the standard of care, respondent acknowledged that it was not as good as it should have been.

26. With regard to two matters, respondent's lack of a self serving motive is a mitigating circumstance. In giving the Trileptal to AM, respondent was not seeking any personal gain. He was intending to be generous and to provide AM with an opportunity to try a drug that he thought might help her. The evidence clearly showed that some of respondent's decisions constituted an extreme departure from the standard of care. But in making the decisions he made to release patients or not to place them on holds, respondent was not seeking some improper personal gain. He testified that he released people because of their right not to be held any longer than required for evaluation or treatment, and his testimony was believable. He was concerned about depriving people of their liberty.

27. The testimony of the four medical directors is reassuring. They have great confidence in respondent as being an excellent psychiatrist. It is true that three of them have not observed his work recently, but the evidence shows that they were very familiar with respondent's performance in the past. And Dr. Granese, the current medical director, is very familiar with respondent's current performance and holds respondent in the same high esteem. Dr. Granese testified that he has reviewed respondent's cases and observed

respondent. He said respondent is an excellent psychiatrist; "he does great clinical work." When Dr. Granese needs a second opinion, respondent is the person he goes to.

28. The evidence does not support imposition of the maximum penalty. The evidence does not show that respondent is unfit to practice. What the evidence shows is that he needs to change his practice in certain respects to conform to the standards of the profession.

29. Considering all of the evidence, it is determined that the appropriate discipline is a stayed revocation and a five-year-probation subject to appropriate conditions.

ORDER

Physician's and Surgeon's Certificate No. G 34731 issued to the respondent, Irwin Ira Rosenfeld, M.D., is revoked. The revocation, however, is stayed, and respondent is placed on probation for five (5) years on the following conditions.

1. Within 60 calendar days of the effective date of this decision, and on an annual basis thereafter, respondent shall submit to the board or its designee, for its prior approval, educational programs or courses that shall be not less than 40 hours per year for each year of probation. The educational programs or courses shall be aimed at correcting areas of deficient practice or knowledge and shall be Category I certified and limited to classroom, conference, or seminar settings. The educational programs or courses shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours shall have been in satisfaction of this condition.

2. Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in prescribing practices, at respondent's expense, approved in advance by the board or its designee. Failure to successfully complete the course during the first 6 months of probation shall be a violation of probation.

3. A prescribing practices course taken after the acts that gave rise to the charges in the accusation but prior to the effective date of the decision may, in the sole discretion of the board or its designee, be accepted toward the fulfillment of this condition if the course would have been approved by the board or its designee had the course been taken after the effective date of this decision.

4. Respondent shall submit a certification of successful completion of the prescribing practices course to the board or its designee not later than 15 calendar days after successfully completing the course or not later than 15 calendar days after the effective date of the decision, whichever is later.

5. Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping, at respondent's expense, approved in advance by the board or its designee. Failure to successfully complete the course during the first six months of probation shall be a violation of probation.

6. A medical record keeping course taken after the acts that gave rise to the charges in the accusation, but prior to the effective date of the decision may, in the sole discretion of the board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the board or its designee had the course been taken after the effective date of this decision.

7. Respondent shall submit a certification of successful completion of the medical record keeping course to the board or its designee not later than 15 calendar days after successfully completing the course or not later than 15 calendar days after the effective date of the decision, whichever is later.

8. Within 60 calendar days of the effective date of this decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine (Program).

9. The Program shall consist of a comprehensive assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill, and judgment pertaining to respondent's specialty or sub-specialty. At a minimum, the Program shall consist of a 40 hour program of clinical education in the area of practice in which respondent was found to be deficient, and the Program shall take into account data obtained from the assessment, decision, accusation, and any other information that the board or its designee deems relevant. Respondent shall pay all expenses associated with the Program.

10. Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the board or its designee of its recommendations for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the Program recommendations.

11. At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination as to whether respondent passed the examination or successfully completed the Program shall be binding.

12. Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the board or its designee agrees in writing to a later time for completion.

13. Failure to participate in and successfully complete all phases of the clinical training program shall be a violation of probation.

14. If respondent fails to complete the clinical training program within the designated time period, respondent shall cease the practice of medicine within 72 hours after being notified by the board or its designee that respondent failed to complete the clinical training program.

15. Prior to engaging in the practice of medicine, the respondent shall provide a true copy of this decision and the accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the board or its designee within 15 calendar days. This condition shall apply to any changes in hospitals, other facilities or insurance carrier.

16. During probation, respondent is prohibited from supervising physician assistants.

17. Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in California. Respondent shall remain in full compliance with any court ordered criminal probation, payments, and other orders.

18. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the board, stating whether there has been compliance with all the conditions of probation.

19. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

20. Respondent shall comply with the board's probation unit. Respondent shall, at all times, keep the board informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the board or its designee.

21. Under no circumstance shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

22. Respondent shall not engage in the practice of medicine in respondent's place of residence.

23. Respondent shall maintain a current and renewed California physician's and surgeon's license.

24. Respondent shall immediately inform the board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

25. Respondent shall be available in person for interviews, either at respondent's place of business or at the probation unit office, with the board or its designee upon request at various intervals and either with or without prior notice, throughout the term of probation.

26. In the event respondent should leave the State of California to reside or to practice respondent shall notify the board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any of the activities defined in sections 2051 and 2052 of the Business and Professions Code.

27. All time spent in an intensive training program outside the State of California which has been approved by the board or its designee shall be considered as time spent in the practice of medicine within the State. A board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

28. Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California total two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

29. In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

30. All time spent in an intensive training program which has been approved by the board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

31. Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

32. Respondent shall comply with all financial obligations not later than 120 calendar days prior to the completion of probation.

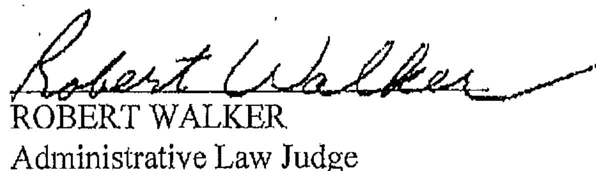
33. On respondent's successful completion of probation, his certificate shall be fully restored.

34. Failure to fully comply with any condition of probation is a violation of probation. If respondent violates probation in any respect, the board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation, a petition to revoke probation, or an interim suspension order is filed against respondent during probation, the board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

35. Following the effective date of this decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The board reserves the right to evaluate respondent's request and to exercise its discretion as to whether to grant the request or to take any other action deemed appropriate and reasonable under the circumstances. On the board's formal acceptance of a surrender, respondent shall, within 15 calendar days, deliver respondent's wallet and wall certificate to the board or its designee, and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation, and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

36. Each year, respondent shall pay the costs associated with probation monitoring as designated by the board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical board of California and delivered to the board or its designee no later than January 31 of each year. Failure to pay costs within 30 calendar days of the due date shall be a violation of probation.

Dated: October 14, 2011



ROBERT WALKER
Administrative Law Judge