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

In the Matter of the Accusation Against: Visit Chatsuthiphan, M.D. Physician's & Surgeon's Certificate No. A 32338 Respondent.	Case No. 800-2019-056616

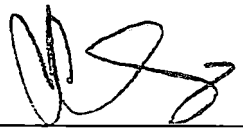
DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on July 31, 2023.

IT IS SO ORDERED: June 30, 2023.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

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

In the Matter of the Accusation Against:

VISIT CHATSUTHIPHAN, M.D.,

Physician's and Surgeon's Certificate Number No. A 32338,

Respondent.

Case No. 800-2019-056616

OAH No. 2022060903

PROPOSED DECISION

Ji-Lan Zang, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter by videoconference from February 13 to February 16, 2023.

Rebecca L. Smith, Deputy Attorney General, represented Reji Varghese, (complainant), Interim Executive Director, Medical Board of California (Board), Department of Consumer Affairs.

Raymond J. McMahon, Attorney at Law, represented Visit Chatsuthiphan, M.D. (respondent) who was present throughout the hearing.

At the hearing complainant moved to amend the Accusation (ex. 1) by interlineation as follows: (1) on page A1, on lines 20 to 21, the words "William Prasifka" are replaced by "Reji Varghese," and the words "Executive Director" are replaced by "Interim Executive Director"; and (2) on page A15, on line 13, the words "July 19, 2019" are replaced by "July 10, 2019," and on line 15, the words "April 12, 2019" are replaced by "July 12, 2019." Respondent did not oppose the motion, and the motion to amend the Accusation was granted.

At the hearing, the ALJ was provided with Exhibits 8, 9, 10, 14, 15, 19, 20, 23, and 24, which contained confidential information. Redaction of the exhibits to obscure this information was not practicable and would not provide adequate privacy protection. To prevent the disclosure of confidential information to the public, the ALJ issued a Protective Order placing these exhibits under seal following their use in the preparation of the Proposed Decision.

Oral and documentary evidence was received. The record remained open until April 4, 2023, for respondent to submit a closing brief regarding complainant's expert testimony, and until April 11, 2023, for complainant to provide a response. The closing brief (marked for identification as Exhibit N) and response (marked for identification as Exhibit 35) were timely filed. The record was closed, and the matter was submitted for decision on April 11, 2023.

SUMMARY

Complainant charged respondent with gross negligence, repeated acts of negligence, and improper medical record keeping in connection with his treatment of four patients. Complainant did not prove respondent was grossly negligent in his care

and treatment of these patients. However, complainant proved respondent kept inadequate medical records for the four patients and thus committed repeated acts of negligence. Considering respondent's reputation in the community and the absence of any discipline for almost 45 years, neither revocation nor probation of respondent's medical certificate is warranted. A public letter of reproval with the requirement that respondent completes a medical record keeping course is sufficient to protect the public.

FACTUAL FINDINGS

Jurisdictional Matters

1. On June 12, 1978, the Board issued Physician's and Surgeon's Certificate Number A 32338 to respondent. This license is scheduled to expire on June 30, 2024.

2. On June 10, 2022, complainant filed the Accusation in his official capacity. Respondent filed a Notice of Defense requesting a hearing. Jurisdiction to proceed with this hearing has been established.

Respondent's Background

3. Respondent received his undergraduate degree from Mahidol University in Bangkok, Thailand in 1971 and his medical degree from the same university in 1974. From 1974 to 1978, after he graduated from medical school, respondent served his internship and residency in the United States. From 1978 to 1998, respondent worked as a psychiatrist at various hospitals in California. From 1998 to 2010, respondent worked as a psychiatrist at San Bernadino County Behavioral Health.

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4. Since 2010, respondent has worked for Inland Psychiatric Medical Group (IPMG), where most of his patients qualify for Medi-Cal or Medi-Care. Respondent treats patients who are generally healthy and stable with mild to moderate psychiatric conditions. Respondent has no prior history of discipline with the Board.

Patient 1

5. Patient 1 (patients and their family members are identified by titles to protect their privacy) was a 30-year-old female when respondent first began to treat her on March 7, 2018. Except for a three-month pause from November 2018 to January 2019, respondent saw Patient 1 once a month at IPMG until May 13, 2020.

6. On June 12, 2019, Patient 1's husband (Husband) filed a complaint against respondent with the Board (Board complaint), alleging respondent continued to prescribe Xanax, a benzodiazepine for the treatment of anxiety and panic disorders, to Patient 1, despite Husband's warning to respondent that Patient 1 was getting high on the drug. (Ex. 4.)

TREATMENT HISTORY: SUBSTANCE USE ISSUES

March 2018 to August 2018

7. During Patient 1's first visit on March 7, 2018, respondent performed an initial psychiatric evaluation. Respondent noted Patient 1 had recurrent depression and anxiety since she was 20 years old. (Ex. 10, p. A199.) Her depression worsened after delivering her baby on October 18, 2017. (*Ibid.*) Patient 1 worked as a nurse, and her complaints included "severe depression, insomnia, loss of energy, feeling tired, poor concentration and memory, loss of interest in activities and sex, anxiety, feeling hopeless and helpless, crying spell." (*Ibid.*) Respondent performed a mental status

examination of Patient 1 and found her appearance, build, posture, insight, and judgment to be within normal limits. (*Id.* at p. A200.) However, her mood was depressed and anxious. (*Ibid.*) Respondent diagnosed Patient 1 with chronic recurrent major depressive disorder and chronic generalized anxiety disorder. He prescribed to Patient 1, Xanax, at the dosage of one 1 mg tablet twice a day as well as Trazodone, an anti-depressant, in addition to other medications. (*Ibid.*) Regarding Patient 1's issues with substance use, under the title, "Presenting Concerns," respondent wrote: "No drug or alc abuse." (*Id.* at p. A199.)

8. At the hearing, respondent testified he questioned Patient 1 about her current and past substance use as a part of his standard initial evaluation on March 7, 2018. According to respondent, he asked Patient 1 questions such as, "do you drink alcohol?"; "when was the last time you used alcohol?"; "how often do you drink?"; "do you use drugs?"; and "when was the last time you used drugs?" Patient 1 denied any drug or alcohol use, either currently or by history. Relying on the truth of Patient 1's answers, respondent did not perform any further substance use assessment. Respondent also recounted he discussed potential side effects when he prescribed medications to Patient 1. Specifically, he discussed with Patient 1 that using Xanax with alcohol can enhance drowsiness. However, this discussion is not documented in the medical records.

9. At Patient 1's next visit on March 21, 2018, respondent noted Patient 1 was compliant in taking her medications. (Ex. 10, p. A202.) However, during her visit on April 18, 2018, respondent noted: "Taking med erraticly [*sic*]- possibly taking Trazodone during the day." (Ex. 10, p. A204.) Respondent also noted Patient 1 was sleeping during the day during the past two weeks. (*Ibid.*) In his testimony at hearing, respondent explained his notation about Patient 1 taking medication erratically

referred to his suspicion that Patient 1 not taking Trazodone at night as prescribed, but taking it during the day, which was causing her daytime drowsiness. Respondent testified Patient 1 admitted she was in fact taking Trazodone during the day. Respondent then reportedly advised Patient 1 to take Trazodone only at night to alleviate her daytime sleepiness.

10. During Patient 1's next visit on May 17, 2018, respondent wrote in her medical record, "husband now in charge of her med." (Ex. 10, p. A206.)

11. During Patient 1's visit on June 20, 2018, respondent noted Patient 1 had been admitted to Desert Hospital for Rhabdomyolysis, a serious medical condition involving the breakdown of muscle tissue that releases damaging proteins into the blood. (Ex. 10, p. A208.) Patient 1 was discharged from Desert Hospital on May 15, 2018. (*Ibid.*) At the hearing, respondent reported he asked Patient 1 about the cause of the Rhabdomyolysis, but Patient 1 told him she did not know. Respondent later learned during the investigation for this case that Patient 1's Rhabdomyolysis resulted from an overdosed of Imodium. However, respondent emphasized he was not aware Patient 1 had suffered any overdose during his treatment of Patient 1, and he never prescribed any Imodium to Patient 1.

12. Patient 1 had additional visits with respondent on July 17 and August 17, 2018, with no noteworthy developments.

Contact from Husband in September 2018

13. On September 24, 2018, Husband called IPMG and left a message with a staff member at IPMG. A memorandum of this phone call in Patient 1's medical records describes the message as "Husband says pt abusing Xanax with alc." (Ex. 10, p. A191.) Alcohol and Xanax are depressants that when taken in combination, can cause

oversedation. This phone call is the only contact from Husband documented in the medical records.

14. At the hearing, Husband claimed he had warned respondent on other occasions about Patient 1's misuse of Xanax and alcohol. Specifically, Husband asserted he took Patient 1 to see respondent in April 2018 while Patient 1 was high on Xanax. According to Husband, he wanted respondent to see "what [Patient 1] looked like" when she was misusing her medication. Husband reportedly told respondent Patient 1 was using her medication inappropriately at this same meeting, and respondent reportedly told Husband that he did not understand how this was possible. Husband also testified he made a second attempt to take Patient 1 to a visit after April 2018, but Patient 1 did not allow Husband to see respondent this second time. Husband recounted he called respondent at IPMG approximately one year after the April 2018 visit to warn respondent again of Patient 1's misuse of medication. Husband, in his own words, "threatened" to report respondent to the Board if respondent continued to prescribe Xanax to Patient 1.

15. Husband's testimony on this issue is deemed not credible for the following reasons. First, Patient 1's medical records do no corroborate Husband's testimony that he met respondent in April 2018. The medical records reflect Patient 1 had one visit with respondent in that month, on April 18, 2018, and the progress note for that visit make no mention of Husband's presence during that visit. In fact, there is no record of Husband ever accompanying Patient 1 to any visit with respondent. The medical records also do not indicate Patient 1 ever consented to respondent speaking with Husband. Second, respondent testified he could not recall Husband's presence at the April 18, 2018 visit, and thus did not corroborate Husband's version of the events. Third, Husband admitted on cross-examination he controlled Patient 1's other

medications, including medications with low risk for abuse, such as Lyrica, a medication to treat nerve pain. This admission raises questions about whether Husband's motivation was to prevent Patient 1 from misusing drugs or to exert control over her healthcare. Fourth, Husband's account of his contacts with respondent is inconsistent over time. In his June 12, 2019 Board complaint, Husband stated that he contacted respondent four times about his wife's purported misuse of medications. (Ex. 4, p. A52.) Husband also referred to a visit, without specifying the date, when he went with his wife to see respondent while Patient 1 was high on benzodiazepines. (*Ibid.*) Nevertheless, in a July 28, 2021 interview with Board Investigator Robert Perez, Husband made no mention of any visit in April 2018 or any other time when he accompanied his wife to see respondent. (Ex. 3, pp. A43-44.) Husband reported to Investigator Perez that he called respondent's office twice, a few months after Patient 1 started treatment with respondent, to tell respondent about his wife's misuse of Xanax. (*Ibid.*)

16. Considering these factors, it was not established by clear and convincing evidence Husband accompanied Patient 1 to her visit with respondent while she was high on Xanax in April 2018, or at any other time. The only contact by Husband that was established by clear and convincing evidence is his September 24, 2018 phone call to respondent's office to report Patient 1's misuse of Xanax with alcohol, as the medical records corroborate this phone call.

