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

In the Matter of the Accusation Against: Gerald Ray Watkins, M.D. Physician's and Surgeon's Certificate No. G 31539 Respondent.	Case No.: 800-2019-059067

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 October 23, 2023.

IT IS SO ORDERED: September 21, 2023.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

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In the Matter of the Accusation against:

GERALD RAY WATKINS, M.D., Respondent.

Agency Case No. 800-2019-059067

OAH No. 2023010260

PROPOSED DECISION

Cindy F. Forman, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on June 12 through June 14, 2023.

Jonathan Nguyen, Deputy Attorney General, Department of Justice, State of California, represented complainant Reji Varghese, Interim Executive Director of the Medical Board of California (Board).

Lindsay Johnson, Esq., Ray & Bishop, PLC, represented respondent Gerald Ray Watkins, M.D., who was present during the hearing.

The ALJ received evidence and heard argument. The record closed and the matter was submitted on June 14, 2023. By her own motion, the ALJ ordered Exhibit 4 be placed under seal to protect patient confidentiality and redacted patient names

from Exhibits 7, 8, and 9. And as discussed below, the ALJ re-opened the record on June 21, 2023, and re-closed the record on July 13, 2023. The matter was deemed submitted on July 13, 2023.

ORDER REGARDING MEDICAL RECORDS

By Order dated June 21, 2023, the ALJ re-opened the record after reviewing the expert report of Laura Davies, M.D., admitted as complainant's Exhibit 20. To support her findings, Dr. Davies cited pages from the medical records for two of respondent's patients whose care she reviewed on complainant's behalf (Patient 1 and Patient 3). Both patients were treated at Southern California Kaiser Permanente Medical Group facilities (Kaiser). Complainant submitted certified medical records that were purportedly complete for each patient for the period from January 1, 2016, through January 22, 2021. The records were admitted during the hearing without objection as Exhibit 7 (for Patient 1) and Exhibit 9 (for Patient 3). However, the medical record page numbers cited by Dr. Davies in her report did not correspond with the page numbers stated on the admitted medical records or the page numbers Case Center (the online evidence program) assigned to those exhibits. Additionally, Dr. Davies made specific factual assertions in her report (which she also mentioned in testimony) about Patient 1's medical care at Kaiser that were not referenced in any of the medical records comprising Exhibit 7. Believing these discrepancies and omissions were administrative or clerical errors, the ALJ directed complainant to update the citations found in Dr. Davies's report with the corresponding Case Center page numbers and submit those records referred to or relied on by Dr. Davies in her report that were not included in Exhibits 7 or 9.

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In response, complainant submitted a document, marked as Exhibit 22, identifying the corresponding Case Center page numbers for 10 citations in Dr. Davies's discussion of Patient 1 (Exhibit 22 misnumbers the entries and mistakenly states there are 11 citations) and for three citations in Dr. Davies's discussion of Patient 3. In addition, complainant offered a new set of certified complete medical records for Patient 1 (marked as Exhibit 23) and a new set of certified complete medical records for Patient 3 (marked as Exhibit 24). Although the patient medical records comprising Exhibits 23 and 24 cover the same period as those patient medical records comprising Exhibits 7 and 9, respectively, the number of pages comprising these exhibits differ markedly notwithstanding each set was certified to be complete. Specifically, Exhibit 7 consists of 374 pages of Patient 1's medical records, while Exhibit 23 consists of 322 such pages; Exhibit 9 consists of 458 pages of Patient 3's medical records while Exhibit 24 consists of 11,260 pages. Complainant did not explain the discrepant page numbers comprising the exhibits, how the contents differed for the exhibits, or why the medical records comprising Exhibits 23 and 24 were not offered for admission at hearing.

Respondent submitted written objections to the admission of Exhibits 22, 23, and 24 into evidence. (Exhibit D.) Respondent contends the admission of these three exhibits violates his right to a fair hearing and is prejudicial because respondent could not address the documents in his case presentation and can no longer cross-examine Dr. Davies on the new evidence. Additionally, respondent contends the information contained in Exhibit 22 has not been authenticated by Dr. Davies as accurate, complainant failed to explain the different page counts between Exhibits 7 and 23 and Exhibits 9 and 24, and complainant should not be permitted to provide additional documentary support post-hearing for Dr. Davies's assertions. Finally, respondent asserts admission of Exhibits 22, 23, and 24 violates Business and Professions Code

section 2334 because it constitutes a material alteration of an expert report within 30 days of the hearing dates.

The ALJ sustains in part and overrules in part respondent's objections. The ALJ admits Exhibit 22 despite its lack of authentication. Dr. Davies's report citations should have been obvious to the parties at the hearing but neither chose to address the discrepancy with the record or Case Center page numbers at that time. The substitution of Dr. Davies's page numbers with Case Center page numbers does not constitute a material change to Dr. Davies's report. Authentication of documents also is not required in administrative hearings. (Gov. Code, § 1513, subd. (c).) Whether the contents of those Case Center page numbers cited in Exhibit 22 support Dr. Davies's assertions will be addressed in the credibility assessment of Dr. Davies's report below.

The ALJ admits pages A2664, A2670, A2681, and A2720 of Exhibit 23 and pages A11978 and A12099 of Exhibit 24. These are the only pages corresponding with Dr. Davies's report citations, and each page is identified in Exhibit 22. Respondent does not complain these pages were not made available in discovery. Although the pages were not produced by complainant at hearing, Dr. Davies expressly referenced the corresponding pages in her report. Counsel for both parties therefore was on notice of the citations at the time of hearing. The admission of these pages in no way affects the analysis of their contents or the credibility of Dr. Davies's report.

The remaining pages of Exhibit 23 (i.e., pages A2551–A2663, A2665–A2669, A2671–A2680, A2682–A2719, and A2721–2833) and Exhibit 24 (i.e., pages A2384–A11977, A11978–A12098, and A12100–A14094) are excluded. Admission of these medical record pages would unduly prejudice respondent's defense as they were not specifically cited in Dr. Davies's report and complainant did not offer them as evidence at hearing.

SUMMARY

Complainant clearly and convincingly proved respondent engaged in conduct subject to discipline in his treatment of the three patients from 2016 through 2019. Respondent has practiced medicine for nearly 45 years without issue. The incidents at issue occurred more than four years ago, and respondent reports he has changed his prescribing methods. Although respondent has been retired from the practice of medicine since January 2022, he needs his license if he is asked again to see patients. Under these circumstances, placing respondent's license on probation for 35 months, with terms requiring further education, evaluation, and monitoring, will be adequate to protect the public.

FACTUAL FINDINGS

Jurisdictional Matters

1. The Board issued Physicians and Surgeons Certificate Number G 31539 (license) to respondent on March 24, 1976. Respondent's license was in effect during the period relevant to the allegations in the Accusation. Respondent's license is scheduled to expire on April 30, 2024.

2. On June 1, 2022, complainant's predecessor William Prasifka, in his official capacity, filed the Accusation against respondent relating to his treatment of three patients. (The patients are identified as Patient 1, Patient 2, and Patient 3 to protect their privacy.) The Accusation alleged respondent engaged in unprofessional conduct, excessively prescribed dangerous drugs, prescribed dangerous drugs without an appropriate examination, prescribed controlled substances to an addict, and failed

to maintain adequate and accurate medical records in violation of Business and Professions Code (Code) sections 725, 2234, subdivisions (b) and (c), 2241, 2242, and 2266. (Exhibit 1, pp. A5–A16.)

3. On June 13, 2022, respondent filed a timely Notice of Defense and requested a hearing. (Exhibit 11.)

4. All jurisdiction requirements have been satisfied to allow this matter to proceed to hearing.

The Complaint and Ensuing Investigation

5. The Accusation is the result of a Board investigation initiated by a complaint signed by Patient 1's mother (N.M.) on August 13, 2019, regarding respondent's care and treatment of Patient 1, who was an adult at the time. The complaint charged respondent prescribed controlled substances to her son despite knowing her son was an addict. (Exhibit 19, p. A2356.)

6. As part of the investigation, Board Investigator Shelby McGarry interviewed Patient 1 and N.M.; her report contains summaries of those interviews. (Exhibit 4, pp. A37–A39.) The Board's investigation also included the review of respondent's controlled substance prescriptions to Patient 1 and his other patients, as reflected in the Controlled Substances Utilization Review and Evaluation System (CURES) reports. That review raised concerns regarding respondent's prescription practices for Patient 2 and Patient 3. Investigator McGarry did not interview Patients 2 or 3, who are also the subject of allegations in the Accusation.

7. The allegations in the Accusation relate to respondent's care of Patients 1, 2, and 3 from 2016 to 2020, even though respondent treated each of these patients

for several years before this period. Except in limited instances, complainant did not consider or review the pre-2016 medical records for the three patients in evaluating respondent's performance. Additionally, complainant offered none of the medical records for the pre-2016 period into evidence. References to any pre-2016 treatment by respondent are found in the medical history sections of more current records.

8. The medical records for the 2016 to 2020 period admitted into evidence at hearing were incomplete. As indicated below, the report and testimony of complainant's expert refer to incidents not found in the admitted medical records. (See Factual Findings 57, 89.) Complainant's post-hearing submission of Patient 3's records contains 10,000 pages more than the medical records for Patient 3 admitted at hearing.

General Background

9. Respondent is 77 years old. He completed medical school in 1974. He did his residency in psychiatric medicine at the Sepulveda Veterans Administration Medical Center, then associated with the University of California, Los Angeles. As of January 25, 2021, respondent had no civil or malpractice cases pending in the past five years and had never been dropped by a malpractice carrier. (Exhibit 10, p. A2114.) Respondent has been retired from the practice of medicine since January 2022.

10. Respondent was employed as a full-time staff psychiatrist by Kaiser from August 1978 to December 2012. He initially worked at Kaiser's Sunset Boulevard facility for 25 years until August 2003 and then transferred to the Kaiser Lancaster facility. He practiced at the Lancaster facility full-time until December 2012, when he was forced to stop working because of Kaiser's mandatory retirement policy at age 65. Soon thereafter, Kaiser rehired respondent on a per diem basis. Until the end of March

2021, and while treating Patients 1, 2, and 3 from 2016 to January 2021, respondent worked at Kaiser in a per diem capacity two to three days a week. From March 2021 until his January 2022 retirement, respondent saw patients via teleconference for half of the day on Mondays and three-quarters of the day on Wednesdays.

