BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of the Petition For Interim Suspension Order of:	Case No. 800-2016-025718
KIMBERLY KIRCHMEYER, Executive Director, Medical Board of California,	OAH No. 2018060033
Petitioner,	
vs.	
STUART H. TUBIS, M.D.	
Physician's and Surgeon's Certificate No. G13754	
Respondent.	

DECISION

This matter was heard before Administrative Law Judge Dena Coggins, Office of Administrative Hearings, State of California, on June 18, 2018, in Sacramento, California.

John Gatschet, Deputy Attorney General, appeared on behalf of petitioner Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board).

Michael Rothschild, Attorney at Law, appeared on behalf of Stuart Tubis, M.D. (respondent), who was present.

Pursuant to Government Code section 11529, declarations and other documentary evidence were received, the record was closed, and the matter was submitted for decision on June 18, 2018.

SUMMARY OF DECISION

Petitioner presented persuasive evidence in the form of declarations and supporting documents that respondent has engaged in prescribing and record-keeping practices that endanger the public. However, the crux of the Petition for Interim Order of Suspension relates to his prescribing patterns and his medical records documentation relating to those prescribing patterns. Restricting respondent's ability to prescribe, dispense, administer, furnish, or possess any controlled substances[1] will address petitioner's primary concerns regarding respondent's safety to practice during the interim period before an accusation is filed and a decision is rendered thereon.

FACTUAL FINDINGS

Procedural History

1. On August 11, 1967, the Board issued Physician's and Surgeon's Certificate Number G13754 (certificate) to respondent. His certificate was in full force and effect at all times relevant to the charges brought in this proceeding, and will expire on January 31, 2019, unless renewed or revoked.

2. On June 1, 2018, petitioner filed and served a properly noticed Petition for Interim Order of Suspension (Petition) with declarations and exhibits in support of the Petition. Generally, petitioner alleged that respondent engaged in unprofessional conduct by prescribing dangerous and highly addictive controlled substances without an appropriate prior examination and medical indication, failing to maintain accurate and adequate medical records, and engaging in conduct that constitutes gross negligence, repeated negligent acts, and incompetence.

Investigation by the Board

3. Respondent has been board certified in psychiatry since 1976. The Board received a complaint that respondent prescribed controlled substances without medical indication to a patient with a history of substance abuse issues. The Board began an investigation of the allegation against respondent.

4. Dennis Scully, an Investigator for the Division of Investigation, Health Quality Investigation Unit, was assigned to the investigation. He gathered Controlled Substance Utilization Review and Evaluation System (CURES) reports relating to respondent's patients

[1] The Business and Professions Code section 4021 defines "controlled substance" as any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

and CURES reports regarding respondent's prescribing of controlled substances.[2] The Board identified respondent's patients with questionable prescribing patterns and obtained medical records for seven of the identified patients.

5. Mr. Scully contacted respondent to obtain patient records and set up an interview with respondent for November 13, 2017. During the interview, Mr. Scully and Vincent Yap, M.D., a district medical consultant for the Board, asked respondent questions about the manner in which he prescribed controlled substances, his medical care of the seven identified patients, and his record-keeping practices and procedures. Mr. Scully characterized the interview as follows:

> When asked to explain how he evaluated and assessed his patients and whether to prescribe controlled substances, [respondent] described a very cursory patient assessment, which consisted only of talking to the patient. [Respondent] acknowledged he took no steps to obtain records or verify prescribing by others. [Respondent] was unfamiliar with and had not registered for the CURES system. . . . He does not obtain prior treatment records or contact current or previous treating physicians. [Respondent] stated repeatedly that he prefers to trust his patients. [Respondent] acknowledged that he prescribed to patients simply because they asked for specific drugs.

After the interview, Mr. Scully provided the documents collected during the investigation to Alex Sahba M.D., for an expert review. The documents to be reviewed by Dr. Sahba included medical records, the transcript of the interview, and CURES reports and prescribing records.

