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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO April 15 2019
BY Sara Pasion ANALYST

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:

David E. Sosin, M.D.
13362 Newport Avenue, Suite A
Tustin, CA 92780

Physician's and Surgeon's Certificate No. G13099,

Respondent.

Case No. 800-2015-016817
Consolidated with 800-2017-035391 and 800-2016-022344

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 April 19, 1967, the Medical Board issued Physician's and Surgeon's Certificate Number G13099 to David E. Sosin, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2019, unless renewed.

3. In a disciplinary action entitled "In the Matter of the Accusation Against David E. Sosin, M.D.," Case No. 8002013000597, the Medical Board of California issued a decision, effective December 2, 2016 (the "2016 Decision"), in which Respondent's Physician's and Surgeon's Certificate was revoked. However, the revocation was stayed and Respondent's was placed on probation for a period of five (5) years with certain terms and conditions. A copy of the 2016 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 unless otherwise indicated.

5. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

6. 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.

7. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not

apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

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

8. 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."

9. Section 2242 of the Code states:

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

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

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

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

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

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

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

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

10. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

11. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence- 4 patients)

12. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code for the commission of acts or omissions involving gross negligence in the care and treatment of Patients 1, 2, 3, 4.[1] The circumstances are as follows:

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

Patient 1

13. Respondent, a psychiatrist, treated Patient 1 from about June 11, 2012 through November 26, 2012 for various conditions, but primarily for ADHD (Attention Deficit Hyperactivity Disorder).[2] During this time period, Respondent started Patient 1 on Adderall, and Ritalin, which are both stimulants used to treat ADHD. Records also indicate that Respondent prescribed to Patient 1 other controlled medications such as Lorazepam (a benzodiazepine medication used to treat anxiety disorder), and Daytrana (a transdermal patch often used to treat pediatric patients (ages 6 to 17) with ADHD.[3]

14. As treatment began to progress, the patient would often send Respondent lengthy emails describing the adverse effects she was experiencing from taking the medications, which were prescribed to her by Respondent, such as Adderall and Ritalin.[4]

15. Despite learning that Patient 1 was using marijuana and experiencing adverse effects from the medications prescribed, Respondent did not seem to take active steps to stop prescribing more controlled medications to the patient, nor did Respondent immediately cease treatment of the patient until about November 26, 2012, more than five months after Patient 1's first visit/treatment by Respondent.[5]

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[2] Respondent diagnosed Patient 1 with ADHD, despite the patient's failure to meet diagnostic criteria for this disorder. Respondent stated in his interview with the Board that "Once [he] diagnose[s] ADD that is the cornerstone of my treatment."

[3] Please note that Patient 1 was not a pediatric patient. Apparently, Respondent was using Daytrana as an "off-label" prescription to treat Patient 1, who was an older patient.

[4] For example, Respondent's records showed that he was aware (even from the first visit on or about June 11, 2012) that Patient 1 was using marijuana. Also, Patient 1's subsequent emails to Respondent in June of 2012 and thereafter, also confirmed that Patient 1 was consuming "marijuana edibles," and "smoking pot....". Patient 1's emails, as early as June 18, 2012 (approximately one week after the first visit) also revealed that the patient was having adverse effects from the medications prescribed, and that the patient even crashed her car into a gas station sign.

[5] In September 2015, Patient 1 filed a complaint against Respondent to the Board, alleging that Respondent had overprescribed stimulants and other narcotics to her, causing severe side effects such as a seizure, which per Patient 1, Respondent said looked "fake."

16. The following acts or omissions committed by Respondent in his care and treatment of Patient 1 constitute an extreme departure from the standard of care:

a. Failure to timely terminate the doctor-patient relationship with Patient 1, upon learning that she was using marijuana and experiencing adverse effects from the medications prescribed.

b. Failure to perform a thorough psychiatric diagnostic evaluation of Patient 1.

c. Failure to obtain an adequate history of Patient 1's mood disorder.

d. Failure to obtain a thorough medication history.

e. Failure to obtain an adequate and complete family history of mental illness.

f. Failure to perform a mental status exam.

g. Failure to ascertain the reason lamotrigine was prescribed, and the medications that were tried prior to it.

h. Failure to consider a differential diagnosis.

i. Failure to discuss Patient 1 with her previous psychiatrist or to obtain medical records.