October 2018 to May 2020

17. Respondent testified he first learned of Patient 1's purported problems with Xanax and alcohol on September 24, 2018, when Husband called his office about Patient 1 abusing Xanax with alcohol. Approximately two weeks after this phone call, respondent saw Patient 1 on October 5, 2018. Respondent wrote in the progress note

for this visit: "Pt weaned off Xanax on her own 2 wk ago [¶] Now Anxious, wants non-addictive med for anxiety." (Ex. 10, p. A224.) On the same day, respondent stopped Patient 1's Xanax prescription. (*Ibid.*) According to his testimony at hearing, respondent believes he addressed the alcohol issue with Patient 1 at this visit, when he talked to Patient 1 about the dangers of using Xanax with alcohol. Respondent reported he had a long discussion with Patient 1 about taking non-addictive anti-anxiety medication. Respondent also asserted he asked Patient 1 about her alcohol use and Patient 1 showed "insight" into her problems. Because Patient 1 had already weaned herself off of Xanax, respondent believed the problem had been resolved, and he stopped the Xanax prescription. On cross-examination, however, respondent admitted the medical records do not contain any documentation of his reminders to Patient 1 that Xanax is to be used only as prescribed or of his discussions with Patient 1 about the dangers of mixing alcohol with Xanax.

18. From November 2018 to January 2019, Patient 1 did not visit respondent. Patient 1 resumed her treatment with respondent on February 27, 2019; respondent did not prescribe Patient 1 Xanax at this visit. (Ex. 10, p. A228-A231.) However, respondent prescribed Xanax to Patient 1 again at her next visit on April 4, 2019, when he also noted Patient 1 had not drunk alcohol since November 28, 2018. (Ex. 10, p. A232.) At this visit respondent maintained the Xanax dosage at one 1 mg tablet, twice a day. (*Ibid.*)

19. Patient 1 saw respondent on May 2, 2019, June 12, 2019, and July 19, 2019. During those visits, respondent reiterated Patient 1 had not drunk alcohol since November 28, 2018 (Ex. 10, p. A237, A241, A245). He continued to prescribe Xanax at the dosage of one 1 mg tablet twice a day to Patient 1 (*id.* at p. A238, A242), until July 19, 2019, when Patient 1 reported to respondent, "My husband would not let me take

Xanax again." (Ex. 10, p. A245.) On that date, respondent changed his prescription of Xanax to one 1 mg tablet per day as needed for anxiety. (*Id.* at p. A246.)

20. Respondent did not make any further notations about Patient 1's alcohol use in his notes for her next five visits on August 8, September 20, October 9, October 30, and November 27, 2019. (Ex. 10, p. A250-A274.) On August 8, 2019, Respondent decreased her prescription of Xanax to one 0.5 mg tablet per day as needed for anxiety.

21. Patient 1 saw respondent for treatment on December 12, 2019, and January 9, January 30, February 19, March 27, April 7, April 29, and May 13, 2020. Respondent maintained Patient 1 on Xanax until April 29, 2020, when Patient 1 expressed a wish to stay off the medication for two weeks. (Ex. 10, p. A298.) During her last visit with respondent on May 13, 2020, Patient 1 again expressed a wish to stay off Xanax, and respondent did not prescribe the medication to her. (*Id.* at p. A301.)

22. At hearing, respondent testified he resumed Patient 1's Xanax prescription only after she confirmed she was not drinking any alcohol. Respondent insisted he was "in control" of Patient 1's use of Xanax, presumably meaning he does not believe Patient 1 was misusing Xanax under his care. Respondent also believes he performed an adequate substance use assessment of Patient 1 by asking her about her alcohol use, and he reasonably relied on her reports of abstinence from alcohol.

June 2020: Treatment with Another Provider

23. On June 9, 2020, after she terminated her doctor-patient relationship with respondent, Patient 1 completed an intake form (2020 Intake) at IPMG. In this 2020 Intake, Patient 1 revealed she had a history of alcohol and drug use. (Ex. 10, p. A163.) On June 11, 2020, Patient 1 began treatment with Jennifer Onyekonwu-McGill,

Nurse Practitioner (NP), at IPMG. During her initial psychiatric evaluation with NP Onyekonwu-McGill, Patient 1 revealed she was hospitalized two years ago for anxiety and an accidental drug overdose at Desert Regional Hospital. (*Id.* at p. A305.) Patient 1 had not disclosed this information to respondent while she was under his care.

24. By Husband's own admission at the hearing, Patient 1 did well under respondent's care, and she worked as a nurse while respondent treated her. It was also undisputed that Patient 1 experienced more difficulties with her mental health and struggled with her employment after terminating her treatment with respondent.

CURES Reports

25. Beginning on July 18, 2018, respondent copied and pasted Patient 1's report from the Controlled Substance Utilization Review and Evaluation System (CURES), California's prescription drug monitoring program, into her progress notes. (Ex. 10, p. A211.) Specifically, respondent copied and pasted Patient 1's CURES reports on the following additional dates: August 17, 2018 (*id.* at p. A216), April 4, 2019 (*id.* at p. A232), August 8, 2019 (*id.* at p. A250), and December 12, 2019 (*id.* at p. A275). Each of these CURES reports usually consisted of Patient 1's last three to four months of prescriptions. Based on Patient 1's CURES reports, respondent was aware of Patient 1's opioid prescriptions, as he noted on July 18, 2018, that Patient 1 was no longer taking Norco, an opioid pain reliever another physician had previously prescribed to her. (*Ibid.*)

26. At the hearing, respondent stated he learned about CURES around April 2018, and before the mandatory implementation of CURES in October 2018, he began to check the database for information on his patients' prescriptions of controlled substances. His practice is to search the CURES website for the specific patient's

information and then copy and paste the first page into his notes. Respondent explained he only copies and pastes the first page because he only needs prescription information from the past four months.

PATIENT 1'S TREATMENT HISTORY: DOCUMENTATION ISSUES

27. Patient 1 had 26 visits in total during her treatment with respondent from March 2018 to May 2020. Throughout these 26 visits, respondent used the same language to describe Patient 1's treatment plan and goals. For each of Patient 1's visits, respondent wrote:

> Treatment is necessary to:
>
> - Reduce risk of patient needing a more intensive level of care.
> - Reduce risk of harm to self and others.
> - Maintain and improve current level of functioning.
>
> Short term Goal: Symptoms relieved
>
> Long term goal: Maintain symptoms free
>
> Plan: Patient to take meds as prescribed
>
> Continue medication management.

(Ex. 10, pp. A202, A204, A206, A208, A211, A216, A220, A224, A228, A232, A237, A241, A245, A250, A251, A255, A260, A265, A270, A276, A284, A287, A290, A293, A296, A299, A302)

28. Respondent explained his recordkeeping practice is to copy and paste his notes from his patients' previous visits and then edit those notes for the current visit, as necessary. However, respondent uses the same "standard" language for his treatment plan and goals for every visit. The medical records show respondent repeated the same treatment plan and goals language not only throughout Patient 1's medical records, but also throughout the medical records of Patients 2, 3, and 4.

29. Respondent also changed Patient 1's medications without documenting any rationale for doing so. For example, during Patient 1's initial evaluation on March 7, 2018, respondent noted Patient 1's past medications included Xanax; Seroquel, an antipsychotic medication; Cymbalta, an antidepressant for the treatment of anxiety; Trazodone, an antidepressant for the treatment of insomnia; Abilify, another antipsychotic; and Trileptal, a mood stabilizer. (Ex. 10, p. A199.) Respondent then discontinued Patient 1's prescriptions of Seroquel, Abilify, and Trileptal, without any documented rationale. (*Id.* at p. A200.) Respondent continued to prescribe to Patient 1 Xanax, Trazodone, and Cymbalta, and he subsequently added Rexulti, another antipsychotic medication, to Patient 1's medication list. (*Ibid.*) However, he documented no rationale for adding Rexulti, or for continuing Cymbalta, despite his note that Patient 1 had "[f]ailed . . . . Cymbalta . . ." (*Ibid.*)

30. In another example, on February 27, 2019, respondent prescribed Gabapentin, an anti-seizure medication, to Patient 1 without documenting any rationale. (*Id.* at p. A229.) However, on April 4, 2019, respondent stopped prescribing Gabapentin and began prescribing Xanax to Patient 1, again without any explanation. (*Id.* at p. A232.) According to respondent's testimony at hearing, he prescribed Gabapentin because he was honoring a prescription of Gabapentin Patient 1 had from a hospital after a recent discharge. On April 4, 2019, respondent stopped prescribing

Gabapentin because Patient 1 was feeling miserable. He began prescribing Xanax to Patient 1, after Gabapentin and Buspar (another anti-anxiety medication Patient 1 was previously prescribed) had failed. Although respondent conceded he had not documented these explanations in the medical records, he insisted that his rationale for prescribing medications was "obvious to any educated reviewer." Respondent believes that his documentation in Patient 1's case was adequate.

THE EXPERTS

31. Richard Moldawsky, M.D. testified as an expert witness on complainant's behalf. Dr. Moldawsky obtained his bachelor's degree in psychology from the University of Pennsylvania in 1971 and his medical degree from Temple University School of Medicine in 1976. He is board certified in psychiatry, and since 1983, he has practiced in the Department of Psychiatry and Addiction Medicine at Kaiser Permanente in Orange County.

32. Daniel F. Chueh, M.D. testified as an expert witness on respondent's behalf. Dr. Chueh obtain his undergraduate degree from Yale University in 1985 and his medical degree from State University of New York at Buffalo in 1989. He has been board certified in psychiatry since 1999. Dr. Chueh is currently the Director of Outpatient Psychiatric Services at Anaheim Global Hospital. He also serves as a consulting psychiatrist at several community hospitals and nursing homes. In addition to his clinical work, Dr. Chueh has served as the Principal Investigator in over 300 clinical pharmacology trials, which have been reviewed by the Food and Drug Administration (FDA) for new drug approval.

33. Drs. Moldawsky and Chueh are equally qualified to render their opinions in this matter, as they both possess abundant knowledge, experience, and expertise in

psychiatry. However, where the opinions of Drs. Moldawsky and Chueh diverge, one expert's opinion is credited over the other, depending on the circumstances presented in each patient's case. Both Drs. Moldawsky and Chueh rendered their opinions based solely on reviewing the records in this case, including the medical records of Patients 1, 2, 3, and 4. Neither Dr. Moldawsky nor Dr. Chueh personally evaluated any of the patients at issue. The expert opinions summarized below are based on the experts' reports (an undated report by Dr. Moldawsky submitted as Exhibit 6 and a January 3, 2023 report by Dr. Chueh,submitted as Exhibit B) and their testimony at hearing.

DR. MOLDAWSKY'S OPINIONS

Substance Use Issues

34. Regarding respondent's assessment of Patient 1's substance use issues, Dr. Moldawsky wrote in his expert report:

> This patient [Patient 1] acknowledged at the outset of treatment her history of substance use disorder(s). Based on the notes reviewed, [respondent] note that there was no current substance use, though there was no apparent attempt to corroborate this by either drug screens or speaking with husband. It was noted that the husband had taken charge of the patient's medications, which is concerning for a presumably-competent adult. There is minimal evidence in the notes that [respondent] considered the possibility of substance use as a factor in the patient's uneven response to medications; at one point, he notes that the patient had had no alcohol for 6 months, raising the

concern about the prior degree of alcohol (or other substance) use. The husband had contacted the office on at least 2 occasions regarding his concerns about the patient; these do not appear to have been responded to in any way by [respondent]. The standard of care for a patient with a history of both psychiatric and substance use disorder calls for periodic and systematic assessment of both, as these tend to be recurring and one affects response to treatment for the other. Checking CURES is part of that standard.

Conclusion

[Respondent] did not appropriately assess (or assessed but didn't document) the patient at any time for substance use in any detail. He did not check CURES, and may not have been aware of the opiate prescriptions. This constitutes an extreme departure from the standard of care.

(Ex. 6, p. A60.)

35. At the hearing, Dr. Moldawsky did not acknowledge until cross-examination that his opinion is based on two factual errors. First, Patient 1 did not disclose any substance use history to respondent. Rather, she first disclosed her history of substance use in her 2020 Intake with another provider at IMPG in June 2020. By that time, Patient 1 had already terminated her doctor-patient relationship with respondent. Dr. Moldawsky, however, mistakenly believed that Patient 1's 2020 Intake was from March 17, 2018, when Patient 1 began her treatment with respondent. Second, although Dr. Moldawsky initially insisted respondent did not check CURES, he

eventually admitted under cross-examination that respondent did in fact check CURES and was aware of Patient 1's opioid prescriptions from other providers.

