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

In the Matter of the Accusation Against:	)	
	)	
Brooke Millon Barton, M.D.	)	Case No.: 800-2015-018519
	)	
Physician's and Surgeon's Certificate No. G 43306	)	OAH No.: 2019041274
	)	
Respondent	)	
	)	

ORDER OF NON-ADOPTION OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted.** A panel of the Medical Board of California (Board) will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit directed at whether the decision should be modified for public protection. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact Kennedy Court Reporters, 920 West 17th Street, Second Floor, Santa Ana, CA 92706. The telephone number is (714) 835-0366.

To order a copy of the exhibits, please submit a written request to this Board.

In addition, oral argument will only be scheduled if a party files a request for oral argument with the Board within 20 days from the date of this notice. If a timely request is filed, the Board will serve all parties with written notice of the time, date and place for oral argument. Oral argument shall be directed only to the question of whether the proposed penalty should be modified. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel. The Board directs the parties' attention to Title 16 of the California Code of Regulations, sections 1364.30 and 1364.32 for additional requirements regarding the submission of oral and written argument.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The mailing address of the Board is as follows:

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831
(916) 263-2451
Attention: Kristen Barkley

Date: November 19, 2020

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

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

In the Matter of the Accusation against:

BROOKE MILLON BARTON, M.D.,

Physician's and Surgeon's Certificate No. G 43306,

Respondent.

Agency Case No. 800-2015-018519

OAH No. 2019041274

PROPOSED DECISION

Howard W. Cohen, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter on January 13 through 17 and February 21, 2020, in Los Angeles, CA, and telephonically on April 27 and May 22, 2020.

Trina L. Saunders, Deputy Attorney General, represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

Tracy Green and Joel B. Douglas, Attorneys at Law, represented respondent Brooke Millon Barton, M.D., who was present throughout the hearing.

Oral and documentary evidence was received. During the hearing, on complainant's motion and over respondent's objection, the ALJ ruled the Accusation amended to add a fourth cause for discipline, for "Repeated Negligent Acts," comprising paragraphs 65 through 67, which read as follows:

> 65. Respondent Brooke Barton is subject to disciplinary action under secretion [*sic*] 2234 (c), in that she was repeatedly negligent in the treatment of three patients. The circumstances are as follows:
>
> 66. Paragraphs 25 through 53 are incorporated by reference as though fully set forth.
>
> 67. Respondent departed from the standard of care by inappropriately prescribing controlled substances to patients A, B, and C, and failing to provide adequate safety monitoring to the patients.

The record was held open to allow: (a) respondent to file and serve respondent's patient records, exhibits B through E, redacted to protect patient privacy rights and highlighted to identify language in the typewritten version of the records that did not appear in the original handwritten version, by May 26, 2020; (b) complainant to file a closing brief by June 19, 2020; (c) respondent to file a closing brief by July 24, 2020; (d) respondent to file a certificate of completion of certain continuing education courses by August 7, 2020; and (e) complainant to file objections and a reply closing brief by August 14, 2020.

Respondent filed, on May 28, 2020, the redacted and highlighted versions of exhibits B through E, which replace the previously filed exhibits assigned those letters, and complainant's exhibits 12 through 16. Complainant timely filed a closing brief on June 18, 2020, and respondent timely filed a closing brief on July 27, 2020; the briefs were marked as exhibits 26 and WW, respectively. Respondent timely filed certificates of completion of two continuing education courses on August 4, 2020, which were marked collectively as exhibit XX. Complainant timely filed a reply closing brief on August 13, 2020; the brief was marked as exhibit 27. Complainant objected to the admission of exhibit XX; the objection was overruled and exhibit XX was admitted into evidence under Government Code section 11513, subdivision (c).

The record was closed and the matter was submitted for decision on August 14, 2020.

SUMMARY

Complainant seeks to discipline respondent's physician's and surgeon's certificate on grounds of (a) unprofessional conduct for failure to cooperate with a Board investigation; (b) gross negligence and repeated negligent acts in the treatment of patients A, B, and C; and (c) inadequate and inaccurate recordkeeping with respect to patients A, B, C, and D.

Complainant alleged that respondent failed to timely produce subpoenaed medical records, failed to submit to a Board interview, and belatedly produced handwritten medical records that were uncertified and illegible; only after a court order did she transcribe those records and produce them to the Board. Complainant alleged gross negligence and repeated negligent acts in assessing and monitoring,

and in prescribing controlled or dangerous substances to, patients A, B, and C over a course of years, and respondent's failure to maintain adequate and complete medical records with respect to patients A, B, C, and D. Respondent denies the allegations and asserts cause for discipline does not exist.

FACTUAL FINDINGS

Jurisdiction

1. Complainant filed the Accusation in her official capacity. Respondent timely filed a notice of defense.

2. The Board issued Physician's and Surgeon's Certificate No. G 43306 to respondent on September 15, 1980. Respondent's certificate was in full force and effect at all relevant times and is scheduled to expire on January 31, 2020.[1]

3. The Board has previously disciplined respondent's certificate. By a Decision and Order effective April 14, 2003, in case number 06-1999-102944, the Board revoked respondent's certificate, stayed the revocation, and placed respondent

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[1] The evidence did not establish whether respondent renewed her license. However, any lapse of a license by operation of law does not deprive the Board of jurisdiction to proceed with any investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license. (Bus. & Prof. Code, § 118.)

on probation for two years with terms and conditions. Respondent completed probation on April 14, 2005.

Expert Witnesses

4. Complainant designated Paul Edward Hartman, M.D. as an expert witness. Dr. Hartman received his medical degree from the University of Western Australia, in Perth, in 1983. He completed an internship and surgical residency at Royal Perth Hospital in Australia in 1984, and a neurosurgical residency at Toronto General Hospital in Canada in 1985, and practiced family medicine in Australia from 1985 to 1991. He then completed a psychiatry residency in at St. Ann's Hospital in Bournemouth, England, in 1992, a three-year adult psychiatry residency at Yale University in 1995, and a two-year child and adolescent psychiatry fellowship at Harvard University in 1997. He is board-certified in adult psychiatry, and in child and adolescent psychiatry, and is licensed to practice in California and Hawai'i. He practices psychiatry at Kaiser's Los Angeles Medical Center.

5. Respondent called no expert witnesses. Respondent offered her own non-expert testimony as to standards to which she chose to adhere in her practice.

