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

In the Matter of the Accusation Against: **Daniel Charles Minton, M.D.** **2444 Wilshire Blvd., Suite 404** **Santa Monica, CA 90403** **Physician's and Surgeon's Certificate No. G 18267,** Respondent.	Case No. 800-2016-021410 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about May 8, 1970, the Medical Board issued Physician's and Surgeon's Certificate Number G 18267 to Daniel Charles Minton, 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 February 28, 2019, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

5. Section 2234 of the Code, in pertinent part, provides:

"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) . . . .

"(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.

". . . ."

6. Section 2266 of the Code provides:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

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7. Section 2241 of the Code provides:

"(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."

8. Section 2242 of the Code provides:

"(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."

9. Section 2238 of the Code provides:

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

10. 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."

APPLICABLE STANDARDS OF CARE

11. PRESCRIBING TO ADDICTS. 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. However, a physician and surgeon shall not knowingly 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 or to an

addict, an individual whose actions are characterized by cravings in combination with impaired control over their drug use, compulsive use, and continued use of the substance despite harmful consequences.

12. PERFORMING PRIOR EXAMINATION. Prescribing sedative-hypnotic benzodiazepines requires a thorough mental status examination with documentation of need for acute and chronic treatment. This includes, but is not limited to, discussion of the risk to benefit ratio of the use of these agents vs. alternative strategies (nonpharmacologic means for the treatment of anxiety such as mindfulness, cognitive behavioral therapy, meditation) or anxiolytic medications with non-addictlng potentials such as gabapentin, buspirone, or hydroxyzine. Other alternatives include the large classes of antidepressants of SSRl's, SNRl's, MAOl's, heterocyclics, and tricyclics. Sedative-hypnotics such as benzodiazepines carry with them several inherent risks such as dependence, tolerance, sleep disruption, fading of anxiolytic response over time, potential for respiratory depression, worsening of conditions such as COPD and sleep apnea, and lethality in combinations with other sedative agents such as, but not limited to, alcohol, opiates (as was the case here), sedating medications, *etc.* When using such medications, it is imperative that their use be constantly be re-evaluated in the context of their efficacy of treatment of sleep/anxiety vs. side effect profile.

13. MAINTAINING ADEQUATE MEDICAL RECORDS. According to NCQA (National Committee for Quality Assurance) standards (which are those adopted by all states in the Union), outpatient progress notes should have certain basic features. It should be noted that progress notes differ from process notes in psychiatry in that process notes reflect the psychiatrist's thoughts, feelings, and even "counter transference" notations regarding the patient's state. They are not meant to be objective representations of the patient's progress in treatment and reflective of their response to medication or psychotherapy *per se*. Progress notes on the other hand are standardized throughout the medical community and, according to NCQA standards, have approximately 20 required basic elements. These elements "flex" based on the length of the visit and what procedures were conducted during the visit. However, many of them are immutable and should be present in every note.

a. Elements in the medical record are organized in a consistent, chronologic manner.

b. The medical records are stored in a manner that protects the safety and confidentiality of the patient.

c. Each page of the medical record has the patient's name or identification on it.

d. Entries are legible.

e. All entries are dated and must be within the record within 72 hours of their occurrence.

f. Entries are initialed or signed by the author.

g. Biographical and personal data are included.

h. An initial history and physical exam.

i. This should include a past medical history and, in the case of a specialty such as psychiatry, a past psychiatric history.

j. Family psychiatric history.

k. Developmental history.

l. Allergy and adverse reaction history.

m. History of response to particular past medications.

n. The history should also include an updated medical problem list.

o. There should also be a history of the patient's chief complaint for that particular visit.

p. For each particular visit there should be a clinical assessment, physical findings, and working diagnosis consistent with those findings.

q. Unresolved problems from the previous visit should be addressed.

r. Current medications should be noted in the record and longer-term medications prescribed by other physicians should be updated quarterly.

s. A plan of action and treatment consistent with the diagnoses should be noted and explained.

t. Follow up instructions and time frames should be noted, as well as a record of the time for the next appointment.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

14. Respondent Daniel Charles Minton, M.D. is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that Respondent committed gross negligence during his care, treatment and management of PATIENT 1,[1] as follows:

A. On April 4, 2016, the Medical Board of California-Central Complaint Unit received an online complaint concerning Respondent, a psychiatrist.

