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

In the Matter of the Accusation Against: **Kathryn Elizabeth Beyrer, M.D.** **450 Gough Street** **San Francisco, CA 94102-4425** **Physician's and Surgeon's Certificate No. G 82334,** Respondent.	Case No. 800-2018-043853 **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 June 19, 1996, the Medical Board issued Physician's and Surgeon's Certificate Number G 82334 to Kathryn Elizabeth Beyrer, 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 April 30, 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.

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, in pertinent part:

> 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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> (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.

6. Section 2242 of the Code provides that prescribing without an appropriate prior examination and a medical indication constitutes unprofessional conduct.

7. Section 2266 of the Code provides that 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.

FACTUAL ALLEGATIONS

8. Respondent specializes in psychiatry. In May 2016, Patient 1[1] sought psychiatric assistance from Respondent for depression and anxiety. Between May 2016 and September 2017, Respondent treated Patient 1 with in-person and telephonic sessions. There were also a number of text message communications between Respondent and Patient 1.

9. Patient 1's initial visit with Respondent was on May 26, 2016. Respondent documented the patient reported sadness and anxiety, loss of appetite, and early morning

[1] The patient is referred to as Patient 1 to protect privacy.

wakening. She noted a history of family dysfunction. Respondent assessed the patient as being depressed, and prescribed the antidepressant Cymbalta[2]. Over the next several weeks, Respondent noted Patient 1 was "distinctly better." On June 8, 2016, Respondent added a prescription for Klonopin,[3] to be used as needed for anxiety and difficulty sleeping. Respondent's note of a June 29, 2016 visit indicated the patient complained of difficulty organizing tasks, a "lifelong issue." Respondent added Attention Deficit Hyperactivity Disorder (ADHD) as a diagnosis, and prescribed the stimulant Adderall[4].

Respondent diagnosed Patient 1 with Major Depression and anxiety, and prescribed Cymbalta and Klonopin to treat those conditions. However, Respondent never obtained and/or documented information sufficient to support her diagnosis. Respondent did not consider and/or document the nature and extent of Patient 1's depression, how it impacted her life, physical or psychological symptoms of depression, or behavioral patterns that would lead to the conclusion the patient suffered from Major Depression. She did not document a comprehensive history of the patient's complaints, a mental health history, a mental status examination, or any current or past medical conditions. She did not document a substance abuse history. Similarly, Respondent diagnosed Patient 1 with ADHD and prescribed Adderall to treat that condition, but never obtained and/or documented a sufficient history or assessment to support the diagnosis and treatment with a habit-forming drug.

10. On Patient 1's intake form, completed in early June 2016, Respondent documented diagnoses of Major Depression and Polysubstance Abuse . Respondent stated during her Board investigative interview that the patient informed her in June 2016 that she had in the past used alcohol and GHB[5] to self-treat depression and anxiety, but the patient assured her she was no

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[2] Cymbalta is a trade name for duloxetine. It is an antidepressant used to treat major depression and general anxiety.

[3] Klonopin is a trade name for clonazepam. It is a benzodiazepine and a controlled substance. It produces central nervous system depression and must be used with caution with other CNS depressant substances, including alcohol.

[4] Adderall is a trade name for a combination of amphetamine and dextroamphetamine. It is a CNS stimulant and a controlled substance. Adderall has a high potential for abuse and the prescriber must take steps to ensure it is not overused or misused.

[5] GHB is gamma-Hydroxybutyric acid, a psychoactive drug that is used recreationally as an intoxicant. It is a central nervous system depressant and has sedative effects. It is particularly dangerous when used with alcohol or combined with other sedatives.

longer using those substances. However, Respondent also informed the Board's investigator that in the summer of 2016, Patient 1 told her she regularly used GHB and drank alcohol when she was alone at night. In November 2016, Respondent made a home visit, and discovered that Patient 1's boyfriend was using their home to grow marijuana. Again, Respondent told the Board's investigators she accepted the patient's representation she was not using marijuana. In January 2017, Respondent noted the patient missed an appointment because she was intoxicated, and also that Patient 1 told her during a phone call that she was drinking alcohol to console herself. In May 2017, Respondent documented that Patient 1 brought her a large quantity of marijuana as a gift in lieu of payment for sessions. Aside from her June 2016 notation in the diagnosis section of the intake form that the patient had Polysubstance Abuse, Respondent's medical record for Patient 1 contains no substance abuse history, and no ongoing assessment of substance abuse or a response to new information received indicating the patient was using GHB and alcohol. Respondent's record contains no reference to any discussion with the patient regarding the risks of using alcohol and/or GHB while taking Klonopin. There is no indication that Respondent at any time took steps to monitor her patient's safe use of the medications she prescribed by way of testing or that she inquired about or determined the frequency of use of the benzodiazepine.

11. Respondent's medical record for Patient 1 consists of brief notations, routinely lacking in significant discussion of the patient's complaints, response to treatment, or the rationale for prescribing. At no time during her care of Patient 1 did Respondent complete a medical history, including an assessment of the patient's mental status, substance abuse history, history of prior psychiatric treatment, or assessment of other underlying or coexisting conditions, an assessment and a treatment plan. A number of the chart entries were inaccurately dated. Respondent represented to the Board's investigators there were significant additional facts, assessments and evaluations that were not included in her medical records.

12. Over the course of treatment, Respondent obtained information indicating Patient 1 was not doing well on her prescribed course of treatment. Respondent noted that Patient 1 had a "meltdown" at work, and had taken a leave of absence and was seeking disability. Respondent's

records contain little assessment of the patient's condition or complaints. Respondent attributed the patient's difficulties to her own absence during a vacation, but her record reflects no meaningful assessment of the patient's mental status or response to treatment. While Respondent occasionally noted her patient complained she was increasingly depressed, anxious and overwhelmed, and remained on disability and unable to work, she documented no assessment of these complaints, and did not change her treatment plan. When the patient cancelled an appointment because she was intoxicated and "drinking to console herself" and then attempted to pay for her treatment with an "enormous jar" of marijuana, and even though Respondent informed the Board's investigators that she wondered if the patient had resumed her use of GHB and alcohol, Respondent failed to conduct any substance abuse assessment. There is no indication in the record that she discussed with the patient the risks posed by consumption of alcohol with a benzodiazepine, or that Respondent ever re-evaluated the efficacy of her treatment plan.

13. Respondent regularly issued prescriptions for Cymbalta, Klonopin and Adderall. She wrote monthly prescriptions for 90 pills of Klonopin, an amount far in excess of the instructed dosage, particularly given Respondent's assertion she prescribed clonazepam for "occasional" use when needed for severe anxiety or difficulty sleeping. Similarly, Respondent wrote monthly prescriptions for 90 pills of Adderall, an amount far in excess of the amount Respondent instructed the patient to take. In June 2017, Respondent issued the patient two Klonopin and two Adderall prescriptions, to be filled in June and July. Respondent stated during her Board interview that she prescribed in large amounts so that the patient would have extra medication on hand in the event she lost her job or insurance or was unable to pay for medication. Respondent continued this practice even after she was aware Patient 1 was abusing alcohol and using GHB.

14. In June 2017, Respondent was away on vacation. Patient 1 understood and expected that Respondent would submit documentation certifying her for extended disability, but the necessary paperwork was not submitted, and Patient 1 was terminated from her employment. Text messages were exchanged between Respondent and Patient 1, and the patient requested a

referral to a new psychiatrist. When Respondent returned from vacation, she learned that the Patient had appeared at work intoxicated.

15. In early August 2017, Patient 1 decided to take herself off of the medication Respondent prescribed, without medical supervision. The patient experienced suicidal thoughts and severe anxiety. She went to a detoxification facility, where she was diagnosed with and treated for sedative, hypnotic or anxiolytic withdrawal and a sedative, hypnotic or anxiolytic use disorder, severe. Patient 1 also reported heavy alcohol use. After leaving the detoxification facility, Patient 1 entered treatment for substance abuse.

16. Respondent's last documented encounter with Patient 1 was on September 2, 2017. Respondent noted she issued prescriptions for one month, and provided the patient with names of other therapists.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts/Prescribing Without Adequate Evaluation/Indication)

17. Respondent is guilty of unprofessional conduct in her care and treatment of Patient 1, and is subject to disciplinary action under sections 2234, and/or 2234(b), and/or 2234(c), and /or 2242 of the Code in that she committed gross negligence and/or repeated negligent acts, and/or prescribed in the absence of an appropriate examination and medical indication, including but not limited to the following:

A. Respondent diagnosed Patient 1 with Major Depression and anxiety, and prescribed medication to treat those conditions, without conducting an adequate and appropriate assessment and examination, and without obtaining sufficient information to support the diagnosis and treatment.

B. Respondent diagnosed Patient 1 with Attention Deficit Hyperactivity Disorder, and prescribed a controlled substance to treat that condition, without conducing an adequate and appropriate assessment and examination, and without obtaining sufficient information to support the diagnosis and treatment.

C. Respondent prescribed medications, including a benzodiazepine and a stimulant, to a patient with a history and diagnosis of polysubstance abuse, without conducting or documenting an evaluation of the patients use of alcohol and other substances or the potential impact of the prescribed medication taken in conjunction with alcohol and other substances, and without informing the patient of the significant risks associated with her use of these substances.

D. Respondent prescribed dangerous drugs and controlled substances, over an extended period of time, without adequate monitoring or follow- up, and without adjusting her treatment plan according to the patient's response.

E. Respondent failed to conduct a substance abuse assessment or history of substance abuse, failed to identify, document, diagnose and address Patient 1's current substance abuse, or to refer her to a provider who could provide necessary assessment and treatment.

F. Respondent prescribed Klonopin and Adderall in amounts far in excess of the intended dosage, for the purpose of allowing a known substance-abusing patient to stockpile medication, and without taking steps to monitor the patient for alcohol use.

G. Respondent failed to adjust her treatment plan even when it became clear that Patient 1's mental state was deteriorating and she was actively abusing alcohol and/or GHB, and failed to assess or evaluate the patient's response to treatment.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Accurate and Adequate Medical Records)

18. Respondent is guilty of unprofessional conduct and subject to discipline for violation of Section 2266 of the Code for failure to keep adequate and accurate medical records.

19. Respondent's medical records fail to include an adequate or full assessment of the patient's presenting condition, her past medical, mental health or substance abuse history, the basis for her diagnosis, the rationale for prescribing, or response to treatment. Respondent did not document an appropriate or adequate informed consent provided to Patient 1 regarding the potential risks of the medications she was prescribed, or the risks associated with use of alcohol or other drugs in connection with the prescribed medication. If indeed Respondent conducted the

additional assessment and evaluation she described to the Board's investigators, that information was not included in Respondent's medical record.

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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 82334, issued to Kathryn Elizabeth Beyrer, M.D.;

2. Revoking, suspending or denying approval of Kathryn Elizabeth Beyrer, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Kathryn Elizabeth Beyrer, 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: MAY 04 2021

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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