j. Failure to refer Patient 1 to an addiction specialist.

k. Failure to adequately mention all of Patient 1's communications and progress in the patient's chart (e.g. Patient 1's emails to Respondent, Patient 1's weight loss, etc.).[6]

l. Failure to consider the risks of prescribing a stimulant to a patient with a mood disorder.

m. Failure to recognize the mood disorder the stimulant prescriptions were producing.

n. Failure to provide appropriate mood stabilization treatment.

o. Prescribing stimulant medication at high dosages at the start of treatment rather than starting at a lower dose and gradually increasing the dosage, if needed.

p. Failure to recognize the adverse effects caused by the stimulant and antidepressant treatment, and to take effective action.

[6] Respondent notes that he would only document "glaring, important pieces of information that would be valuable to anyone that's looking at the chart."

q. Excessively prescribed controlled substances to Patient 1.

Patient 2

17. Patient 2 was a thirty-one-year-old female who treated with Respondent from approximately March 10, 2015 to approximately November 10, 2015. Patient 2 was found dead in a Jacuzzi on November 11, 2015.[7]

18. During her first visit on March 10, 2015, Respondent had Patient 2 fill out an "ADD Questionnaire" developed by Respondent, but it appeared that he never actually diagnosed Patient 2 with any mental or mental health disorder for which his treatment was appropriate. Nevertheless, records indicate that Respondent prescribed to Patient 2 a wide variety of dangerous, toxic medications, which are even more dangerous in combination, including Adderall (amphetamine salts), Alprazolam (Xanax), Zaleplon (a sedative),[8] Norco (Hydrocodone), Carisoprodol (Soma), as well as other medications.

19. The following acts or omissions committed by Respondent in his care and treatment of Patient 2 constitute an extreme departure from the standard of care:

a. Prescribing to Patient 2 a wide variety of dangerous, toxic medications, which are even more dangerous in combination, including Adderall, Alprazolam, Zaleplon, Norco, Carisoprodol, as well as other medications, without any basis, or any "good faith" examination.

b. Misdiagnosing Patient 2 with severe chronic back pain requiring opioids and barbiturate-like medications.

c. Misdiagnosing Patient 2 with an insomnia disorder requiring treatment with daily hypnotic sedatives.

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[7] An autopsy report showed that at the time of her death, Patient 2 weighed approximately seventy pounds. On her first visit of March 10, 2015, Respondent listed Patient 2 as weighing 105 pounds. Interestingly, Respondent had two distinct looking notes, dated November 10, 2015, one day prior to Patient 2's death, which included many inconsistencies, including a note from Respondent that Patient 2 weighed 93 pounds, despite the autopsy showing that Patient 2 had weighed seventy (70) pounds.

[8] Records show that CVS Pharmacy contacted Respondent on October 26, 2015, regarding his atypical use of Zaleplon, but it did not appear that Respondent made any corrections in his prescribing.

d. Misdiagnosing Patient 2 with an anxiety disorder requiring treatment with chronic hypnotic sedatives.

e. Misdiagnosing Patient 2 with Attention Deficit Hyperactivity Disorder (ADHD) persisting into adulthood, requiring treatment with high dose amphetamines.

f. Failure to diagnose Patient 2 with iatrogenic amphetamine-induced malnutrition, which was potentially fatal.

g. Prescribing of chronic extra-strength Hydrocodone to Patient 2 for pain, despite the improper diagnosis of same by Respondent.

h. Prescribing of daily Zaleplon to Patient 2 for insomnia with no proper work-up for possible causes of insomnia in a young adult.

i. Failure to make any corrections in prescribing, despite being notified by a pharmacy regarding Respondent's use of Zaleplon to Patient 2.

j. Prescribing of chronic daily Alprazolam to Patient 2 for anxiety, without the proper work-up for said condition.

k. Excessively prescribed Adderall, Alprazolam, Zalepelon, Norco, and Carisoprodol to Patient 2.

