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

In the Matter of the Accusation Against: Edward Joseph Erbe, M.D. Physician's & Surgeon's Certificate No G 76886 Respondent.	Case No.: 800-2020-071474

DENIAL BY OPERATION OF LAW
PETITION FOR RECONSIDERATION

No action having been taken on the petition for reconsideration, filed by January 2, 2025, and the time for action having expired at 5:00 p.m. on January 2, 2025, the petition is deemed denied by operation of law.

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

In the Matter of the Accusation Against: **Edward Joseph Erbe, M.D.** **Physician's & Surgeon's Certificate No. G 76886** **Respondent.**	**Case No. 800-2020-071474** **ORDER GRANTING STAY** **(Government Code Section 11521)**

Complainant Reji Varghese, Executive Director, has filed a Request for Stay of execution of the Decision in this matter with an effective date of December 23, 2024, at 5:00 p.m.

Execution is stayed until January 2, 2025, at 5:00 p.m.

This Stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: December 20, 2024

Reji Varghese
Executive Director
Medical Board of California

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

In the Matter of the Accusation Against: Edward Joseph Erbe, M.D. Physician's & Surgeon's Certificate No. G 76886 Respondent.	Case No. 800-2020-071474

DECISION

The attached Corrected 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 December 23, 2024.

IT IS SO ORDERED: November 22, 2024.

MEDICAL BOARD OF CALIFORNIA

Michelle A. Bholat, MD

Michelle A. Bholat, M.D., Interim Chair
Panel A

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

In the Matter of the Accusation Against:

EDWARD JOSEPH ERBE, M.D., Respondent

Case No. 800-2020-071474

OAH No. 2024020159

CORRECTED PROPOSED DECISION[1]

Mary Agnes Matyszewski, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on September 23, 24, 25, and 26, 2024, by videoconference.

Giovanni Mejia, Deputy Attorney General, represented complainant, Reji Varghese, Executive Director of the Medical Board of California (board).

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[1] The Proposed Decision was issued on October 25, 2024. On October 29, 2024, pursuant to Government Code section 11518.5, technical corrections were made to the preamble, correctly spelling and identifying the Executive Director and including respondent's middle name.

Nicholas Jurkowitz, Attorney, Fenton Jurkowitz Law Group, LLP, represented respondent, Edward Joseph Erbe, M.D., who was present.

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on September 26, 2024. Personal identifying information in respondent's curriculum vitae was redacted after submission.

PROTECTIVE ORDER

A protective order has been issued sealing exhibits identified in the order. It is not practical to redact these documents. A reviewing court, parties to this matter, and a government agency decision maker or designee under Government Code section 11517 may review materials subject to the protective order provided that this material is protected from disclosure to the public.

FACTUAL FINDINGS

Licensing and Jurisdictional Background

1. The board issued Physician and Surgeon's Certificate No. G 76886 to respondent on April 11, 2018. That certificate was in full force and effect at all times herein and will expire on April 30, 2026, unless renewed. There is no history of discipline against that license.

2. The accusation was signed by complainant in his official capacity on October 2, 2023. Complainant alleged respondent violated Business and Professions Code sections 2227 and 2234, subdivision (b), when he committed gross negligence in his care and treatment of Patients A and B (First Cause for Discipline), and violated

Business and Professions Code sections 2227 and 2234, subdivision (c), when he engaged in repeated negligent acts during his care and treatment of Patient A (Second Cause for Discipline). Complainant requested discipline be imposed, and sought the costs of the investigation and enforcement of this matter. Notably, although the accusation contained various contentions made in the factual assertions, only four gross negligence allegations were made regarding Patient A (Paragraphs 29-32, inclusive), only one gross negligence allegation was made regarding Patient B (paragraph 56), and only one allegation regarding repeated negligent acts regarding respondent's care and treatment of Patient A was made (Paragraph 59). However, respondent did not object to the introduction of all of those opinions for failure to give notice as required by Government Code section 11503. He is deemed to have waived that argument and all opinions expressed at hearing are addressed herein.

3. Respondent timely submitted a notice of defense in which he asserted two affirmative defenses. He asserted the allegations were barred by the statute of limitations set forth in Business and Professions Code section 2230.5, and were barred by laches. Respondent bore the burden of proof for those affirmative defenses, but offered no evidence in support of them, and they are denied.

4. After the pleadings were filed, this hearing followed.

Respondent's Education, Experience, and Employment History

5. Respondent received a bachelor of arts degree in theological studies from St. Louis University in 1983. He received a bachelor of arts degree in biology from St. Louis University in 1985. He received his medical degree from St. Louis University School of Medicine in 1990. He completed a psychiatry internship from 1990 to 1991 and a psychiatry residency from 1981 to 1994, both at Walter Reed Army Medical

Center. Respondent was board certified in psychiatry by the American Board of Psychiatry and Neurology in 2017.

Respondent has been employed at Richard J. Donovan Correctional Facility (Donovan) since May 2021, where approximately 3,000 inmates have psychiatric diagnoses. Respondent treats the same conditions at Donovan that are at issue in this matter. He testified that if the board orders he be placed on probation, he would be terminated from Donovan because the terms of his contract require he have an unencumbered license.

Prior to working at Donovan, respondent was employed at California Health Care Facility for one year. Before that, he was a staff psychiatrist at Family Health Centers of San Diego for two years, where the two patients at issue herein were treated. From 2012 to 2018, he was the Medical Director at Western Montana Mental Health Center, and was a staff psychiatrist there from 2001 to 2018. From 1999 to 2001, respondent was a staff psychiatrist and intake coordinator at Samaritan Counseling and Education Center in Colorado. From 1998 until 1999, he provided psychotherapy and spiritual direction in a private practice setting at Spiritual Directions Counseling Services in Colorado. From 1997 to 1998, he was assigned to the 84th Medical Detachment at Fort Carson in Colorado, a combat stress control detachment unit whose main duty was to provide preventative and direct services for soldiers with battle fatigue, as well as traditional mental health services. In that role, respondent also served as Chief of Clinical Operations. He wrote the Standard Operating Procedures to guide clinical functions and served as the on-call psychiatrist at Irwin Army Community Hospital in Colorado.

In 1996, respondent served with the 84th Medical Detachment in Bosnia where he was the Officer in Charge and psychiatrist for a Combat Stress Control Prevention

Team, and served as the primary psychiatrist for the 212th Mobile Army Surgical Hospital, and chief psychiatrist for the inpatient psychiatric unit of the 84th Medical Detachment unit. From 1994 until 1995, he was the Department Chief of the Community Mental Health (Psychiatry) Service at Evans Army Community Hospital, where he also served on several committees, including the Quality Improvement Committee, Risk Management Committee, Utilization Management Committee, and Pharmacy Committee. Respondent provided psychiatric consultation to the Drug and Alcohol Treatment Program, performed fitness for duty evaluations, and provided outpatient psychiatric care. He also served as Chief of the Inpatient Psychiatry Service where his duties included evaluating and treating psychiatric inpatients.