11. Respondent's psychiatric practice at Kaiser was limited to treating adults. During his tenure at Kaiser, respondent treated over 3,000 patients. While at the Lancaster facility, respondent treated over 1,000 patients. Respondent was never subject to any discipline by Kaiser and never had his hospital privileges revoked. He has never been disciplined by the Board in his 46 years of practice.

Expert Testimony

12. Laurie Davies, M.D., testified as an expert on behalf of complainant. Respondent did not designate an expert.

13. Dr. Davies is a board-certified psychiatrist with subspecialty certification in child and adolescent psychiatry. She is licensed to practice medicine in the states of California, Hawaii, and Ohio. After graduating from medical school in May 1997 and until 2003, Dr. Davies worked as a resident in child and adolescent psychiatry and general adult psychiatry at the University of California, San Francisco. Dr. Davies maintained a private psychiatric practice in California treating adults, adolescents, and children from August 2002 to September 2017. She resumed her private practice in July 2019. She is a member of the medical staff at St. Francis Hospital and Marin General Hospital. Dr. Davies was a regional medical officer and psychiatrist for the United States Department of State from September 2017 to June 2019. She has been an expert reviewer for the Board since 2010. Dr. Davies was qualified to testify as an expert on the standard of care in this case.

Patient 1

14. According to Patient 1's medical records, respondent started treating Patient 1 in November 2013, when Patient 1 was almost 19 years old. Respondent initially diagnosed Patient 1 with anxiety disorder and then added a diagnosis of panic disorder without agoraphobia in January 2014. (Exhibit 7, pp. A99, p. A101.) On a date not made clear in the record, respondent prescribed Patient 1 clonazepam (Klonopin), a benzodiazepine, to treat his anxiety and panic. At an appointment on August 28, 2014, Patient 1 complained clonazepam made him feel too sleepy and hung over the next morning and requested a shorter-acting anti-anxiety medication to take during the day. In response, respondent reduced the dosage of clonazepam, which was to be taken at night, and prescribed one mg of alprazolam (Xanax), another benzodiazepine, up to twice a day. (Id., p. A146.)

15. Because of a change in Patient 1's insurance status, Patient 1 left Kaiser's care sometime in 2014 or 2015 and sought treatment from different doctors. N.M. (Patient 1's mother) testified at hearing that Patient 1's new psychiatrist would not prescribe benzodiazepines to Patient 1 because he failed a drug test. Complainant did not offer any medical records reflecting Patient 1's treatment after he left Kaiser.

16. In August 2016, Patient 1's insurance changed again, and he again sought treatment with respondent. Consistent with Kaiser's practice, Patient 1 was first evaluated by Kaiser marriage and family therapist (MFT) Hans William Borough before seeing respondent. MFT Borough took a patient and social history, discussed Patient 1's chief complaints, and performed a mental status exam. (Exhibit 7, pp. A115–A123.) In his report, MFT Borough described Patient 1's Chief Complaint as follows:

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> [Respondent] is seeking services today to address: a continuation of taking the Xanax 1 mg two times a day or PRN. Pt reports he has been prescribed this medication for the last four years and Dr. Mystery at HDMG [High Desert Medical Group] was the last physician who prescribed this medication. And he wants to continue with this medication and possibly change to three times a day for "Generalized Anxiety Disorder and Panic Disorder." Patient requests a medication evaluation only due to the recent loss of his insurance.

(*Id.*, p. A117.)

17. MFT Borough noted Patient 1 "reports a history of uncontrolled reaction of anxiety without medication." (Exhibit 7, p. A118.) Patient 1 told MFT Borough he did not use any controlled substances outside of those prescribed. Patient 1 reported his anxiety moderately impaired his performance of school and work tasks and his participation in the usual social and community activities. (*Id.*, p. A121.) MFT Borough's report also indicates Patient 1 scored 0 on a PHQ 9 assessment for depression, and 13 on a GAD 7 assessment for anxiety. (*Id.*, p. A118.) The scores indicated no to minimal depression and moderate anxiety.

18. On August 23, 2016, the day after his evaluation by MFT Borough, Patient 1 called Kaiser to request respondent to refill his alprazolam prescription from December 2014. In response, respondent prescribed Patient 1 60 tablets of one mg of alprazolam, without any refills. Respondent indicated Patient 1 would need to see him at his appointment scheduled for September 1, 2016, before respondent would write any additional prescriptions. (Exhibit 7, p. A131.)

19. On August 26, 2016, before respondent's appointment with Patient 1, N.M. (Patient 1's mother) called the Kaiser psychiatry department to report Patient 1 was addicted to and abusing his medication. According to the call note, N.M. told the nurse that Patient 1 was smoking pot every day, appeared like a zombie, was drooling while talking, slurring his words, and "at night he can barely open his eyes." N.M. also stated she thought Patient 1 would benefit from counseling. The note further indicates the onset or duration of the problem was for more than a year. (Exhibit 7, pp. A136-A137.)

20. In response to N.M.'s call, respondent discontinued Patient 1's alprazolam prescription. He also communicated to the nurse that "ideally" Patient 1 should see a counselor in the cannabis dependency program for "what sounds like at least a moderate cannabis dependence problem now." (Exhibit 7, p. A137.)

21. Respondent met with Patient 1 for a 60-minute evaluation on September 1, 2016. According to his clinical notes, respondent diagnosed Patient 1 with panic disorder and anxiety disorder. Respondent's notes indicate Patient 1 reported his panic attacks were very well controlled and his anxiety disorder was under reasonably good control by taking two to three mg of alprazolam each day. At the evaluation, Patient 1 indicated he wanted to switch from taking two to three mg of alprazolam a day to taking two to four mg of clonazepam at night. (Exhibit 7, p. A153.) Patient 1 also reported he quit smoking marijuana in 2013, contrary to his mother's claim. (*Id.*, p. A154.) Based on Patient 1's reporting, respondent "went along" with Patient 1's request and agreed to resume prescribing two to four mg of clonazepam each night at bedtime. Respondent also recommended Patient 1 taper his alprazolam use to avoid severe withdrawal symptoms and wrote him a gradual withdrawal tapering schedule for 0.5 mg of alprazolam tablets. (*Id.*, p. A155.) Respondent instructed Patient 1 to

return in about a year or sooner if his symptoms worsened or failed to improve. (*Id.*, p. A143.) The clinical notes make no mention of any discussion regarding cannabis counseling or Patient 1's PHQ 9 and GAD 7 test scores. Respondent did not order a drug test before prescribing benzodiazepines.

22. Between September 1, 2016, and August 10, 2017, respondent did not meet with Patient 1, but he adjusted Patient 1's medication several times, as follows:

- In December 2016, respondent increased Patient 1's clonazepam dosage to six mg a day, without any explanation. (Exhibit 7, p. A168).

- On February 10, 2017, after Patient 1 complained he did not like how the clonazepam made him feel, respondent reduced the clonazepam dosage to four mg a day and increased the dosage of alprazolam to two mg a day until Patient 1's next appointment, which was scheduled for March 9, 2017. Respondent warned Patient 1 to be careful not to use heavy machinery or drive if he took the clonazepam in the morning and the alprazolam in the evening. (*Id.*, pp. A208–A210.)

- Although Patient 1 failed to appear for his March 9, 2017 appointment, respondent continued to prescribe up to two mg of alprazolam and up to four mg of clonazepam daily until May 9, 2017. At that time, respondent increased the prescribed dosage of alprazolam to up to three mg a day, without explanation. (Exhibit 11, p. A2221.)

23. Respondent met with Patient 1 on August 10, 2017, 11 months after his previous visit. During the August 10 visit, Patient 1 reported the frequency and severity of his panic attacks had significantly decreased, now occurring an average of once a week, but that he still felt socially anxious and agoraphobic. (Exhibit 7, p. A232.) Patient

1 requested respondent change his clonazepam prescription to one mg twice a day but maintain the alprazolam prescription at two to three mg a day. (Id., p. A231.) Respondent increased Patient 1's prescription to up to four mg of alprazolam and two mg of clonazepam daily. Respondent did not provide any explanation for his decision to increase the dosage of alprazolam beyond Patient 1's request. Respondent again indicated Patient 1 should return for another visit in a year. (Id., p. A227.) Respondent did not order Patient 1 to undergo a drug screen at this time.

24. Respondent's notes for Patient 1's September 1, 2016, and August 10, 2017 visits do not reflect any discussions with Patient 1 regarding his mother's concerns. There is no reference to any discussion regarding therapy or the use of anti-depressants instead of benzodiazepines to treat Patient 1's conditions. Respondent's notes do not refer to any discussions about the long-term risks of taking benzodiazepines or Patient 1's reactions to the medication. The notes suggest the dosages of respondent's prescriptions were based on Patient 1's requests.

25. On October 6, 2017, N.M. called the Kaiser psychiatry department to request respondent to stop refilling Patient 1's prescriptions. N.M. reported Patient 1 was addicted to the medication respondent prescribed. (Exhibit 7, p. A237.) A Kaiser nurse then called Patient 1 regarding his mother's call. According to the medical records, Patient 1 told the nurse the prescribed medication was effective, and that he was using it as directed. Patient 1 denied any addiction or medication issues. He also indicated he would not authorize Kaiser to release information to his mother. (Id., p. A238.)

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26. Patient 1's records do not reflect any change in respondent's prescription orders in response to N.M.'s call. On November 27, 2017, respondent increased Patient 1's dosage of alprazolam to six mg a day, without explanation. (Exhibit 7, p. A240.) Respondent did not order Patient 1 to undergo a drug screen.

27. On July 9, 2018, Patient 1 called the Kaiser pharmacy to request an early refill of his alprazolam medication because he had spilled the medication in the sink. (Exhibit 23, p. A2664.) Respondent refused to refill the prescription early. (*Ibid.*)

28. Respondent saw Patient 1 on January 9, 2019, more than 16 months after Patient 1's last visit. Respondent's notes indicate he added a diagnosis of social anxiety disorder based on Patient 1's reports of social anxiety in looking for a job. Respondent's notes further state Patient 1 reported the frequency of his panic attacks decreased from virtually every day and night to three times a week on average and his anxiety disorder was under control on the "relatively high" (respondent's characterization) daily dose of two mg of clonazepam and six mg of alprazolam. (Exhibit 7, p. A287.) Patient 1 also reported to respondent he no longer smoked marijuana and only used public transportation. (Id., p. A286) At the visit, respondent recommended Patient 1 continue the same daily doses of clonazepam and alprazolam. However, respondent advised Patient 1 that he would begin decreasing the daily dose of both medications shortly, beginning with clonazepam. (*Id.*, p. A319.) According to respondent, Patient 1 agreed to the tapering program without "much protest." (*Ibid.*) Respondent also suggested Patient 1 consider taking a selective serotonin reuptake inhibitor (SSRI) to address his social anxiety. (Id., p. A318.) Respondent requested Patient 1 schedule a return visit in a year.

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29. Respondent's notes for the January 9 visit do not reflect any discussions with Patient 1 regarding his mother's concerns. Although the notes indicate respondent proposed treating Patient 1's condition with SSRIs, Patient 1's response is not indicated. The notes also do not show that respondent broached therapy as an alternative to the prescribed medication. Nor do the notes reflect any discussion regarding side effects Patient 1 may be experiencing from the medication or the long-term risks of taking benzodiazepines. Respondent did not order a drug screen for Patient 1 at this visit.

30. Respondent began to taper Patient 1's benzodiazepine dosages at his next visit on May 24, 2019. The notes indicate respondent recommended Patient 1 "very gradually decrease" his daily dose of clonazepam to one mg a day and "then later probably decrease his daily dose" of alprazolam to no more than four or five mg a day. (Exhibit 7, p. A320.) Respondent also recommended Patient 1 consider attending a weekly anxiety and depression or stress management group. Respondent's records do not discuss Patient 1's reactions to his suggestions.

31. Sometime in August 2019, N.M. found Patient 1 on the floor passed out, and discovered heroin in his room. On August 13, 2019, N.M. left a message for the Clinical Manager of Kaiser's psychiatry department to return her call. She stated Patient 1 was a heroin addict and "the medication in his blood was way above average." She expressed her frustration about respondent's continued prescribing of drugs to Patient 1. She also indicated Patient 1 was selling the prescribed medication to buy heroin. (Exhibit 7, p. A335.) When respondent was contacted by his superior about N.M.'s call, respondent informed him he already was gradually tapering Patient 1 off clonazepam and alprazolam. (Id., p. A336.) As of August 2019, respondent still

prescribed Patient 1 up to six mg of alprazolam daily and had tapered Patient 1's clonazepam use from two mg to one mg a day.

32. Respondent next met with Patient 1 on February 3, 2020. (Exhibit 7, p. A367.) Respondent's notes reflect Patient 1 was seen in Kaiser's Addiction Medicine Department on August 22, 2019, and diagnosed with severe polysubstance disorder including alprazolam, marijuana, and heroin. Patient 1 then attended Kaiser-led groups to address his addiction issues. According to his notes, respondent became aware of Patient 1's addiction on August 13, 2019, and "on 12-2-19, [he] wrote an order for "Patient 1] to gradually taper off of and discontinue his prescription for 2 mg Alprazolam (XANAX) tablets, and on 12-23-10 to begin tapering off of his 0.5 Clonazepam (KLONOPIN) tablets and then to discontinue taking it as well." (*Id.*, p. A371.) At the February 3 visit, Patient 1 reported he had been clean and sober from heroin and opiates for eight months, but he still smoked marijuana on the weekends. (*Id.*, p. A372.) Respondent recommended the continued tapering of alprazolam and prescribed gabapentin, an alternative antianxiety medication. (*Id.*, at p. A374.)

33. Respondent stopped prescribing clonazepam to Patient 1 on January 18, 2020. On April 13, 2020, respondent started tapering Patient 1's alprazolam from 1 mg to 0.25 mg a day. (Exhibit 7, p. A411.) According to Kaiser's pharmacy records, Patient 1 last filled a prescription for 0.25 mg of alprazolam on July 23, 2020, for seven pills. (Exhibit 14, p. A2266.)

34. Medical records produced in response to the ALJ's June 20, 2023 order and admitted per the order indicate on May 22, 2019, a Kaiser pharmacist wrote that an order for a "drug of abuse screen" for Patient 1 was "placed under" respondent. (Exhibit 23, p A2670.) In a note dated June 4, 2019, the same Kaiser pharmacist stated the drug screen was not completed on May 24, 2019, and he would remind

respondent and Patient 1's primary care provider (PCP) to have Patient 1 complete the drug screen. The pharmacist also confirmed Patient 1's clonazepam dose was slowly being tapered. (*Id.*, p. A2681.) It was not made clear at hearing whether respondent was made aware of the request to drug test Patient 1 or received any notes from the pharmacy regarding the need for drug testing. These two pages were not in the medical records admitted during the hearing. There is no evidence of any request by the pharmacy for drug testing before May 22, 2019.

CURES REPORT AND KAISER PHARMACY RECORDS

35. According to Patient 1's CURES report, Patient 1 filled prescriptions for a two-day supply of acetaminophen with codeine (Tylenol with codeine) on February 12, 2017, and again on February 26, 2017, and a three-day supply of Tylenol with codeine on May 1, 2018. (Exhibit 11, pp. A2221, 2222, A2219.) The Kaiser pharmacy records also show Patient 1 filled prescriptions for a five-day supply of Tylenol with codeine on August 8, 2016, a seven-day supply of hydrocodone with acetaminophen (Norco), an opioid, on August 15, 2016, and another seven-day supply of Norco on August 29, 2016. (Exhibit 14, pp. A2259.) Each of these prescriptions was written by medical professionals other than respondent. There is no indication in respondent's records that he had any discussions with Patient 1 about these prescriptions.

TESTIMONY BY PATIENT 1

36. Patient 1's testimony at hearing differed significantly from the interview summary provided by Investigator McGarry in her report. The differences make large portions of both his interview statements and testimony unreliable. According to Investigator McGarry, Patient 1 stated he lied to respondent when he told him he suffered from anxiety and panic attacks and he sought treatment solely to obtain

alprazolam for recreational purposes. (Exhibit 4, p. A38.). Patient 1 told Investigator McGarry he often sold the alprazolam he did not take and used the money to buy painkillers such as Soma, Norco, and Oxycontin. Patient 1 also told Investigator McGarry he would have abused drugs regardless of respondent's treatment but respondent made it easier to access other drugs because he was able to sell the excess alprazolam. (Id., p. A39.)

37. At hearing, Patient 1 denied telling Investigator McGarry he fabricated stories to obtain alprazolam. Patient 1 testified he suffered from anxiety and panic attacks since his senior year of high school. He believed the medication prescribed by respondent alleviated his panic attacks but as time went on, he started suffering significant side effects. He was sleepy, unable to eat, shaky, and sweating. Patient 1 did not tell respondent about these effects because the medication was helping him. Respondent never asked about any side effects during Patient 1's appointments.

38. Patient 1 denied telling Investigator McGarry he sold the alprazolam that he did not use. Patient 1 testified he may have given some pills to his friends but denied he ever sold alprazolam. Patient 1 also testified the basis for his request for an early refill of alprazolam was truthful because his pills had fallen in the sink.

39. Patient 1 recalled discussions with respondent regarding replacing the benzodiazepines he was taking with antidepressants. Patient 1 testified he told respondent he did not want to take antidepressants for fear the medication would adversely affect his sex drive. He also recalled discussing therapy with respondent, but again he refused to participate. According to Patient 1, respondent never requested he take a drug test.

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40. In 2017 and 2018, Patient 1 started taking Soma and Norco and using heroin in addition to the benzodiazepines prescribed by respondent. He took money from his mother and used money from a settlement to purchase the drugs. The side effects from the benzodiazepines worsened after he started taking the street drugs.

41. Patient 1 is currently not taking alprazolam or clonazepam. However, his anxiety has increased exponentially. He also suffers from what believes are lingering effects from his long-term use of alprazolam. He does not know whether his use of Soma, Norco, or heroin exacerbated these effects.

RESPONDENT'S TESTIMONY

42. Respondent did not have a "very good" independent recollection of his treatment and care of Patient 1. (Exhibit 10, p. A2127.) His testimony was largely based on his review of the medical records.

43. Respondent asserted he based his diagnosis of Patient 1 on the observations of MFT Borough, Patient 1's answers to respondent's questions, and the version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) then in effect. Respondent was aware Patient 1 had a prior cannabis dependency when he resumed treating Patient 1 in 2016. However, he believed Patient 1 was clean at the time because Patient 1 had self-reported he was clean and sober and his self-reporting was supported by at least one other Kaiser provider. (Exhibit 7, p. A100.)

44. Respondent first prescribed clonazepam to Patient 1, he then added alprazolam at Patient 1's request. Respondent intended the benzodiazepines to address Patient 1's sleep issues, panic disorder, and depression. Respondent preferred to prescribe a longer-acting benzodiazepine because it had less abuse potential and fewer problems with immediate withdrawal. However, he found patients wanted

shorter-acting medication to address early morning panic attacks. He recalls Patient 1 complained clonazepam made him too sleepy during the day. Respondent therefore prescribed alprazolam to be taken in the morning and clonazepam to be taken at night. He asserted his prescriptions were driven by Patient 1's specific clinical situation.

45. Respondent testified he discussed Patient 1's symptoms of panic attacks and his sleeping difficulties at subsequent visits. Patient 1 reported the medication was helping him in school and at work. According to respondent, Patient 1 seemed calmer, less anxious, and less agitated because of the medication.

46. Respondent recalls discussing SSRIs with Patient 1 on more than one occasion but that Patient 1 consistently refused the medication because of the sexual side effects. Patient 1 also refused to participate in any group or individual counseling. The intake counselor offered him an opportunity to have individual counseling but Patient 1 refused. Respondent testified Patient 1 had been referred to addiction medicine at least twice but Patient 1 refused to follow through. (Exhibit 7, p. A2202.)

47. Patient 1 refused to consent to respondent speaking with his mother. Patient 1 told respondent his mother exaggerated and he should not believe what she was saying. Respondent acknowledged he could have stopped treating Patient 1 when he refused to sign an authorization allowing respondent to discuss Patient 1's care with his mother, but respondent did not want to threaten his relationship with Patient 1.

48. Respondent did not see any evidence Patient 1 was abusing drugs while Patient 1 was under his care. Although respondent was concerned about the addictive nature of alprazolam, he continued to prescribe it because Patient 1 reported it was working, he never observed Patient 1 to be intoxicated or slurring his words, and he

had only asked for one early refill, which respondent refused. Respondent explained Patient 1 was not subject to drug screens because he was not prescribed opiates and did not have a history of active drug abuse. Respondent was not aware of a Tylenol with codeine prescription for a toe injury at the time of treatment.

49. Respondent changed Patient 1's dosages from time to time based on Patient 1's description of his condition. He was aware Patient 1 was taking high dosages and warned him not to drive or operate any machinery. Patient 1 assured him he was using public transportation to get around.

50. Respondent testified it was his practice to see patients once a year if they were stable. He relied on the patients themselves and other Kaiser doctors and therapists to report any problems that needed his attention between appointments. In retrospect, respondent acknowledged he should have seen Patient 1 every four months. Additionally, respondent now believes he should have started tapering Patient 1's benzodiazepine medication much sooner. Respondent also acknowledged he should have insisted Patient 1 permit him to speak with N.M. If treating Patient 1 today, he would prescribe a much lower daily dose of benzodiazepines, would not prescribe two benzodiazepines in combination, and would try other medication before prescribing benzodiazepines.

EXPERT TESTIMONY

Combining Benzodiazepines

51. According to Dr. Davies, it was not the standard of care from 2016 to 2019 to prescribe two benzodiazepines simultaneously. If a doctor decided to do so, the standard of care required him to have solid clinical justification. Dr. Davies opined respondent departed from this standard of care when he prescribed both clonazepam

and alprazolam simultaneously to Patient 1 over three years. She noted respondent was aware alprazolam had a shorter half-life and a higher risk of abuse than clonazepam. Respondent was also aware he prescribed "a relatively high dose" of the two medications. Dr. Davies concluded respondent's decision to prescribe two benzodiazepines constituted a simple departure from the standard of care.

Benzodiazepine Prescribing

52. Dr. Davies asserted the standard of care during the 2016 to 2019 period was to prescribe the lowest effective dose of benzodiazepines for the shortest possible time because of their addictiveness. According to Dr. Davies, prescribing high doses of benzodiazepines over a long period leads to tolerance and addiction, with an increased risk of overdose and death. The medication also causes reduced psychomotor and cognitive function in chronic users and addicts, and patients taking such high doses should not drive. Dr. Davies testified 0.5 to one mg of alprazolam is a typical dosage with a limitation of eight tablets a month.

53. Dr. Davies opined respondent departed from the standard of care by prescribing high doses of alprazolam and clonazepam over three years to Patient 1 without solid clinical justification. Since the medication is also a depressant, such high dosages would have worsened Patient 1's mood. Additionally, Patient 1 showed symptoms of addiction including loss of cognitive function, which his mother reported. The medication was dangerous if Patient 1 decided to drive. Dr. Davies contends respondent also was alerted to the dangers of benzodiazepines by Kaiser's pharmacists when they requested drug screening.

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History, Examination, Diagnosis, and Follow-up

54. Dr. Davies asserted the standard of care required respondent to obtain a complete history, perform a proper examination and diagnosis, and require a routine follow-up when prescribing benzodiazepines. Dr. Davies also found it contrary to the standard of care to not screen a patient for substance abuse with a history of known drug abuse.

55. Dr. Davies opined respondent departed from the standard of care because he did not perform a complete history, examination, diagnosis, or follow-up in his care of Patient 1. As examples, Dr. Davies pointed to respondent's failure to screen Patient 1 for substance abuse at his initial 2016 appointment and his subsequent visits, his failure to ask about side effects, his failure to explore non-benzodiazepine treatments or encourage psychotherapy, his failure to address Patient 1's opiate prescriptions, and his continued prescribing of controlled substances despite his awareness of Patient 1's history of cannabis dependence. Dr. Davies asserted respondent's failure to insist on seeing Patient 1 on at least a quarterly basis, considering the high doses of benzodiazepines prescribed, was contrary to engaging Patient 1 in therapy and treatment. She further asserted Patient 1 dictated his medication needs, not respondent. Additionally, Dr. Davies stated respondent should have been on notice Patient 1 may have been abusing medication considering N.M.'s repeated calls and several red flags including Patient 1's early request for a refill, his use of codeine medication for a toe injury, and his inconsistent test scores showing him to have no symptoms of depression but moderate symptoms of anxiety. Dr. Davies pointed out that Patient 1's PHQ 9 score of 0 and GAD 7 score of 13 taken during his initial assessment when compared with his complaints of high anxiety to respondent were strong indications Patient 1 was gaming the system. Dr. Davies found

respondent's failure to actively monitor Patient 1's care constituted an extreme departure from the standard of care.

ANALYSIS

56. The evidence established respondent prescribed high doses of benzodiazepines to Patient 1 over three years without adequate clinical justification and monitoring. Despite the highly addictive nature of these drugs, respondent saw Patient 1 only three times between September 2016 and January 2019. During this period, although Patient 1 was resistant to using SSRIs and engaging in therapy, respondent made no sustained effort to overcome such resistance. The records do not evidence respondent discussed with Patient 1 the dangers of long-term benzodiazepine therapy. The records also do not reflect any rationale for the dosages respondent prescribed; it appeared Patient 1 originated many of the medication dosage decisions, not respondent. Additionally, despite a history of cannabis abuse, repeated calls from Patient 1's mother, some discussion with Patient 1 about using cannabis during his treatment, and evidence of prescriptions for opiates during Patient 1's treatment, respondent never required any drug screening before renewing Patient 1's prescriptions.

57. Several of Dr. Davies's statements in her report are either contrary to or not supported by the evidence. In her report, she cites Investigator McGarry's interview summary of Patient 1 stating Patient 1 sold alprazolam to purchase opioid pills. However, Patient 1 denied ever selling alprazolam in his testimony. Dr. Davies states respondent did not do a full intake of Patient 1 in 2016 because he had done one two years before, but the page she cites in support of that assertion only indicates respondent's last examination of Patient 1 was in 2014; there is also no indication respondent's examination of Patient 1 when combined with MFT Borough's evaluation

did not constitute a "full intake." Dr. Davies contends Patient 1's prescription for Tylenol with codeine for a toe injury was another red flag for respondent; however, none of the admitted medical records reflected such injury or whether respondent was aware of such injury. Dr. Davies also points to respondent's failure to comply with Kaiser's pharmacy's instructions to test Patient 1 as proof of respondent's failure to address the dangers of alprazolam. The record though did not establish respondent was ever aware of those instructions, and the testing directive was not issued until 2019, after Kaiser's directive became effective and when respondent had already started tapering at least one benzodiazepine prescription.

58. Although Dr. Davies's reliance on these factors undermines the persuasiveness of her opinion on certain issues, these factors are not central to an analysis of respondent's treatment of Patient 1. Respondent did not dispute Dr. Davies's description of the standard of care. And there is no question respondent prescribed two benzodiazepines over three years to a patient who had a history of cannabis use, did not make a sustained effort to pursue other alternatives, did not discuss any side effects from the prescribed medication, and did not provide adequate follow-up. Even if Patient 1's inconsistent test scores, prescriptions for opiates, and request for an early refill did not raise red flags for respondent, Patient 1's mother's repeated calls should have placed respondent on notice that Patient 1 may be abusing the prescribed medication. Nonetheless, respondent continued to prescribe high doses of alprazolam without drug testing based on infrequent visits and failed to make any changes in Patient 1's medication until 2019. Until respondent decided to taper Patient 1's medication, it appeared Patient 1 was dictating his medication dosages, not respondent. Under these circumstances, complainant convincingly and clearly established respondent's treatment of Patient 1 constituted both simple and extreme departures from the standard of care.

Patient 2

59. Patient 2 did not testify at hearing. The nature of respondent's care is gleaned entirely from her medical records and respondent's testimony.

MEDICAL RECORDS

60. Patient 2 was born on March 19, 1982. Respondent started treating her in 2009 when Patient 2 was 27 years old.

61. Respondent's first appointment with Patient 2 noted in the available medical records was on February 18, 2016, when she was 34 years old. At that time, respondent diagnosed Patient 2 with severe major depressive disorder, panic disorder, generalized anxiety disorder, pain disorder associated with general medical conditions and psychological factors, persistent insomnia disorder, social anxiety disorder, and attention deficit hyperactivity disorder (ADHD). (Exhibit 8, p. A526.) Additionally, Patient 2 was treated at Kaiser for several physical ailments including fibromyalgia, pain disorder, and scoliosis. She was also a tobacco smoker. (*Id.*, p. A537.) Respondent's notes of the February 18 visit indicate Patient 2 did not feel any better than when he last saw her. He observed she was anxious, apathetic, more depressed, and hopeless, and her thought process was subjectively racing. (*Id.*, p. A535.)

62. After Patient 2's February 18, 2016 visit, respondent prescribed Patient 2 the following medications daily to treat her various psychiatric conditions: 60 mg dextroamphetamine-amphetamine (Adderall XR); 30 mg dextroamphetamine-amphetamine (Amphetamine Salt Combo) (collectively Adderall XR and Amphetamine Salt Combo are referred to as Adderall herein); six mg alprazolam; up to 10 mg zolpidem (Ambien); up to 60 mg duloxetine (Cymbalta); and 300 mg bupropion (Wellbutrin XL). (Exhibit 8, p. A537.) According to respondent's plan, Adderall was to

address Patient 2's depression and ADHD, alprazolam was intended to address Patient 2's panic disorder and generalized anxiety disorder, and Ambien was to address Patient 2's insomnia. (*Id.,* p. A536.) The notes did not indicate the purpose of the Cymbalta or Wellbutrin prescriptions. Respondent stopped prescribing Patient 2 trazodone for insomnia because of its ineffectiveness at low doses and side effects at high doses. (*Id.,* p. A537.)

63. Respondent next saw Patient 2 on April 18, 2017, 14 months after her last appointment. (Exhibit 8, p. A745.) According to respondent's notes, Patient 2 felt no better than her last appointment and still had difficulty falling and staying asleep. (*Id.,* p. A764.) Respondent did not change her medication dosages except he added a prescription for trazodone. (*Id.,* p. A766.)

64. Respondent continued to refill Patient 2's prescriptions although she canceled or missed appointments on January 29, April 4, June 25, and June 26, 2018. (Exhibit 8, pp. A857, A899, A947, A958.) On June 28, 2018, respondent conveyed to Patient 2 she had to attend her July 23, 2018 appointment for future refills (*Id.,* p. A966.) At her July 23, 2018 appointment, 15 months after her previous appointment, Patient 2 reported she was still unable to manage her time, procrastinates, and is late for everything despite taking 120 mg of Adderall daily. She also reported no change in her mood and inability to sleep. (*Id.,* p. A998.) Respondent did not change her medication and recommended she continue to take the same daily doses. (*Id.,* p. 1000.)

65. Patient 2 canceled her February 8, 2019 appointment with respondent. (Exhibit 8, p. A1124.) On April 8, 2019, respondent started to decrease Patient 2's dosage of alprazolam from six mg to three mg a day because Patient 2 was also taking Norco prescribed by her PCP. (*Id.,* pp. A1191, A1199.) When Patient 2 called to inquire

about the change, Respondent explained Kaiser policy required him to reduce her dose of alprazolam because of the adverse effects of combining opiates with benzodiazepines.

66. On April 12, 2019, respondent decreased Patient 2's alprazolam dosage further to two mg daily. (Exhibit 8, pp. A1198–A1200.) Although Patient 2's PCP further reduced her Norco dosage, respondent denied Patient 2's request to increase her alprazolam dosage, citing Kaiser's policy limiting benzodiazepines to a 30-day supply and noting most psychiatrists would insist her dosage be reduced to 0.5 mg tablets twice a day. (*Id.,* p. A1219–A1220, A1231.)

67. At Patient 2's next appointment on May 31, 2019, Patient 2 again indicated she wanted to resume taking six mg of alprazolam a day while also continuing a lower dose of Norco. (Exhibit 8, p. A1272). Respondent increased respondent's alprazolam dosage to three mg daily. (Id., p. A1263) There is no explanation for the basis for the increased dosage. Respondent did not change her Adderall prescription dosages.

68. Respondent next met with Patient 2 by telephone on June 29, 2020, more than 12 months after her prior visit. At that time, respondent informed Patient 2 he would start tapering her daily dosage of alprazolam to 0.5 mg twice a day and then taper her off the medication altogether unless she tapered the Norco prescribed by her PCP. (Exhibit 8, p. A1518). Respondent made no changes to Patient 2's other prescriptions.

69. There is no discussion in respondent's notes (from 2016 to 2019) as to why he prescribed Patient 2 six mg of alprazolam a day or whether he considered any alternative medications or therapy for Patient 2. The records do not reflect any

discussion of side effects Patient 2 may have had from the drugs. The records also indicate Patient 2's symptoms were unchanged despite her use of Adderall. (Exhibit 8, p. A1274.) Respondent never requested a drug screen for Patient 2.

CURES Reports and Kaiser Pharmacy Records

70. Patient 2's CURES reports show her PCP prescribed Norco from 2016 through 2019. (Exhibit 12.) The Kaiser pharmacy records indicate Patient 2's PCP's last prescription for Norco was on August 7, 2020, for a 30-day dose. (Exhibit 15, p. A2304.)

Respondent's Testimony

71. According to respondent, Patient 2 had a problem with alcohol in her early 20s and she had been sober for three years when she began treatment with him in 2009. Patient 2 did not show any symptoms of alcohol addiction during the time he treated her. The medical records do not indicate Patient 2 was treated for alcoholism and make no mention of any history of alcohol use.

72. Respondent asserted he would have preferred to see Patient 2 every four to six months but she would frequently miss appointments. Respondent characterized Patient 2's ADHD as severe, and her condition caused her to be confused and disorganized. She often could not remember where his office was located.

73. In his Board interview, respondent asserted he routinely spoke to Patient 2 about participating in an anxiety management class or therapy, but he acknowledged he had not documented the discussions in his notes. Respondent further asserted Patient 2 was not interested in participating in either individual or group therapy. He stated that his 2015 notes indicated she was scheduled to

participate in a pain management group and seek counseling but there is nothing in his notes regarding what happened with those efforts. (Exhibit 10, p. A2442.)

74. Respondent started tapering Patient 2's alprazolam in response to Kaiser's January 2019 policy directive discouraging the concurrent prescription of benzodiazepines and opiates. Because Patient 2 was taking opiates to address her back pain and fibromyalgia, she could not also take benzodiazepines.

75. In hindsight, respondent wished he had cut down on respondent's alprazolam dosage sooner. He now recognizes he also should have discussed a lower dose of Adderall medication with Patient 2 or attempted some other class of ADHD medication, as Adderall had not helped Patient 2.

EXPERT TESTIMONY

Inappropriate Benzodiazepine Prescribing

76. Dr. Davies found fault with respondent's prescribing alprazolam to Patient 2 for many of the same reasons she asserted regarding Patient 1. First, respondent's prescription of six mg of alprazolam daily for more than three years was excessive. Additionally, respondent did not document the basis for such a high dose in his records and did not explore other medications. Dr. Davies further asserted the standard of care required respondent to refrain from prescribing benzodiazepines to an individual with a history of alcohol addiction. Thus, as respondent was aware of Patient 2's previous alcohol abuse, Dr. Davies concluded he departed from the standard of care by prescribing such large doses of alprazolam over a long period without screening and little follow-up. Dr. Davies found respondent's alprazolam prescribing to Patient 2 constituted an extreme departure from the standard of care.

Inappropriate Stimulant Prescribing

77. In her report, Dr. Davies found respondent's prescribing of Adderall to Patient 2 constituted an extreme departure from the standard of care because his prescription was not tied to a diagnosis of ADHD and the dose was inappropriate. However, Dr. Davies withdrew her conclusion after it was demonstrated at hearing that the medical records showed respondent had diagnosed Patient 2 with ADHD in 2011. Dr. Davies acknowledged the high dose of Adderall respondent prescribed therefore may have been justified.

Inappropriate Treatment

78. Dr. Davies opined respondent provided inappropriate treatment to Patient 2 when he prescribed simultaneously high doses of stimulants (Adderall), a sedative-hypnotic (alprazolam), and a non-benzodiazepine sedative-hypnotic (duloxetine). The effects of these drugs were contradictory. Thus, the standard of care when prescribing such high doses required at least monthly follow-up; however, respondent saw Patient 2 only three times over more than three years. She found respondent did not explore alternative options to the drugs and made no substantive effort to minimize the dosages of the medications even though Patient 2 complained the medication was not effective. As with Patient 1, Dr. Davies found respondent departed from the standard of care by failing to explore alternative medication and therapies. Dr. Davies concluded respondent's conduct constituted an extreme departure from the standard of care.

Prescribing Based on Patient Wishes

79. In her report, Dr. Davies mistakenly assumed Patient 2 self-diagnosed her ADHD and respondent prescribed Adderall based on Patient 2's diagnosis. After a

review of the medical records showing respondent's diagnosis of Patient 2's ADHD, Dr. Davies withdrew her conclusion that respondent's prescribing of Adderall to Patient 2 constituted a departure from the standard of care.

ANALYSIS

80. Respondent's care of Patient 2 suffered from many of the same problems identified in his care of Patient 1. Respondent prescribed Patient 2 large doses of alprazolam for over three years with little follow-up, no drug screening, and no sustained efforts, at least according to respondent's notes, in trying alternative medications or therapy. Respondent persisted in prescribing large doses of alprazolam and Adderall notwithstanding Patient 2's complaints that her condition remained unchanged. Although Patient 2 did not report or exhibit symptoms of alcohol abuse in the three times respondent saw her, respondent was aware of her history of alcohol abuse but did not tailor his practice to address the possibility that Patient 2 was vulnerable to addiction. Accordingly, complainant proved by clear and convincing evidence that respondent's treatment of Patient 2 constituted an extreme departure from the standard of care.

Patient 3

81. Patient 3 did not testify at hearing. The nature of respondent's care is gleaned entirely from his medical records and respondent's testimony. The medical records admitted into evidence were a small subset of the available medical records, as described more fully in Factual Finding 8, *supra*.

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FACTUAL BACKGROUND

82. Respondent treated Patient 3 from approximately 2006, when Patient 3 was 54 years old, through 2020, when Patient 3 was 69 years old. (Contrary to the Accusation, Patient 3 was not 40 years old at the time the Accusation was filed. (See Exhibit 1, p. A13.) During this period, Patient 3 suffered from generalized anxiety disorder, panic disorder, physiologic tremor, bruxism, persistent insomnia, and major depressive order. (Exhibit 9, p. A1727.) In addition, Patient 3 suffered from a host of medical problems including atherosclerosis, diverticulitis, diabetes, obesity, chronic kidney disease, gastroesophageal reflux disease, melanoma, and irritable bowel syndrome. Patient 3 was also a former smoker. Patient 3 was treated by numerous Kaiser doctors between 2006 and 2020 and was also assigned a Kaiser case manager.

83. Patient 3's first office visit with respondent fully reflected in the medical records for the 2016 to 2020 period is on April 3, 2017, 16 months after his last visit. (Exhibit 9, p. A1732.) Patient 3 reported daily panic attacks, chronic severe anxiety, 24-hour teeth grinding, and chronic insomnia. Patient 3 also requested, based on his neurologist's recommendation, an increase in his daily dosage of alprazolam (which was then three mg daily) because of his worsening physiologic tremor. (*Id.*, pp. A1733–1734.) Respondent's prescription plan was for Patient 3 to take 60 mg of mirtazapine, an antidepressant, to address Patient 3's panic disorder, depression, insomnia, and generalized anxiety disorder, 30 mg of temazepam to address insomnia, and an increase in Patient 3's alprazolam prescription to four mg a day to address his panic disorder, insomnia, anxiety disorder, and physiologic tremor. (*Id.*, pp. A1734–1735.) The medical records indicate Patient 3 had been prescribed Norco by his PCP during this time, but he reported he had not been taking it. Respondent told Patient 3 he need not return until after a year. (*Id.*, p.A1727.)

84. Patient 3's next office visit with respondent was on November 16, 2018, more than 19 months later. (Exhibit 9, p. A1858.) In the interim, respondent did not change Patient 3's prescriptions, and another Kaiser doctor had repeatedly prescribed Patient 3 a 28-day supply of Norco. (*Id.*, p. A1861.) The admitted medical records reflect no communication between respondent and the other Kaiser doctor. At the visit, Patient 3 described he had undergone major ocular surgery and faced the loss of vision. As a result, he partially relapsed into a moderately severe depression, experienced increased anxiety, and an inability to sleep more than two to three hours. (*Id.*, p. A1865.) Patient 3 also reported his tremor had significantly increased in severity. (*Id.*, p. A1866.) Respondent continued Patient 3's prescriptions but added 200 mg of trazodone, to help with his anxiety, sleep, and depression. (*Id.*, p. A1867.) Respondent also told Patient 3 to return in a year. (*Id.*, p. A1858.)

85. Starting in January 2019, respondent reduced Patient 3's daily dose of alprazolam to one mg a day per the Kaiser directive discouraging doctors from prescribing benzodiazepines when patients were taking opiates. (Exhibit 13, p. A2248.) At the time, Patient 3 was still prescribed Norco. However, another Kaiser doctor increased Patient 3's alprazolam dosage to two mg a day on April 21, 2019, and respondent continued that same dosage from May through August 2019. (*Id.*, pp. A2246, A2247.) Patient 3's records do not indicate why respondent stopped tapering Patient 3's alprazolam.

86. Patient 3's next office visit with respondent took place on September 11, 2019, ten months after his last visit. (Exhibit 9, p. A1982.) Patient 3 reported almost daily panic attacks, significantly increased anxiety, chronic insomnia, and moderate depression. Respondent recommended Patient 3 take the same daily dose of mirtazapine, continue to taper his alprazolam to one mg daily, and start taking

gabapentin. He also recommended Patient 3 continue to take quetiapine (Seroquel), an antipsychotic, which he noted in the record had first been prescribed to Patient 3 earlier in the year by Patient 3's PCP, who had another Kaiser physician, to help his insomnia. (*Id.,* p. A1989.) He also noted the PCP had stopped respondent's prescription of trazodone. (*Ibid.*) At the time, respondent was aware Patient 3 was taking Norco as prescribed by his PCP. (*Id.,* p. A1991.) Respondent asked Patient 3 to return in six months. (*Id.*, p. A1982.)

87. In October and November 2019, respondent continued to prescribe Patient 3 alprazolam with instructions to taper his usage to one mg a day. In December 2019, respondent prescribed Patient 3 up to one mg of alprazolam a day. (Exhibit 16.) Respondent did not explain why he did not continue tapering the medication.

88. On January 10, 2020, Patient 3's PCP diagnosed Patient 3 with moderate sedative, hypnotic, or anxiolytic use disorder. Patient 3 denied he had any substance abuse problem and refused counseling. (Exhibit 9, p. A2034.) The medical records contain no detail about the diagnosis.

89. On May 28, 2020, respondent was admitted to Antelope Valley Hospital. None of the medical records for respondent's stay were made available at the hearing. The first page of the discharge summary was admitted after the hearing pursuant to the ALJ's order. The discharge summary lists Patient 3's discharge diagnoses, as follows: encephalopathy, underneath which is written "improving. partly medication related"; altered mental status; diabetes mellitus, type 2; and thrombus of aorta. (Exhibit 24, p. A11978.) The summary further states a psychiatrist who evaluated Patient 3 was concerned Patient 3's use of alprazolam and morphine could have contributed to his confusion and altered mental state. (*Ibid.*) The summary also states

the psychiatrist therefore discontinued Patient 3's topiramate prescription (ordered by a Kaiser doctor other than respondent) and decreased Patient 3's mirtazapine and alprazolam prescriptions. (*Ibid.*) It is not known whether these prescriptions were limited to Patient 3's hospital stay as there is nothing in the admitted medical records indicating such prescription changes were made after Patient 3's discharge from the hospital.

90. On June 5, 2020, Patient 3's PCP requested a psychiatric evaluation because of Patient 3's recent admission for "altered mental status" with "no obvious cause." (Exhibit 9, p. A2096.) Patient 3 was reported to be "quite anxious" which worsened his stomach pain. His PCP also reported Patient 3 was trying to limit his alprazolam use. (*Ibid.*)

91. Patient 3's next appointment (by telephone) with respondent was on July 1, 2020. At the July 1 appointment, Patient 3 complained of chronic abdominal pain, poor memory, and confusion. He reported he had stopped taking many of the drugs prescribed. According to respondent's clinical notes, Patient 3 last filled his prescriptions for gabapentin on February 11, 2020, Seroquel on January 11, 2020, and mirtazapine on May 5, 2020, and the three prescriptions had been discontinued. (Exhibit 9, p. A2086.) Patient 3 also reported he was currently taking 1 mg daily of alprazolam as well as morphine tablets prescribed by his pain management doctor. (*Ibid.*) Patient 3 told respondent he had stopped taking Norco because of the adverse side effects; he also did not believe any of the other sedative-hypnotic medications previously prescribed to him had been effective. Additionally, Patient 3 and his wife told respondent alprazolam was the only medication that helped with Patient 3's extreme anxiety and chronic abdominal pain. Respondent's notes indicated he discontinued Patient 3's prescriptions for Norco and morphine because of Patient 3's

increased disorientation and confusion, and he increased the alprazolam dosage from one to 1.5 mg of alprazolam daily. (*Id.,* pp. A2086–A2087.)

RESPONDENT'S TESTIMONY

92. Respondent first met Patient 3 in 2004 and stopped seeing him in 2020, four weeks before Patient 3's death. Respondent reported Patient 3's psychiatric condition deteriorated as his physical health worsened.

93. Respondent learned after the fact that Patient 3 had been hospitalized in June 2020 for "altered mental status." Respondent asserted the cause for Patient 3's altered mental status was never determined. There was some speculation Patient 3's condition may have been caused by medication or by a urinary tract infection. Respondent stated he did not believe alprazolam caused Patient 3's condition because respondent had started tapering Patient 3's alprazolam dosage nearly ninth months earlier. Patient 3's PCP had previously diagnosed Patient 3 with a moderate sedative addiction before his hospitalization and referred Patient 3 to Kaiser's addiction medicine department. However, respondent stated there was nothing in the records to support the diagnosis, as the diagnosis had been reviewed by Kaiser's Medical Quality Panel and found to be without basis, and Patient 3 and his wife denied any substance abuse disorder.

EXPERT TESTIMONY

Inappropriate Benzodiazepine Prescribing

94. Dr. Davies found respondent departed from the standard of care by prescribing more than the minimal effective dose of benzodiazepines to Patient 3. According to Dr. Davies, there is a risk of cognitive issues, hip fractures, and loss of

balance or coordination if more than the minimal effective dose is prescribed to medically ill patients. She asserted a dose of two to four mg of alprazolam daily for an extended period was excessive for a patient who had been on opioid therapy for years. In addition, despite a diagnosis of sedative-hypnotic use disorder and admission to the hospital for "altered mental status," respondent failed to change Patient 3's benzodiazepine prescription to a longer-acting drug, which was less likely to be abused. Dr. Davies also asserted respondent did not taper Patient 3's alprazolam use in the fall of 2019 because he increased the frequency Patient 3 should take the medication, even though he had reduced its strength. Although Dr. Davies acknowledged other Kaiser doctors also prescribed alprazolam to Patient 3, she found respondent's alprazolam prescribing to Patient 3 constituted an extreme departure from the standard of care.

Inappropriate Psychopharmacological Treatment

95. In her report, Dr. Davies asserts respondent's treatment of Patient 3 constituted an extreme departure from the standard of care because respondent prescribed Patient 3 multiple psychiatric drugs when he was also taking other psychiatric drugs ordered by other Kaiser physicians. According to Dr. Davies, the standard of care requires a psychiatrist to limit psychopharmacological medication because it contributes to delirium and altered mental status. Dr. Davies found that as of early 2020, respondent prescribed Seroquel, alprazolam, and mirtazapine to Patient 3 while other Kaiser doctors were prescribing an opioid and topiramate. She believed all this medication was too much for an extremely ill patient such as Patient 3. In testimony, Dr. Davies acknowledged she "could not draw a direct line" from the medication prescribed by respondent to Patient 3's altered mental status but that alprazolam, mirtazapine, and Seroquel all could have contributed to Patient 3's

condition. Dr. Davies found respondent's medication choices for Patient 3 and his failure to take into account the other medications prescribed by others constituted an extreme departure from the standard of care.

ANALYSIS

96..... As with Patients 1 and 2, several of Dr. Davies's statements in her report are either contrary to or not supported by the evidence. However, unlike her misstatements involving Patient 1 and Patient 2, Dr. Davies's misstatements in analyzing Patient 3's care are central to her conclusions and therefore undermine their persuasiveness. (See *Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924 ["Like a house built on sand, the expert's opinion is no better than the facts on which it is based.....[W]here 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.".]; *Pacific Gas & Electric Co. v. Zuckerman* (1987) 189 Cal.App.3d 1113, 1135-36 ["Where an expert bases [her] conclusion upon assumptions which are not supported by the record, upon matters which are not reasonably relied upon [by] other experts, or upon factors which are speculative, remote or conjectural, then [her] conclusion has no evidentiary value. [Citations.]".)

97. For instance, Dr. Davies asserts the medical records state Patient 3's May 2020 hospital admission was for "Altered mental status 'partly medication related'." (Exhibit 20, p. A2368.) However, the cited medical record makes no such statement. Although one psychiatrist suggests certain of Patient 3's medication could have contributed to his altered mental state, the quoted language concerns Patient 3's encephalopathy, not his altered mental status. The records also do not indicate which of the medications prescribed to Patient 3 caused his condition. (See Exhibit 24, p. A11978.)

98. Dr. Davies also places much emphasis on respondent's failure to address Patient 3's January 2020 diagnosis of substance abuse disorder. However, as respondent testified, nothing in the medical records supports that diagnosis. As respondent testified, the Kaiser Medical Quality Committee was unable to substantiate the diagnosis. Patient 3's other Kaiser doctors continued to prescribe Norco despite the stated diagnosis. (Exhibit 16, pp. A2235, A2236.) The records also indicate Patient 3's wife stated Patient 3 was taking his drugs as recommended, and both Patient 3 and his wife denied any substance abuse disorder.

99. Dr. Davies also mistakenly asserts respondent did not taper Patient 3's use of alprazolam in the Fall of 2019 because "the increased frequency made up for the decreased dosage." (Exhibit 20, p. 2370.) The Kaiser pharmacy and CURES reports reflect in August 2019, respondent prescribed Patient 3 a 30-day supply of 60 one mg alprazolam tablets with instructions to take one tablet twice a day, or up to 2 mg daily. (Exhibit 16, p. A2331.) However, in September 2019, respondent prescribed Patient 3 a 20-day supply of 60 0.5 mg tablets directing him to reduce his use to one .05 mg tablet in the morning and two .05 mg tablets at night for one week, and then take one .05 mg tablet every 12 hours. Thus, respondent tapered Patient 3's use from two mg daily to 1.5 mg and then to one mg per day. (*Id.*, p. A2332.) And in December 2019, respondent limited Patient 3's alprazolam use to one mg daily.

100. Dr. Davies additionally takes issue with respondent's prescribing alprazolam "over years" while Patient 3 was taking Norco prescribed by another physician. (Exhibit 20, p. A2370.) However, Patient 3 denied taking Norco at times during the relevant time. (Factual Findings 83, 91.) Dr. Davies also did not establish the standard of care before 2019 was not to prescribe benzodiazepines and opiates

concurrently. Per Dr. Davies's report, Kaiser did not issue its policy recommending doctors not prescribe the two medication classes simultaneously until January 1, 2019.

101. Based on the foregoing, the evidence did not clearly and convincingly establish respondent departed from the standard of care in prescribing alprazolam to Patient 3. Dr. Davies did not demonstrate why three or four mg daily of alprazolam was not a minimum effective dose, given Patient 3's chronic anxiety and his neurologist's recommendation of an even greater dose to deal with Patient 3's worsening tremors. An article entitled "Benzodiazepine use, abuse, and dependence," found in the Journal of Clinical Psychiatry and included in Dr. Davies's report, states, "Due to the chronic nature of anxiety, long-term low-dose benzodiazepine treatment may be necessary for some patients; this continuation of treatment should not be considered abuse or addiction." (Exhibit 20, p. A2401.) Dr. Davies did not explain why Patient 3 was not such a candidate. Moreover, contrary to Dr. Davies's assertions, respondent started to taper Patient 3's alprazolam in January 2019 in response to Kaiser's policy directive and then renewed his efforts in the fall of 2019. Dr. Davies also failed to address respondent's assertion there was no support for a diagnosis of sedative-hypnotic disorder.

102. Nor did the evidence support Dr. Davies's conclusion respondent departed from the standard of care by providing Patient 3 with inappropriate psychopharmacological treatment. Dr. Davies's finding that the combination of Seroquel, mirtazapine, and alprazolam contributed to the altered mental status in May 2020 is speculative and unsupported by the evidence. Contrary to Dr. Davies's assertion, the discharge summary does not state Patient 3's altered medical status was due to his medication. Patient 3's PCP stated the condition had no "obvious cause." (Factual Finding 90.) Moreover, Dr. Davies failed to address respondent's clinical notes,

which indicated he stopped prescribing Seroquel to Patient 3 months before his hospital admission (Factual Finding 91), and had started tapering Patient 3's alprazolam more than nine months prior (Factual Finding 87).

103. It was also not made clear at the hearing from the admitted medical records who was responsible for coordinating Patient 3's psychopharmacological treatment at Kaiser. Dr. Davies's assumption respondent was responsible for coordinating such medication is again speculative. The admitted medical records did not reflect any discussion or coordination among the many doctors involved in prescribing Patient 3 psychopharmacological medication. The prescriptions all appear to have been issued without consultation with the other Kaiser physicians. Additionally, respondent's prescribing decisions were not made in a complete vacuum; in at least three instances, he prescribed medication based on other Kaiser physicians' requests or prescriptions. (See Factual Findings 83, 86, 91.)

104. In sum, based on the available medical records, complainant did not establish by clear and convincing evidence respondent departed from the standard of care in his treatment of Patient 3.

Respondent's Additional Evidence

105. Respondent received a certificate from Kaiser in recognition of his distinguished and devoted service from 1978 to 2011. (Exhibit C, p. B23.) He also received a certificate of recognition from Kaiser in 2019. (*Id.,* B22.)

106. Respondent participated in extensive continuing education offered by the Neuroscience Education Institute (NEI) in recent years. (Exhibit B.) In 2023, respondent completed a two-and-a-half-day live course offered by NEI addressing pharmacology issues. (*Id.*, p. B6.) He has learned through training and reviewing the

literature on prescribing of the specific dosage limits for prescribing benzodiazepines. (Exhibit 10, p. 2207.)

107. Respondent presented as a credible witness and a caring physician. He took responsibility for his prescribing practices for Patients 1 and 2, and expressed remorse for some of his decisions. He asserted that since 2019, his prescribing practices regarding benzodiazepines have changed.

108. Respondent would like to retain his license because he would like to continue to participate in medical education regarding new psychiatric medications and also be available if Kaiser needs him to assist with patients. He believes he is a good medical care provider and a compassionate and caring physician. He is dedicated to eliminating his patient's mental and physical suffering.

CHARACTER EVIDENCE

109. Scott Stieglitz, M.D., testified and wrote a letter to the Board on respondent's behalf. (Exhibit B, p. B4.) Dr. Stieglitz was licensed to practice medicine in California in 1983. He worked with respondent at Kaiser from 1985 to 2017. Since 2017, Dr. Stieglitz speaks with respondent on the telephone or socializes with him a few times a year.

110. Dr. Stieglitz worked in the same hallway as respondent when respondent worked at Kaiser. He had frequent contact with him between seeing patients, and Dr. Stieglitz would often cover for respondent. Dr. Stieglitz described respondent as a very caring, conscientious, and kind physician who would often stay late to telephone his patients and complete his records. Although Dr. Stieglitz did not know the specifics of the Accusation, he was aware it focused on respondent's prescription practices. Dr.

Stieglitz voiced no concerns about respondent's treatment decisions. He also noted respondent attended many seminars and kept up with his educational obligations.

111. Several other colleagues vouched for respondent's character, work ethic, and dedication to his patients in letters submitted to the Board. (Exhibit A.)

- Naresh Arulampalam, M.D., a board-certified psychiatrist who was chief of the psychiatric department at Kaiser from 2008 through 2017, worked closely with respondent. He was aware of the Board's charges against respondent. He found respondent to be a "very conscientious physician" with an "extensive knowledge of psychopharmacology" and who is "proficient in his decision-making skills." (*Id.,* p. B1.)

- Robert Geoghegan, M.D., a psychiatrist at Kaiser who worked with respondent from 1978 to 2003 and has remained a close friend since, considers respondent to be a "highly skilled psychiatrist who provided excellent care" to a large caseload of Kaiser patients. Dr. Geoghegan was aware of the charges against respondent. He wrote respondent was experienced in treating a broad range of serious and complex mental illnesses and knowledgeable regarding the use of psychiatric medications. Dr. Geoghegan recalled respondent often stayed late to complete his charts and pitched in to help with challenging cases. (*Id.,* pp. B2–B3.)

- Chris R. Repomonto, R.N., worked as respondent's psychiatric nurse from 2016 until respondent's retirement. R.N. Repomonto described respondent as a "great asset . . . , reliable, dedicated . . . and knowledgeable." He too described respondent's late hours and noted his kindness and competency. (*Id.,* p. B5.)

Costs

112. Complainant seeks reimbursement of investigation and enforcement costs totaling $68,260. (Exhibit 17.) Of those costs, $3,520 are an estimate of additional hours to be incurred and billed between the submission of the cost bill and the commencement of hearing. The breakdown of the actual costs incurred shows that two attorneys did the bulk of the work. The first attorney spent 48.75 hours on the matter in four months, incurring $10,725 in costs. The second attorney spent 218 hours on the matter over nine months, incurring $47,960 in costs. The overwhelming majority of the hours, at least 170 hours, were spent performing "Document Analysis." (*Id.*, pp. A2344–2348.)

113. Respondent is retired. He no longer treats any patients. He is widowed and supports his adult daughter.

LEGAL CONCLUSIONS

1. Complainant has the burden of proving the charges in the Accusation by clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This means the burden rests on complainant to establish the charging allegations by proof that is clear, explicit, and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

2. Protection of the public is the Board's highest priority in exercising its licensing, regulatory, and disciplinary functions. "Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount." (Code, § 2001.1) The Board is charged with the duty to

protect the public against incompetent, impaired, or negligent physicians" and is responsible for enforcing disciplinary provisions of the Medical Practice Act. (*Lewis v. Superior Court* (2017) 3 Cal.5th 561, 567 (Citations omitted).)

First Cause for Discipline – Gross Negligence and Repeated Acts of Negligence

3. The Accusation alleges respondent's license is subject to discipline under Code section 2234, subdivisions (b) and (c), because he was grossly negligent and engaged in repeated acts of negligence in his care and treatment of Patients 1, 2, and 3.

4. The Board may discipline a physician's license for engaging in unprofessional conduct. (Code, § 2234.) Unprofessional conduct includes gross negligence and repeated negligent acts. (Code, § 2234, subds. (b) & (c).) Repeated negligent acts consist of two or more negligent acts or omissions. "An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care constitutes repeated negligent acts." (Code, § 2234, subd. (c).)

5. 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.)

6. Complainant proved by clear and convincing evidence respondent departed from the standard of care in his treatment of Patient 1 and Patient 2 as set forth in Factual Findings 14 through 80. Complainant did not prove by clear and convincing evidence respondent departed from the standard of care in his treatment of Patient 3. (Factual Findings 81–104.) Cause therefore exists to discipline respondent's license for gross negligence and repeated acts of negligence under Code section 2234, subdivisions (b) and (c), for his treatment of Patients 1 and 2.