Patient 3

20. Respondent treated Patient 3 (a sixty-two-year old female) from about 1999 through 2016 for various conditions, but primarily for ADHD, despite no records/data which showed that Patient 3 had suffered from symptoms of ADHD, or had been treated or diagnosed with ADHD in the past, or during childhood. During this time period, Respondent prescribed medications such as Prozac and Celexa, which are antidepressants, to Patient 3, but the main medication which was prescribed to Patient 3 during this time period was Adderall (an amphetamine/stimulant), which was often specifically requested by Patient 3 for her own use, as well as for use by others in her family.[9]

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[9] Patient 3's case came to the attention of the Medical Board via a complaint by a representative from Cigna Insurance Company, which alleged that Respondent may be overprescribing Adderall to Patient 3 and her son. Apparently, Patient 3 and her family was fully insured, but no claims were submitted for the numerous prescriptions for Adderall Patient 3 and (continued…)

21. Throughout this seventeen year period, there was no history, symptom report, mental status examination, or diagnoses recorded. There was no documentation that Respondent inquired how Patient 3 obtained stimulant medication in the past, whether the medications were prescribed or purchased illicitly, the quantities Patient 3 was taking, over what period of time, Patient 3's use of other stimulants, or any general substance abuse treatment. There was also no documentation that Respondent made any inquiry about possible diagnoses to support the prescribing of Adderall or Ritalin to Patient 3 in the past, or how to obtain past records or to request past records. There was also no documentation that Respondent made any inquiry about Patient 3's deficits or symptoms. Also, there was also no documentation that Respondent ever took a history of Patient 3's depressive symptoms, sleep history, family history, or her use of alcohol, benzodiazepines, or other sedatives.

22. Respondent began prescribing dangerous controlled medications before ever recording any history or other information to warrant such prescribing practices. Respondent did not maintain records to explain the medical basis for the amounts of the controlled stimulants he was prescribing to Patient 3. There were also no explanations for the opioids he was prescribing to Patient 3.[10]

23. The following acts or omissions committed by Respondent in his care and treatment of Patient 3 constitute an extreme departure from the standard of care:

a. Prescribing to Patient 3 dangerous drugs, including Adderall, Prozac, Celexa, and opioids without any basis or any good faith examination.

b. Failure to perform a thorough psychiatric diagnostic evaluation of Patient 3.

c. Failure to obtain a thorough medication history.

(...continued)
her son had obtained from Respondent during the period ranging from January 7, 2013 through July 29, 2015.

[10] Throughout this time period, Respondent continued to prescribe dangerous controlled substances (sometimes increasing the dosage) to Patient 3, and Respondent seemed to ignore many signs that Patient 3 may have been abusing drugs and/or diverting same (e.g. Patient 3 would request medications for her mother and children; Patient 3 would also use some of her daughter's Adderall, Patient 3 would, at times, request, the doses she wanted, the amounts, and the "brand name" medication, etc.). Patient 3, at one point, also claimed that her meds were stolen.

d. Failure to make a differential diagnosis.

e. Failure to take an adequate past medical and social history.

f. Failure to obtain medical records.

g. Failure to recognize that Patient 3 was exhibiting drug-seeking behavior.

h. Failure to recognize that Patient 3 was abusing her medication.

i. Failure to recognize that Patient 3 was diverting medication.

j. Allowing Patient 3 to dictate the course of her medical care.

k. Excessively prescribed Adderall, Prozac, Celexa, and opioids to Patient 3.

Patient 4

24. Patient 4 is a twenty-seven-year-old male who treated with Respondent from approximately 1998 to approximately 2015.[11] Per records, Patient 4 was on Dexadrine given to Patient 4 by his mother, but Respondent does not document how Patient 4's mother obtained the Dexadrine, or why the Dexadrine was given to Patient 4. Respondent also did not document any diagnosis or treatment plan, nor did he request to speak with Patient 4's teachers or obtain any of Patient 4's school records, and pediatric records. Throughout this time period, Respondent prescribed controlled medications to Patient 4, including Ritalin, Vyvanse, and Adderall.[12]

25. Respondent was apparently treating Patient 4 for ADHD, but Respondent did not obtain any history of Patient 4's time in utero, any toxic substances to which Patient 4's mother may have been exposed, any perinatal history, any description of Patient 4's relations with his family, or any indication of Patient 4's strengths, weaknesses, and emerging personality. There is no documentation that Respondent ever performed the most basic psychological or neuropsychological testing on Patient 4 to confirm his diagnosis of ADHD. There is no

[11] Patient 4 began treating with Respondent at around age 7. Apparently, Respondent had been treating Patient 4 for ADHD, despite no objective testing by Respondent to confirm said diagnosis other than Respondent's dependence on the account of Patient 3, who was Patient 4's mother.