Opinion of the Board's Expert

6. Dr. Sahba is a physician and surgeon licensed by the Board to practice medicine in California. He is board certified in psychiatry and neurology. He has practiced as a psychiatrist since 2004, and has specialized training in the area of forensic psychiatry. In December 2017, the Board requested Dr. Sahba review the materials sent to him by Mr. Scully. Dr. Sahba prepared a detailed report and declaration setting forth his conclusions and opinions after reviewing the materials.

7. In his declaration, Dr. Sahba noted that a psychiatrist's initial evaluation of a patient should include an adequate patient history identifying the chief complaint, past medical and psychiatric history, and past and current substance/alcohol use or abuse. The

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[2] CURES is a tool used by psychiatrists who prescribe controlled substances. The reports generated by CURES provide information regarding the prescribing and dispensing of controlled substances.

psychiatrist must obtain a history of past suicidal ideation or attempts, and the patient's educational, vocational, social, family, and legal history. Additionally, the psychiatrist must conduct a mental status examination and elicit information about current medications prescribed by other physicians and drug allergies. The psychiatrist must then formulate a working diagnosis and a treatment plan. At subsequent follow up visits, the psychiatrist must obtain an interval history of how the patient has been doing, assess the efficacy of medication treatment, and formulate a plan for future treatment. The medications and medication dosages must be based on a clear indication for the patient's presenting symptomology and the psychiatrist's working diagnosis. Also, the psychiatrist must provide informed consent, which includes explaining the risks, benefits, medication alternatives, and recommended treatment. The psychiatrist must determine if the patient is receiving medication from other providers, and, if so, the psychiatrist should obtain authorization from the patient to contact the other prescribers to obtain information or records. This evaluation and prescribing process is the standard of care for a psychiatrist.

8. Dr. Sahba further noted in his declaration that the standard of care for a psychiatrist requires him to maintain accurate and adequate medical records. Accurate and adequate medical records require the psychiatrist to document the initial and follow up examination and patient assessment, medical indication for each treatment and prescription, the working diagnosis and treatment plan, and a periodic assessment of the patient's treatment response. The psychiatrist must document steps taken to ensure the patient is safely and properly using prescribed medication, and that the drugs are not being diverted. Maintaining accurate and complete medical records serves to document the care provided and communicate treatment information to other health care providers and for those reviewing the quality of medical care. There was no evidence to dispute Dr. Sahba's characterization of the standard of care for psychiatrists as to prescribing medications or keeping adequate and accurate medical records.

9. After reviewing the charts of the seven patients at issue, Dr. Sahba determined respondent "failed to conform to even the most basic standard practice," as the charts lacked "any meaningful assessment or evaluation of the patients." Dr. Sahba stated:

> There is no indication in any of the charts that [respondent] conducted a formal initial evaluation, or a meaningful follow up evaluation and assessment, or that he made any effort to obtain substance abuse history. No mental status examination appears to have been taken, and there is no indication [respondent] reached a working diagnosis for any of the patients. His only treatment plan was to prescribe the controlled substances, without apparent question.

10. In his report and declaration, Dr. Sahba described respondent's care and treatment of patients AS, KF, SW, BD, FT, MZ, and AB as reflected in respondent's medical records and respondent's interview with the Board. Summarized below are Dr. Sahba's findings with regard to these patients:

(a) Patient AS. AS specifically requested Xanax and Ambien, a benzodiazepine and benzodiazepine analog, respectively. Benzodiazepines and benzodiazepine analogs are highly habit forming drugs that can be dangerous even at the lowest doses. Respondent prescribed both requested drugs to AS, with a high dose of Xanax prescribed per day. Respondent was unaware AS was obtaining prescriptions from other providers, that AS had a significant psychiatric history, or that AS was an addict with prior overdose admissions. The chart contained no meaningful assessment of AS, any evaluation of his mental state, and no rationale or justification for the prescriptions issued. Dr. Sahba found AS's medical record to be largely illegible.

(b) Patient KF. Respondent prescribed benzodiazepines (Xanax and Klonopin), benzodiazepine analog (Ambien), and Hydrocodone, a narcotic pain reliever that has a high potential for abuse, to KF without explanation. Respondent prescribed Xanax at a high dose per day. He also prescribed the patient Adderall, an amphetamine stimulant that is habit forming. The Adderall prescription was not noted in the medical record. Another physician warned respondent by facsimile that KF was an opiate addict, taking Suboxone, and under a contract not to take benzodiazepines or opioids. Respondent continued prescribing benzodiazepines to KF, and never contacted the warning physician or consulted CURES. Dr. Sahba found the patient chart to be incomplete and lacking a diagnosis or any justification for the prescriptions issued by respondent. Dr. Sahba found the patient chart to be difficult to read and partially illegible.

(c) Patients SW, BD, and FT. Dr. Sahba found the medical records for all three patients to be incomprehensible and illegible. He further observed they contained no initial evaluation, no diagnosis, and no treatment plan, which Dr. Sahba opined failed to conform to the standard of care. Also, Dr. Sahba did not find respondent's documented rationale for prescribing Adderall to SW and Ativan, a benzodiazepine, to BD.

(d) Patient MZ: Respondent prescribed Klonopin and Ambien to MZ, prescribing Klonopin at a high dose per day. Respondent stated he was aware MZ's prior physician was attempting to get him off of benzodiazepine, but respondent decided to prescribe the medication to him anyway without explanation. Dr. Sahba found the medical record to be incomplete, lacking any

meaningful assessment, evaluation, treatment plan, or diagnosis for MZ.

(e) Patient AB: Respondent prescribed Ambien, and two benzodiazepines (Valium and Ativan) to AB, although respondent's note in AB's chart indicated "too much reliance on Benzos + Adderall . . ." AB's chart contained a note that a pharmacy informed respondent that AB was selling methadone and Xanax, but he continued to prescribe other medications to AB. Dr. Sahba found the record contained no working diagnosis and no rationale for prescribing. Dr. Sahba also found the medical record to be difficult to read and partially illegible. Dr. Sahba further determined that portions of the record are incomplete and inadequate, and he found it impossible to discern a treatment plan.

11. Dr. Sahba concluded that in each of the seven patient cases, respondent committed multiple extreme departures from the standard of care in his prescribing patterns and/or medical records documentation. Dr. Sahba expressed additional concern that respondent was unfamiliar with the CURES system, that he admitted during his interview that he does not coordinate with other physicians who may be prescribing to his patients, rather, choosing to rely on what his patients chose to disclose to him. Dr. Sahba further found respondent to have little understanding of the controlled substances he prescribes and respondent was unable to explain why he started patients on high doses of habit forming medication.

12. Dr. Sahba further found that respondent self-prescribed Xanax in 2016 and hydrocodone in 2014 without logical explanation. Dr. Sahba found respondent's self-prescribing to be an extreme departure from the standard of care, in which, generally, physicians should not self-prescribe medications for themselves, except on rare occasions, which was not the case here.

13. In conclusion, Dr. Sahba stated:

> It is my professional opinion that [respondent] has engaged in an unsafe practice that is far outside the standard of care for treatment of and prescribing to psychiatric patients.

Respondent's Evidence

14. Respondent submitted a redacted transcript of his November 13, 2017 Board interview, a Board informational relating to California law mandating the use of CURES, effective October 2018, and Legislative Council's Digest documents about Senate Bill 482 pertaining to CURES. Respondent also submitted medical records for patients SW and FT regarding their medical history. Additionally, respondent submitted a declaration of Vickie

Razo. Ms. Razo is the office manager at Fair Oaks Psychiatric Associates, where respondent maintains his practice. Prior to July 1, 2016, Ms. Razo registered respondent with CURES.

Discussion

15. Respondent filed an opposition to the Petition. In his opposition, respondent argued: (1) respondent was trained as a psychoanalyst and has conducted a psychoanalytic or psychodynamic practice, wherein it is particularly important to maintain contact with the patient rather than the computer; (2) his notes are readable, but appear "scratchy," as he was trying to write fast because he wanted to listen to his patients; (3) respondent acknowledges his handwriting is "terrible," but he believed his notes were for him, not anyone else; (4) the records for patient BD contained the patient's medical history, formal diagnosis, and treatment plan; (5) respondent did not prescribe the medication patient AB was allegedly selling in the pharmacy parking lot, and, once he received this information from the pharmacist, he told AB he could no longer treat her, referred her to County Mental Health, and only continued to briefly see her for purposes of tapering off her medication; (6) respondent has made changes to his practice, which include giving all new patients a medication treatment agreement and requiring all patients to perform a urine test; (7) there is no evidence that respondent caused harm to any patient throughout his years of practice; and (8) he was registered for the CURES system and received the reports, contrary to petitioner's assertions.

16. However, the opinion of Dr. Sahba provided persuasive evidence that respondent has been prescribing excessive amounts of controlled substances that have a high potential for abuse and misuse and dangerous potential side effects without adequate examination or follow-up monitoring. Dr. Sahba's opinion that respondent's treatment of his patients represented an extreme departure from the standard of care was also persuasive. Although respondent was able to provide some information regarding the seven patients' chief complaints, medical history, diagnoses, and/or treatment plans, the more persuasive evidence showed the medical charts lacked meaningful assessment and/or evaluation and rationale or justification for the prescription. While respondent appears to have been registered for the CURES system and had access to some of the CURES reports before July 2016, the evidence did not show he had the ability to access the CURES reports for at least five of the seven patients, or that he coordinated with or identified other physicians who may be prescribing to his patients.

17. Petitioner also provided persuasive evidence that respondent committed extreme departures from the standard of care in maintaining accurate and adequate medical records. The standard of care required respondent to maintain accurate and complete medical records, an essential part of the practice of medicine, in order to document the care he provided to his patients for his own records, but also to provide treatment information to other health care providers, subsequent treating physicians, and those reviewing the quality of his medical care. Dr. Sahba persuasively opined respondent's medical records, as to the seven patients at issue, were difficult to read, partially illegible, incomprehensible, and incomplete. Respondent did not provide any evidence that his training as a psychoanalyst

provided sufficient justification for his failure to maintain accurate and complete medical records.

18. Respondent appears to acknowledge issues relating to his record keeping and concerns about his prescribing methods based upon his new practice of having all patients complete a medication treatment agreement and submit to urine testing. These changes will provide some safeguards to his patients that were not previously provided. Additionally, at hearing, respondent suggested limiting his prescribing authority to certain Schedules instead of being suspended from the practice of medicine during the interim period before the accusation is filed and a decision is rendered.

19. Respondent argued that he has hundreds of patients and has not caused harm to any of them throughout his years of practice. He further argued that removing him from patient care will cause irreparable harm to those who have depended on him as a psychiatrist and trusted counselor. Public protection is the highest priority. A physician who is not safe to practice must be suspended or his practice must be restricted in order to ensure that he will not injure patients. There is no prerequisite that a patient must be harmed before a physician's license is suspended or his practice is restricted pursuant to an interim order of suspension.

20. After reviewing the evidence as a whole, petitioner presented persuasive evidence in the form of declarations and supporting documents that respondent has engaged in prescribing and record-keeping practices that endanger the public. However, the crux of the Petition for Interim Order of Suspension relates to his prescribing patterns and his medical records documentation relating to those prescribing patterns. Restricting respondent's ability to prescribe, dispense, administer, furnish, or possess any controlled substances will address petitioner's primary concerns regarding respondent's safety to practice during the interim period before an accusation is filed and a decision is rendered.

LEGAL CONCLUSIONS

1. Government Code section 11529, subdivision (a), provides, in pertinent part, that an interim order suspending a medical license may be issued where it is shown that a licensee "has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practices Act . . . , or is unable to practice safely due to a mental or physical condition, and that permitting the licensee to continue to engage in the profession for which the license was issued will endanger the public health, safety, or welfare." Under this section an administrative law judge may also impose conditions upon a medical license, including drug testing, continuing education, supervision of procedures, limitations on the authority to prescribe, furnish, administer, or dispense controlled substances, or other license restrictions.

2. Government Code section 11529, subdivision (e), provides that the administrative law judge shall grant the interim order if, in the exercise of discretion, the administrative law judge concludes that:

(1) There is a reasonable probability that the petitioner will prevail in the underlying action.

(2) The likelihood of injury to the public in not issuing the order outweighs the likelihood of injury to the licensee in issuing the order.

3. Business and Professions Code section 2234, in relevant 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:

[¶] . . . [¶]

(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.

[¶] . . . [¶]

(d) Incompetence.

4. Business and Professions Code section 2242, subdivision (a), 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.

5. Business and Professions Code section 2266 provides:[3]

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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[3] The Petition mistakenly makes reference to Business and Professions Code section 2236, by indicating that section 2236 "provides that the failure to maintain accurate and adequate medical records constitutes unprofessional conduct." The section providing that language is Business and Professions Code section 2266.

6. Petitioner need only prove her case by a preponderance of the evidence, and this requires a demonstration of a reasonable probability that petitioner will prevail in establishing the violations complained of in seeking the injunction or, in this case, an interim suspension order. (*People v. Frangadakis* (1960) 184 Cal.App.2d 540, 549-50.) Further, when a governmental entity seeks to enjoin a statutory violation, evidence that it is reasonably probable that the agency will prevail on the merits gives rise to a rebuttable presumption that the potential harm to the public outweighs the potential harm to the defendant. (*IT Corp. v. County of Imperial* (1983) 35 Cal.3d 63, 72-73.)

7. There is a reasonable probability that petitioner will prevail in the underlying action based upon respondent having engaged in acts or omissions constituting a violation of the Medical Practice Act, including Business and Professions Code sections 2234, subdivisions (b) and (c), 2242, and 2266, and that permitting him to continue to engage in the medical practice will endanger the public, health, safety, or welfare. The evidence in support of the Petition indicates a likelihood that the Board will prevail on the merits of the underlying case. As set forth in the Factual Findings, petitioner submitted evidence showing respondent engaged in extreme departures from the standard of care in his treatment and prescribing practices of his patients. As a result, there is a rebuttable presumption that the potential harm to the public in not issuing the interim suspension order outweighs the potential harm to respondent in issuing the order. Respondent did not rebut the presumption. Thus, petitioner established that an interim order under Government Code section 11529 should be issued to ensure that the public health, safety, and welfare are adequately protected until an accusation is filed and a decision is rendered thereon.

8. However, as set forth in Factual Finding 20, the evidence established that the public health, safety, and welfare would be adequately protected if respondent were allowed to continue to practice during the interim period before the accusation is filed and a decision is rendered provided respondent's ability to prescribe, dispense, administer, furnish, or possess any controlled substances is restricted.

ORDER

The Petition for an Interim Suspension Order is GRANTED. Physician's and Surgeon's Certificate Number G13754 issued to Stuart H. Tubis, M.D., is SUSPENDED until an accusation is issued and a decision is rendered thereon in accordance with Government Code section 11529, subdivision (f), or this matter is otherwise resolved. However, the suspension is stayed so long as respondent complies with the following restrictions and conditions:

1. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined in the California Uniform Controlled Substances Act.

2. Respondent is prohibited from practicing medicine until respondent provides documentary proof to the Board or its designee that respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any state prescription forms and all controlled substances order forms. Thereafter, respondent shall not reapply for a new DEA permit without the prior written consent of the Board or its designee.

3. If respondent fails to comply in any respect with the restrictions and conditions set forth above, the stay shall be lifted and the suspension shall go into immediate effect.

DATED: June 28, 2018

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DENA COGGINS
Administrative Law Judge
Office of Administrative Hearings