Second Cause for Discipline – Excessive Prescribing

7. The Accusation seeks to discipline respondent's license for excessive prescribing to Patients 1, 2, and 3 in violation of Code section 725. Under section 725, subdivision (a), "repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering drugs" contrary to the standard of care constitutes unprofessional conduct. However, a practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering prescription controlled substances is not subject to discipline under section 725. (Code, § 725, sub. (c).)

8. Complainant proved by clear and convincing evidence respondent excessively prescribed benzodiazepines to Patients 1 and 2. (Factual Findings 14–80.) Complainant did not prove by clear and convincing evidence respondent excessively prescribed alprazolam to Patient 3. (Factual Findings 81–101.) Cause therefore exists to discipline respondent's license under Code section 725 for clearly excessive prescribing to Patients 1 and 2.

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Third Cause for Discipline – Prescribing to an Addict

9. The Accusation seeks to discipline respondent's license under Code section 2241 for prescribing controlled substances to Patients 1 and 2, "who had signs of drug or alcohol addiction." (Exhibit 1, p. A14.)

10. Code section 2241, subdivision (b), prohibits a physician or surgeon from prescribing, dispensing, or administering dangerous drugs or controlled substances to a person he knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose. Alprazolam and clonazepam are controlled substances and dangerous drugs. (Code, § 4022.)

11. Complainant proved by clear and convincing evidence respondent prescribed benzodiazepines to Patient 1 despite a reported history of addiction and repeated calls from Patient 1's mother that he was an addict and was using the drugs or substances for a nonmedical purpose. (Factual Findings 14–41.) Complainant failed to prove by clear and convincing evidence respondent prescribed alprazolam or any other drug to Patient 2 with the knowledge she would use the drugs for a nonmedical purpose. Although according to respondent, Patient 2 had struggled with alcoholism in the past, she had been sober for three years when respondent started treating her in 2009, and no evidence was presented Patient 2 drank alcohol while respondent was treating her or was abusing the medication prescribed to her. None of the medical records for Patient 2 indicated she had a past or current alcohol problem. (Factual Finding 71.)

12. Cause therefore exists to discipline respondent's license under Code section 2241 for prescribing dangerous drugs and controlled substances to Patient 1.

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Fourth Cause for Discipline – Furnishing Dangerous Drugs Without a Prior Examination or Medical Indication – Patients 1 and 2

13. The Accusation seeks to discipline respondent's license under Code section 2242 because respondent furnished dangerous drugs to Patients 1 and 2 without conducting an appropriate prior examination and without medical indication or justification. Additionally, the Accusation alleges respondent continued to prescribe dangerous drugs to Patient 1 and Patient 2 without an appropriate medical diagnosis and treatment plan.

14. Under Code section 2242, subdivision (a), prescribing, dispensing, or furnishing a dangerous drug without an appropriate prior examination and medical indication constitutes unprofessional conduct. "Medical indication" has been defined as the "existence of symptoms or presence of satisfying evidence which suggests to a doctor the need or advisability of prescribing the use of a dangerous drug." (*Whitlow v. Board of Medical Examiners* (1967) 248 Cal.App.2d 478, 482.)

15. Complainant did not prove by clear and convincing evidence respondent prescribed dangerous drugs to Patient 1 and Patient 2 without conducting an appropriate prior examination and without medical indication or justification. The evidence demonstrated Patient 1 first was assessed by a therapist and then by respondent before he was prescribed dangerous drugs. (Factual Finding 16, 17, 21.) The medical records reflecting respondent's treatment of Patient 2 before 2016 were not made available and therefore it was not known the scope and nature of the examination he conducted before prescribing her dangerous drugs. Both Patient 1 and Patient 2 complained and exhibited symptoms suggesting the need for the prescribed medication. Cause therefore does not exist to discipline respondent's license under Code section 2242.

Fifth Cause for Discipline – Inadequate Records

16. The Accusation seeks to discipline respondent's license under Code section 2266 for failure to maintain adequate and accurate records of his care and treatment of Patients 1, 2, and 3.

17. The failure of a physician to maintain adequate and accurate records relating to the provision of services to the physician's patients constitutes unprofessional conduct. (Code, § 2266.)

18. Complainant proved by clear and convincing evidence respondent failed to maintain adequate and accurate records of his care and treatment of Patients 1, 2, and 3. (Factual Findings 22, 24, 26, 29, 30, 35, 69, 73, 85, 87.) His clinical notes fail to reflect any discussions with Patient 1 or Patient 2 regarding alternative medications or participating in therapy. The records also fail to explain respondent's reasons for the medication and dosages he prescribed for each of the three patients. Cause therefore exists to discipline respondent's license under Code section 2266 for failure to maintain adequate records.

Disposition

19. With causes for disciplinary action established, the Board has the discretion to determine the suitable discipline, "subject to the Legislative mandate that the Board's highest priority be protection of the public; and, secondarily, discipline should 'aid in the rehabilitation of the licensee.' (Code, § 2229, subds. (a) & (b).)'" (*Pirouzian v. Superior Court* (2016) 1 Cal.App.5th 438, 448.) In exercising its discretion, the Board considers the Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th Edition 2016) (Guidelines) that it has adopted. (Cal. Code Regs., tit. 16, § 1361, subd. (a).) "Deviation from these orders and guidelines, including the standard

terms of probation, is appropriate where the Board in its sole discretion determines by adoption of a proposed decision or stipulation that the facts of the particular case warrant such a deviation – for example: the presence of mitigating factors; the age of the case; evidentiary problems." (*Ibid.*)

20. The Guidelines provide for a minimum discipline of five years of probation and a maximum discipline of revocation for licensees who have committed gross negligence, repeated negligent acts, excessive prescribing, or maintained inadequate medical records.

21. Respondent's misconduct was serious. He ignored signs of possible abuse with Patient 1. He prescribed excessive dosages of benzodiazepines for years without proper oversight for Patients 1 and 2. For Patients 1, 2, and 3, he failed to maintain accurate and complete records. Although respondent is retired, he indicated he would return to practice if asked. It is therefore important respondent be monitored and participate in additional education and training so the Board is assured he has the skills and knowledge necessary to detect and address addiction, maintain adequate records, and engage in appropriate prescribing practices.

22. However, a departure from the recommended length of probation is warranted by the circumstances of this case. Respondent has practiced medicine for more than 46 years without any prior discipline. He enjoys a good reputation. He has been retired from the practice of medicine for more than a year. Before he retired, he changed his practices so he saw his patients more regularly and limited their access to benzodiazepines. He acknowledged his responsibility for his actions and expressed remorse and regret at the hearing. He continues to take educational courses to improve his prescribing practices and expand his knowledge about psychopharmacology. Therefore, the length of probation shall be 35 months instead of

five years, with terms and conditions to ensure the protection of the public. Additionally, considering respondent's length of practice without discipline and the recent changes he has made in his practice, the terms and conditions do not include suspension, surrender of respondent's DEA permit, or the maintenance of controlled substance records, as requested by complainant's counsel at hearing.

Costs

23. Pursuant to Code section 125.3, complainant is entitled to recover the reasonable costs of investigation and enforcement of this matter. Complainant seeks to recover costs of $68,260, including estimated costs of $3,520. (Factual Finding 112.) Complainant's request for $3,520 in estimated costs does not satisfy the requirement of California Code of Regulations, title 1, section 1042, insofar as complainant failed to "explain the reason actual cost information is not available." Accordingly, the estimated costs of $3,520 may not be recovered from respondent.

24. In *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the Supreme Court set forth factors to be considered in determining the reasonableness of the costs sought pursuant to statutory provisions like section 125.3. These factors include: (1) whether the licensee has been successful at hearing in getting charges dismissed or reduced; (2) the licensee's subjective good faith belief in the merits of his or her position; (3) whether the licensee has raised a colorable challenge to the proposed discipline; (4) the financial ability of the licensee to pay; and, (5) whether the scope of the investigation was appropriate in light of the alleged misconduct.

25. Considering the *Zuckerman* factors, a reduction of the award of complainant's reasonable costs by 80 percent is appropriate. Respondent used the

hearing process to obtain the dismissal of some of the charges. The amount of time complainant's counsel spent on document analysis (at least 170 hours) is unreasonable given the issues. Additionally, respondent is currently retired and supports his adult daughter. Therefore, respondent shall be required to pay the costs of enforcement of this matter in the amount of $12,948.

ORDER

Physicians and Surgeons Certificate Number G 31539 issued to respondent Gerald Ray Watkins, M.D., is revoked. However, revocation is stayed and respondent is placed on probation for 35 months upon the following terms and conditions.

1. EDUCATION COURSE

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

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2. PRESCRIBING PRACTICES COURSE

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. MEDICAL RECORD KEEPING COURSE

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any

information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. CLINICAL COMPETENCE ASSESSMENT PROGRAM

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of respondent's physical and mental health and the six general domains of clinical competence as

defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require respondent's on-site participation for a minimum of 3 and no more than 5 days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the

respondent did not successfully complete the clinical competence assessment program, the respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

5. MONITORING - PRACTICE

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

6. NOTIFICATION

Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

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8. OBEY ALL LAWS

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. QUARTERLY DECLARATIONS

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. GENERAL PROBATION REQUIREMENTS

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

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Place of Practice

Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

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12. NON-PRACTICE WHILE ON PROBATION

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

13. COMPLETION OF PROBATION

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

14. VIOLATION OF PROBATION

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. LICENSE SURRENDER

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his or her license. The

Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. PROBATION MONITORING COSTS

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

17. COST RECOVERY

Respondent shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code Section 125.3 in the amount of $12,948. Respondent shall be permitted to pay these costs in a payment plan approved by the Board, with payments to be completed no later than three months prior to the end of the probation term.

If respondent has not complied with this condition during the probationary term, and respondent has presented sufficient documentation of his good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may grant an extension of respondent's probation period up to

one year without further hearing in order to comply with this condition. During the one-year extension, all original conditions of probation will apply.

DATE: 08/11/2023

CINDY F. FORMAN
Administrative Law Judge
Office of Administrative Hearings