36. After realizing his mistakes, Dr. Moldawsky, nevertheless, opined other events during Patient 1's treatment warranted a systematic assessment of her substance use issues. Specifically, Dr. Moldawsky pointed to respondent's April 18, 2018 note stating Patient 1 was taking her medications erratically and his May 17, 2018 note that Husband was now in charge of Patient 1's medications as indications of a need for substance use assessment. (See *ante*, Factual Findings 9 & 10.) Dr. Moldawsky described Husband's taking charge of Patient 1's medication as "very unusual and concerning," and should have resulted in further investigation by respondent. According to Dr. Moldawsky, Patient 1's report on June 20, 2018, that she had been admitted to Desert Hospital for Rhabdomyolysis (see *ante*, Factual Finding 11) also should have caused concerns about a possible drug overdose because antipsychotic medications can cause the condition.

37. Dr. Moldawsky further testified Husband's September 24, 2018 phone call to respondent's office about Patient 1's abuse of alcohol and Xanax should have "raised a flag" about potential substance abuse issues. (See *ante* Factual Findings 13-16.) Dr. Moldawsky opined respondent should have clarified with Patient 1 what was going on between her and Husband. Dr. Moldawsky further opined respondent should have tried, with Patient 1's consent, to contact Husband to reduce the risk of Patient 1 misusing drugs. Dr. Moldawsky asserted Patient 1 made other concerning statements later during her treatment with respondent. For example, during her visits from April 2019 to July 2019, Patient 1 reported not having had alcohol since November 2018; on July 19, 2019, she reported Husband would not let her take Xanax again; and on April 29, 2020, she expressed a desire to stay off Xanax. (See *ante* Factual Findings 19-21.)

According to Dr. Moldawsky, these self-reports were further indications of a need for systematic substance use assessment. Additionally, Dr. Moldawsky found respondent did not document any discussions with Patient 1 about her alcohol issues, even though respondent did note Patient 1's abstinence from alcohol for six months.

Documentation Issues

38. Dr. Moldawsky testified the standard of care for documentation is to set forth an assessment of the patient, noting any changes from prior visits and problems with medication. The standard of care also requires a psychiatrist to document their thought process about a patient's diagnosis and treatment plan, as well as provide a rationale for any changes in medication. According to Dr. Moldawsky, every progress note should reflect the patient's current condition, the physician's thoughts on the patient's condition, and the plan for treatment. Dr. Moldawsky opined proper documentation is important to assess patient progress, track new patient developments, and ensure the continuity of care because medical records are a form of communication with subsequent providers.

39. Dr. Moldawsky pointed out that many of respondent's progress notes are repetitive and appear to be copied from prior notes unchanged. He described respondent's notes as having "no real functional assessment," that is, no clarification of how Patient 1 was functioning at home, at work, or socially. Dr. Moldawsky also found respondent prescribed medication and changed medications without documenting his rationale for doing so. Thus, Dr. Moldawsky believed it was difficult to draw conclusions about respondent's thought process and medical judgment. He noted that when respondent made any change in medication, the rationale must be inferred from the prescription. That is, when respondent prescribes a medication to treat anxiety, for example, no rationale is documented; the rationale can only be inferred from

descriptions of patient symptoms of feeling anxious or the patient's anxiety disorder diagnosis. Dr. Moldawsky stated the standard of care is to document the rationale for prescribing each medication. Dr. Moldawsky also criticized respondent for "minimal proper description of symptom[s]." He stated many of respondent's descriptions of Patient 1's symptoms as "less anxious," "sleeps better" (Ex. 10, p. A206) do not meet the standard of care. Dr. Moldawsky explained a physician must provide a proper description of symptoms to track a patient's changes over time to determine whether a medication is having the desired effect. For example, if a physician prescribes a medication to address a patient's panic attacks and properly documents that the number of panic attacks decreases, then the physician knows the medication is working. Dr. Moldawsky opined that these deficiencies in documentation constitute a simple departure from the standard of care.

DR. CHUEH'S OPINIONS

Substance Use Issues

40. Dr. Chueh disagreed with Dr. Moldawsky's statement in his expert report that "[Patient 1] acknowledged at the outset of treatment her history of substance use disorder(s)." (Ex. 6, p. A60.) Dr. Chueh testified that at Patient 1's initial evaluation in March 2018, respondent asked Patient 1 about her substance use history, but Patient 1 denied alcohol or drug use. According to Dr. Chueh, it is within the standard of care for respondent to rely on Patient 1's report, in part because any corroborating evidence of a substance use disorder, such as driving under the influence incidents, job loss, alcoholic breath, smell of marijuana, was absent in Patient 1's case. Patient 1 had no documented history of substance use disorder, and she had never been diagnosed with substance use disorder by any medical provider. Dr. Chueh asserted Dr. Moldawsky is the only provider who diagnosed Patient 1 with substance use

disorder. However, Dr. Chueh opined that it is inappropriate for Dr. Moldawsky to do so without having personally evaluated Patient 1 because substance use disorder is a psychiatric condition that can only be diagnosed after a personal evaluation.

41. Regarding Husband's phone call to respondent's office in September 2018, Dr. Chueh opined respondent could not have called Husband, as Dr. Moldawsky suggested, to corroborate Husband's report that Patient 1 was abusing Xanax with alcohol. Dr. Chueh explained respondent could only contact Husband with the consent of Patient 1; otherwise, respondent would have violated the patient-psychiatrist relationship and the Health Insurance Portability and Accountability Act (HIPAA), which protects patient health information from being disclosed without patient consent. Dr. Chueh pointed out that after Husband's phone call in September 2018, respondent, at Patient 1's next visit on October 5, 2018, stopped his prescription of Xanax, and respondent also noted in several of the following visits that Patient 1 had not had any alcohol since November 2018. Dr. Chueh also found respondent's resumption of prescribing Xanax to Patient 1 on April 4, 2019, to be appropriate to address Patient 1's anxiety because six months have elapsed since Patient 1 was last prescribed Xanax. Dr. Chueh described this pattern of medication as "intermittent use," with a lower potential for abuse than "long term use." Dr. Chueh opined that respondent's monitoring of Patient 1 for potential misuse of Xanax and alcohol was "more than adequate."

42. Dr. Chueh opined respondent met the standard of care by checking CURES. Dr. Chueh explained CURES was certified for state use on April 2, 2018, and only became mandatory on October 2, 2018. (Ex. B, p. B2.) Patient 1's medical records reflect that respondent began to cut and paste relevant portions of Patient 1's CURES

reports into his progress notes beginning on July 18, 2018, before CURES became mandatory.

43. According to Dr. Chueh, Patient 1 presented an unusual, difficult case because Husband attempted to intervene in Patient 1's psychiatric care without her consent. Dr. Chueh believes respondent handled these challenges professionally, without violating HIPAA. Dr. Chueh concluded that respondent did not deviate from the standard of care in his treatment of Patient 1.

Documentation Issues

44. Dr. Chueh disagreed with Dr. Moldawsky's opinion that respondent's recordkeeping was inadequate. Dr. Chueh wrote in his January 3, 2023 expert report:

> . . . There is no deviation from the standard of care [in respondent's documentation in Patient 1's case]. The psychiatric records provide sufficient information for a psychiatrist to understand the care provided and the basis for same. Indeed, it is further worth noting that many psychiatrists do not want to be influenced by the thought process of preceding providers. The nature of psychiatry is in that respect different than some other medical specialties.

(Ex. B, pp. B6-B7.)

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CREDIBILITY FINDINGS

Substance Use Issues

45. Dr. Moldawsky's opinions on the substance use issues in Patient 1's case are not credible for the following reasons. First, Dr. Moldawsky's assertion that respondent should have spoken to Husband to corroborate Patient 1's substance use issues assumes respondent had authority to do so. However, Patient 1 did not testify at the hearing, and there is no evidence Patient 1 ever gave respondent consent to speak to Husband. Thus, Dr. Chueh's opinion that respondent would have violated HIPAA and physician ethics by speaking to Husband about Patient 1's case was persuasive.

46. Second, Dr. Moldawsky made several significant concessions during cross-examination that eroded the credibility of his opinions. For example, Dr. Moldawsky asserted in his expert report that Patient 1 had substance use disorder (see *ante* Factual Finding 34), but he conceded under cross-examination that Patient 1 had never been diagnosed with substance use disorder by any medical provider. Dr. Moldawsky also assumed Patient 1 had substance use disorder without having personally evaluated her. In another example, during direct examination, Dr. Moldawsky pointed to several "flags" in the medical records indicating respondent's need to perform a systematic substance use assessment, but under cross-examination, Dr. Moldawsky conceded these "flags" might have other meanings. Specifically, Dr. Moldawsky agreed the April 18, 2018 note regarding Patient 1 taking her medications erratically could mean Patient 1 was taking Trazadone during the day. With respect to the May 17, 2018 note that Husband was now in charge of Patient 1's medications, Dr. Moldawsky admitted he was unaware of Husband's admission that he was controlling Patient 1's other medications, including medications with low risk for abuse. Dr.

Moldawsky agreed respondent's October 5, 2018 notation that Patient 1 had weaned herself off Xanax is "usually a sign that the patient was not abusing Xanax." Additionally, Dr. Moldawsky agreed that Patient 1's self-report during the next several visits that she had not had any alcohol since November 2018 is a "good sign" that the patient was not abusing alcohol in the last six months.

47. Third, as Dr. Moldawsky admitted during cross-examination, he premised his opinions on two serious factual errors. Namely, Dr. Moldawsky assumed Patient 1 revealed a history of substance abuse at the outset of her treatment with respondent, when in fact, Patient 1 did not disclose her history of substance use until she was in treatment with another provider in June 2020. Dr. Moldawsky also assumed respondent did not check CURES, when in fact, he cut and pasted CURES reports into Patient 1's progress notes. At hearing, when these mistakes were pointed out to Dr. Moldawsky, he was at first unwilling to admit them. Once he admitted to the mistakes, however, Dr. Moldawsky's explanations for how they occurred were troubling. Dr. Moldawsky explained he mistook Patient 1's 2020 Intake as an intake she completed in March 2018 because it was commingled with documents from 2018. However, all the documents that surround the 2020 Intake are from 2020, and all three pages of the 2020 Intake bear the following stamp at the bottom of page: "Completed by [Patient 1] on June 09, 2020 at 02:22 PM." (Ex. 10, pp. A161-163.) Additionally, Dr. Moldawsky initially denied that portions of CURES reports respondent cut and pasted into his progress notes were CURES reports. He later changed his testimony several times in response to questions about whether the documents were in fact CURES reports. Under cross-examination, Dr. Moldawsky eventually admitted his statements that respondent did not check CURES and respondent was not aware of Patient 1's opioid prescription were "probably false."

48. Dr. Moldawsky's reluctance to admit his mistakes demonstrates defensiveness and damages his credibility. Moreover, Dr. Moldawsky's disingenuous explanation for how he mistook the 2020 Intake as a document from 2018 not only casts doubt on how thoroughly he reviewed Patient 1's medical records, but also on his veracity as a witness. An expert's opinion is no better than the facts on which it is based and, "where the facts underlying the expert's opinion are proved to be false or nonexistent, not only is the expert's opinion destroyed but the falsity permeates his entire testimony; it tends to prove his untruthfulness as a witness." (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923-924.)

49. Nevertheless, the record does support Dr. Moldawsky's opinion that respondent did not document his discussions of alcohol issues with Patient 1. It is reasonable to infer respondent had some type of conversation with Patient 1 about using Xanax and alcohol, as he stopped prescribing Xanax to her after her Husband's communication in September 2018 and respondent noted several times that Patient 1 was abstaining from alcohol. Respondent also testified he repeatedly cautioned Patient 1 against using alcohol with Xanax (see *ante*, Factual Findings 8 & 17), but such discussions are not documented in the medical records.

50. Therefore, it was not established by clear and convincing evidence respondent departed from the standard of care by failing to assess Patient 1 for substance use; failing to corroborate Patient 1 had no current substance use by either performing drug screening tests or speaking with her husband; or failing to document any consideration if the possibility of substance abuse during his care and treatment of Patient 1. Additionally, it was not established by clear and convincing evidence that respondent failed to check CURES or document his checking of CURES. It was, however, established by clear and convincing evidence that respondent departed from

the standard of care by failing to document his discussion with Patient 1 about alcohol issues.

Documentation Issues

51. Dr. Moldawsky's opinions on the documentation issues in Patient 1's case are more convincing than those of Dr. Chueh because they were reasonable and supported by the evidence. Respondent did not document his rationale for prescribing medications, including Xanax, Gabapentin and Cymbalta, to Patient 1. His reasoning for prescribing certain medications, such as Xanax for anxiety, must be inferred from his description of Patient 1's symptoms, but there is no documentation of his thought process. Dr. Chueh's assertion that documentation of rationale is not necessary for psychiatrists because psychiatrists do not wish to be influenced by the thought processes of previous providers is unreasonable. Psychiatrists, like other physicians, are professionals capable of forming their own independent judgment. Dr. Moldawsky's opinion, that good recordkeeping ensures continuity of care and serves as a mode of communication between providers, is more persuasive. Additionally, respondent repeated the same language to describe Patient 1's treatment plan and goals throughout her treatment over the course of approximately two years, even though Patient 1's condition changed over the same period. This repetition shows respondent did not tailor his documentation of Patient 1's treatment plan or goals for each patient visit and supports Dr. Moldawsky's opinion that respondent's documentation does not meet the standard of care.

52. Therefore, clear and convincing evidence established respondent departed from the standard care in his recordkeeping in Patient 1's case. Specifically, respondent's documentation of his care and treatment of Patient 1 is repetitive in format and content, and respondent's documentation fails to reflect his thought

process and medical judgment regarding the changes in the patient's medications over time.

Patient 2

53. Patient 2 was an elderly man who first started treatment with respondent on February 27, 2006. However, only Patient 2's medical records from January 20, 2017, to July 22, 2020, were reviewed for this matter. Patient 2 saw respondent every two to three months for treatment of major depressive affective disorder and moderate dementia. Due to his dementia, Patient 2 was unable to self-report and understand informed consent. Therefore, respondent relied on the reports of his son and daughter-in-law, who lived with and cared for Patient 2.

TREATMENT HISTORY: PRESCRIPTION OF ATIVAN AND RESTORIL

54. Patient 2's medical records under review in this matter begin with a visit on January 20, 2017, when Patient 2 was 86 years old. (Ex. 14, p. A350.) In the progress note for this visit, respondent wrote that Patient 2's son, who accompanied his father, reported Patient 2 was having insomnia. (*Ibid.*) Respondent described Patient 2's symptoms as "less depressed [¶] less anxious [¶] poor concentration [¶] insomnia." (*Ibid.*) Respondent prescribed to Patient 2 Restoril, a benzodiazepine, with instructions to take one 30 mg capsule "every day at bedtime as needed," and Ativan, another benzodiazepine, with instructions to take one 1 mg tablet "by oral route 3 times every day as needed." (Ex. 14, p. A352.) Although respondent indicated in the progress note that he prescribed Restoril to Patient 2 for insomnia, he did not indicate the basis for his Ativan prescription. At the hearing, however, respondent explained he prescribed Ativan to treat Patient 2's anxiety, but respondent conceded he did not document a rationale for doing so.

55. Respondent maintained Patient 2 on the same dosage of Ativan and Restoril from January 20, 2017, until July 10, 2019, when he decreased the Ativan dosage to one 1 mg tablet twice a day as needed. Respondent indicated in the July 10, 2019 progress note that the Ativan was for "anxiety." (Ex. 14, p. A436.) Respondent continued to prescribe Restoril to Patient 2 at the dosage of 1 mg tablet every day at bedtime as needed. (*Id.* at p. A437.) On June 17, 2020, respondent again decreased Patient 2's Ativan dosage to one 1 mg tablet once a day as needed but made no changes to the Restoril prescribed dosage. (Ex. 14, p. A458.) Respondent continued to prescribe Ativan and Restoril in these dosages until July 22, 2020. (*Id.* at p. A461.)

56. At the hearing, respondent testified Patient 2 had taken Ativan and Restoril for years, and Patient 2 was stable on these medications. Respondent also stated that Patient 2's family was happy with the care respondent provided to him. During cross-examination, respondent admitted that both Ativan and Restoril have a sedative effect and elderly patients require monitoring of their reactions to these medications. Additionally, respondent admitted that even though Patient 2's son and daughter-in-law were present at every visit with Patient 2, he only documented their presence for two of those visits. Furthermore, respondent admitted that he uses the same treatment and goal language that he used for Patient 1 to describe Patient 2's treatment plan. That is, for every visit by Patient 2, respondent repeated the following language:

> Treatment is necessary to:
>
> - Reduce risk of patient needing a more intensive level of care.
>
> - Reduce risk of harm to self and others.

- Maintain and improve current level of functioning.

Short term Goal: Symptoms relieved

Long term goal: Maintain symptoms free

Plan: Patient to take meds as prescribed

Continue medication management.

(Ex. 14, p. A350.)

DR. MOLDAWSKY'S OPINIONS

57. Regarding respondent's treatment of Patient 2, Dr. Moldawsky opined the standard of care requires a psychiatrist to monitor patients with dementia who are prescribed benzodiazepines. Dr. Moldawsky explained benzodiazepines have a sedative effect, and the risks of prescribing these medications to the elderly include increased risk of falling, increased risk of stroke, unsteadiness, and slower or stopped breathing. Respondent prescribed Patient 2 two benzodiazepines, Restoril and Ativan, in combination, which increases the risk of oversedation. Benzodiazepines should only be prescribed for the shortest time necessary, at the lowest dosage possible. Thus, the standard of care is to document the rationale for initiating and continuing the two benzodiazepines and to monitor any ongoing need for these medications. Dr. Moldawsky wrote in his expert report, "[b]ut it is also noted that [respondent] did decrease the lorazepam [Ativan's generic name] dose from 3 daily (as needed) to 2 daily (as needed) and, later, 1 daily as needed. It's reasonable to assume that [respondent] had thought about this issue, though documentation was lacking." (Ex. 6, p. A61.)

58. Specifically, Dr. Moldawsky pointed to respondent's January 20, 2017 progress note, in which respondent prescribed Patient 2 30 mg of Restoril every day at bedtime as needed, and 1 mg of Ativan three times every day as needed. (Ex. 14, p. A352.) Dr. Moldawsky conceded that under certain circumstances, it is appropriate to prescribe two benzodiazepines at the same time. However, it is difficult to determine the appropriateness in this case due to poor documentation. For example, respondent did not document why he prescribed Ativan and Restoril to be taken as needed, and how Patient 2 was to take the medication. Dr. Moldawsky explained that elderly patients are more likely than others to be prescribed multiple medications, and patients with dementia may unintentionally take more medication than prescribed. Elderly patients also tend to forget to take their medication. Therefore, to meet the standard of care, respondent needed to document how Patient 2 was taking the benzodiazepines, how often he was taking them, and what effect, if any, the medications were having. Respondent also did not document whether he considered less risky alternatives to prescribing two benzodiazepines at the same time. Moreover, Dr. Moldawsky opined that respondent's descriptions of patient treatment and plan should be specific to Patient 2. Finally, Dr. Moldawsky opined respondent should have documented Patient 2's level of dementia and his level of impairment in communication skills. Based on the three years of medical records Dr. Moldawsky reviewed, the documentation was unclear about whether Patient 2 could engage directly with his physician without the assistance of his family. According to Dr. Moldawsky, these deficiencies in documentation constitute simple departures from the standard of care.

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DR. CHUEH'S OPINIONS

59. In his expert report and in his testimony at hearing, Dr. Chueh disagreed with Dr. Moldawsky's opinions regarding the documentation issues in Patient 2's case. Dr. Chueh asserted respondent's boilerplate language that medication was "necessary to reduce the risk of patient needing a more intensive level of care, reduce the risk of harm to self and others" served as the rationale for his prescription of medications to Patient 2. (Ex. B., p. B7.) Furthermore, Dr. Chueh opined respondent met the standard of care in his prescription of benzodiazepines to Patient 2. Dr. Chueh contended respondent was providing palliative and comfort care to Patient 2, who suffered from severe dementia, to allow him to live in the least restrictive setting possible. Dr. Chueh believes that a psychiatrist is given more license to prescribe controlled substances under these circumstances.

CREDIBILITY FINDINGS

60. Dr. Moldawsky's opinions on the documentation issues in Patient 2's case were more convincing than those of Dr. Chueh. Dr. Moldawsky's explanations on the sedative effects of benzodiazepines and why it is important to document efforts to monitor its effects on elderly patients are clear and well-reasoned. Dr. Chueh, on the other hand, contended that respondent's prescription of Restoril and Ativan to Patient 2 met the standard of care because respondent was providing palliative care. However, Dr. Moldawsky's opinion is not that respondent's prescription of these medications deviated from the standard of care. Indeed, Dr. Moldawsky conceded that under certain circumstances, it is appropriate to prescribe two benzodiazepines at the same time. However, when doing so, it is important to document the physician's monitoring of the patient's response, including how the patient was taking the medication, how

often the medication is taken, effects on the patient, and consideration of alternative medication.

61. Furthermore, Dr. Chueh's insistence that respondent's boilerplate language for patient plan and treatment serves as documentation of the rationale for prescribing Restoril and Ativan was not persuasive. When the same plan and treatment language are used for every visit, it does not reflect a physician's thinking and what symptom the physician is trying to address by prescribing a certain medication. Dr. Chueh also made several concessions during cross-examination. Specifically, Dr. Chueh admitted elderly patients can be more susceptible to the sedative effects of Ativan and that patients should be frequently monitored according to patient response. Dr. Chueh also conceded Restoril is a short-term treatment for insomnia, and it is generally prescribed for seven to 10 days. Patients who are prescribed Restoril should be re-evaluated or assessed for their continuing or the medication. Furthermore, when questioned about whether respondent documented his consideration of alternatives to Restoril and Ativan, Dr. Chueh avoided the question and instead insisted respondent's documentation was sufficient to meet the standard of care. Dr. Chueh's evasions damaged his credibility on these issues.

62. Therefore, clear and convincing evidence established respondent departed from the standard care in his recordkeeping in Patient 2's case. Specifically, respondent failed to document how the two benzodiazepines he prescribed to Patient 2, Restoril and Ativan, were to be actually taken by the patient, the rationale for instituting and continuing the two benzodiazepines, the alternatives to prescribing these two benzodiazepines concurrently, the ongoing need for the patient to take the two benzodiazepines concurrently, and the side effects associated with the medications at the prescribed doses.

Patient 3

63. Patient 3 was a 32-year-old man who started treatment with respondent on October 12, 2017, and continues to be respondent's patient as of the date of the hearing. However, only Patient 3's records from October 12, 2017, to August 20, 2020, were reviewed for this matter. Patient 3 saw respondent every month for the treatment of Attention Deficient Hyperactivity Disorder (ADHD) and Generalized Anxiety Disorder (GAD).

TREATMENT HISTORY

Prescription of Adderall

64. During his initial evaluation on October 12, 2017, respondent noted Patient 3 was five foot tall and weighed 279 pounds, placing him in the obese category. (Ex. 19, p. A493.) Patient 3 suffered from anxiety and insomnia due to issues relating to having full custody of his 13-year-old son. (*Ibid.*) Respondent wrote Patient 3 was "anxious about son's violent and uncontrolable [*sic*] behavior." (*Ibid.*) Patient 3 was diagnosed with ADHD in kindergarten, and he has taken two 20 mg tablets of Adderall, a stimulant for the treatment of ADHD, twice a day (80 mg total per day) for three years "with good result." (*Id.* at p. A494.) At this visit, respondent prescribed Patient 3 Adderall at the dosage of two 20 mg tablets twice a day (80 mg total per day). Respondent also prescribed Patient 3 Clonidine, a second medication for the treatment of ADHD, with instructions to take half a 0.1 mg tablet three times a day.