Respondent's Cooperation with the Board's Investigation

6. The Board's Central Complaint Unit (CCU) received a consumer complaint about respondent's prescribing practices. James Nuovo, M.D., in the CCU, generated a Controlled Substance Utilization Review and Evaluation System (CURES) report showing a history of medications respondent had prescribed for her patients. Dr. Nuovo identified on the CURES report patients he believed may have received excessive prescriptions from respondent.

7. The CCU referred the matter to the Health Quality Investigations Unit (HQIU). The HQIU assigned Ellen Coleman, an investigator in the unit's Glendale office, to investigate the matter. Ms. Coleman received Dr. Nuovo's report and the consumer complaint, and forwarded Dr. Nuovo's findings to Jill Klessig, M.D., an in-house medical consultant at HQIU. Ms. Coleman asked Dr. Klessig to render an opinion as to whether respondent had excessively prescribed any medications and whether she concurred with Dr. Nuovo's selection of patients. Dr. Klessig found respondent had excessively prescribed medications and identified patients she felt were recipients of excessive prescribing.

8. Ms. Coleman obtained the addresses of three patients identified by Dr. Klessig and two patients identified by Dr. Nuovo. She sent release forms to the patients, requesting authorization to obtain their medical records from respondent, but the patients were unwilling to release their records. Ms. Coleman then subpoenaed the records from respondent, who did not respond to the subpoenas. Ms. Coleman left respondent a voicemail message requesting a reply. Alan Kaplan, respondent's attorney, emailed Ms. Coleman and asked her to send the subpoenas to his office. Ms. Coleman did so, but still did not receive the records.

9. Ms. Coleman referred the matter to the Office of the Attorney General to enforce the subpoenas. A Deputy Attorney General petitioned the Superior Court of California, County of Los Angeles, in case number BS174337, for an order to show cause (OSC) re contempt and an order compelling respondent to produce medical records. On November 2, 2018, the court granted the petition, and on November 5, 2018, the court issued a signed order requiring respondent to produce medical and

billing records related to patients A, B, C, D, and E, in accordance with the Board's subpoenas for those records, by November 18, 2018.[2]

10. Respondent failed to comply with the court order that she produce the records.

11. After respondent failed to produce the documents and failed to appear at a case management conference on December 17, 2018, the court issued an Order to Show Cause re: Contempt, returnable on January 3, 2019. Robert Pulido, Commander of the Los Angeles region of HQIU, and HQIU Glendale Acting Interim Supervisor at that time, personally served respondent with the OSC re contempt on December 18, 2018. (Ex. 22, p. 23.)

12. On December 19, 2019, respondent produced handwritten, uncertified medical records for patients A through E, and billing records for patient D, to the Office of the Attorney General. At this administrative hearing, Ms. Coleman acknowledged that she received the subpoenaed medical records from respondent. Ms. Coleman characterized the records, however, as "a mess," testifying that they were not separated by patient, they were nearly illegible, and they were not certified. (See Exs. 7-11.)

13. On January 3, 2019, the court held a contempt hearing; respondent did not appear. The court issued a bench warrant for respondent's arrest.

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[2] Complainant did not raise in the Accusation any of respondent's actions with respect to patient E.

14. On January 11, 2019, respondent produced five record certifications for the records she had produced on December 19, 2018. As of the date the Accusation in this matter was filed, respondent had not produced legible copies of the medical records for patients A through E.

15. On January 7, 2019, the Board served respondent with a subpoena to appear and testify in an interview at the Glendale office of the HQIU on January 28, 2019. On January 28, 2019, respondent failed to appear for the Board interview.

16. At this administrative hearing, respondent testified that she did not timely produce her records because she was having difficulty obtaining her patients' consent to do so, and an attorney she hired, Zachary Wechsler, told her the law was not clear as to whether the Board could compel production over a patient's objection. She also argued that a licensee's attendance at a Board interview is not mandatory and that she did not appear because her patients did not want her to discuss their confidential information with the Board.

17. Respondent created and produced to complainant typewritten transcripts of the handwritten medical records for patients A, B, C, and D. The typewritten transcripts were not identical to the handwritten notes. Certain abbreviations in the handwritten notes were spelled out in the typewritten transcripts. Some language that did not appear in the handwritten notes appeared in the typewritten transcripts, usually in brackets; according to respondent, she added the bracketed language to explain and provide context to certain note entries. There may have been some additional changes. The records were not uniformly redacted to protect the patients' confidentiality.

18. During the hearing, by order of the ALJ, the records were thoroughly redacted to protect the privacy rights of the patients. The ALJ also ordered respondent to highlight in the transcripts all modifications she had made to the handwritten transcripts, and to submit those to replace what had been marked as exhibits 12 through 16. The redacted exhibits, without highlighting, were lodged with OAH on April 20, 2020. The highlighted versions were lodged with OAH on May 28, 2020. The ALJ admitted the highlighted redacted copies into evidence as exhibits B through E, replacing the previously marked exhibits B through E and the previously marked but not admitted exhibits 12 through 16.

19. Complainant seeks to discipline respondent for unprofessional conduct under Business and Professions Code section 2234, subdivision (a), for failure to comply with the court order, issued to enforce a subpoena, requiring that she produce medical records of patients A, B, C, D and E. Complainant also prayed for civil penalties in the amount of $10,000. To justify her noncompliance with the court order, respondent cites case law supporting the privacy rights of the patients whose records the Board subpoenaed, as well as *Bearman v. Superior Court* (2004) 117 Cal. App.4th 463, 472, for the proposition that the Board, in subpoenaing medical records, is limited to a focused inquiry. There is no basis on this record to conclude that the Board's inquiry was not focused, or that the patients' privacy rights have not been protected. The *Bearman* court found that, where the subpoenas are not overbroad and the materials to be disclosed are relevant to the subject matter of the Board's inquiry, Business and Professions Code section 2225, subdivision (a), provides the necessary protection for the patients' privacy rights. Such is the case here.

20. Respondent also argues that respondent substantially complied with the Board's subpoenas, eventually producing handwritten records, and later certifying

them. Respondent argues that she followed the advice of counsel in responding to the subpoenas, and that complainant, therefore, has not demonstrated by clear and convincing evidence that her noncompliance with the superior court's order to produce records was willful.

21. The record reflects, however, respondent's unreasonable resistance to complying, even substantially. Respondent failed to produce records subpoenaed by her licensing agency. She then continued to refuse to produce them despite a court order that she do so. Only after a bench warrant issued did respondent even partially comply with the court order, over a month after the court-ordered production date. She produced uncertified patient records that were largely illegible. Another month passed before respondent finally certified the records.

Respondent's Treatment of Patients A, B, and C, and Recordkeeping for Patients A, B, C, and D

22. Respondent is a psychiatrist in private practice in Los Angeles. Complainant alleges that respondent engaged in gross negligence and repeated negligent acts by prescribing controlled substances to three patients, patients A, B, and C, without justification, and by creating incomplete, inadequate medical records that were also so illegible that no subsequent treating physician could provide those patients appropriate continuing care.

23. Dr. Hartman opined that respondent repeatedly failed to follow the standard of care related to documentation of history, physical exam, treatment plan, periodic review, and informed consent in the patients' medical records. Dr. Hartman also opined that respondent committed gross negligence and simple negligence with each of the four patients.

24. Dr. Hartman concluded that respondent committed gross negligence in that she prescribed controlled substances without indication for the drugs prescribed, and in doses and quantities that were significantly above the recommended doses and quantities. She prescribed these controlled substances in combinations that were dangerous to the health and life of the patients. Respondent did not properly monitor the patients after prescribing dangerous drugs to them. Respondent did not have a treatment plan to taper the patients to lower doses and eventually wean them off the dangerous drug regimens she had placed them on.

25. Dr. Hartman testified that the applicable standard of care is what a reasonably prudent psychiatrist would do in treating a patient under like circumstances. Dr. Hartman acknowledged that a licensed physician may properly prescribe differently than what is set forth in the Physician Desk Reference (PDR) or Food and Drug Administration (FDA) drug inserts, and that the off-label use of FDA-approved drugs is medically accepted.

26. Dr. Hartman's testimony regarding the standard of care is given great weight in this matter, as it is not contradicted by any expert testimony for respondent. Respondent's testimony about her own beliefs concerning the standard of care serves only to establish why she acted as she did in treating the patients in question, not to establish the actual standard of care. Moreover, her stated belief that the standard of care governing the practice of psychiatric medicine for Kaiser patients differs from the standard of care for patients of private practitioners treating patients "on the Westside" of Los Angeles reflects questionable judgment. Every psychiatric patient in California is entitled to receive the same level of care whether they see a doctor in a managed care facility or in the physician's private office, as established by the standard of care in the community.

27. Respondent testified that she generally derived her understanding of the standard of care from the American Psychiatric Association practice guidelines for the psychiatric evaluation of adults. From 2012 to 2015, she would speak with patients at their first session about taking addictive medication as directed. She would document those discussions with the notation, "risks/benefits/alternatives/side effects." Respondent testified she discussed medication risks and benefits with patients A through D, consistent with her practice. She told them of the short-term and long-term effects, and that the benzodiazepines she was prescribing posed a risk of habituation, possible addiction, possible depression, mental slowing, and short-term memory loss.

28. Respondent testified that she has changed her practice in that she now has a written medication agreement that patients must sign. She now issues only one refill at a time, and checks with the pharmacy every month.

29. As for record keeping, respondent testified that it is unlikely another psychiatrist would ever read her notes. Even among patients who transfer from her care to that of another psychiatrist, very few request that their records be sent to the new psychiatrist. If respondent receives such a request, she sends a summary she types from her notes in lieu of actual records. Respondent's testimony on these points was credible, though Dr. Hartman's statement of the standard of care, requiring complete and legible notes, was persuasive.

30. In response to Dr. Hartman's opinion that she failed to adequately document mental status examinations (MSE's), respondent testified that, with respect to her weekly sessions with patients, the entire session is an MSE. This loose, and all too convenient, definition of an MSE was not a persuasive statement of the applicable standard of care. With respect to Dr. Hartman's opinion about the records lacking

appropriate treatment plans, respondent testified that the APA guidelines do not require them, but only suggest them. Again, on this record, respondent is not convincing. She testified that documenting informed consent, which she did not always do in the past, is not required by the standard of care, which mandates only that the treating psychiatrist discuss risks and benefits with the patient and document what she or he thinks is important for each patient.

31. As already noted, respondent testified she has changed her practice and now uses a written consent form. Her testimony as to both the standard of care and as to her current practice was not credible. Respondent introduced documentation of the consent form she claims to use. That documentation, however, is a collection of County of Sacramento forms that respondent printed out, and does not include a copy of respondent's purported actual consent form. Respondent also testified that she keeps no written list of medications she has prescribed to her patients. She admitted that such a list could be useful, but cavalierly, and not convincingly, claimed to be able to create such a list in two minutes by going through her charts.

PATIENT A

32. Patient A visited respondent about 185 times from February 2012, when Patient A was 76 years old, through December 2015. Respondent diagnosed Patient A with depression after conducting a brief MSE and taking a past medical history. The medical history showed patient A suffered from fibromyalgia and chronic fatigue

syndrome, and had used Didrex[3] for 10 years. On November 5, 2015, respondent noted that patient A was experiencing grief and taking medications. In the records covering the three-year period that Dr. Hartman reviewed, this is the only documented MSE he found. An MSE is objective documentation of the patient's condition at that time; the treating physician, or a subsequent treating physician, can look back at MSE's and determine the patient's progress in order to create appropriate treatment plans.

33. Dr. Hartman testified that respondent did not document her monitoring, if any, of Patient A's body weight, vital signs, EKG's, or informed consent. The medical records lack any rationale for long-term prescribing of benzphetamine and triazolam, a sleep medication, and lack any plan for tapering the dose of and ultimately discontinuing those medications.

34. According to Dr. Hartman, respondent departed from the standard of care by failing to prescribe the fewest effective medications at the lowest effective dose. The combination of medications respondent prescribed included two sedating medications with additive side effects, Seroquel and Halcion, as well as Didrex. Prescribing all three medications together presents cumulative risks, so the doctor must monitor the patient's response to the medications and balance that against safety concerns.

35. Seroquel, an antipsychotic medication, is used off-label for insomnia and is not habit forming. Dr. Hartman acknowledged that patient A's primary care

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[3] Didrex is a brand name for benzphetamine, a controlled substance stimulant similar to an amphetamine, and an appetite suppressant prescribed to patients with severe obesity.

physician, Dr. Mitch Cohen, approved the use of Seroquel for sleep, reflecting appropriate communication between the internist and respondent.

36. Halcion (Triazolam), a benzodiazepine like Xanax, is FDA-approved for sleep. Dr. Hartman testified that Halcion is recommended for short-term use, around 10 days, though some patients need it for longer periods to treat, for example, crippling panic attacks or agoraphobia. The standard of care then is to try to taper and discontinue it, to document that, and to use alternative non-addictive medications. Respondent prescribed it for long-term use, and at twice the recommended adult dose. For an elderly person, not more than 0.25 mg daily is recommended, due to the possibility of serious side effects. Respondent prescribed a daily dose of 0.5 mg.

37. Didrex helped the patient wake up in the morning. Dr. Hartman testified that using 400 mg for that purpose, however, could indicate possible abuse, and should be considered a red flag to the doctor to exercise caution and begin tapering. A CURES report shows respondent prescribed 60 50 mg tablets to patient A, to be taken two times per day. The recommended initial dose is 25 mg daily; though 50 mg three times per day, or 150 mg per day, may be acceptable, it is standard practice to use the lowest effective dose. Continuing to prescribe it at a high dose, if the physician is unsure that it is safe for this patient, would be an extreme departure from the standard of care. Dr. Hartman could not ascertain from the records why Didrex was prescribed, whether it was being used on-label for weight loss or for some off-label use (e.g., severe fatigue, or to augment an antidepressant medication). Dr. Hartman testified that it is important to be able to discern the physician's rationale from the note. Dr. Hartman also questioned the use of Didrex because patients become dependent on that medication and it has many side effects. In older patients, amphetamines can cause elevated blood pressure, agitation, sleeplessness, weight

loss, arrhythmia, heart attack, and stroke. These effects may be exacerbated when the medication is used, as here, in combination with some other medications. Dr. Hartman testified respondent should have waited for the Effexor she prescribed to take effect, and then tapered patient A off Didrex.

38. Respondent also prescribed Provigil (modafinil) for patient A. The FDA has approved Provigil for wakefulness problems, i.e., sleepiness during day due to sleep apnea, shiftwork sleep disorder, or narcolepsy. Dr. Hartman testified that he could not ascertain from the patient's chart why respondent used it for this patient, nor why she used it with another stimulant, benzphetamine; using both creates a risk of serious cardiovascular side effects and sleep disorders such as difficulty falling asleep, depressed appetite, and weight loss. Also, on June 27, 2012, Dr. Cohen, patient A's physician, wanted to prescribe Provigil, but patient A was already taking Phentermine, so Provigil would have been excessive. Dr. Hartman testified respondent should have tapered one of them before trying another in order to avoid dangerous additive side effects.

39. Respondent prescribed 1 mg of Xanax, another benzodiazepine, increasing it to 1.5 mg. Xanax acts quickly to relieve anxiety, but it has side effects, especially when combined with another benzodiazepine, and is highly addictive; prescribing two benzodiazepines simultaneously is not within the standard of care. Dr. Hartman did not see a diagnosis of anxiety in patient A's record; he surmised that respondent may have used Xanax to counteract the anxiety-producing effects of benzphetamine.

40. Dr. Hartman testified that there were no identified treatment goals in respondent's records for this patient, and therefore no apparent justification for long-term use of several medications.

41. Benzphetamine is recommended for short-term use to address obesity and should be used for no more than several weeks to a maximum of six months. Respondent prescribed it to this patient in high doses for three years, without proper monitoring.

42. Respondent prescribed Triazolam, recommended for short-term use, in twice the recommended dose for an adult, without appropriate monitoring. Respondent prescribed Alprazolam, another highly addictive medicine in the benzodiazepine family, for three years. It was dangerous to prescribe any of these medications to a 76-year-old patient in large quantities and high doses. Prescribing two benzodiazepines substantially increased the risk of over-sedation, intoxication, falls, and accidents. In addition, respondent's prescribing modafinil in combination with the other medications increased the risk of potentially serious cardiovascular side effects.

43. Dr. Hartman testified that the standard of care required avoiding prescribing multiple stimulants and sedatives and prescribing at lower doses. The standard of care also required with regular periodic review to adequately justify why the patient would need to continue medication treatment with these agents over several years, informed consent, discussion of the risks of long term use, and a plan to taper and eventually discontinue the medications. Dr. Hartman testified that respondent's primary medication treatment goal for patient A should have been to treat her with an antidepressant. Vibrid was tried, but it is the only antidepressant listed in the records. Respondent used stimulants rather than antidepressants to treat patient A's depression because the patient would stop using antidepressants after two days. Dr. Hartman testified that it is the treating psychiatrist's job to educate their patients and ask them to persevere with the prescribed treatment, not to stop and rely

on stimulant medications as respondent did. Respondent even combined the stimulant medications, risking dependence. Prescribing as respondent did, without adequate safety monitoring in an elderly patient, was an extreme departure from the standard of care in prescribing to patient A, as well as multiple simple departures.

44. On the other hand, Dr. Hartman acknowledged, patient A was regularly assessed medically by her physician, Dr. Cohen, and was functioning well. Respondent discussed medications with the patient, including negative effects, and performed an ongoing assessment regarding patient A's mental status. And patient A was able to continue working while under respondent's care.

45. Dr. Hartman reported difficulty reviewing respondent's nearly illegible handwritten records. In the typed version of the notes respondent later produced, respondent added typewritten notations that were not in the handwritten notes. For example, an entry in the typewritten version of patient A's chart includes the parenthetical typed language, "eventually get her off Didrex". (Ex. 12, p. 88.) But language in the handwritten notes about discontinuing Didrex states, "Didrex may help for few hrs. We discuss alternatives to Didrex. . . . None better than Didrex of 20 plus yrs." (Ex. 7, pp. 127-128.) The typewritten "get her off Didrex" differs significantly from the original handwritten note, raising questions about respondent's credibility. Dr. Hartman testified that the typewritten notes did not change his opinions that it is difficult to follow the sequence of treatment or ascertain what was happening and what medications were being prescribed or discontinued, or to discern the indications for some medications.

46. Respondent testified that the medications she prescribed provided patient A symptom relief, and that respondent obtained the patient's informed consent for each new medication following a discussion of risk, benefits, and

alternatives. She closely monitored the patient for medication effects and side-effects, adjusting and changing the pharmacology as circumstances warranted and weaning the patient off the medication when appropriate. Through medication management and talk psychotherapy sessions, respondent testified, she was able to keep Patient A, a businesswoman, fully functional. Respondent kept Dr. Cohen apprised of patient A's prescriptions.

47. Respondent testified she prescribed Didrex to patient A solely to augment the antidepressant, Vibrid (vilazodone HCI), which by itself was not adequately controlling the patient's depression. Respondent testified that the off-label use of stimulants to enhance an antidepressant's effect is an accepted modality. According to respondent, Dr. Cohen was aware of and approved respondent's use of Didrex, and of the Xanax and Halcion that patient A had been taking for years. Dr. Cohen did not testify to corroborate respondent's position that he ratified respondent's use of Didrex, Xanax, and Halcion, and none of Dr. Cohen's own records was introduced at hearing.

48. Respondent argued that Xanax at 0.5 mg twice per day is a reasonable dose, particularly in this anxious patient. Respondent kept her on this dose despite the risk of the patient developing a tolerance for it. Halcion, another benzodiazepine, was needed for the patient's insomnia because Xanax is not indicated for sleep. Dalmane (flurazepam), an alternative sleep medication, was tried, but the patient reported better results with Halcion. Dr. Barton added Seroquel (quetiapine), a non-benzodiazepine sedating anti-psychotic medication, also to help the patient sleep.

49. Respondent argued that the medications she prescribed to patient A were properly used over the long term. Both patient A and respondent felt the patient was benefiting by them. At each visit after prescribing a new medication, respondent

reviewed with patient A her medications, their effects, and any unwanted side-effects. Respondent did not believe the standard of care required formal written consent, unlike in a hospital setting. This belief resulted in records that include no documentation that she discussed with patient A the risks and benefits of the medications.

PATIENT B

50. Patient B visited respondent about 29 times from January 2012, when Patient B was 48 years old, through December 2016. Respondent noted that he had sleep apnea and sleep disorder, daytime fatigue, grumpiness, and troubles concentrating. MSE notes state that he did not suffer from depression or anxiety. Over the course of treating Patient B, respondent prescribed Seroquel 100 mg, Ambien (zolpidem) 10 mg, Provigil 200 mg, Klonopin (clonazepam), Risperdal 3 mg, Xanax (alprazolam), and Zolpidem 10 mg. Alprazolam, clonazepam and zolpidem are sedatives that can be addicting and abused by patients.

51. Complainant's allegation that the patient was 80 years old when respondent treated him was based on a mistaken conclusion drawn by Dr. Hartman. During the hearing, when he was apprised that the patient was 48 years old when he began seeing respondent, Dr. Hartman testified that many of his original conclusions were still valid, but for reasons connected with patient B's sleep apnea rather than his age. For example, Dr. Hartman wrote in his report that the sleep medications respondent prescribed are recommended for short-term use only and should have been tapered for the elderly patient B; this applies equally to patients with sleep apnea. Dr. Hartman admitted, though, that some of his concerns were not justified given the patient's true age. Dr. Hartman acknowledged his uncertainty as to whether the changes support a finding of only simple departures from the standard of care

with respect to some of respondent's actions respecting patient B, not extreme departures. (Ex. 17.) Given his uncertainty, it cannot be established that clear and convincing evidence has been produced to demonstrate an extreme departure from the standard of care in every instance.

52. Dr. Hartman found that respondent's medical records lack any rationale for long-term prescribing of benzodiazepines in combination with other sleep medications, i.e., alprazolam, clonazepam, and zolpidem, all sedatives and all of which can be addictive and can be abused by patients. His review of the CURES report revealed a pattern of combined prescriptions for clonazepam and zolpidem over several years. Respondent continued to prescribe high doses for Patient B without clear documentation of medical need or safety monitoring and in a manner that placed Patient B at risk for over-sedation. Dr. Hartman testified that this constituted an extreme departure from the standard of care. Respondent documented one MSE, no informed consent, no active treatment planning, and no discussion of dependence or risk of combining medications. These are multiple simple departures. The records are also unclear about when she started and stopped some medications, requiring significant CURES data supplementation. This is a very important omission, and a covering psychiatrist might prescribe the wrong medication as a result.

53. Dr. Hartman testified that the standard of care requires a physician to monitor the use of controlled substances, avoid combining medications that can place patients potentially at risk of harm, document discussions of the risks and benefits of long term use, and periodically review ongoing medication treatment to ensure safety, and plan to taper and discontinue use. Here, respondent's prescribing of excessive quantities of these drugs without clear documentation of medical need or safety monitoring was dangerous. The medication combinations could be lethal, especially if

taken together with alcohol. They are also highly addictive. When there are safer non-addictive medication alternatives available, continuing to prescribe multiple stimulants and multiple sedatives, and prescribing multiple drugs from the same class, placed the patient at unnecessary risk of potential harm.

54. Dr. Hartman testified that respondent's handwritten and typewritten records related to this patient were very confusing and unclear, especially regarding which medications were being prescribed and the timeline of this prescribing. This was an extreme departure from the standard of care. The typewritten records alerted Dr. Hartman to patient B's sleep apnea. The patient's sleep apnea put him at a significantly increased risk of death during sleep when given sleeping pills and an even higher risk when prescribed combinations of sedatives. Prescribing those drugs to this patient was contraindicated. The standard of care required respondent to seek consultation and find a medication that was not contraindicated.

55. Dr. Hartman acknowledged that respondent's notation in the chart on the relative effects on patient B of Ambien and Klonopin suggests respondent obtained the patient's informed consent.

56. Respondent testified that the patient was aware of the potential risks of the medications prescribed, including the potential risks associated with combining two benzodiazepines at bedtime for sleep or in combination with alcohol. Patient B, respondent testified, liked to have control over his treatment and he did not necessarily take all the prescribed medications together, but switched between various drugs. Respondent, however, kept no record of when or how often the patient took each drug, or when he switched between them, leaving this solely in the hands of the patient.

57. Respondent justified her approach by testifying that the patient was smart, organized, and successful and kept meticulous notes of his medication regimen. There is, however, no separate standard of care for treating patients with these qualities. The standard of care requires the physician to control the patient's medication, not to delegate that responsibility to the unlicensed patient. Respondent did not act within the standard of care when the evidence demonstrates that she relied on her patient to manage numerous dangerous medications that she simultaneously and in quantity prescribed, based on her estimate of his intelligence and her faith in the accuracy of his reporting, in essence subcontracting to a lay patient her licensed responsibilities.

58. Respondent testified that patient B was seeing a sleep specialist, Dr. Zakarian, who was aware of and approved Dr. Barton's prescribing of different sleep medications to target continued symptoms of poor sleep and daytime fatigue and altering the medication to avoid the risk of developing tolerances or diminution of potency. Dr. Zakarian did not testify, nor were his notes introduced in evidence.

59. Respondent disputed Dr. Hartman's claim that use of benzodiazepines for sleep is contraindicated, testifying that recognized textbooks state the opposite. She acknowledged that when, in 2013, the FDA recommended lower doses of Ambien, this may have affected patient B, but argued that doctors do not automatically receive copies of updated FDA guidelines. This does not justify respondent's ignorance of the change in FDA prescribing standards.

60. Respondent argued that her medication management for patient B was working, and that patient B was conscientious about rotating medication in acceptable forms and combinations, avoiding building up tolerances and creating drug dependency, keeping detailed records of medication effects, and avoiding the over-

sedation that could result from respondent's prescribing combinations of benzodiazepines.

61. Respondent testified that she had a clinical rationale for combining Seroquel, which is not a central nervous system depressant, and an alternating regimen of Ambien and Klonopin for two to three weeks each, because they work better when you stop and then restart them. Ambien more than Klonopin helps the patient sleep quickly; Seroquel deepens sleep and lets you sleep longer. Klonopin depresses the central nervous system and worsens sleep apnea more than Ambien.

PATIENT C

62. Patient C visited respondent about 66 times from February 2012, when Patient C was 52 years old, through January 6, 2016. Respondent noted that Patient C's chief complaint was "trouble connecting." Notes of an MSE show the patient was depressed and withdrawn, with suicidal ideation without a plan. Respondent diagnosed Patient C with major depression.

63. Respondent prescribed benzphetamine (Didrex) from 2012 through 2015, which, Dr. Hartman testified, is far beyond the recommended duration. Respondent did not document a clinical justification for the long-term prescription. In July 2012, respondent began to also prescribe modafinil, a medication used to treat sleep disorders. The records do not show that Patient C underwent a diagnostic sleep evaluation, or any other rationale for prescribing modafinil, alone or in combination with benzphetamine. Both medications have a risk of abuse. The medical records show only occasional blood pressure measurements, no other vital signs, and no electrocardiogram. They show three cursory MSE's and no informed consent for the medications prescribed.

64. Dr. Hartman reported that respondent engaged in an extreme departure for the standard of care for record keeping, documenting no informed consent and no appropriate treatment plan in the handwritten and the typewritten transcription versions of the patient's chart.

65. Respondent's pattern of prescribing concerned Dr. Hartman. She prescribed Phentermine at a high dose in February and March 2012, then discontinued it for April, then resumed it in May. Phentermine is only approved for short-term use, for weight reduction, not for many months, as here, and the medical record does not indicate why she prescribed it long term. The purpose of prescribing the Phentermine was not clear from the medical record; its labelled use is for obesity, and it may be used off label to boost energy or wakefulness, or as augmentation for depression medications. Also concerning is that respondent combined Phentermine with Xanax, another controlled substance, used for anxiety. A side effect of Phentermine is anxiety, so Dr. Hartman speculated that is why respondent prescribed Xanax, but the chart is unclear. Then respondent added Modafinil, another stimulating controlled substance with a risk of addiction and abuse, with no documentation in the clinical notes. Respondent prescribed Alprazolam without clear reasons in the chart. Benzodiazepines should not be prescribed long-term to patients, such as patient C, with a history of alcoholism.

66. Dr. Hartman opined that respondent engaged in an extreme departure from the standard of care, prescribing a combination of two stimulant medications without clear clinical indication or safety monitoring; prescribing Alprazolam long-term for an alcoholic; having no taper-and-discontinue plan; and failing to document any consideration of alternative anxiety treatments. Although respondent documented treatment plans on several dates, Dr. Hartman was unable to discern from the patient

medical records when respondent started prescribing a particular drug to the patient, when she stopped prescribing the drug, and when she resumed prescribing the drug. His review of the CURES report revealed that respondent was prescribing Ambien (zolpidem 10 mg #60); Klonopin (clonazepam 1 mg #90); Xanax (alprazolam 0.5 mg#30); and Belsomra (suvorexant). A pattern of combined prescriptions for clonazepam and zolpidem continued over several years.

67. In or about November of 2019, Dr. Hartman received and reviewed the respondent's typewritten record of the patient's first visit, in 1996. The clinical note suggested alcohol abuse. While that typewritten note did not provide clarification regarding the drugs prescribed to respondent or suggest that there was a medically sound reason for the long-term prescribing of the drugs discussed, it did show a tendency towards over-prescribing. Furthermore, this patient received no documented warning about mixing drugs with alcohol.

68. Patient C did not receive any coordinated care from another physician. Respondent referred this patient to see a primary care physician. The patient refused to do so. Despite the patient's non-compliance, respondent continued to prescribe to this patient for three years.

69. Respondent testified that the first time she saw the patient, on October 22, 1996, she diagnosed major depression, rule out bipolar disorder, alcohol abuse, and rule out medical causes. Respondent's plan at that time was to give the patient Zoloft for depression and Revia (naltrexone), an opioid antagonist. There was no mention in 1996 about prescribing Xanax, Prozac, Abilify, Lamictal, modafinil and phentermine, as alleged in the accusation.

70. Nor did she overprescribe multiple controlled substances for an extended period without appropriate clinical indications and without documenting adequate safety monitoring of the patient. In all cases, she testified, she prescribed only with medical indication, in a therapeutic dose within acceptable dosing parameters for the patient, after obtaining informed consent. And respondent monitored Patient C and encouraged her to visit her primary care physician.

71. She prescribed Phentermine for the recognized off-labeled purpose of augmenting the effects of the anti-depressant to positively impact mood, not for diet. Provigil was given for daytime alertness, not for weight control. The patient had a weight issue and considered bariatric surgery, but she was not under respondent's care for that.

72. Patient C was missing work due to her dysfunctional mental state. Respondent tried Patient C on different anti-depressants and gave the patient Phentermine to enhance their effect. The anti-depressants were not controlling the patient's depression without the augmentation of this stimulant medication. To stabilize mood, respondent also prescribed Lacmictal, a mood stabilizer. To address the patient's poor concentration and tendency to fall asleep at the wheel of her car, respondent prescribed Provigil to foster alertness. When respondent concluded Prozac was not adequately controlling the patient's anxiety, panic, and agoraphobia, respondent added Xanax as needed. The dose of two to three milligrams over a period of several years are within acceptable guidelines given the specifics of the patient's circumstances. The patient was counseled about the risk of sedation in taking alcohol with Xanax. Respondent provided talk therapy and encouraged the patient to live a healthy lifestyle and seek outside medical consultation. The patient's attitude, mood

and behavior improved greatly over the course of the care. Eventually, respondent was able to wean the patient off the phentermine and begin tapering off the Xanax.