6. Respondent testified about his background, including serving active duty in the U.S. Army for four years. He volunteered to be deployed to Bosnia, where he was in charge of the Combat Stress Detachment Team. He holds medical licenses from California, Montana and North Carolina, and has never had any issues or discipline other than this accusation.

Experts' Education, Experience, and Employment History

COMPLAINANT'S EXPERT'S QUALIFICATIONS

7. Complainant retained Jesse Koskey, M.D., a licensed psychiatrist, as his expert. Dr. Koskey was board certified as a psychiatrist by the American Board of Psychiatry and Neurology in 2019. Dr. Koskey received his bachelor of arts degree in studio art from Hope College in Michigan in 1998. In 2011, he graduated from the Postbaccalaureate Premedical Program at Columbia University College of Physicians and Surgeons in New York. Dr. Koskey testified that after working for a few years, he decided to go to medical school, so needed to attend this program to take the

required courses before he could apply to medical school. Dr. Koskey received his medical degree from Columbia University College of Physicians and Surgeons in 2015. He was a resident physician in psychiatry at New York University from 2015 to 2019.

From 2019 to 2021, Dr. Koskey was a residency core faculty member and staff psychiatrist for Kaiser Permanente in Oakland, California. From 2020 to 2021, he was a volunteer clinical faculty member of the University of California, San Francisco. He had a solo private practice in Elk Grove, California from 2021 to 2022. He was a clinical supervisor and clinical psychiatrist for Sensible Care in Santa Ana, California, from 2021 to 2022. Since 2022, he has been employed by the University of California, Davis (UC Davis), starting as an Assistant Professor of Clinical Psychiatry, and thereafter also serving as a Specialty Advisor in Psychiatry, beginning in 2023; serving as Co-Instructor of Record, Brain and Behavior, beginning in 2023; serving as Thread Director, Behavioral Health, since 2024; and serving as Director of Adult Psychiatric Services since 2024. Dr. Koskey has written numerous articles, participated in teaching activities, and given several presentations. His curriculum vitae also set forth the honors and awards he has received, the professional societies, and professional and community services in which he participates, the organizations with which he consults, and the scholarships and research he has received.

8. Dr. Koskey has been in a paid teaching position at University of California, Davis, since 2022. He testified that 50 percent of his practice involves caring for his own patients, the residents', trainees, or nurse practitioners' patients, and 50 percent of his practice involves academic and administrative work. Dr. Koskey had a 13 year gap between college and medical school, during which time he worked as an artist. He reviewed one case for the board before this matter. This is his first time testifying as a board expert.

9. Dr. Koskey authored a report, and a supplemental report, which identified reference materials he relied upon in formulating his opinions. He was familiar with the definitions of extreme and simple departures and the applicable standards of care. He testified consistent with his report, except for the opinions he withdrew, as noted below. While withdrawing his opinions demonstrated Dr. Koskey was an impartial witness, it also showed he had not carefully reviewed the records.

RESPONDENT'S EXPERT'S QUALIFICATIONS

10. Respondent retained Samuel I. Miles, M.D., Ph.D., a licensed psychiatrist, as his expert. Dr. Miles is board certified in psychiatry by the American Board of Psychiatry and Neurology, with certifications in general psychiatry, forensic psychiatry, and addiction psychiatry, having been recertified in the latter two specialties. Dr. Miles obtained his bachelor of science degree from the City College of New York in 1970, and his medical degree from New York Medical College in 1974. Dr. Miles did his internship from 1974 until 1975 at Georgetown Medical Service, D.C. General Hospital in Washington, and his residency in psychiatry at Cedars Sinai Medical Center from 1975 to 1978, serving as the Chief Resident from 1977 until 1978. Dr. Miles was a clinical associate from 1977 to 1986 at the Southern California Psychoanalytic Institute, obtaining his Ph.D. from that Institute in 1986. Dr. Miles has had a private practice in psychiatry since 1978. He served as an Assistant Clinical Professor of psychiatry at the University of California, Los Angeles School of Medicine from 1978 to 1997, and as an Associate Clinical Professor of psychology there from 1988 to the present. He was an instructor at the Southern California Psychoanalytic Institute from 1986 until 2005, and has been an Instructor at the New Center for Psychoanalysis since 2005. Since 1984, Dr. Miles has been an Independent Medical Examiner and a Qualified Medical Evaluator for the California Department of Industrial Relations. Since 1990, he has been

a member of the psychiatric panel for both the US District Court, Central District of California, and the Los Angeles County Superior Court. Dr. Miles was a subject matter expert for the California QME Examination for Cooperative Personnel Services.

At Cedars Sinai Medical Center, Dr. Miles has been an attending psychiatrist since 1978, and served on several committees, including the Medical Executive Committee from 2001 to 2005 and again from 2011 to 2014, the Pharmacy and Therapeutics Committee from 1980 to 1991, the Utilization Review Committee from 1990 to 1992, and the Quality Assurance Committee from 1983 to 1986. Dr. Miles also practices at the Department of Psychiatry and Behavioral Neuroscience, Cedars Sinai Medical Center, where he served as Clinical Chief from 2011 to 2014, Interim Chair in 2012, and Associate Clinical Chief from 1998 to 1999 and again from 2005 to 2010. He chaired, served, and serves on numerous committees there, including the Inpatient Performance Improvement Committee from 1995 to 1999, the Departmental Performance Improvement Committee since 1998, the Quality Assurance Committee from 1990 to 1992, the Quality Assurance and Utilization Review Committee from 1984 to 1989, the Consultation-Liaison Advisory Committee from 1986 to 1988, the Psychiatric Advisory Committee from 1984 to 1986, the Chemical Dependency Unit Advisory Committee from 1990 to 1992, and the Utilization Review Committee from 1990 to 1993. Dr. Miles is a member of several organizations, has published numerous articles, and received several honors and awards as documented in his curriculum vitae.

11. Dr. Miles authored a report and testified consistent with it at this hearing. Dr. Miles began consulting and doing forensic work in the 1980s. His teaching experience has included supervising psychiatric residents and fellows. Dr. Miles testified that in addition to the documents he reviewed, he also met with respondent,

asking him specific questions about his treatment of the two patients, and those answers also factored into his opinions, as referenced below. He was familiar with the definitions of extreme and simple departures and the applicable standards of care.

DSM-5 Excerpts

12. Complainant introduced excerpts from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,* (DSM-5),[2] a publication by the American Psychiatric Association for the classification of mental disorders using a common language and standard criteria. It is the main book used for the diagnosis and treatment of mental disorders. Complainant introduced excerpts from the DSM-5 which contained the diagnostic criteria that must be met in order to make diagnoses of Major Depressive Disorder, and Attention Deficit/Hyperactivity Disorder (ADHD).

MAJOR DEPRESSIVE DISORDER CRITERION

13. The DSM-5 identifies the diagnostic criteria required to make a diagnosis of major depressive disorder. The criteria are broken down into five sections. Criterion A requires five or more symptoms to be present during the same two-week period and represent a change from previous function, and at least one of the symptoms to be depressed mood or loss of interest or pleasure. The symptoms listed in Criterion A are (1) depressed mood most of the day, nearly every day; (2) markedly diminished

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[2] The DSM-5 was revised in 2022 and the current version is the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR). Respondent did not object to this older version being introduced and referenced, and no evidence was offered that the criteria complainant relied upon from the DSM-5 had changed in the DSM-5 TR.

interest or pleasure in activities most of the day nearly every day; (3) significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day; (4) insomnia or hyposomnia nearly every day; (5) psychomotor agitation or retardation nearly every day; (6) fatigue or loss of energy nearly every day; (7) feelings of worthlessness or excessive or inappropriate guilt nearly every day; (8) diminished ability to think or concentrate or indecisiveness nearly every day; and (9) recurrent thoughts of death, recurrent suicidal ideation without a specific plan, a suicide attempt, or a specific plan for committing suicide. Criterion B requires the symptoms to cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Criterion C requires that the episode not be attributable to the psychological effects of a substance or another medical condition. The DSM-5 states: "**Note**: criteria A-C represent a major depressive episode" (emphasis in original). Criterion D requires the major depressive episode to not be better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders. Criterion E requires there to never have been a manic episode or a hypomanic episode, but notes that this exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or attributable to the psychological effects of another medical condition.

ATTENTION DEFICIT HYPERACTIVITY DISORDER CRITERION

14. The DSM-5 identifies the diagnostic criteria required to make a diagnosis of ADHD. The criteria are broken down into five sections. Criterion A requires there be a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development as categorized by (1) inattention and/or (2) hyperactivity and impulsivity. Both categories require that for adults, five or more of several listed

symptoms in each section must have persisted for at least six months to a degree that is inconsistent with developmental level and negatively impacts directly on social and academic/occupational activities. Criterion B requires the symptoms to have been present prior to age 12. Criterion C requires that several of the symptoms be present in two or more settings. Criterion D requires there be clear evidence that the symptoms interfere with, reduce the quality of, social, academic, or occupational functioning. Criterion E requires that the symptoms not occur exclusively during the course of schizophrenia or another psychotic disorder, and not be better explained by another mental disorder.

Prescriber's Guide

15. Complainant introduced the Prescriber's Guide, Sixth Edition, written by Stephen Stahl. Dr. Koskey relied on this publication in rendering his opinions. Dr. Koskey testified this publication is an authority in the psychiatry field and its contents are consistent with the standard of care. Dr. Koskey relied on this publication in rendering his opinions regarding the dosages of medications respondent prescribed.

16. Dr. Miles opined he has seen this publication, but is not entirely familiar with, and it does not establish the standard of care. It is an educational material with cartoons associated with its text. The standard of care is defined as the kind of care a prudent practitioner uses and what Stahl puts in his guidebook is but one piece of the standard of care; no one specific document defines the standard of care, it is the way care is rendered in the community by prudent practitioners.

Evidence Regarding Patient A

17. Patient A's medical records, 2019 psychological evaluation, Department of Justice Controlled Substance Utilization Review and Evaluation System (CURES)

report, Walgreen's pharmacy profile, and death certificate, the transcript of Dr. Erbe's board interview, the investigation reports,[3] DSM-5 excerpts, and Stahl's Prescriber's Guide, as well as testimony from Dr. Erbe, the experts, and Patient A's mother were received in evidence. The following factual findings are based thereon. Of note, the records alternatively contained both the generic and the brand names of the drugs prescribed, and both will be used in the decision consistent with the records.

Patient A's 2019 Psychological Evaluation

18. Both experts had reviewed a psychological evaluation performed on June 11, 2019, by Raymond G. Murphy, Ph.D., when Patient A was incarcerated at Las Colinas. Dr. Murphy's report contained information contrary to what Patient A told respondent and others at the clinic, detailing Patient A's extensive psychotic history, including hearing voices and receiving directions from a demon, as well as her history of a suicide attempt, suicidal ideation, and psychiatric holds while incarcerated. Dr. Murphy also noted that Patient A was medicated "quite heavily" with two antipsychotic medications, one antidepressant (Trazodone), and two anti-anxiety medications, medications she did not disclose to respondent or others at the clinic, other than

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[3] The reports were received pursuant to *Lake v. Reed*, (1997) 16 Cal.4th 448, 461-464, which set forth how peace officer reports may be received. The report documented the timeline of the investigation. The summaries of interviews with witnesses who did not testify or discussions with individuals who did not testify did not overcome hearsay exceptions and may not be used to make factual findings. The summary of the interview with Patient A's mother, who testified in this hearing, was received as administrative hearsay pursuant to Government Code section 11513, subdivision (d).

Trazadone. Patient A also told Dr. Murphy why she was incarcerated, and gave a concerning alcohol and marijuana use history, all of which she did not share with respondent or anyone at the clinic.

19. As respondent credibly testified, had he been aware of this report or the information contained in it, he would not have prescribed Adderall to Patient A. However, it was not established that respondent ever saw this report, knew of its existence, or knew of any of the facts contained therein. As such, this report cannot be considered when evaluating respondent's treatment of Patient A. Moreover, Dr. Koskey referenced this report in his findings, calling into question his opinions as he seemed to have based them on information that was not available to respondent.

Patient A's Records from Family Health Centers of San Diego

20. The Family Health Centers of San Diego records for each visit were comprised of several documents, many of which contained similar entries.

JANUARY 2, 2020, VISIT WITH LCSW

Two-Page Note

21. Patient A was seen on January 2, 2020, by a Licensed Clinical Social Worker (LCSW) with a chief complaint of "Behavioral Health Assessment GAD7 Treatment Plan." Her vital signs were not taken and the subjective note entry states: "Patient History Entered on 12/30/2019." The history was noted to be hyperlipidemia (high cholesterol), anxiety, and major depressive disorder. The family history noted that Patient A's sister has "mental health concerns." Patient A's social history was that she lived in a hostel alone. She denied tobacco use, having quit in 2015 when she was smoking one-half a pack per day for 15 years. She drinks alcohol socially. She denied

drug use and uses marijuana "on rare occasion." She had gender reassignment surgery in 2010. The Active Problem List noted major depressive disorder. The Other Orders documented "No Diagnosis Code Nursing" and that nursing had completed the chief complaint.

GAD-7 Questionnaire

22. The GAD-7 questionnaire completed by Patient A on January 2, 2020, noted that for several days she felt nervous, anxious, or an edge, was not able to stop or control worrying, was worrying too much about different things, and was becoming easily annoyed or irritable. She denied being so restless that it was hard to sit still or feeling afraid that something awful might happen.

Client Treatment Plan

23. The January 2, 2020, Client Treatment Plan prepared by the LCSW was electronically signed by both the LCSW and Patient A. The LCSW gave Patient A initial diagnoses of unspecified depressive disorder, unspecified anxiety, rule out generalized anxiety disorder, major depressive disorder, recurrent episodes, persistent depressive disorder. Patient A's "Presenting Problems" were: "GAD7[4] = 5; PHQ9[5] 12/30 = 22;

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[4] The Generalized Anxiety Disorder 7-item scale is a widely used self-administered diagnostic tool designed to screen for and assess the severity of generalized anxiety disorder (GAD). Scores of 0-4 indicate minimal anxiety, scores of 5-9 indicate mild anxiety, scores of 10-14 imply moderate anxiety, and a score greater than 15 is a sign of severe anxiety.

[5] The Patient Health Questionnaire (PHQ-9) is a diagnostic tool used to screen adult patients in a primary care setting for the presence and severity of depression.

trouble getting going in the morning, lack of motivation, low energy level." Patient A felt some improvement with the change to Wellbutrin (Wellbutrin is the brand name for bupropion, an antidepressant.) She had antidepressants prescribed 20 years ago, and took them for less than one year. Her long term goal was "Improved mood. Finding work." Her current symptom was depressed mood. Her goals for treatment were PHQ9 was less than 15 [12/30]. The intervention/types of services would be medication management by psychiatry, a behavioral health assessment with updates every six months or sooner. Patient A agreed to attend appointments and report on her progress and medication adherence. The timeframe for treatment was six months. No barriers or obstacles were reported. Patient A's strengths/abilities were listed as "intelligent, resourceful, insightful."

Columbia-Suicide Severity Rating Scale

24. A Columbia-Suicide Severity Rating Scale completed by Patient A indicated that in the past month she had not wished she was dead or wished to go to sleep and not wake up. She had no thoughts of killing herself. In her lifetime she had never done anything to end her life. (As was later learned, this was incorrect, but respondent never learned of Patient A's prior suicide attempts or suicidal ideation until after her death.) The LCSW noted that no crisis intervention plan was created because Patient A was at "No Risk" for suicide. Patient A reported she had family out of state and friends in San Diego who were supportive. She had no history of suicidal ideation or suicidal ideation behavior. She had no current suicidal ideation, homicidal ideation,

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Scores of 0 to 4 indicate none to minimal depression, scores of 5 to 9 indicate mild depression, scores of 10 to 14 indicate moderate depression, scores of 15 to 19 indicate moderately severe depression, scores of 20 to 27 indicate severe depression.

AH or VH (acronyms not explained). The Access and Crisis phone number was provided to her.

Adult Behavioral Health Assessment

25. A January 2, 2020, Adult Behavioral Health Assessment documented an initial therapy interview/assessment of Patient A, who was the source of the information obtained. Electronic health records were reviewed and the referral source was Patient A's primary care provider. The "Presenting Problem" section documented: "GAD7 = 5; PHQ9 12/30 = 22"; Patient A presented for mental health intake and referral to psychiatry. She reported having trouble getting going in the morning, lack of motivation, and low energy level. She felt some improvement with the change to Wellbutrin. She had antidepressants prescribed 20 years ago out of state, but did not recall the name. She did not remember how long she took them, but stated it was less than one year. Her only mental health treatment has been while she was in jail at Las Colinas Detention Center (Las Colinas) for about two years, where she saw a therapist. She declined to share details about the incident leading to her arrest/jail time. She was not interested in therapy at this time, but would like to think about it. She was working with the LGBT center to find a place that was able to prescribe her needed medications in one location. She saw someone at SVDP Health Center who was able to give her [hormone replacement therapy] and her psychotropic medications, but would not prescribe Wellbutrin due to the "street value." The duration of her symptoms had been over one year. She declined to share her trauma history.

The Safety Assessment part of the assessment documented that no domestic violence was reported. There were no suicide attempts. No self-injurious behavior, fleeting thoughts, passive suicidal ideation, active suicidal ideation, or homicidal ideation were reported. Patient A denied suicidal ideation, homicidal ideation, AH/VH

(acronyms not explained). The Substance Use Information section documented that none was reported. The Medical History referred to the electronic records and the medication section stated: "titrate down on Zoloft. [Patient A] states Trazodone while in jail." (Zoloft is the brand name for sertraline, a selective serotonin reuptake inhibitor (SSRI) used to treat depression, SSRIs are a class of drugs typically used as antidepressants; Trazadone is an antidepressant often also used to treat insomnia due to its sedating effects.) The Mental Health History section documented that Patient A's Las Colinas records were requested by her primary care provider. She was noted to be compliant with her psychotropic medications, and was referred to respondent for a psychiatric evaluation.

The Mental Health Status Exam of the assessment documented that Patient A's level of consciousness was alert and lethargic [*sic*], she was oriented times four, she had good hygiene, age-appropriate dress, normal weight, soft speech, coherent and concrete thought process. Her behavior was guarded, her affect was flat, her intellect was average, her mood was dysphoric and depressed, her memory was normal, her motor was slowed, and her judgment and insight were both age-appropriate. An entry in the "Other observations" section noted that Patient A commented that she had only seen a nurse practitioner, not a doctor, and was hesitant to see a psychiatrist because she would rather see a general practitioner who could prescribe all her medications.

Patient A's diagnoses were unspecified depressive disorder, unspecified anxiety, and rule out generalized anxiety disorder, major depressive disorder, recurrent episodes, and persistent depressive disorder. Her strengths were that she was intelligent and resourceful. Her family was out of state, supportive, but not involved. She declined services/referrals at this time. The recommended treatment was referral to the psychiatry department for medication management and visits every one to

three months for the next six months. The anticipated goal was improved mood through use of medication.

The Adult Medi-Cal Mental Health Severity Analysis section documented that Patient A's risk level was "N/A." Her clinical complexity was "moderate," meaning she had schizophrenia, major mood or anxiety disorder-stable on medications, baseline function, sustained recovery; prior history of effective treatment, uncomplicated management; minimal cognitive impairment; no recent hospitalizations; and/or alcohol or drug disorder misuse. Her life circumstances were "mild," meaning she had emotional distress arising in the course of normal life stresses, adequately resourced and supported, and/or resilient. The benefit of integrated care was "high," meaning already established, effective care in primary care setting for chronic stable medical plus co-occurring mild mental illness/emotional distress.

Informed Consent

26. On January 2, 2020, Patient A initialed and signed the Informed Consent for Mental Health Treatment and Acceptance of Program Standards form, agreeing to comply with Family Health Centers of San Diego's requirements regarding treatment.

JANUARY 10, 2020, FIRST VISIT WITH RESPONDENT

Two-Page Note

27. Patient A first saw respondent on January 10, 2020, when she was 38 years old. The Chief Complaint stated Patient A was here for mental health medication evaluation and also stated "See [behavioral health assessment dated January 2, 2020]." Patient A's vital signs were taken and the "Subjective" section was the same as referenced above. Respondent testified that the social history documenting Patient A

denied tobacco use having quit in 2015 when she was smoking one-half a pack per day for 15 years, drinks alcohol socially, denied drug use, and uses marijuana "on rare occasion" referred to past history for tobacco, alcohol, and drug use; not current usage. However, the entry was written in the present tense, and clearly showed a present use of alcohol socially and a present use of marijuana on rare occasion.

The Active Problem List contained a diagnosis of major depressive disorder. Respondent prescribed bupropion hydrochloride XL 300 mg every 24 hours. Respondent was now increasing the dose from 150 mg QAM (every morning) to 300 mg QAM, one tablet to be taken orally every morning. He was also prescribing Trazodone hydrochloride 100 mg, two tablets to be taken orally at bedtime. The Other Orders section documented a "No Diagnosis Code Nursing," and that nursing staff had taken Patient A's chief complaints and vital signs.

Psychiatric Medication Evaluation

28. Patient A self-referred for a chief complaint of "My depression and anxiety." In the History section, respondent documented that he began with a review of the electronic health records. Patient a was a 38-year-old transgender male/female woman with depression and concentration problems. She took sertraline 200 mg every morning in the year prior to December 30, 2019. On December 30, 2019, bupropion XL 150 mg every morning was started and her sertraline was reduced to 100 mg every morning for one week, and then stopped. "She asked to go back on Trazodone but her [primary care provider] was concerned about serotonin syndrome and deferred this question to [respondent]." Patient A was given melatonin 5-10 mg QHS (take at bedtime) for her poor sleep. She was referred to the clinic's Transgender Clinic. During the Behavior Health Analysis performed on January 2, 2020, Patient A "would not discuss if there was any history of trauma." Patient A reported she had not noticed

much benefit from the bupropion. She rated her mood at a six on a scale of 10, with 10 being the worst depression she could imagine and zero being no depression. She had no thoughts of wanting to die. The past week she was able to continue in her housing and found part-time work. Most of the time, her anxiety was high. She did not think she was less anxious on the sertraline. She might have panic attacks. On a typical night she got six hours of sleep. She previously had a good response to Trazodone. Respondent planned to add back Trazodone 200 mg QHS. Patient A had several episodes of severe depression. She and respondent discussed either adding back the sertraline to reduce her anxiety and depression, or increasing the bupropion, and Patient A wanted to increase the bupropion.

29. In the Drug Abuse section, respondent documented that Patient A "has never been addicted to alcohol or street drugs." She had no past psychiatric history other than as noted in History and Social/Developmental History. She had no known allergies and had taken medication for her hypercholesterolemia in the past. The social/developmental history was the same as noted in the other visits, and a family history was not obtained.

In the Mental Status Exam section, respondent documented that Patient A was cooperative, made appropriate eye contact, her speech was within normal limits, her language was articulate, her thought process was linear, her associations were appropriate, her thought content was normal, she had no delusions, no suicidal ideation, and no homicidal ideation. Her judgment/insight, fund of knowledge, attention span/concentration, and recent/remote memory were all appropriate. Her mood/affect was flat.

Respondent diagnosed major depressive disorder, recurrent, moderate. In the Plan section, respondent documented: "Problem #1 Depression: Fluoxetine brought a

few weeks of improvement in energy and motivation, but then seemed to stop working." (Fluoxetine, brand name Prozac, is used to treat depression and panic attacks.) "Sertraline did not do much to improve energy for motivation. If [Patient A] had a partial response to the full dose of bupropion, we may add citalopram or escitalopram." (Citalopram, brand name Celexa, is used to treat major depressive disorder. Escitalopram, brand name Lexapro, is used to treat depression and anxiety.) "Increase bupropion XL to 300 mg QAM. Problem #3 [*sic*] Insomnia: Start Trazodone 200 mg QHS." Patient A would follow up in four weeks.

30. In the Adult Medi-Cal Mental Health Severity Analysis section, respondent documented that Patient A's risk level was "moderate," meaning she had passive ideation or low-level active with danger to self/danger to others history; rare loss of impulse control, mid-level nonviolent arrests, brief jail time; fair insight and/or ego dystonic. Respondent documented that Patient A's clinical complexity was "moderate," and her life circumstances were "moderate," meaning she had intermittent emotional distress as a manifestation of a mental illness which has worsened by life stresses; limited resources and support; and/or strained resilience. He documented that the benefit of integrated care was "medium," meaning high medical, low behavioral and/or high behavioral low medical.

Respondent's Testimony About January 10, 2020, Visit

31. Patient A was first seen by a nurse practitioner who referred her to an LCSW for a behavior health assessment. The patient was then referred to respondent. Respondent testified that he interpreted the entry that respondent used marijuana on rare occasion and used alcohol socially as past usage, not current use. Respondent reviewed all of the prior clinic records and explained that the markings he entered in the chart, "* * *," were to distinguish the information he obtained from his records

review from what he obtained from his patient interview. Respondent also reviewed nurse practitioner notes that, for some unknown reason, were not in the medical records produced in discovery or provided at this hearing. Respondent testified about information he obtained from those notes, which he documented in his records, and no evidence refuted that testimony.

Respondent noted the medications Patient A reported to the LCSW. Other than what was noted in the chart, Patient A did not disclose any other mental health issues to the LCSW or respondent other than major depressive disorder. Patient A did not tell respondent she was taking antipsychotic medications. From the LCSW's notes, respondent was aware that Patient A was not using substances and he confirmed that she was not addicted to alcohol or street drugs when he first saw her. He had no reason to suspect her symptoms were due to either a use or misuse of drugs. She did not appear to be using or be addicted to alcohol or street drugs. He had no reason to think there was a connection between her past use and her current symptoms.

Respondent reviewed the records, and asked Patient A questions. The medical history he documented was based on his records review and discussions Patient A. He asked her about delusions which is why he checked the "No" box. In his discussions with Patient A, nothing about her presentation suggested she was delusional, and there was no indication she had ever had psychosis. He has treated patients who have psychoses, and knows how to identify the symptoms. Patient A did not present with psychotic symptoms, and her flat affect suggested depression.

Regarding the dose of Trazodone he prescribed, it was a dose Patient A took before, tolerated well, and was effective in treating her condition. Respondent could have started her at 50 mg, which he normally does with patients, but he did not see a reason to delay treating the sleep problems Patient A was having. She was very tired,

and lethargic, so respondent thought he would get her on a dose that worked. Psychiatrists should listen to patients and support what they say. He had no concerns regarding prescribing 200 mg; he has found many patients who require that amount to treat their symptoms. It is not a large dose and Trazodone can be dosed up to 400 mg per day. Recent studies started patients at 150 mg, so 200 mg was "not outside of that ballpark."

Patient A also reported having high anxiety levels, which respondent thought could be panic attacks. He discussed Zoloft and Wellbutrin, but Wellbutrin only treats depression, so he would need a combination of medications to treat Patient A's anxiety and depression. Patient A preferred to increase her Wellbutrin, and not take Zoloft, which she reported did not do much for her condition. Respondent stated that 300 mg of Wellbutrin is a "middle dose," the maximum is 400 mg, and if Patient A got to that level, respondent could have added another medication.

When respondent first saw Patient A, she disclosed a prior Trazodone prescription, but was not currently taking it. The only antidepressant she disclosed taking was Zoloft during the prior year, which respondent took to mean she had depressive symptoms for at least one year. Respondent discussed with Patient A her past depressive episodes, and she revealed several episodes of severe depression over the course of her lifetime. When asked about current use of drugs or alcohol, none were reported. The clinic requested the patient's prior records from Las Colinas, but to respondent's knowledge, they were never produced, and all he had available when he began treating Patient A were the clinic records which contained the information Patient A told the LCSW.

During the mental health status exam, respondent noted that Patient A was both alert and lethargic, which was before she was taking Trazodone. He explained

that lethargy can be a symptom of depression; it is a tiredness that affects one's ability to concentrate. Patient A also had soft speech which can be a sign of depression. She had a flat affect which can also be a sign of depression. Her mood was dysphoric and her motor was slowed, the latter of which can be a significant sign of depression, and is one of the DSM-5 criterion. At no time did Patient A have serotonin syndrome (a serious drug reaction caused by medications that increase serotonin levels), and she was never prescribed sufficient medications to cause that syndrome. Respondent does not see a problem with prescribing both Zoloft and Trazodone to patients.

Respondent noted that Patient A was unwilling to discuss her history of trauma. Given her depression while on Wellbutrin, and that she was being tapered off Zoloft, it was important to get information regarding her depression, which respondent did. He discussed with Patient A adding back the Zoloft since her anxiety was increasing and adding Trazodone at a 200 mg dose, which she reported worked in the past, was appropriate. Respondent normally starts patients at 50 mg, but thought it would be reasonable to add it back at 200 mg. Patient A never mentioned taking any other medications. The only symptoms she discussed were depression and sleep issues. Respondent testified that the standard of care did not require him to get any additional information to rule out bipolar disorder, hallucinations, or delusions and, based on the history, chief complaints, and all the information he had, the only diagnoses that were pertinent were depression, sleep problems, and, later, ADHD.

Respondent also explained his records-keeping method. He testified that the problems listed in the records often referred to past medical histories or patient reports, which was his way to keep track of patients' conditions at each visit.

JANUARY 30, 2020, VISIT WITH RESPONDENT

Two-Page Note

32. Patient A next saw respondent on January 30, 2020. Her vital signs were taken, and her Chief Complaint was "[Mental Health] Medication Follow-Up." The Subjective note was the same at the prior visit. The Active Problem List contained a diagnosis of anxiety for which respondent prescribed Venlafaxine ER - 75 mg oral, one tablet to be taken each morning for two weeks, then switch to 150 mg capsule, one tablet to be taken orally each morning for two weeks, then switch to Venlafaxine ER 150 mg, one capsule to be taken every morning. (Venlafaxine, brand name Effexor, is used to treat depression.) The "Other Orders" documented "No Diagnosis Code Nursing" and that Nursing had completed the chief complaint and taken the vitals.

Psychiatric Medication Follow-Up

33. Patient A's chief complaint was: "The bupropion is making me dizzy and nauseated." In the Interval History section, respondent documented he would check Patient A's thyroid stimulating hormone (TSH) at her next appointment. She had nausea and dizziness with the starting dose of bupropion XL. When she increased to 300 mg each morning, those side effects worsened, and she stopped the bupropion. The Trazodone was helping her sleep, but she now said, "I need to sleep all the time." Patient A asked about venlafaxine, which respondent noted "is the only good option as she has failed fluoxetine and sertraline and now the bupropion." Respondent discussed "common side effects and common risks of venlafaxine," and discussed venlafaxine continuation syndrome. Patient A's social history was the same as previously documented. None of the boxes under Medication Side Effects were checked, but the box for Drug Abuse was checked "No." A review of systems was not

performed. The Mental Status Exam portion of the Interval History was the same as at the January 10, 2020, visit, but Patient A's mood/affect at this visit was restricted.

Respondent diagnosed major depressive disorder, recurrent, moderate. He noted as his Assessment, "[i]t would be reasonable to try venlafaxine given 2 failures with SSRI's and side effects to the bupropion." The Plan section stated: "Problem #1 Depression: Fluoxetine and sertraline did not significantly improve energy or motivation. Bupropion caused nausea and dizziness. Start venlafaxine ER 75 mg QAM for 2 weeks, then 150 mg QAM thereafter. At the next appointment I will check for TSH. Problem #3 [*sic*] Insomnia: Continue Trazodone 200 mg QHS." None of the Medication Side Effects boxes were checked. The Drug Abuse "No" box was checked. A review of systems was not performed. The Diagnosis and Assessment/Plan sections contained the same information as listed in the Interval History. The patient was noted to be compliant and would follow up in four weeks. In the Adult Medi-Cal Mental Health Severity Analysis section, respondent documented that Patient A's risk level, clinical complexity, and life circumstances were "moderate," and her benefit of integrated care was "medium."

FEBRUARY 25, 2020, VISIT WITH RESPONDENT

Two-Page Note

34. Patient A saw respondent again on February 25, 2020. Her vital signs were taken, but the chief complaint section on this document was blank. The subjective note was the same at prior visits. The Active Problem list noted ADHD, Predominantly Inattentive Type, and Insomnia. Respondent prescribed Adderall 20 mg oral, one tablet to be taken twice a day with at least four hours between the first and

second dose for Patient A's ADHD. For her insomnia, respondent ordered labs to assess Patient A's TSH.

Psychiatric Medication Follow-Up Note

35. Patient A's chief complaint was: "The new medication isn't doing anything." In the Interval History section, respondent documented that Patient A "continues to sleep 10-12 hours per day. Sometimes she sleeps 16 hours every 24 hours." She "does not snore, does not wake up gasping for air and has never been told she stops breathing at night." Patient A "continues to have very low interest, very low motivation and very low energy." Respondent noted that he would check Patient A's TSH today. Patient A asked respondent if he would consider prescribing modafinil, and he "would, but the problem is that insurance will not pay for it." Patient A was "having difficulty concentrating" and reported being prescribed Ritalin when she was six years old. Respondent "ask[ed] about symptoms of ADHD. The patient reports a history of often making careless mistakes, sometimes having difficulty with attention to detail, difficulty with follow through, sometimes losing things, often forgetful, difficulty staying organized, and is easily distracted." Respondent thought the patient "has ADHD" and suggested "trying Adderall."

Respondent's Interval History contained a Social History in which respondent documented that Patient A's parents separated when she was 15, and she felt both neglected and loved her. She stopped high school to work. She reported being molested by several men beginning at age 8 until age 15. She currently worked at the hostel where she lives. She received food stamps, and her family provided some financial support. She denied medication side effects, and denied drug abuse. A review of systems was not performed.

Patient A's Mental Status Exam was the same as documented above, but her mood/affect was restricted. Patient A was compliant and would follow up in four weeks. Respondent diagnosed major depressive disorder, recurrent, moderate, and ADHD, inattentive. Patient A's pertinent medical history was hypercholesterolemia. Respondent's assessment was: "It would be reasonable to try adding a stimulant for her ADHD. I also hope it may augment the venlafaxine and improve interest and motivation." Respondent's Plan identified three problems. "Problem #1 Lack of Energy/Lack of Interest/Lack of Motivation: Sleep apnea has been ruled out because [Patient A] does not snore, does not wake up gasping for air and has never been told that she stops breathing at night. Fluoxetine and sertraline did not significantly improve energy or motivation. Buspirone caused nausea and dizziness. Continue venlafaxine ER 150 mg QAM." "Problem #2 reduced Concentration: Start Adderall 20 mg at 8 AM and 20 mg at noon; #60; No [refills]." "Problem #3 insomnia: Continue Trazodone 200 mg QHS." "Addendum: A Controlled Substance Agreement . . ." Patient A denied medication side effects and drug abuse. A review of systems was not performed. Respondent's Diagnosis and Plan/Assessment section were duplicative of the entries in the Interval History section. Patient A was noted to be compliant. In the Adult Medi-Cal Mental Health Severity Analysis section respondent documented that Patient A's risk level, clinical complexity, and life circumstances were "moderate," and her benefit of integrated care was "medium."

CURES 2.0 Note

36. Respondent documented his review of the CURES database for the period of February 25, 2019, through February 25, 2020, "with negative results," meaning no controlled substances were noted.

Prescription Drug Prior Authorization

37. A Prescription Drug form documented that respondent ordered a new therapy of Adderall, 20 mg to be given twice a day, 60 pills, with refills for 12 months. The diagnoses listed were anxiety, major depressive disorder, history of tobacco use, insomnia, male to female transsexual, hyperlipidemia, and ADHD, predominantly inattentive type.

Lab Results

38. The lab results for Patient A's TSH were normal.

Testimony of January and February 2020 visits

39. Respondent testified that Patient A was doing much better in January and February 2020. She reported feeling trust towards her mother and improving. However, after several weeks, there was deterioration, guardedness, and a worsening of her depression. Respondent explained that if he knew she was taking or had been prescribed antipsychotic medications, he would have increased the Wellbutrin or added Zoloft, as these medications do well as antidepressants and antipsychotics. He would not have added Adderall. Patient A was not upfront and honest about her medical history, and never reported a psychotic history. At the January 30, 2020, visit, Patient A reported dizziness and other symptoms that could be associated with low thyroid which is why respondent wanted to check her TSH.

Patient A also reported the desire to sleep all the time which is a known side effect of Trazodone. Respondent explained that he has been prescribing Trazodone for over 30 years, and half of his patients report tiredness on it. He suggested decreasing her dosage but she was not willing to do that, but he does not recall why. He was

willing to go with what Patient A wanted, and his "guess was she needed that, it was the dose she needed to work." She had also stopped her antidepressants and having depression and stopping the medication could be the reason why she was sleeping. Prior to his first office visit with her, Patient A reported decreased energy and lethargy, so her sleeping complaints predated respondent's prescription for Trazodone. He discussed Venlafaxine, an antidepressant commonly known as Effexor, with respondent and started her at 75 mg for two weeks then increased it to 150 mg.

At these visits, Patient A had no signs or characteristics of psychosis. Respondent explained that when antidepressants are started, typically changes are not seen for at least four weeks. This is why the plan at the January 2020 visit was to follow up with Patient A in four weeks and check her thyroid at that next visit.

40. At his third and final visit with Patient A on February 25, 2020, she said the Effexor was "doing nothing." Patient A was failing treatment with Prozac, Zoloft, Wellbutrin, and now Effexor had not worked. She had low interest, low energy, and low motivation which was very concerning to respondent. It was important for him to consider a differential diagnosis, and he was asking himself if major depressive disorder fully explained all Patient A's symptoms, and if there was anything else he should consider. He discussed with Patient A her difficulty concentrating which made him start thinking ADHD might also explain her symptoms. Patient A disclosed having Ritalin prescribed at age six for ADHD. (Ritalin is the brand name for methylphenidate, a central nervous stimulant used to treat ADHD.) Ritalin is only indicated in children for ADHD or narcolepsy, the latter which respondent did not have, so it was reasonable to conclude her Ritalin had been prescribed for ADHD.

41. Respondent and Patient A discussed her current symptoms, which he documented. Respondent was convinced that Patient A had major depressive disorder

and ADHD, so he discussed prescribing Adderall with her, discussing the risks of Adderall, and got her informed consent to start that medication.

42. Respondent testified that "absolutely not" would he have prescribed Adderall if he knew when treating Patient A of Patient A's antipsychotic medication history or history of psychosis, because Adderall can increase psychotic symptoms. However, Patient A never reported her psychotic history or history of being prescribed antipsychotic medications to respondent or anyone at the clinic. At his last visit with Patient A, respondent also considered sleep apnea as contributing to her symptoms, but that was unlikely given her responses to his questions about sleep apnea. Respondent ordered the TSH lab test, which was normal, so Patient A's thyroid was not a reason for her low energy and tiredness.

At the February 2020 visit, respondent rewrote Problem #1 because he was not successful in treating Patient A's depression, so he changed the problem from depression to "lack of energy, lack of interest, lack of motivation" because those were the most distressing aspects of Patient A's depression. He added a diagnosis of ADHD, explaining that Patient A met the DSM-5 criteria of having ADHD before age 12 given the Ritalin prescription at age six. Respondent testified that Patient A did not "grow out" of ADHD. She had symptoms as an adult. Respondent normally prescribes Adderall doses of 10 mg two times per day for uncomplicated patients with ADHD, but Patient A was not an uncomplicated patient as she also had major depressive disorder, as a result, he did not think 10 mg was enough.

43. Respondent thought the minimum dose of 20 mg twice a day to address Patient A's ADHD and augment the prescribed Effexor was appropriate. Respondent referenced studies discussing appropriate Adderall dosages based on patient weight, and noted his dosage fell within those studies. However, respondent acknowledged

that Patient A would have been excluded from the studies because was currently using other psychotropic medications, and in another study subjects underwent testing which was not performed on Patient A. He also acknowledged that one study had a relatively small subject size, had not been conducted in the "real world," and another study discussed a gradual increase in dosage. However, he explained that the significance of the studies is that they discuss how higher doses of stimulants may be needed for adults, which was part of the reason why he prescribed the dose he did.

Death Certificate

44. On March 7, 2020, respondent died by suicide.

Patient A's Mother's Testimony

45. Patient A's mother testified about her daughter's mental illness, including her troubling behaviors beginning in the "early 2010s." She described "out of the ordinary" statements her daughter made, many of which were "very delusional" and included reports of hearing voices. She described the psychiatric treatment her daughter received while incarcerated, which gave Patient A "moments of clarity" for the first time in years. She described how they repaired their relationship once Patient A was released from custody, and the almost daily phone calls they had.

However, beginning in February 2020, Patient A's mother began noticing concerning behaviors beginning again. Patient A's mother testified about statements Patient A made to her, and how she told Patient A to notify respondent about the behavioral changes she was experiencing after being prescribed Adderall. However, she admitted that she does not know if respondent ever notified respondent about those behavioral changes, does not know if Patient A told respondent or others at the clinic why she had been incarcerated, and does not know if Patient A gave respondent

her complete psychiatric history, including the "out of the ordinary" statements Patient A made, many of which were "very delusional" and included reports of hearing voices. Patient A's mother does not know if respondent was aware of her behavior, her mental health conditions, or all the medication she had been prescribed while incarcerated.

Accordingly, it was not established that respondent was aware of any of the events Patient A's mother testified about, including her experiences after respondent prescribed Adderall to her. As such, complainant did not establish that respondent was aware of any of the information regarding Patient A's psychoses, psychotic behaviors, or antipsychotic medication prescriptions, and none of that information can be used in evaluating the causes for discipline alleged against him. In fact, respondent's unrefuted testimony was that Patient A either refused, or failed, to share her history with him or anyone at the clinic.

Opinions Regarding Patient A's Care

INADEQUATE PSYCHIATRIC HISTORY ALLEGATION

46. Complainant alleged that respondent committed gross negligence by failing to take or document and adequate psychiatric history.

Dr. Koskey's Opinions regarding Inadequate History

47. Dr. Koskey testified that the standard of care for taking a history requires learning the history of the patient in as much detail as possible or is reasonable. This includes learning how the patient is doing currently, including asking about a past medical history and allergies, medical issues, family history, and social history. These are important because they have a bearing on how the patient is currently doing. In

psychiatry, there is no objective testing that can be performed, so it is important to understand what the patient is saying in the context of the patient's past experiences.

48. Dr. Koskey noted there are medical records at respondent's clinic that predated his office visit with Patient A, testifying that the January 2, 2020, LCSW note documented that Patient A worked with psychiatrists in the past, and was provided with crisis management resources in the community. The LCSW also documented legal issues, including arrests and incarceration, and that a prior prescription for Wellbutrin, an antidepressant, was not provided given a concern regarding its street value in the jail setting. Dr. Koskey opined that respondent did not ask enough questions at his initial January 10, 2020, office visit to take a complete psychiatric history.

49. While he may have learned some information from the electronic health record, it was incumbent upon him to ask questions, including questions about prior hospitalizations, outpatient treatment, prescriptions, social, legal and medical histories. Patient A had reported risk factors, including arrests, incarceration, alcohol/marijuana use, and the reluctance of a physician to provide medication due to its street value, although Dr. Koskey acknowledged there is no indication when the comment regarding Wellbutrin having a street value was made. In any event, respondent would have wanted to ask questions about those things himself to understand Patient A's current state, especially since drugs or alcohol can "color symptoms that seem like sleep or mood disorders." Respondent's failure to do so was an extreme departure from the standard of care because he did not really ask any of the basic questions used to establish a psychiatric history.

50. Dr. Koskey wrote in his report that prescribing antidepressants to someone with a bipolar disorder, prescribing stimulants to someone with a history of psychotic disorder, or prescribing controlled substances to someone with a substance

use disorder, may worsen symptoms. Because substance use and withdrawal can mimic the symptoms of mood, anxiety and psychotic disorders, it is important to assess for any historical relationship between substances and symptoms. Taking a complete psychiatric history for all new patients is the standard of care. Questions include asking new patients about prior diagnoses, symptoms, and treatments, including hospitalizations, prior medications, dosages, benefits, side effects, suicide attempts, drug abuse, substance use disorder diagnoses, drug treatment, substance abuse, onset of use, and history of withdrawals or overdoses. When the prior medical records are available, a psychiatrist should review those to be further informed about the patient's psychiatric history.

51. Dr. Koskey opined that at respondent's first appointment with Patient A on January 10, 2020, he documented that he reviewed the electronic health record. He documented Patient A's psychiatric history as "none other than [as documented] in History and Social/Developmental History." Those sections of respondent's note do not indicate that he asked sufficient questions to establish a psychiatric history. Although Patient A did not disclose her history of bipolar disorder, psychosis, psychiatric hospitalization, suicide attempts, and violence, she did disclose she was an occasional user of alcohol and cannabis, had been arrested and incarcerated, was on probation, that prior prescribers had concerns about writing prescriptions with a street value, and that she suffered from depressed symptoms in the past. At a minimum, these revelations should have prompted respondent to rule in or out historical substance abuse problems, episodes of major depressive disorder or bipolar disorder, and investigate any potential link between depressed symptoms and substance use. Instead, respondent simply noted that Patient A had "never been addicted to alcohol or street drugs." Respondent did not ask the questions necessary to distinguish between occasional substance use and addiction, nor did he ask for details about prior

mood episodes. As such, respondent failed to take the basic elements of a psychiatric history which was an extreme departure from the standard of care.

52. Dr. Koskey opined that respondent did not follow up on facts he learned from the records or that Patient A provided. There was no mental health treatment given to her other than prescribing antidepressants. Even before Patient A was prescribed Trazodone, she had difficulty getting going, low energy, and a lack of motivation. Dr. Koskey agrees that physicians can review other treaters' documents, but this is no substitute for the physician asking his own questions. The LCSW is not a physician. Respondent would want to understand these things himself before making a diagnosis. Respondent should be asking these questions himself, not relying on LCSW notes. The Behavioral Health Assessment documented the duration of the symptoms was over one year.

53. Dr. Koskey opined that respondent did not take into account that substance use could be the reason for Patient A's symptoms or exacerbations. However, he acknowledged that given the documentation in the records of "no use" of substances, there was no evidence Patient A was currently using any substances when respondent saw her. However, because Patient A had a history of some substance use, respondent should have asked her questions about substance use as sometimes patients feel uncomfortable disclosing information to non-physicians. Dr. Koskey agreed there was no evidence in the records of substance use, but given Patient A's prior history, he felt there "was a very real chance" Patient A was presently using substances. Although Dr. Koskey acknowledged that even though the records showed past use and no current use or addiction, respondent should still have done more to rule out substances as the cause of Patient A's symptoms, especially as she was only

willing to disclose some of her prior history, and not being addicted to a substance does not rule out that the patient is not using alcohol or street drugs.

54. The fact that the LCSW documented that no substance use was reported, does not change Dr. Koskey's opinion that respondent should have been asking these questions himself. Even though Patient A did not provide a complete psychiatric history, it is still incumbent on respondent to ask those questions. