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

In the Matter of the Accusation Against: **LAWRENCE H. WARICK, M.D.** **2444 Wilshire Blvd., Suite 418** **Santa Monica, CA 90403** **Physician's and Surgeon's Certificate No. G 7011,** Respondent.	Case No. 800-2018-042918 **ACCUSATION**

PARTIES

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

2. On or about August 15, 1961, the Medical Board issued Physician's and Surgeon's Certificate Number G 7011 to Lawrence H. Warick, 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 May 31, 2022, 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 (Code) unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> ...
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> (b) Gross negligence.
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> (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.
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> (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.
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> (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.
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6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent Lawrence H. Warick, M.D. is subject to disciplinary action under Code section 2234, subdivision (b), in that he committed gross negligence in the care and treatment of Patient 2.[1] The circumstances are as follows:

8. During the relevant time period, Respondent operated a solo private psychiatry practice in Santa Monica, California.

9. In or around March 2016, Patient 1 sought and commenced psychiatric care and treatment with Respondent.

10. At their first visit, Patient 1 asked Respondent if he could also treat her adult daughter, Patient 2. Patient 1 reported that her daughter, then 26 years old, had received psychiatric treatment since she was 6 years old. Patient 1 did not believe Patient 2's current psychiatrist was helping her.

11. Respondent declined to treat Patient 2, telling Patient 1 that it was unethical. He further explained that he would have had to obtain releases from all of Patient 2's other providers and inform them of his involvement.

12. According to Respondent, Patient 1 persisted in asking Respondent to treat Patient 2.

13. Respondent told the Board's investigators that on or about December 7, 2016, Patient 1 brought Patient 2 to an appointment with Respondent and "manipulated" him into seeing Patient 2.

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[1] The patients are identified by number to address privacy concerns. The patients' identities are known to Respondent.

14. At that visit, Respondent diagnosed Patient 2 as "borderline"[2] and suggested medication.

15. Respondent did not document his recommendation for medication in Patient 2's medical record.

16. Respondent also did not document Patient 2's diagnosis of "borderline" in her medical record.

17. According to Respondent, Patient 2 had a history of feeling depressed and alienated throughout her life. Her relationship with her parents was poor and her romantic relationships were exclusively online. Despite having a graduate degree, Patient 2 did not work and was dependent upon her parents.

18. Respondent saw Patient 2 again on December 22, 2016. Respondent billed a total of $600 for the two December 2016 visits with Patient 2 under the DSM-V Diagnostic Code of F43.23 "Adjustment Disorder with Mixed Anxiety and Depressed Mood." Respondent used this code for all of his billings related to Patient 2.

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[2] In the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), Borderline Personality Disorder (BPD) is diagnosed on the basis of (1) a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and (2) marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

1) Frantic efforts to avoid real or imagined abandonment; this does not include suicidal or self-mutilating behavior covered in criterion 5;

2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation;

3) Markedly and persistently unstable self-image or sense of self;

4) Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating); this does not include suicidal or self-mutilating behavior covered in criterion 5;

5) Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior;

6) Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days);

7) Chronic feelings of emptiness;

8) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, or recurrent physical fights); and

9) Transient, stress-related paranoid ideation or severe dissociative symptoms. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.* 5th ed. Arlington, VA: American Psychiatric Association; 2013. 663-6.

19. Respondent did not see Patient 2 again until June 29, 2017. During this time, Respondent continued to treat Patient 1.

20. When Patient 2 presented to Respondent in June 2017, he described her as "very happy." She reported that she had recently become involved with a new man, S. She had met S. online and he was moving to Los Angeles.

21. Respondent told the Board's investigators that during her ensuing treatment with Respondent, Patient 2 would obsessively and constantly text S. When S. would not respond, she would become frustrated and angry.

22. In July 2017, S. relocated to Los Angeles and he and Patient 2 had a relationship, and Patient 2 reported to Respondent that she had thought they were going to get married. S. broke off the relationship with Patient 2 in approximately August, 2017.

23. According to Respondent, Patient 2 was very upset over the break up. Respondent reported that she was angry and depressed with fleeting suicidal ideation.

24. By the end of August 2017, Respondent reports that he was worried about Patient 2 and tried to involve her parents.

25. In his August 28 and 31, 2017, note in Patient 2's medical record, Respondent wrote: "I am in contact with her mother [Patient 1] and express my worries about [Patient 2] – I arranged to meet her parents to discuss options – see under [PATIENT 1.]" This is a reference to Patient 1's medical record. At this time, Respondent was treating Patients 1 and 2 concurrently.

26. While Patient 2 was under Respondent's care, she moved out of her parents' house and into an empty nearby residence, which her parents also owned. Patient 2 lived alone in the house.

27. Respondent met with Patient 2's parents on three occasions. According to Respondent, he recommended hospitalization, electroconvulsive therapy, trans magnetic therapy and ketamine, as treatment options and gave them referrals, but Patient 2 was noncompliant. Respondent did not document any of these treatment recommendations or the fact of Patient 2's noncompliance in her medical record.

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28. According to Respondent, Patient 1 expressed concern that Patient 2 had been going online and buying drugs from Mexico. When Respondent had asked Patient 2, she denied doing so.

29. Respondent documented Patient 1's concern in Patient 2's medical record on October 4 and October 17, 2017, stating: "She denies to me buying any drugs from Mexico. My note: Mother worries about her purchasing drugs to kill self."

30. From the time that Patient 2 returned to treatment with Respondent in June 2017 until the end of October 2017, Respondent billed for rendering services to Patient 2 on twenty-one (21) different days.

31. Respondent admits that at no point in his care and treatment of Patient 2 did he attempt to contact any of her concurrent or previous medical or psychological providers in order to obtain her records or discuss or coordinate Patient 2's treatment plan. Respondent stated that Patient 2's parents would not give him permission to contact her other therapists. He asked her parents because he had determined Patient 2 to be "psychologically infantile," though none of this is documented in her medical record.

32. During the time that Respondent treated Patient 2, he occasionally prescribed her medication, which she generally refused to take. For example, on August 9, 2017, Respondent prescribed Luvox,[3] which Patient 2 refused to take because she was concerned that it leads to weight gain. On August 13, 2017, he prescribed Risperdal, which she refused to take because it is an antipsychotic mediation. Patient 2 took the prescriptions from Respondent and said she was not going to fill them.

33. Despite recommending hospitalization to Patient 2's parents, Respondent did not think forced hospitalization was a viable option since Patient 2 was "rational," and not psychotic.

34. At no point during the course of treatment did Respondent review Patient 2's CURES Report or conduct any drug screening.

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[3] Luvox is the brand name of the prescription drug fluvoxamine, which is used to treat obsessive-compulsive disorder (OCD). The medicine may also help treat social phobias, panic disorders, eating disorders, and depression.

35. In October 31, 2017, Patient 2 called Respondent to report that she could not come in because she was sick and vomiting. Respondent documented in Patient 2's record that she denied food poisoning, cleansing (she had purged in the past) or any abuse of medication. Respondent recommended that she go to the emergency room. He also prescribed her six (6) 5 mg Compazine for nausea.

36. The next day, Patient 2 was found unresponsive in her bed. Her cause of death is undetermined, but believed to be suicide by ingestion.

37. The standard of care in the medical community requires that the initiation of psychiatric services commence with a psychiatric evaluation. The evaluation may take place over several appointments and is not limited to directed examination of the patient. The evaluator can obtain information about the patient through a variety of methods, including interviews, review of medical records, physical examination, diagnostic testing or history-taking from collateral sources. The amount of time it takes to complete the evaluation depends upon the complexity of the problem, the clinical setting, and the patient's ability and willingness to cooperate with the evaluation. Ultimately, a psychiatric evaluation will consist of a history of the present illness, psychiatric history, substance use history, medical history, review of systems, family history, personal and social history, examination including mental status examination, an impression (including an estimation of the patient's suicide risk) and treatment plan. The purpose of the psychiatric evaluation is to make a working diagnosis of the patient, formulate the case, and develop a recommended treatment plan to be discussed with the patient and agreed to by the patient.

38. Respondent failed to conduct and/or document a psychiatric evaluation of Patient 2, either at the outset of her care in December 2016, or when she returned in June 2017, that could inform diagnosis, formulation, and treatment planning. This constitutes an extreme departure from the standard of care.

39. The standard of care in the medical community requires that a psychiatrist make a working diagnosis and initial formulation of a patient. The diagnosis and formulation may change over time and the course of treatment.

40. The only diagnosis Respondent ever documented for Patient 2 was "Adjustment Disorder with Mixed Anxiety and Depressed Mood," which was the diagnostic code he used to bill for all of her care and treatment. Suicide ideation, however, which Respondent identified as a symptom of Patient 2 over the course of her care and treatment, is not expected with Adjustment Disorder with Mixed Anxiety and Depressed Mood, and suggests another diagnosis. Respondent stated that he had also diagnosed her with Borderline Personality Disorder, with which suicidal ideation is associated. Respondent intentionally did not document this diagnosis purportedly to protect Patient 2's confidentiality. Respondent committed an extreme departure from the standard of care when he failed to document any diagnosis associated with the psychiatric symptom of suicide ideation in Patient 2's medical record and/or to ever revise his initial diagnosis after a new symptom emerged.

41. The standard of care in the community provides that a suicide assessment is a necessary part of a psychiatric evaluation and ongoing suicide risk assessment is indicated, particularly when a patient experiences new stressors or psychiatric symptoms or has a psychiatric diagnosis associated with suicidal ideation and attempt, such as Major Depressive Disorder or Borderline Personality Disorder. A suicide risk assessment includes both active and passive current suicidal ideas, suicide plans, and suicide attempts. If suicide ideation is present, further assessment includes 1) patient's intended course of action if current symptoms worsen, 2) access to suicide methods including firearms, 3) patient's possible motivations for suicide, 4) reasons for living, and 5) quality and strength of therapeutic alliance. The standard of care includes taking action to hospitalize a patient against their will if necessary, if the patient may be at imminent risk of suicide.

42. Respondent committed an extreme departure from the standard of care when failed to conduct and/or document a baseline and then ongoing suicide risk assessment of Patient 2 and failed to take appropriate preventative action with Patient 2, given her risk factors and the direct and collateral evidence available. Specifically, Respondent did not include a formal suicide risk assessment in any psychiatric evaluation of Patient 2 or otherwise in her medical record. Respondent also did not obtain Patient 2's records from other providers who had documented her

suicide risk. Respondent also acknowledged that he did not have a strong therapeutic alliance with Patient 2, yet he was aware Patient 2 experienced suicidal ideation and was concerned that she would experience it, if S. broke up with her. Patient 1 had also warned Respondent that Patient 2 was buying drugs from Mexico to be used to commit suicide. Additionally, when Patient 2 called Respondent on October 31, 2017, complaining of nausea and vomiting, Respondent failed to assess that she could have been in the midst of attempting suicide by ingestion. Respondent did not call 911, request that emergency services conduct a wellness check or take action to have Patient 2 evaluated at a hospital against her will. Instead, Respondent prescribed anti-nausea medication and told Patient 2 to go to the emergency room.

43. The standard of care in the medical community requires that physicians maintain adequate and accurate records relating to the provision of services to their patients.

44. Respondent committed an extreme departure from the standard of care when he failed to maintain adequate and accurate records for Patient 2. For example, Respondent did not document Patient 2's diagnosis of Borderline Personality Disorder, a complete psychiatric evaluation of Patient 2, her medication record, his assessment of progress toward her treatment goals, his ongoing safety assessment of this high-risk patient, and a plan for subsequent services. Additionally, Respondent did not document his various efforts to medicate Patient 2, her response or her consents for services. Respondent also intermingled the records of Patients 1 and 2.

45. The standard of care in the community requires that psychotropic medication should be prescribed when there is a clear indication and recognized evidence-base. "Off-label" prescribing should include clear documentation of the prescriber's rationale. Informed consent for medication and a record of prescriptions and estimation of adherence should be documented.

46. Respondent committed an extreme departure from the standard of care when he failed to document his rationale for prescribing specific medications to Patient 2, obtain written informed consent from Patient 2, record prescriptions with their date, name of medication, dose, route, number of pills, refills, benefit, and adverse effects. Further, Respondent suspected that Patient 2 was not compliant with her medication and may have been retaining his prescriptions.

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47. Respondent's acts and/or omissions as set forth in paragraphs 8 through 46, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. As such, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

48. Respondent Lawrence H. Warick, M.D. is subject to disciplinary action under Code section 2234, subdivision (c), in that he committed repeated negligent acts in the care and treatment of Patient 2. The circumstances are as follows:

49. Paragraphs 8 through 46 are incorporated by reference and re-alleged as if fully set forth herein.

50. The standard of care in the community requires that after conducting a psychiatric evaluation, formulating the case, and making a diagnosis, treatment should begin after the development of a treatment plan that is discussed with and agreed to by the patient, and which includes treatment options, risks and benefits of treatment, and risks of untreated illness. A treatment plan for a patient with suicidal ideation might include psychotropic medication and/or psychotherapy, and should include safety planning.

51. Respondent departed from the standard of care when he initiated interventions (e.g., psychotropic medication) and deferred indicated interventions (e.g., evidence-based psychotherapy) without a clear treatment plan in place for Patient 2. Specifically, Respondent attempted to prescribe medication to Patient 2 without documenting an evidence-based indication, written informed consent from Patient 2, and without Patient 2's agreement to take the medication. Additionally, Respondent did not document that he initiated any evidence-based psychotherapy modality for Borderline Personality Disorder or made arrangements to collaborate with a psychotherapist who would, while he prescribed Patient 2 medication. Likewise, Respondent failed to formulate a safety plan for Patient 2 or to conduct ongoing safety assessments of Patient 2.

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52. The standard of care in the community requires a psychiatrist to maintain confidentiality and the boundaries of the doctor-patient relationship when treating multiple members of the same family. Care should be taken in documenting about other family member patients in a patient chart and requests related to care should be made of the appropriate family member patient.

53. Respondent departed from the standard of care when he failed to maintain patient confidentiality and boundaries. Specifically, Respondent discussed Patient 2's care and treatment with her parents without obtaining her written authorization to do so. Additionally, Respondent made a reference to Patient 1's medical record in Patient 2's medical record. Respondent also intermingled the billing records of Patients 1 and 2.

54. The standard of care in the community requires a psychiatrist to have a system in place to respond to patient emergencies directly or to have a designated covering psychiatrist available to respond to patient emergencies. If an answering service is used, it should allow for a message to be left or directly contact the psychiatrist or covering psychiatrist so that an emergency can be responded to in a timely manner.

55. During the relevant time period, if Respondent was not available to answer his office phone, the call was referred to an answering service. The answering service, however, did not allow the caller to leave a message or directly contact Respondent or any covering psychiatrist. Respondent's lack of access in an emergency is a departure from the standard of care.

56. Respondent's acts and/or omissions as set forth in paragraphs 49 through 55, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts pursuant to section 2234, subdivision (c), of the Code. As such, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)

57. Respondent Lawrence H. Warick, M.D. is subject to disciplinary action under Code section 2266, in that he failed to maintain adequate records concerning his care and treatment of Patient 2. The circumstances are as follows:

58. Paragraphs 8 through 46, and 50 through 55 are incorporated by reference and re-alleged as if fully set forth herein.

59. Respondent's acts and/or omissions as set forth in paragraph 58, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute inadequate record keeping in violation of section 2266 of the Code. As such, cause for discipline exists.

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:

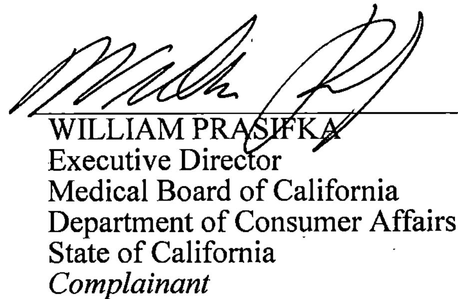
1. Revoking or suspending Physician's and Surgeon's Certificate Number G 7011, issued to Lawrence H. Warick, M.D.;

2. Revoking, suspending or denying approval of Lawrence H. Warick, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Lawrence H. Warick, 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: July 28, 2020



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