PATIENT D

73. Complainant alleged, based on Dr. Hartman's review of the records, that respondent failed to maintain adequate and accurate records in her care and treatment of patient D, as well as of patients A, B, and C. Respondent failed to maintain legible records that documented pertinent and required information related to the care and treatment of four patients.[4] Her records were scant, illegible, and incomplete. Dr. Hartman testified that the standard of care for a physician prescribing dangerous drugs requires basic documentation of history and physical, a treatment plan, periodic review that includes the effects of the medicine, the actual medications being taken by the patient, and informed consent. The standard of care requires that these items be placed in a treatment record to verify that the controlled substances being prescribed are appropriate and to explain to subsequent medical providers that these medications are warranted.

74. Respondent saw patient D, a 51-year-old man, for 10 visits from February 9, 2013, through February 27, 2014. Dr. Hartman testified that the handwritten medical records are difficult to read. Respondent diagnosed the patient with panic disorder and prescribed Prozac 20 mg and Xanax (alprazolam).

75. Dr. Hartman testified that respondent engaged in an extreme departure from the standard of care with respect to Patient D. Patient D was prescribed Prozac 20 mg, and Xanax in large quantities. For example, on February 9, 2013, respondent

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[4] The Accusation inaccurately refers to six patients.

prescribed 60 tablets of 1 mg alprazolam. Two days later she prescribed 120 tablets, and then seven days later 90 tablets. The following month patient D received more prescriptions, for an additional 450 tablets of 1 mg alprazolam. A pharmacy printout from Enterprise Rx showed excessive prescriptions for alprozolam, including 400 tablets in April of 2013. Several entries in the patient chart indicate that the patient is "less anxious," but for unknown reasons his Xanax dose was then increased. On another occasion, the patient reported having fewer panic attacks, yet his refill was increased from three times per day to four times per day. Additionally, the CURES report demonstrated that between August and November of 2013, the patient also received prescriptions for alprazolam from another prescriber (400 tablets). On February 9, 2013, respondent prescribed 60 1 mg tablets of alprazolam to be taken twice per day. Three days after having his first prescription filled, patient D had filled a prescription for 120 tablets of alprazolam, or 1 mg four times per day, a daily dose of 4 mg. There is no note in the medical record indicating the justification for this. Approximately one week after that, patient D was prescribed an additional 90 tablets of alprazolam. In March 2013, patient D had filled prescriptions for 180 tablets of alprazolam. In April 2013, patient D had filled prescriptions for 400 tablets of alprazolam.

76. Dr. Hartman testified that the standard of care for prescribing alprazolam requires careful prescribing and periodic review of ongoing medication treatment to ensure safety. Dr. Hartman testified that alprazolam is potentially highly addictive, and respondent prescribed high doses for patient D. At a daily dose of 4 mg, the medication can cause serious over-sedation and symptoms of intoxication. Potential risks of high dose alprazolam include respiratory depression, accidents, and death. The medical record does not show that the patient was warned of the risks associated with taking this medication at the doses prescribed, including the risk of addiction and the

risks associated with the combining the medication with other drugs or alcohol, or that respondent obtained patient D's informed consent. There is no clinical evidence of any treatment plan to eventually taper and discontinue the medication, or of a consideration of substituting it with a less addictive and safer alternative. Elements of MSE's were missing, as were any rationale for the high doses. The patient record demonstrated no justification for respondent prescribing in the manner that she did, which constituted an extreme departure from the standard of care, especially considering the patient's requests for early refills.

77. Respondent testified patient D works in the film industry. He was already taking 1 mg Xanax prescribed by his primary care physician for five years prior to seeing respondent, but he was always running out. MSE's reflect that patient D regularly uses a benzodiazepine; he is anxious about work. His panic attacks decreased when respondent increased his Xanax regimen to three times per day and moved his last daily dose to just before bedtime in order to build up a steady state blood level and eliminate anticipatory anxiety about a possible panic attack.

78. Respondent's notes show that she made some inquiries about patient D's pharmacy profile. Respondent obtained a pharmacy printout of the patient's profile for reasons not explained in the patient's records. The patient explained that he had a large supply of Xanax because he was traveling a lot. Respondent was prescribing up to 20 mg of Prozac, but noted in an MSE that the patient was unhappy. Respondent questioned patient D's wife to find out why so many Xanax prescriptions were filled. The patient's wife disclosed that the patient had three vials of the drug left. When respondent tried to restrict patient D's access to excess medication, he stopped his visits.

79. Dr. Hartman acknowledged that he had some understanding from the notes of what was happening with the four patients. But the records did not clearly show when particular medications were started and stopped; a doctor would have had to search CURES from 2012 to 2016 to learn what was being prescribed. Dr. Hartman testified that the records include several MSE's, but they are inadequately detailed and just summarize events in the patient's life, rather than discuss clinically how the patient presents. There is evidence of treatment planning in the notes, which show recommendations of alternative medications to Xanax and reduced doses of Xanax. And the records include some assessments of whether medications were helping the patient. The records show a working diagnosis of panic disorder and an exploration of alternative diagnoses, e.g., attention deficit disorder and obsessive-compulsive behaviors, for which Prozac is an appropriate medication.

80. Dr. Hartman testified that medical records belong to the patient, who may need to show them to other treatment providers. The records are also necessary to protect the public by allowing the Board to evaluate the quality of patient care through expert examination. Dr. Hartman testified that it would be impossible for a subsequent treating doctor or covering physician to look at the patient records and determine what care the patients were receiving and the medications they were prescribed, and when. They would have to rely on CURES to obtain a clear idea of respondent's prescribing history.

81. Respondent testified that the patients' medical records were for her own use and that she did not need to keep medical records in a form that allowed another treating physician to understand the care and underlying rationale. Testifying about keeping her handwritten medical notes secure to protect patients' privacy, respondent testified that "my handwriting is my best weapon," that is, her poor penmanship

safeguards her patients' privacy. Respondent testified that if another treating doctor requests a copy of the patient records, she prepares a summary for them. At other times in her testimony she denied that her medical records were difficult to read. This testimony called into question respondent's credibility and her understanding of the standard of care.

82. Respondent argued that, absent a hospital setting or a medical procedure or surgery, informed consents need not be in writing. As with the other three patients, there is no evidence Patient D did not know what he was taking and the risk, benefits, and alternatives. This does not meet the standard of care as established on this record, as respondent did not provide any expert evidence to controvert the testimony of Dr. Hartman.

83. Dr. Hartman testified that during his initial evaluation of this case he had to rely on incomplete, inadequate, and largely illegible records. Respondent was repeatedly negligent in that she prescribed controlled substances to her patients without indication for the drugs prescribed. Respondent committed gross negligence in that she prescribed controlled substances in doses and quantities that were significantly above the recommended doses. She prescribed these controlled substances in combinations that were dangerous to the health and life of her patients. Respondent did not properly monitor the patients after prescribing dangerous drugs to them. Respondent did not have a treatment plan for the patients or a plan to wean them to lower doses and eventually taper her patients off the dangerous drug regimens she prescribed.

84. Respondent has, since the filing of the Accusation in this matter, completed the PACE records-keeping and prescribing course. Her use of CURES should identify any future patient like Patient D who may be abusing prescribed medications.

LEGAL CONCLUSIONS

1. The rigorous education, training, and testing requirements for obtaining a physician's license justify imposing on complainant a burden of proving her claims by clear and convincing evidence. (Evid. Code, § 115; see *Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856; *Imports Performance v. Dept. of Consumer Affairs, Bur. of Automotive Repair* (2011) 201 Cal.App.4th 911.)

Applicable Authority

2. The Board is responsible for enforcing the disciplinary provisions of the Medical Practice Act. (Bus. & Prof. Code, § 2004, subd. (a)). The Board's highest priority is to protect the public. (Bus. & Prof. Code, § 2229.) A certificated practitioner who violates the Medical Practice Act may have his or her certificate revoked or suspended or placed on probation, be publicly reprimanded, or have "other action taken in relation to discipline" as the Board deems proper. (Bus. & Prof. Code, § 2227.)

3. The Board may discipline a practitioner's certificate for unprofessional conduct, which includes, among other things, any violation of the Medical Practice Act, gross negligence, repeated negligent acts, incompetence, and failure to maintain adequate and accurate records of services provided to patients. (Bus. & Prof. Code, §§ 2234, subds. (a)-(c), 2261, 2266.) It is a violation of the Medical Practice Act to excessively prescribe controlled substances or to prescribe them without an appropriate prior examination and a medical indication. (Bus. & Prof. Code, §§ 725, 2241.5, subds. (c) & (d), 2242; see Health & Saf. Code, § 11153.)

4. The absence of any harm resulting from treatment does not negate whether a violation of the Medical Practice Act has occurred. (*Shea v. Board of Medical*

Examiners (1978) 81 Cal.App.3d 564, 578-579, citing *Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 949-950.)

5. "[A] physician is required to possess and exercise, in both diagnosis and treatment, that reasonable degree of knowledge and skill which is ordinarily possessed and exercised by other members of his profession in similar circumstances." (*Landeros v. Flood* (1976) 17 Cal. 3d 399, 408.) "The courts require only that physicians and surgeons exercise in diagnosis and treatment that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of the medical profession under similar circumstances." (*Mann v. Cracchiolo* (1985) 38 Cal. 3d 18, 36.)

Causes for Discipline

6. Cause exists to discipline respondent's certificate under Business and Professions Code sections 2234, subdivision (a), and 2225.5, subdivision (b)(1), in that she engaged in unprofessional conduct by refusing to comply with a court order for the production of certified medical records, by reason of Factual Findings 6 through 21.

7. Cause exists to discipline respondent's certificate under Business and Professions Code sections 2234, subdivision (b), and 2242 for committing gross negligence by inappropriately prescribing controlled substances to patients without justification and providing poor medical care, risking the health and safety of her patients, by reason of Factual Findings 22 through 84.

8. Cause exists to discipline respondent's certificate under Business and Professions Code section 2266, in that she failed to maintain adequate and accurate medical records, by reason of Factual Findings 22 through 84.

9. Cause exists to discipline respondent's certificate under Business and Professions Code section 2234, subdivision (c), in that she committed repeated negligent acts in the treatment of three patients, inappropriately prescribing controlled substances to patients A, B, and C, and failing to provide adequate safety monitoring to the patients, as set forth in Factual Findings 22 through 84.

Level of Discipline

10. The purpose of a disciplinary action such as this is to protect the public, and not to punish the licensee. (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.) On this record, probation will appropriately protect the health and safety of patients and the public.

11. It was established by clear and convincing evidence that respondent engaged in unprofessional conduct by refusing to comply with a court order that she produce certified medical records the Board had subpoenaed. It was established by clear and convincing evidence that some of the care respondent provided to each of patients A, B, and C constituted extreme or repeated departures from the standard of care. Complainant has also clearly and convincingly established simple departures in the care of each of those patients. And respondent failed in numerous instances with respect to each of the four patients to maintain adequate records. These failures demonstrate that respondent repeatedly acted in violation of the Medical Practice Act and of statutory and regulatory provisions governing the professional practice of medicine. The purpose of a disciplinary action such as this is to protect the public, and not to punish the licensee. (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.) In this case, the civil penalties complainant seeks are unnecessarily punitive and shall not be ordered. Accordingly, the Order that follows is both necessary and sufficient for the protection of the public.

ORDER

Physician's and Surgeon's Certificate No. G 43306, issued to respondent Brooke Millon Barton, M.D., is revoked pursuant to determination of the first, second, third, and fourth causes for discipline, separately and for all of them. The revocation is stayed, however, and respondent's certificate is placed on probation for three years on the following terms and conditions:

1. Notification

Within seven days of the effective date of this Decision, respondent shall provide a true copy of this Decision and 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 change(s) in hospitals, other facilities or insurance carrier.

2. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

3. Obey All Laws

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

4. Quarterly Declarations

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.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

5. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice: Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California: 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.

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.

6. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

7. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying

with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of 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; General Probation Requirements; and Quarterly Declarations.

8. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

9. Violation of Probation

Failure to fully comply with any term or 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, or 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.

10. License Surrender

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 to surrender his license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the 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. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

11. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, 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 calendar year.

12. Education Course

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 program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) 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 were in satisfaction of this condition.

13. Prescribing Practices Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at respondent's

expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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 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.

Respondent shall submit a certification of successful completion 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.

14. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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.

Respondent shall submit a certification of successful completion 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.

15. Monitoring - Practice

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the

monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's physician assistant supervision practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's physician assistant supervision practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or

unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

DATE: October 26, 2020

DocuSigned by:
Howard W. Cohen
HOWARD W. COHEN
Administrative Law Judge
Office of Administrative Hearings