B. According to the complaint, PATIENT 1, died on Thanksgiving Day, November 26, 2015 from a drug overdose. PATIENT 1 was only 29 years old.

C. The coroner determined the cause of death was the result of the patient's intake of oxycodone, alcohol, and alprazolam.

D. PATIENT 1 was prescribed Xanax by Respondent in 2013. At the time, PATIENT 1 resided in California. PATIENT 1 hailed from Arizona where she returned to live sometime in 2014. Respondent continued to prescribe Xanax to PATIENT 1 up until the time of her death. Respondent had not examined or even seen PATIENT 1 since PATIENT 1 moved to Arizona.

E. PATIENT 1 had sought treatment at several rehabilitation facilities. She was an inpatient at Sierra Tucson during the last six months of her life. Previously, she was an outpatient at Desert Star facility in Tucson, Arizona. She was required to leave that program for non compliance. PATIENT 1 lived in Los Angeles from 2012 to 2014. The patient's family was originally from Tucson, Arizona. When PATIENT 1 ran out of money in 2014, she moved back to Tucson to live with her mother. However, while living in and around Los Angeles, PATIENT 1 began seeing Respondent. She had previously been treated for depression and had taken Zoloft or Prozac. Respondent prescribed Xanax and she quickly became addicted. While Respondent prescribed three daily doses of 2 mg each, PATIENT 1 often took more than prescribed and he would authorize early refills.

[1] All patient references are by initials only in order to protect his or her rights of privacy.

F. PATIENT 1 was also an alcoholic and would drink while taking Xanax. She overdosed several times and was hospitalized. PATIENT 1 was arrested in Tucson for driving under the influence. Respondent wrote a letter to the court on her behalf.

G. One month prior to her death PATIENT 1 had a laparoscopic procedure to evaluate the possibility of her having endometriosis. She was prescribed oxycodone. Reportedly, when she prematurely ran out she went to the physician's office demanding an early refill. She then went to her primary care physician and demanded an early refill of oxycodone.

H. At the time of her death, PATIENT 1 was no longer in a rehabilitation facility and, allegedly, was no longer taking Xanax.

I. Respondent was aware from the onset of treatment that he was dealing with a patient with an addictive disorder.

J. Respondent's medical records, while extremely brief, establish that PATIENT 1 was on Revia (naltrexone) and had a history of alcohol abuse when she first presented to Respondent in December 2012. Other than his entry for PATIENT 1's first visit, there were few other records. During the Board's investigation, Respondent provided 22 pages of records. Only five pages of which contained information other than prescriptions written by Respondent.

K. One of the records was a copy of a letter written by him in connection with PATIENT 1's arrest for driving under the influence, in which he wrote that PATIENT 1 would be better served by receiving chemical dependency treatment rather than serving correctional time.

L. In light of Respondent's letter, a prudent physician would not freely prescribe sedative-hypnotics in large doses on a continuing basis and without routine in-person examinations.

M. PATIENT 1 was receiving Xanax in doses up to 6mg a day.

N. Respondent was clearly and continuously providing high dose benzodiazepine

treatment to a patient whom he had previously treated in the office, but with whom he subsequently had no legitimate, ongoing therapeutic relationship.

O. The prescriptions written by Respondent and his lack of records or other notes shows that he was not examining her in good faith and, more importantly, had more than a passing awareness that she had a serious chemical dependency problem. Such conduct, whether negligent or intentional, constitutes an extreme departure from the applicable standard of care.

P. From 2012 through 2015, Respondent continued to prescribe Adderall, then Xanax and Prozac. Within one year he raised her from what was a very small dose of Xanax—namely, 0.25 mg po QD, to a rather large dose of 2mg of Xanax QD, then jumping the dose to 6 mg a day for the treatment of an anxiety disorder which is ill described.

Q. At the same time, there is no indication that he saw the patient in the office face to face or that he spoke to her on the phone to determine the nature of her anxiety, the frequency, duration, precipitants, or mitigating factors which came to play in its etiology and treatment. It is clear that he did not seem to know about her concomitant substance use disorders, or her multitude of substance use admissions. In aggregate, the reader is left with no clarity as to why this patient needed high dose alprazolam monthly for 2 years, or any understanding of why she was not checking in on a regular basis in the office, or for structured phone visits with Respondent.

R. During an interview with representatives of the Medical Board of California, Respondent reported that he advised PATIENT 1 to get more formalized treatment in Arizona, but there is absolutely no documentation to that effect.