65. Respondent continued to prescribe Adderall at the dosage of 80 mg per day until November 5, 2019, when a CURES report cut and pasted in Patient 3's progress note shows that respondent increased the Adderall dosage to 120 mg per day. (Ex. 19, p. A568.) Patient 3 did not have a visit with respondent on November 5,

2019, and there is no explanation in the medical records as to why Patient 3's Adderall dosage was increased on that day. At Patient 3's next visit on November 27, 2019, respondent continued to prescribe two 30 mg tablets of Adderall twice a day (120 mg total per day), but he documented no rationale for the increase in Adderall dosage. (*Id.* at p. A569.) The Adderall dosage increase is also inconsistent with Patient 3's symptoms, which were documented as "[i]mproving[,] [f]eeling better[,] [c]almer[,] [l]ess impulsivity[,] [l]ess anxious[, and] [b]etter concentration. . . ." (*Id.* at p. A568.)

66. At the hearing, respondent explained he increased Patient 3's Adderall dosage to 120 mg per day on November 5, 2017, because during a previous visit on October 30, 2019, Patient 3 was feeling miserable and wanted to increase the Adderall dosage to 120 mg per day. Respondent did not prescribe what Patient 3 requested on that date but asked him to call back five days later to see if the symptoms improve. On November 5, 2019, Patient 3 called respondent and stated he was having trouble concentrating at school and at work. Thus, respondent increased the Adderall dosage to 120 mg per day. Once Patient 3 was doing better, however, respondent lowered the Adderall dosage to 60 mg per day.

67. Respondent's October 30, 2019 conversation and his November 5, 2019 phone call with Patient 3, during which the patient requested an increase in Adderall due to his concentration problems, are not documented in the medical records. However, a letter from Patient 3, dated January 4, 2023, corroborates respondent's account on this issue. Specifically, Patient 3 wrote, in relevant part:

> Prior to [respondent's] prescribing of Adderall, my primary care physician, Dr. Hemchand Koll was prescribing me Adderall 30 mg 2 tablets twice daily between 2014 to 2018.

> I was taking 120 mg/day and [respondent] decreased it to 60 mg/day.
>
> I feel [respondent] prescribes what is right for my needs. [Respondent] had to increase my Adderall dose to 120 mg/day for a couple of months because I could not do well in school and could not concentrate in school. After that, [respondent] decreased my dose back down to 60 mg/day.

(Ex. J.)

68. Respondent maintained Patient 3 on 120 mg of Adderall per day until April 22, 2020, when he decreased the dosage to one 20 mg tablet twice per day (40 mg total per day). (Ex. 19, p. A589.) However, on May 29, 2020, respondent increased the Adderall dosage again to two 30 mg tablets twice per day (120 mg total). (*Id.* at p. A592.) At the time of this second increase, respondent documented Patient 3's symptoms as "[b]etter concentration but still lacking" and "[c]oncentration: Fair – poor." (*Id.* at p. A591.) Medical records show respondent maintained Patient 3 on the Adderall dosage of 120 mg per day until Patient 3's medical records until at least August 20, 2020. (*Id.* at p. A602.)

69. While Patient 3 was on Adderall, respondent did not monitor Patient 3's heart rate or blood pressure. Respondent asserted that Patient 3's primary care physician was monitoring his pulse and blood pressure, which were all normal. However, on cross-examination, respondent could not indicate in the medical records his documentation of any follow-ups with Patient 3's primary care physician about his pulse and blood pressure.

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Prescription of Xanax

70. During Patient 3's initial evaluation on October 12, 2017, respondent noted that in the past, Patient 3 was prescribed Buspar, an anti-anxiety medication, but respondent "refused to take it" because he reported that "[i]t messed up [his] sex." (Ex. 19, p. A494.) To treat his anxiety, respondent prescribed Patient 3 one 0.5 mg tablet of Xanax two times per day. (*Ibid.*) At Patient 3's next visit on November 1, 2017, respondent increased the Xanax dosage to one 1 mg tablet twice a day. At the next visit on December 6, 2017, respondent once again increased Patient 3's Xanax dosage to one 1 mg tablet three times every day, as needed. (*Id.* at p. A498.) Respondent maintained Patient 3 at this dosage (one 1 mg tablet three times every day, as needed) until May 29, 2020, when he decreased the dosage to one 1 mg tablet every day. (*Id.* at p. A592.) At Patient 3's next visit, however, respondent increased the Xanax dosage again to one 1 mg tablet three times a day (*id.* at p. A595), and respondent maintained this dosage until at least August 20, 2020 (*id.* at p. A602). From 2018 to 2020, respondent continued to prescribe to Patient 3 three milligrams of Xanax per day, even though he consistently documented Patient 3's symptoms as "less anxious." (*Id.* at p. A500, A502, A505, A507, A509, A511, A513, A515, A519, A523, A528, A531, A534, A537, A541, A544, A547, A552, A555, A558, A564, A568, A570, A576, A597, A600.)

71. Respondent testified he considered alternatives to Xanax before prescribing the medication to Patient 3. Specifically, respondent reported he talked to Patient 3 about taking selective serotonin reactive inhibitors (SSRIs) or serotonin and norepinephrine reuptake inhibitors (SNRI) as alternatives to Xanax, but Patient 3 did not want these medications. Respondent stated Patient 3 had taken Buspar in the past and did not like the sexual side effects. Therefore, respondent ruled out SSRI and SNRI for Patient 3. During cross-examination, however, respondent could not locate in the

medical records any documentation of his discussion with Patient 3 about SSRI and SNRI. Additionally, when asked why he prescribed Xanax at the dosage of 3 mg per day to Patient 3, respondent answered the higher dosage was prescribed because Patient 3 was anxious. When asked why he continued to prescribe this higher dosage of Xanax to Patient 3 from 2018 to 2020 when he listed Patient 3's as "less anxious," respondent's answers were incoherent and jumbled. Nevertheless, respondent reiterated his belief that his documentation of Patient 3's care is adequate. Respondent also averred Patient 3 did well under his care, and he continues to be respondent's patient.

CURES Reports

72. The medical records reflect respondent copied and pasted CURES reports into Patient 3's progress reports on July 27, 2018 (ex. 19, p. A515), August 24, 2018 (*id.* at p. A519), December 12, 2018 (*id.* at p. A531), April 24, 2019 (*id.* at p. A544), August 14, 2019 (*id.* at p. A558), November 27, 2019 (*id.* at p. A568), and March 5, 2020 (*id.* at p. A586). Respondent testified he checked and reviewed Patient 3's CURES reports. Respondent was aware that while Patient 3 was taking Xanax, the patient was also filling opioid prescriptions from another provider. Respondent also asserted he discussed the dangers of taking Xanax with opioids with Patient 3. However, when asked during cross-examination to find documentation of those discussions in the medical record, respondent was unable to do so.

DR. MOLDAWSKY'S OPINIONS

Prescription of Adderall

73. Dr. Moldawsky opined respondent departed from the standard of care by failing to document a rationale for prescribing a high dose of Adderall to Patient 3 and

failing to monitor Patient 3's heart rate and blood pressure while he was on Adderall. Dr. Moldawsky explained Adderall is a controlled substance and dangerous drug that can cause agitation, insomnia, elevation in pulse and blood pressure, and in rare cases, paranoia or psychosis. According to Dr. Moldawsky, a low dose of Adderall is 5 to 15 mg per day; a moderate dose is 20 to 40 mg per day; and a high dose is above 40 mg per day. As Dr. Moldawsky wrote in his expert report, while there is no absolute maximum dosage when prescribing Adderall, the standard of care is to document why high doses are indicated. (Ex. 6, p. A62.) Dr. Moldawsky further opined in his expert report: "This patient [Patient 3] was taking 80 mg from the start of [respondent's] treatments already higher than usually recommended (and the patient was already taking a second ADHD drug - clonidine). [Respondent] increased the Adderall from 80 to 120 at the same time he documented the patient had 'better concentration' and was 'less impulsive,' so the rationale to increase to such high doses is lacking." (*Ibid.*)

74. Patient 3's medical records reflect two increases in Patient 3's Adderall dosage to 120 mg, the first time on November 5, 2019 (see *ante*, Factual Finding 65), and a second time on May 29, 2020 (see *ante*, Factual Finding 68). However, Dr. Moldawsky critiqued only the increase in dosage on November 5, 2019, in his expert report and his testimony at hearing. Respondent and Dr. Chueh also only addressed the November 5, 2019 increase in Adderall dosage. Therefore, the discussion that follows is limited to that event.

75. At the hearing, Dr. Moldawsky also opined the standard of care requires a physician, when prescribing Adderall, to monitor a patient's symptoms of ADHD and any side effects of the medication. This monitoring consists of not just self-reporting from the patient, but also measuring the patient's level of function, such as performance at school or work, remembering to pay bills, and not losing keys or cell

phones. Additionally, when prescribing Adderall, factors such as the patient's use of other medications, consumption of caffeine, and other cardiovascular risks determine the need for a physician to monitor the patient's pulse and blood pressure. Furthermore, in Dr. Moldawsky's opinion, the higher dose of Adderall prescribed, the more consideration must be given to periodically checking on a patient's pulse and blood pressure. In Patient 3's case, respondent prescribed a high dose of Adderall of over 40 mg per day. Patient 3 is also obese, which is a cardiac risk. Dr. Moldawsky opined these two factors increase the propriety of checking Patient 3's pulse and blood pressure. Dr. Moldawsky testified respondent should have checked on Patient 3's pulse and blood pressure "at least at some point along the way because all the [Adderall] dosing was in the high or very high category." Dr. Moldawsky concluded that prescribing such high doses of Adderall without a documented rationale or closer monitoring constitutes an extreme departure from the standard of care.

Prescription of Xanax

76. Dr. Moldawsky opined that the long-term prescription of medium to high doses of benzodiazepines, such as Xanax, for the treatment of GAD, is not standard. Respondent prescribed Xanax to Patient 3 for almost three years, at the dosage of 1 mg to 3 mg per day, which Dr. Moldawsky believes is a "medium dosage." Dr. Moldawsky explained that benzodiazepines have sedative effects and may cause dependence. Dr. Moldawsky further opined respondent should have considered other effective treatments for GAD, such as psychotherapy, instead of prescribing benzodiazepines for a long period. Additionally, other medication therapy, such as SSRIs or SNRIs, should have been considered because they do not cause sedation or dependence. Dr. Moldawsky noted that during the October 12, 2017 initial evaluation, Patient 3 revealed he tried Buspar in the past, but he refused the medication because

it caused sexual problems. (See *ante*, Factual Finding 70.) However, Dr. Moldawsky pointed out that Buspar is not an SSNI or SSRI. While Patient 3 had a sexual side effect with Buspar, it cannot be assumed he would suffer the same side effect with an SSNI or SSRI. Dr. Moldawsky found no notation in the medical records that respondent considered prescribing an SSRI or SNRI to Patient 3.

77. Dr. Moldawsky conceded that in certain situations, the prescription of long-term benzodiazepines may be appropriate. For example, some patients will not agree to take an SSRI or SNRI. However, in these situations, the standard of care requires the physician to attempt to lower the benzodiazepine dosage. Although Patient 3 had no apparent problems with the long-term use of Xanax, Dr. Moldawsky contended respondent should have periodically re-evaluated whether the current dosage was necessary and discussed with him whether a lower dosage would be effective. In Patient 3's case, such re-evaluation and discussion were not performed.

78. Dr. Moldawsky concluded respondent's failure to document his rationale for prescribing a medium dosage of Xanax to Patient 3 on a long-term basis is a simple departure from the standard of care.

CURES Reports

79. Dr. Moldawsky asserted respondent did not check CURES and did not seem to be aware of Patient 3's opioid prescription from other providers. Dr. Moldawsky explained that because both benzodiazepines and opioids have sedative effects, prescribing them in combination can be risky. As an example, Patient 3's CURES report shows that although another provider prescribed Vicodin, an opioid, on October 8, 2018 (Ex. 20, p. A605), respondent prescribed Xanax, a benzodiazepine, to Patient 3 on October 25, 2018 (*ibid*).

80. Although Dr. Moldawsky conceded respondent cut and pasted CURES reports into Patient 3's progress report, he opined respondent's documentation was still insufficient because it does not show respondent had reviewed the CURES report. However, Dr. Moldawsky also admitted that in 2018, it was not the standard of care for a psychiatrist to check CURES at every patient visit. Dr. Moldawsky testified there was "no absolute frequency" for physicians to check CURES in October 2018. The standard of care of that time, according to Dr. Moldawsky, was for a physician to be generally aware of the medication other providers have prescribed a patient. Dr. Moldawsky opined the absence of any periodic notes showing CURES was reviewed or reflecting respondent's awareness of Patient 3's medications prescribed by other providers constitutes a simple departure from the standard of care.

DR. CHUEH'S OPINIONS

Prescription of Adderall

81. Dr. Chueh disagreed with Dr. Moldawsky's opinion that respondent's prescription of Adderall and his monitoring of Patient 3 deviated from the standard of care. Dr. Chueh testified that 120 mg of Adderall per day is considered a high dosage, but it is also "used relatively frequently." Dr. Chueh opined that there is no upper limit on Adderall dosage. According to Dr. Chueh, although the some guidelines recommend a maximum dosage of 60 mg of Adderall per day, physicians exceed the dosage guidelines all the time, so long as the high dose is prescribed for a short period.

82. In his January 4, 2023 expert report, Dr. Chueh asserted respondent increased Patient 3's Adderall dosage because the patient was still having symptoms. (Ex. B, p. B9.) Chueh also disagreed with Dr. Moldawsky's critique of respondent for not

documenting a rationale for increasing the Adderall dosage. Dr. Chueh asserted it was "blatantly obvious" respondent was titrating the medication, that is, adjusting the Adderall dose based on patient response until the desired clinical effect is achieved. Dr. Chueh stated that the standard of care does not require a physician to document the titration of a medication.

83. Dr. Chueh also opined that Adderall causes a "relatively small" increase in blood pressure, and the standard of care is for a physician to monitor a patient's pulse and blood pressure only if there is a history of cardiac issues or blood pressure issues such as hypertension. Dr. Chueh concluded respondent met the standard of care in his dosing of Adderall, in his documentation of the rationale for Adderall, and in his monitoring of Patient 3.

Prescription of Xanax

84. Dr. Chueh disagreed with Dr. Moldawsky's opinion that the long-term prescription of benzodiazepines is not standard. Dr. Chueh cited studies showing 34 percent of benzodiazepine users are long-term users and there are approximately 10 million long-term benzodiazepine users in the United States. Regarding Dr. Moldawsky's opinion that respondent should have considered using an SSRI or SNRI instead of long-term benzodiazepines, Dr. Chueh noted Patient 3 previously rejected Buspar based on its sexual side effects. Dr. Chueh opined in his expert report: "Therefore, it has already been considered that [Patient 3] would not consent to an SSRI and SNRI as he already rejected that type of agent because of the side effects." (Ex. B, p. B8.) Dr. Chueh further concluded:

> [The] standard of care [for long-term use] of benzodiazepines should be based upon clinical

presentation. [Patient 3] was clearly getting clinical relief and efficacy from the Xanax. Dr. Moldawsky does NOT deny this. Nor does he suggest that there is any misuse by [Patient 3]. Therefore, there is no deviation from the standard of care.

(Ex. B, p. B8.)

CURES Reports

85. Dr. Chueh opined that respondent checked and reviewed Patient 3's CURES reports, consistent with the standard of care.

CREDIBILITY FINDINGS

Prescription of Adderall

86. Dr. Moldawsky found that on November 5, 2019, the increase in Patient 3's Adderall dosage from 80 mg to 120 mg per day lacked rationale because, at the time of this prescription, respondent documented Patient 3 as "less impulsive" and having "better concentration." (Ex. 19, p. A568.) However, the evidence at the hearing established there was a rationale for the increase in the dosage. The rationale, according to respondent's testimony, though not documented in the medical records, was that Patient 3 reported having concentration problems at school and he had previously been on the same 120 mg per day dosage of Adderall without side effects. (See *ante*, Factual Finding 66.) This testimony is credible because it is corroborated by Patient 3's January 4, 2023 letter. (See *ante*, Factual Finding 67.)

87. Dr. Chueh, on the other hand, opined respondent increased the Adderall dosage due to patient response, and 120 mg of Adderall per day, while considered a

high dose, is used "relatively frequently" by practitioners. (See *ante*, Factual Finding 81.) Dr. Chueh's opinion on this issue is deemed more credible. To begin with, during cross-examination, Dr. Moldawsky admitted Patient 3 had reported to respondent problems with concentration at school, leading to the increase in Adderall dosage. Dr. Moldawsky, nevertheless, insisted he "had never heard of a patient being prescribed 120 mg of Adderall a day." However, the fact that Dr. Moldawsky has never heard of a patient being on 120 mg of Adderall a day does not establish the standard care. As Dr. Moldawsky conceded, and as Dr. Chueh confirmed, the standard of care does not set a ceiling on the maximum dosage of Adderall, and therefore physicians may exceed the recommended guideline amount of 60 mg per day. Hence, Dr. Chueh's opinion that respondent's dosing of Adderall at 120 mg per day did not violate the standard of care was more convincing.

88. The opinions of Dr. Moldawsky and Dr. Chueh are equally credited on the necessity of monitoring Patient 3's pulse and blood pressure while he was on Adderall. On the one hand, Dr. Chueh's opinion that Adderall causes only small increases in pulse and blood pressure is supported by the Adderall medication guide and package insert, which states that "[s]timulant medications cause a modest increase in average blood pressure (about 2 to 4 mmHg) and average heart rate (about 3 to 6 bpm). . . ." (Ex. 34, p. A928.) Thus, Dr. Chueh's opinion that monitoring for pulse and blood pressure is only required when the patient has cardiac or blood pressure problems seems reasonable. Dr. Moldawsky opined Patient 3's obesity and the high dosage of Adderall called for monitoring of his pulse and blood pressure. However, while obesity is a cardiac risk, there is no evidence that Patient 3 had either cardiac or blood pressure problems. On the other hand, Patient 3 was on a high dose of Adderall (120 mg per day) which is twice the guideline maximum (60 mg per day) for many months. Dr. Moldawsky's opinion that under these circumstances, periodic monitoring of pulse

and blood pressure is appropriate also seems reasonable. Because complainant bears the burden of proof in this matter and Dr. Moldawsky's opinion was not more convincing than that of Dr. Chueh, it was not established by clear and convincing evidence respondent deviated from the standard of care for failing to monitor Patient 3's pulse and blood pressure while he was on Adderall.

89. On the documentation of a rationale for the Adderall prescription, Dr. Moldawsky opined the standard of care is to document why high doses of the medication are indicated, while Dr. Chueh opined such documentation is unnecessary because respondent was titrating the Adderall dosage. Dr. Moldawsky's opinion on this issue is deemed more credible. Respondent increased Patient 3's Adderall dosage from 80 mg a day to 120 mg a day on November 5, 2019. (See *ante* Factual Finding 65.) This is a 50 percent increase in dosage, not an incremental increase to gauge optimal patient response. Furthermore, respondent testified he increased the Adderall dosage for Patient 3 on November 5, 2019, because Patient 3 had called him to request an increase in Adderall dosage due to difficulties concentrating in school. (See *ante* Factual Finding 66.) During cross-examination, Dr. Chueh admitted this November 5, 2019 phone call from Patient 3 is not documented, and he could not provide a coherent reason for respondent's failure to document this event in the medical records. Given the substantial increase in Adderall dosage and respondent's failure to document the November 5, 2019 phone call with Patient 3, Dr. Moldawsky's opinion that the lack of documentation of a rationale is a departure from the standard of care is given greater weight. Thus, it was established by clear and convincing evidence respondent deviated from the standard of care by failing to document a rationale for prescribing to Patient 3 a high dose of Adderall.

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Prescription of Xanax

90. Dr. Moldawsky's opinion on the standard of care for prescribing long-term benzodiazepines is deemed more credible than that of Dr. Chueh. Dr. Chueh cited studies and statistics showing that over one-third of benzodiazepine users are long-term users. However, these statistics do not reveal the patient dosage or whether SSRIs or SNRIs are viable alternatives for these patients. According to Dr. Moldawsky, it is not within the standard of care for a patient to be on a medium dose of benzodiazepines, as Patient 3 was, for the long term without consideration of SSRIs or SNRIs, which are less addictive and have no sedative effects. Dr. Moldawsky's opinion is more nuanced and reasonable. Furthermore, Dr. Chueh's opinion that SSRIs or SNRIs are not appropriate for Patient 3 because the patient had previously rejected Buspar due to the drug's sexual side effects is not credible. As Dr. Moldawsky pointed out, Buspar is not an SSRI or an SNRI, and it cannot be assumed that an SSRI or an SNRI would cause similar side effects. Respondent did not document any discussions he had regarding SSRIs or SNRIs with Patient 3, or Patient 3's rejection of those medications. Therefore, it was established by clear and convincing evidence respondent's failure to document his rationale for prescribing a medium dosage of Xanax to Patient 3 on a long-term basis is a departure from the standard of care.

CURES Reports

91. Dr. Moldawsky's opinion that respondent departed from the standard of care by failing to review Patient 3's CURES reports for use of opioids is given little weight because it is not supported by the evidence. The medical records reflect respondent checked CURES reports by cutting and pasting the reports into Patient 3's progress notes. (See *ante*, Factual Finding 72.) There is no evidence to indicate respondent was not aware of Patient 3's opioid prescription from another provider.

Thus, it was not established by clear and convincing evidence respondent deviated from the standard of care in this respect.

Patient 4

92. Patient 4 was a 60-year-old woman when she first began treatment with respondent on April 20, 2017. She saw respondent on a monthly or bimonthly basis for the treatment of major depression disorder and GAD. Patient 4's records under review for this matter end on September 10, 2020.

TREATMENT HISTORY

Patient 4's Psychotic Symptoms

93. At her initial evaluation on April 20, 2017, respondent noted Patient 4 had a 12-year history of depression and anxiety. (Ex. 23, p. A632.) Patient 4 was suffering from severe depression and insomnia. (*Ibid.*) She reported waking up every two hours and feeling tired, hopeless, and helpless. (*Ibid.*) Patient 4 experienced auditory hallucinations, reporting to respondent that she heard "[p]eople calling me." (*Ibid.*) She also experienced visual hallucinations, reporting to respondent that she saw "things at the corners of her eyes." (*Ibid.*) Respondent also noted that two pelvic tumors and a lump in the right breast were recently found in Patient 4, but these tumors were being investigated. (*Ibid.*)

94. At the hearing, respondent testified his evaluation of Patient 4's psychotic symptoms was adequate. Respondent asserted Patient 4 already had hallucinations before the tumors were found in her pelvis and breast. Therefore, he does not believe there was a need to contact Patient 4's oncologist to investigate

whether Patient 4's psychotic symptoms had nonpsychiatric origins, such as cancer spreading to the brain.

Prescription of Xanax and Ambien and CURES Reports

95. At her initial evaluation on April 20, 2017, respondent prescribed to Patient 4, among other medications, Xanax at the dose of one 1 mg tablet twice a day as needed for anxiety. Respondent testified that in 2017, he was not aware of the existence of CURES, and he did not check CURES during Patient 4's initial evaluation. Thus, he was unaware that two days before, on April 18, 2017, Patient 4 filled a prescription for Norco, an opiate, from another prescriber. (Ex. 24, p. A750.) Nevertheless, respondent insisted that in 2017, the CURES system was not available for physicians to check prescriptions for controlled substances from other providers.

96. Respondent maintained Patient 4 on the same dose of Xanax at her next visit on June 15, 2017 (ex. 24, p. A635), and again at her visit on July 13, 2017 (*id.* at p. A637-A638). At the July 13, 2017 visit, however, respondent also added Ambien, at the dose of one 5 mg tablet a day, to Patient 4's medications for her insomnia. (*Ibid.*)

97. Respondent maintained Patient 4 on the same dose of Xanax (one 1 mg tablet twice a day as needed) until February 14, 2018, when he increased the dose to one 1 mg tablet three times a day. (Ex. 23, p. A655.). The 3 mg per day dosage of Xanax was maintained until June 10, 2020, when respondent decreased the dose to 2 mg of Xanax per day. (*Id.* at p. A718.) Patient 4 continued to take 2 mg of Xanax per day at least until September 10, 2020. (*Id.* at p. A727.)

98. Respondent maintained Patient 4 on 5 mg of Ambien per day from July 15, 2017, until April 19, 2019, when he increased the dose to 10 mg per day. (Ex. 23, p. A684.) The 10 mg per day dose of Ambien was maintained until at least September 10,

2020. (*Id.* at p. A727.) Respondent reported he counseled Patient 4 about the dangers of taking Xanax with Ambien, two medications with sedative effects, but under cross-examination, respondent also could not find any documentation of such counseling in the medical records.

99. Patient 4's CURES report shows she was filling prescriptions for Norco from another provider while respondent was prescribing Xanax and Ambien to her. (Ex. 24, pp. A745-750.) Patient 4's medical records reflect respondent cut and pasted Patient 4's CURES reports into her progress notes on August 3, 2018 (ex. 23, p. A667), December 28, 2018 (*id.* at p. A674), April 19, 2019 (*id.* at p. A683), October 16, 2019 (*id.* at p. A698), February 19, 2020 (*id.* at p. A709), and June 10, 2020 (*id.* at p. A718).

Prescription of Seroquel and Latuda

100. At her initial evaluation on April 20, 2017, respondent prescribed Latuda, an antipsychotic medication, at the dose of one 40 mg tablet per day to Patient 4, without documenting a rationale. (Ex. 23, p. A633.) Respondent continued to prescribe Latuda to Patient 4 at the same dosage until at least September 10, 2020. (*Id.* at p. A727.)

101. On August 3, 2017, while Patient 4 was still being prescribed Latuda, respondent added Seroquel, an antipsychotic medication, at the dosage of one 300 mg tablet per day to Patient 4's medication list without documenting a rationale. (Ex. 23, p. A639.) Patient 4's prescription of Seroquel continued until October 5, 2017, when respondent stopped prescribing the medication.

102. At the hearing, respondent stated he prescribed Latuda to treat Patient 4's paranoia and depression, and he later added Seroquel to help Patient 4 with her sleep because another medication he prescribed before, Trazodone, had failed.

However, under cross-examination, respondent was not able to find documentation of the rationale for these medications in the medical records. Regardless, respondent believes his documentation in Patient 4's case is adequate.

DR. MOLDAWSKY'S OPINIONS

Prescription of Xanax and Ambien and CURES Reports

103. Dr. Moldawsky opined the combination of Xanax, Ambien, and an opioid is risky to a patient due to the potential for dependency. The standard of care also requires respondent to have documented discussions with the patient about the potential dangers of taking these habit-forming drugs. Dr. Moldawsky testified respondent did not check CURES in 2017 and did not appear aware Patient 4 was taking an opioid prescribed by another provider. Even though the mandate to check CURES was implemented in October 2018, Dr. Moldawsky insisted that in 2017, physicians were required to check CURES periodically to be aware of the controlled substances a patient is taking. Dr. Moldawsky opined it was not sufficient for respondent to have cut and pasted CURES reports into Patient 4's progress notes after 2017; there must be indications in the medical records that CURES reports were reviewed and analyzed. According to Dr. Moldawsky, respondent's practices constitute simple departures from the standard of care.

104. Dr. Moldawsky summarized these opinions in his expert report:

> [Respondent] prescribed moderately-high doses of alprazolam [Xanax] with an appropriate dose of zolpidem [Ambien] while the patient was also on [N]orco. There is no documentation of whether CURES was checked, or if there was discussion with the patient about these potentially-

harmful combinations off [*sic*] dependence-inducing medications. [Respondent] notes on the recorded interview that he was not aware he could access CURES.

(Ex. 6, p. A63.)

Evaluation of Psychotic Symptoms/Prescription of Seroquel and Latuda

105. Dr. Moldawsky opined Patient 4 had psychotic symptoms which were unusual for someone suffering from depression. In Dr. Moldawsky's opinion, respondent should have conducted a more extensive evaluation of Patient 4's psychotic symptoms, including consulting with other physicians regarding the possibility that Patient 4's cancer was spreading to the brain. Dr. Moldawsky also noted respondent did not document the duration of Patient 4's psychotic symptoms, which could have clarified Patient 4's diagnosis and whether her hallucinations were a result of psychiatric illness or other medical condition. Furthermore, Dr. Moldawsky noted respondent prescribed Latuda, an antipsychotic, to Patient 4 at her April 20, 2017 initial evaluation without an explanation for the prescription. Three months later, respondent added Seroquel, a second antipsychotic sometimes also used for depression, without an explanation. According to Dr. Moldawsky, respondent's failure to further evaluate Patient 4's psychotic symptoms and document those symptoms as well as his rationale for prescribing Seroqel and Latuda constitute simple departures from the standard of care.

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DR. CHUEH'S OPINIONS

Prescription of Xanax and Ambien and CURES Reports

106. Dr. Chueh testified it was not the standard of care to check CURES before the mandate was implemented in October 2018. According to Dr. Chueh, most physicians were unaware of the existence of CURES in 2017. Dr. Chueh opined respondent checked CURES appropriately in 2018 and thus did not depart from the standard of care.

Evaluation of Psychotic Symptoms/Prescription of Seroquel and Latuda

107. Dr. Chueh opined it is not the standard of care for respondent to consult with Patient 4's physician about possible non-psychiatric causes for her psychotic symptoms. Dr. Chueh testified Patient 4 had pelvic and breast tumors that were being investigated and it was not known whether Patient 4 even had cancer. Until Patient 4's primary care physician or oncologist had a definitive diagnosis, the cause of Patient 4's hallucinations was most likely psychiatric because severe depression is linked with hallucinations. In Dr. Chueh's opinion, coordination of care during Patient 4's initial evaluation would not have been helpful.

108. Dr. Chueh testified respondent prescribed Latuda to treat Patient 4's hallucinations. The medication was successful because, according to the medical records, Patient 4's hallucinations stopped when she was compliant with her medications. In his expert report, Dr. Chueh wrote Seroquel was prescribed because "Seroquel is FDA approved as an adjunctive treatment for depression." (Ex. B, p. B10.)

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CREDIBILITY FINDINGS

Prescription of Xanax and Ambien and CURES Reports

109. Dr. Moldawsky's opinion that physicians were required to check CURES periodically in 2017 is not credible because, as Dr. Chueh pointed out in his expert report, CURES was not certified for statewide use until April 2, 2018. (Ex. B, p. B6.) Thus, respondent's failure to check CURES in 2017 did not depart from the standard of care. Dr. Moldawsky's opinion that respondent failed to check CURES in 2018 and was not aware of Patient 4's opioid prescriptions is not credible as it is not supported by the evidence. The medical records show respondent checked CURES, and he cut and pasted Patient 4's CURES reports into her progress notes. (See *ante* Factual Finding 99.) However, Dr. Moldawsky's opinion that respondent failed to document counseling Patient 4 on the dangers of taking Xanax with Ambien is credited, as this opinion is supported by the evidence.

Evaluation of Psychotic Symptoms/Prescription of Seroquel and Latuda

110. Dr. Chueh's opinion that it is not within the standard of care for respondent to coordinate care with Patient 4's other medical providers about her psychotic symptoms is compelling. Dr. Moldawsky's opinion that respondent should have consulted with Patient 4's other medical providers about the possibility of her cancer having spread to her brain assumes Patient 4 was diagnosed with cancer. However, the medical records indicate Patient 4 had tumors that were under investigation; there is no evidence that Patient 4 had cancer. (See *Ante*, Factual Finding 101.) Therefore, Dr. Chueh's opinion that in the absence of a definitive cancer diagnosis, the cause of Patient 4's hallucination is most likely psychiatric is more

reasonable and persuasive. Thus, it was not established by clear and convincing evidence that respondent departed from the standard of care by failing to conduct a more extensive evaluation of Patient 4's psychotic symptoms.

111. However, it was established by clear and convincing evidence respondent departed from the standard of care based on his failure to document any rationale for his prescription of Latuda and Seroquel. Additionally, although Dr. Chueh speculated respondent prescribed Seroquel as an adjunctive medication for Patient 4's depression, respondent testified he prescribed Seroquel to help with Patient 4's sleep. This discrepancy highlights the importance of documentation, as even Dr. Chueh could not surmise the purpose of respondent's prescription of Seroquel due to poor recordkeeping.

Character Evidence

NEELIMA KUNAM M.D

112. Neelima Kunam M.D., Medical Director of IPMG, testified at the hearing on respondent's behalf. Dr. Kunam is a board-certified psychiatrist who is a part owner of IMPG. Dr. Kunam has known respondent since she was nine years old. She described respondent as professional and dedicated to his patients and his work. Dr. Kunam reported that respondent even sees patients when he is sick. To Dr. Kunam's knowledge, there have been no patient complaints against respondent at IPMG. Under cross-examination, however, Dr. Kunam admitted she has limited understanding of the allegations in the Accusation,

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ANTHONY DUKE, M.D.

113. Anthony Duke, M.D., respondent's colleague at IPMG, testified at the hearing on respondent's behalf. Dr. Duke has worked as a psychiatrist at IPMG since 2005, and he has known respondent for approximately 15 years. Dr. Duke described respondent as "a tough psychiatrist" who does not overprescribe and who confronts his patients if they are not using medication as prescribed. According to Dr. Duke, respondent's practice is to cut and paste his patients' CURES reports into the progress notes. It is clear to Dr. Duke, when reviewing respondent's charts, that respondent reviews CURES. Dr. Duke testified respondent's notes are thorough, and he has no concerns about respondent's prescription practices. Dr. Duke believes respondent is one of the best psychiatrists at IPMG, and he would not hesitate to refer his friends or family members to respondent.

NENITA C. BELEN, M.D.

114. Nenita C. Belen, M.D., another of respondent's colleagues at IPMG, testified at the hearing on respondent's behalf. Dr. Belen has worked at IPMG since 2011, and she recruited respondent to work at IPMG, after getting to know him through other doctors working in the same area. At IPMG, Dr. Belen worked as a medical director who reviewed respondent's work annually. She performed random chart reviews of respondent's work and found no issues. Dr. Belen described respondent as "hard working," "trustworthy," and "knowledgeable." Dr. Belen believes respondent is a very competent and reliable physician who is dedicated to his patients. Under cross-examination, Dr. Belen admitted that the last quality review she performed of respondent's charts was several years ago. She also did not review the Accusation before testifying on respondent's behalf.

Costs

115. Complainant requests the following in recovery costs: (1) costs of investigation totaling $1,738 (ex. 31, p. A908); (2) expert costs totaling $2,800 (ex. 32, p. A912); and (3) actual costs of prosecuting this matter by the Department of Justice (DOJ) totaling $22,066.25(ex. 33, p. A915). The DOJ costs consist of the following: 95 hours of attorney time billed at $220 per hour; 4.5 hours of paralegal time billed at $205 per hour; and 1.25 hours of analyst time billed at $195 per hour. (*Id.* at pp. A917-A918.) Total costs claimed are $26,604.25.