[12] Throughout Respondent's treatment of Patient 4, most of Respondent's assessments were that Patient 4 was "doing great" or "doing well." Despite these assessments, Respondent often increased the dosages of the meds prescribed to Patient 4, often at the suggestion of Patient 4's mother, and without explanation by Respondent justifying the change in meds and/or the change in dosing.

documentation that Respondent ever obtained objective testing of the severity of Patient 4's hyperactivity, impulsivity, or attentional problems.

26. Also, Respondent never obtained any metabolic testing to determine why he believed that Patient 4 needed the doses of medications which were often many times above the recommended maximum dosage. There is no documentation that Respondent ever considered, discussed, or referred Patient 4 to a treatment program for non-medication treatments for the alleged ADHD.[13] There is no documentation that Respondent ever considered any treatment for Patient 4 other than stimulant medications.

27. Respondent's records are extremely inadequate. There is no documentation explaining or justifying any dose increases or decreases. There is no report of any attempt to verify Patient 4's symptoms. It is unclear if Patient 4 ever had symptoms of ADHD, or whether the medications prescribed to Patient 4 was ever justified or indicated.[14]

28. The following acts or omissions committed by Respondent in his care and treatment of Patient 4 constitute an extreme departure from the standard of care:

a. Failure to perform a thorough diagnostic evaluation of Patient 4.

b. Failure to take a complete medical history of Patient 4.

c. Failure to have psychological and neuropsychological testing performed on Patient 4.

d. Failure to obtain any testing on Patient 4 regarding the severity of hyperactivity, impulsivity, and attentional problems.

e. Failure to obtain a full medical history from Patient 4's mother.

f. Failure to obtain Patient 4's pediatric records.

g. Failure to obtain Patient 4's school records.

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[13] At one point, Patient 4 was involved in non-medication treatment, yet there is no documentation that Respondent ever sought those records or any information about the treatment that was being provided.

[14] As stated above, Patient 3 and 4's health care insurer filed a complaint with the Board after noticing signs often associated with substance abuse (i.e. paying for the prescriptions in cash, despite having insurance, as well as the large amounts of high dose abusable medications that were being prescribed).

h. Failure to follow up with laboratory screening/testing while Patient 4 was on stimulant medication.

i. Failure to render a differential diagnosis.

j. Failure to render an adequate treatment plan.

k. Failure to refer Patient 4 to a treatment program for non-medication treatment of ADHD.

l. Failure to perform an ongoing evaluation of Patient 4 that would justify symptomology for long-term use of stimulant medication.

m. Excessively prescribed medications to Patient 4.

29. Respondent's acts and/or omissions as set forth in paragraphs 12 through 28, inclusive, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts-4 patients)

30. By reason of the facts and allegations set forth in the First Cause for Discipline above, Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in his care of Patients 1 through 4 above.

32. Respondent also committed a simple departure from the standard of care by using an invalidated rating scale of his own creation to make the diagnosis of ADHD in Patients 1 through 4.

THIRD CAUSE FOR DISCIPLINE

(Incompetence-4 patients)

33. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 2234, subdivision (d), of the Code, in that Respondent showed a lack of knowledge in his care and treatment of Patients 1 through 4.

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FOURTH CAUSE FOR DISCIPLINE

(Prescribing Without Exam/Indication-4 patients)

34. By reason of the facts and allegations set forth in the First Cause for Discipline above, Respondent is subject to disciplinary action under section 2242 of the Code, in that Respondent prescribed dangerous drugs to Patients 1 through 4 without an appropriate prior examination or medical indication therefor.

FIFTH CAUSE FOR DISCIPLINE

(Excessive Prescribing- 4 patients)

35. By reason of the facts and allegations set forth in the First Cause for Discipline above, Respondent is subject to disciplinary action under section 725 of the Code, in that Respondent excessively prescribed dangerous drugs to Patients 1 through 4.

SIXTH CAUSE FOR DISCIPLINE

(Prescribing to an Addict-Patient 3)

36. Respondent is subject to disciplinary action under section 2241 of the Code in that Respondent prescribed controlled substances to Patient 3, a patient who had signs of substance abuse/dependency.

37. The facts and circumstances in paragraphs 20 through 23, above, are incorporated by reference as if set forth in full herein.

SEVENTH CAUSE FOR DISCIPLINE

(Inadequate Records-4 patients)

38. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to maintain adequate and accurate records of his care and treatment of Patients 1 through 4.

CAUSE TO REVOKE PROBATION

(Incompetence/Failure to Pass CPEP)

39. At all times after the effective date of Respondent's probation, Condition 7 of the 2016 Decision states in pertinent part:

"Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program equivalent [e.g. Center for Personalized Education for Physicians (CPEP)] to the Physician Assessment and Clinical Education ("PACE") Program offered at the University of California - San Diego School of Medicine ("Program").

...

... Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. Determination as to whether Respondent successfully completed the examination or successfully completed the program is solely within the program's jurisdiction...

If Respondent fails to....successfully complete the clinical training program.....Respondent shall.....cease the practice of medicine within three (3) calendar days after being so notified....Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period."

40. Respondent has failed to pass the CPEP program, thus violating his probation. The circumstances are as follows:

A. Respondent enrolled in CPEP program on July 31 through August 1, 2017, after settlement of an Accusation concerning Respondent's care and treatment of patient MC, which is more fully described in the 2016 Decision.

B. Overall, CPEP found that Respondent's medical knowledge and patient care was not at the level of a practicing psychiatrist. Per CPEP'S assessment, Respondent's most significant weaknesses were in the areas of psychopharmacology, evaluation of suicidal ideation,

and ADD/ADHD evaluation components.

C. Respondent completed a Psychiatry Clinical Science Subject Test examination and achieved a score of 58% correct with a total test percentile rank of 1%. Overall, Respondent's performance on the examination was poor with need for further study in psychiatry.

D. CPEP also assessed Respondent's clinical judgment and reasoning and identified significant concerns regarding Respondent's controlled substance prescribing. For example, CPEP consultants opined that Respondent was not applying evidence-based principles to his patient care, and that Respondent rarely considered or used non-controlled substances in his ADD/ADHD patients. CPEP consultants also found that Respondent prescribed benzodiazepines in several of his simulated patients without clear indication, and the consultants opined that Respondent needs to be more cautious in his prescribing of benzodiazepines. There was no indication that Respondent was reviewing the prescription drug monitoring program (CURES) to see if his patients were receiving controlled substances from other providers.

E. CPEP reviewed Respondent's documentation of simulated patient charts, as well as evaluated Respondent's physician-patient communication. Overall, CPEP found that the quality of documentation in Respondent's outpatient charts was poor, and that Respondent's physician-patient communication skills during the exercise were poor.

41. Respondent's lack of basic medical knowledge as shown by objective and subjective factors shows that he is incompetent and subjects his license to discipline.

DISCIPLINE CONSIDERATIONS

42. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that effective December 2, 2016 (the "2016" Decision), in a prior disciplinary action entitled *In the Matter of the Accusation Against David E. Sosin, M.D.*, case no. 8002013000597, before the Medical Board of California, Respondent's license was placed on five

years probation, with terms and conditions. The 2016 Decision is now final and is incorporated by reference as if fully set forth.

43. Effective June 14, 1999 (the "1999" Decision), in a prior disciplinary action entitled *In the Matter of the Accusation Against David E. Sosin, M.D.,* case no. 04-1996-66892, before the Medical Board of California, Respondent's license was placed on three (3) years probation with terms and conditions. Moreover, on February 24, 2012, a Public Letter of Reprimand (PLR) was issued against Respondent's physician's and surgeon's certificate for overprescribing stimulants to a patient. The "1999" Decision and PLR are now final and are incorporated by reference as if fully set forth.

PRAYER

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

1. Revoking the probation that was granted by the Board in Case No. 8002013000597 and imposing the disciplinary order that was stayed, thereby revoking Physician's and Surgeon's Certificate No. G13099 issued to Respondent;

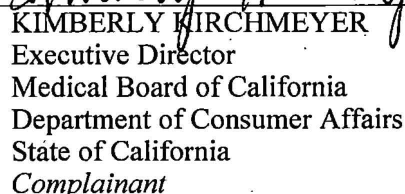
2. Revoking or suspending Physician's and Surgeon's Certificate Number G13099, issued to David E. Sosin, M.D.;

3. Revoking, suspending or denying approval of David E. Sosin, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code and advanced practice nurses;

4. Ordering David E. Sosin, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: April 15, 2019



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

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