S. With respect to prescribing without appropriate prior examination, Respondent's actions represent extreme departures from the usual standard of care.

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T. Respondent's records reflect a complete paucity in the normal evaluation and follow ups seen in a patient who is being treated for attention deficit disorder, and mood and anxiety disorder.

U. There is absolutely no evidence of the seminal items necessary to form the skeletal outline of a normal outpatient chart. Even his intake note is not reflective of the normal, minimal data set necessary to form the diagnostic impression to be able to treat a patient adequately.

V. Respondent failed to perform a regular mental status examination, ask and document the appropriate questions necessary to codify the diagnoses, and prescribe for these same diagnoses.

W. Respondent's follow up visits constitute mainly a documentation of his prescriptions without evidence of any discussion with the patient, or his rationale for use of any of the medications he prescribed.

X. Most seriously, when she moved out of the area he showed no documentation of his rationale for continuing to provide prescriptions (especially in light of high dose benzodiazepines) to an alcohol abuser who had already received a DUI. There is no notation of his mandate to the patient to obtain a prescriber in her local area. There is no documentation of providing her with "bridge" prescriptions.

Y. There is no documentation of phone calls with the patient. Essentially there is only documentation of prescriptions given. At best this is grossly inadequate, even if the patient were in the area seeing the physician in his office. In this more extreme case, she was not in the area, not seeing this physician, and in fact was in a multitude of chemical dependence facilities receiving care for the very substance he was prescribing. Nothing can be gleaned from these records as to her behavior, state of mind, or use of medications.

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Z. The paucity of records prepared and maintained by Respondent and other failures, as noted above, at best constitute repeated negligent acts and, at worse, extreme departures from the applicable standards of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence)

15. Respondent Daniel Charles Minton, M.D. is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that he committed repeated acts of negligence gross negligence during his care, treatment and management PATIENT 1, as follows:

A. Complainant refers to and, by this reference, incorporates Paragraph 14, above, as though fully set for the herein.

THIRD CAUSE FOR DISCIPLINE

(Prescribing to an Addict)

16. Respondent Daniel Charles Minton, M.D. is subject to disciplinary action pursuant to Business and Professions Code section 2241 in that he prescribed controlled substances to PATIENT 1, knowing that the patient was an addict, as follows:

A. Complainant refers to and, by this reference, incorporates Paragraph 14, above, as though fully set for the herein.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

17. Respondent Daniel Charles Minton, M.D. is subject to disciplinary action pursuant to Business and Professions Code 725 section in that he excessively prescribed controlled substances to PATIENT 1, as follows:

A. Complainant refers to and, by this reference, incorporates Paragraph 14, above, as though fully set for the herein.

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FIFTH CAUSE FOR DISCIPLINE

(Prescribing without Examination or Justification)

18. Respondent Daniel Charles Minton, M.D. is subject to disciplinary action pursuant to Business and Professions Code section 2242 in that he prescribed controlled substances to PATIENT 1 without first performing either a physical or mental examination, as follows:

A. Complainant refers to and, by this reference, incorporates Paragraph 14, above, as though fully set for the herein.

SIXTH CAUSE FOR DISCIPLINE

(Violation of Drug Laws)

19. Respondent Daniel Charles Minton, M.D. is subject to disciplinary action pursuant to Business and Professions Code section 2238 in conjunction with Business and Professions Code sections 725, 2241 and 2242, in that he violated applicable drug statutes and regulations during his care, treatment and management of PATIENT 1, as follows:

A. Complainant refers to and, by this reference, incorporates Paragraph 14, above, as though fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

20. Respondent Daniel Charles Minton, M.D. is subject is subject to disciplinary action pursuant to Business and Professions Code section 2266 in that he failed to prepare and maintain adequate medical records pertaining to provision of his medical services to PATIENT 1, as follows:

A. Complainant refers to and, by this reference, incorporates Paragraph 14, above, as though fully set for the herein.

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

21. Respondent Daniel Charles Minton, M.D. is subject to disciplinary action pursuant to Business and Professions Code section 2234 in that he committed unprofessional conduct, generally, during his care, treatment and management of PATIENT 1, as follows:

A. Complainant refers to and, by this reference, incorporates Paragraph 14, above, as though fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 18267, issued to Daniel Charles Minton, M.D.;

2. Revoking, suspending or denying approval of Daniel Charles Minton, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Daniel Charles Minton, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: March 8, 2018

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