LEGAL CONCLUSIONS

Standard and Burden of Proof

1. Complainant has the burden of proof in an administrative action seeking to suspend or revoke a professional license, and the standard is clear and convincing proof to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

2. Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

Governing Law and Legislative Intent

3. The Medical Practice Act governs the rights and responsibilities of the holder of a physician's and surgeon's certificate. (Bus. & Prof. Code, §§ 2000 et seq.) The state's obligation and power to regulate the professional conduct of its health

practitioners is well settled. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 577.) Protection of the public is the highest priority for the Board in exercising its disciplinary authority and is paramount over other interests in conflict with that objective. (Bus. & Prof. Code, § 2001.1.)

4. The Board is required to take action against any licensee who is charged with unprofessional conduct. (Bus. & Prof. Code, § 2234.) Unprofessional conduct includes violation of any provision of the Medical Practice Act, gross negligence, and repeated negligent acts, which consist of two or more negligent acts or omissions. (*Id.*, subd. (a), (b), & (c).)

First Cause for Discipline

5. The Accusation alleges respondent's certificate is subject to discipline under Business and Professions Code section 2234, subdivision (b), because respondent was grossly negligent in his care and treatment of Patient 1 and Patient 3. The Medical Practice Act does not define "negligence." Generally, negligence is conduct that falls below the standard established by law for the protection of others against unreasonable risk of harm. (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997, Restatement (Second) of Torts § 282 (1965).) It is well settled that the standard of care for physicians is the reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of the medical profession under similar circumstances." (*Avivi v. Centro Medico Urgente Medical Center* (2008) 159 Cal.App.4th 463, 470; *Brown v. Colm* (1974) 11 Cal.3d 639, 643.) Importantly, a medical professional is held to the standard of care in their own "school" or specialty. Specialists are held to that standard of learning and skill normally possessed by such specialists in the same or similar locality under the same or similar circumstances. (*Quintal v. Laurel Grove Hospital* (1964) 62 Cal.2d 154, 159.) Gross

negligence includes "the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Van Meter v. Bent Const. Co.* (1956) 46 Cal.2d 588, 594.)

6. Complainant did not prove by clear and convincing evidence respondent departed from the standard of care by failing to assess Patient 1 during his care and treatment for substance use; failing to corroborate Patient 1 had no current substance use by either drug screening tests or speaking with Husband; or failing to document any consideration of the possibility of substance abuse during his care and treatment of Patient 1. (Factual Findings 7-24, 34-37, 40-43, & 45-50.) Complainant also did not prove respondent did not check CURES. Respondent checked and documented his review of CURES reports, which met the standard of care. (Factual Findings 25, 35, 42, 47, & 50.)

7. Complainant did not prove by clear and convincing evidence respondent departed from the standard of care when he prescribed a high dosage of Adderall to Patient 3 and then failed to monitor Patient 3's blood pressure and pulse. (Factual Findings 64-69, 73-75, 81-83, & 86-89.)

8. Complainant proved by clear and convincing evidence respondent departed from the standard of care by failing to document his discussion with Patient 1 about alcohol issues and by failing to document his rationale for prescribing a high dosage of Adderall to Patient 3. (17, 49, 37, 65-67, 75, & 89.) However, complainant did not prove by clear and convincing evidence that these departures amounted to an extreme departure from the standard of care within the meaning of Business and Professions Code section 2234, subdivision (b). Complainant failed to demonstrate respondent's charting omissions were egregious or reflected a want of even scant care for his patients. The evidence did not establish respondent's deficient records

compromised the care of any patient. Notably, in Patient 3's case, the patient submitted a letter verifying that respondent increased his dosage of Adderall because he had previously been maintained on that high dosage for three years and he was having concentration problems at school. (See *ante*, Factual Finding 67.) Thus, respondent had a rationale for the high Adderall dosage, though it was undocumented. Patient 1 did not submit any letters and did not testify at the hearing regarding her treatment under respondent, but it is undisputed that both Patients 1 and 3 had done well under respondent's care. (See *ante*, Factual Findings 24 & 67.) Respondent's recordkeeping therefore did not rise to the level of gross negligence.

9. Cause therefore does not exist to discipline respondent's certificate for gross negligence under Business and Professions Code section 2234, subdivision (b).

Second Cause for Discipline

10. The Accusation alleges respondent's certificate is subject to discipline under Business and Professions Code section 2234, subdivision (c), because he committed repeated negligent acts in his care and treatment of Patients 1, 2, 3, and 4.

11. Complainant proved by clear and convincing evidence respondent departed from the standard of care in his documentation of his treatment of Patient 1. The documentation in Patient 1's case is repetitive in format and content, and respondent's documentation fails to reflect his thought process and medical judgment regarding the changes in the patient's medications over time. (Factual Findings 27-30, 38-39, 44, & 51-52.)

12. Complainant proved by clear and convincing evidence respondent departed from the standard care by failing to document how the two benzodiazepines he prescribed to Patient 2, Restoril and Ativan, were to be actually taken by the

patient, the rationale for instituting and continuing the two benzodiazepines, the alternatives to prescribing these two benzodiazepines concurrently, the ongoing need for the patient to take the two benzodiazepines concurrently, and the side effects associated with the medications at the prescribed doses. (Factual Findings 54-62.)

13. Complainant proved by clear and convincing evidence respondent departed from the standard of care by failing to document his rationale for prescribing a medium dosage of Xanax to Patient 3 on a long-term basis. (Factual Findings 70-71, 76-78, & 84-90.) However, complainant did not prove by clear and convincing evidence respondent did not check CURES and was not aware of Patient 3's opioid prescriptions from another provider. (Factual Findings 72, 79, 85, & 91.)

14. Complainant proved by clear and convincing evidence respondent departed from the standard of care by failing to document his counseling of Patient 4 about the dangers of taking Xanax with Ambien and by failing to document a rationale for his prescriptions of Latuda and Seroquel. (Factual Findings 95-98, 100-108, & 111.) However, complainant did not prove by clear and convincing evidence respondent did not check CURES or document in the medical records Patient 4's CURES reports. (Factual Findings 99, 103-104, 106 & 109.) Complainant also did not prove by clear and convincing evidence that respondent departed from the standard of care by failing to conduct a more extensive evaluation of Patient 4's psychotic symptoms, including consulting with other providers and reviewing the patient's non-psychiatric medical records. (Factual Findings 93-94, & 111.)

15. Cause therefore exists to discipline respondent's certificate based on his violation of Business and Professions Code section 2234, subdivision (c), based on his inaccurate and inadequate medical record keeping.

Third Cause for Discipline

16. The Accusation alleges respondent is subject to disciplinary action because he failed to maintain adequate and accurate medical records for Patients 1, 2, 3, and 4.

17. 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. (Bus. & Prof. Code, § 2266.) Accurate and adequate records promote a physician's skillful treatment of a patient, contain the essence of what the physician was told and what the physician observed, and trace the physician's medical decision-making process. Accurate and adequate records permit a review of the progression of an illness or disease, and document what treatment proved successful and what did not. A physician's memory does not constitute an adequate medical record. A patient may be seen by other physicians. Patients move, change health care plans, and seek second opinions. Poor charting practices may support claims of unprofessional conduct and provide patients, attorneys, expert witnesses, and others with a basis for asserting negligence when none exists. Accurate charting both protects a physician from false claims and promotes skillful patient treatment.

18. Complainant established by clear and convincing evidence that respondent's medical recordkeeping was inadequate for Patients 1, 2, 3, and 4. (Factual Findings 27-30, 38-39, 44, 51-52, 54-62, 70-71, 76-78, 84-90, 95-98, 100-108, & 111.) Respondent documented minimal patient symptoms, and he did not document much of his rationale for prescribing medications. While respondent's documentation may have been understandable to respondent and at times to Dr. Chueh, it provides no insight into respondent's thinking for other doctors and is insufficient to ensure his patients' continuity of care. Cause therefore exists to discipline respondent's license for

inadequate medical record keeping under Business and Professions Code section 2266.

Disposition

19. Under the Board's Disciplinary Guidelines (Guidelines), a finding of repeated acts of negligence, unprofessional conduct, or inadequate medical record keeping warrants license probation to monitor a physician's activities. (Ex. 28, p. A892.) The evidence here demonstrates that a deviation from the Guidelines' recommended discipline is warranted because probation is not necessary to safeguard the public. The evidence does not indicate a need for monitoring of respondent's practice at work. Complainant has not demonstrated any deficiency in respondent's clinical skills; his peers have vouched for those skills; and respondent has practiced for almost 45 years without prior discipline.

20. Respondent's inadequate recordkeeping practices, however, are concerning. Respondent's belief to the contrary, that his charts are adequately documented, is also troubling. Respondent testified his practice is to cut and paste his notes from prior patient visits and edit them for the current patient visit. (See *ante*, Factual Finding 28.) But this method of recordkeeping resulted in using the same boilerplate treatment and goals language to describe the treatment plans of four patients who suffered from very different conditions. (See *ante*, Factual Findings 27-28, & 56.) The same language was also used to describe the treatment plans after almost every patient visit over the course of years, even though the patients' conditions changed over time. (See *ante*, Factual Finding 27 & 56.) Respondent's practice also resulted in serious inconsistencies in the medical records. For example, respondent prescribed to Patient 1 Cymbalta, even though he noted Cymbalta had previously failed. (See *ante*, Factual Finding 29.) He documented Patient 3 as having better

concentration and yet increased his Adderall prescription from 80 mg per day to 120 mg per day. (See *ante*, Factual Finding 65.)

21. Respondent has practiced as a psychiatrist for a long time, but whether he has taken a recent course in recordkeeping is unknown. Respondent must take such a course to ensure his documentation skills are up to modern standards. The Board must be certain respondent's records capture the information essential to ensure not only respondent's safe practice but also the safe practice of any other doctor who treats respondent's patients and relies on respondent's charts. In addition, the records must include information necessary to satisfy legal and other needs.

22. Considering respondent's record of unblemished practice for 45 years, and the positive character references from his colleagues, a public reprimand is warranted with the condition that respondent takes and successfully completes a medical record keeping course. A public reprimand will serve to remind respondent that the same or similar misconduct will likely result in a far more serious disciplinary action. It also provides notice to the public and others of the nature and extent of respondent's misconduct.

Costs

23. The ALJ may direct a Board license found to have committed a violation or violations of the Medical Practice Act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. (Bus. & Prof. Code, § 125.3, subd. (a).) In *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32 (*Zuckerman*), the Supreme Court set forth factors to be considered in determining the reasonableness of the costs sought. These factors include: 1) the licentiate's success in getting the charges dismissed or the severity of the discipline imposed reduced; 2) the

licentiate's subjective good faith belief in the merits of his or her position; 3) whether the licentiate raised a colorable challenge to the proposed discipline; 4) the licentiate's financial ability to pay; and 5) whether the scope of the investigation was appropriate in light of the alleged misconduct. (*Zuckerman*, supra, 29 Cal.4th at p. 45.)

24. Complainant requests reimbursement of $26,604.25 in actual costs of prosecution and enforcement. Complainant's request for reimbursement of $26,604.25 for actual costs is unreasonable under the *Zuckerman* factors. Although the scope of the Board's investigation was appropriate and there was no evidence showing respondent lacked the financial resources to pay the Board's costs, respondent succeeded in getting the most significant charges dismissed and reduced the severity of the discipline imposed. He raised a colorable challenge to the proposed discipline. He also had a subjective good faith belief in the merits of his position. It is therefore appropriate to reduce the amount of costs by 50 percent, for a total of $13,302.

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ORDER

1. Visit Chatsuthiphan, M.D., holder of Physician's and Surgeon's Certificate No. A 32338 is hereby publicly reproved pursuant to Business and Professions Code sections 495 and 2233.

2. Respondent shall enroll in a Board-approved medical recordkeeping course within 60 days of the effective date of this decision.

3. Respondent shall pay $13,302 to the Board in reimbursement for its costs of investigation and enforcement based on a payment plan approved by the Board.

DATE: 05/11/2023

Ji-Lan Zang

JI-LAN ZANG
Administrative Law Judge
Office of Administrative Hearings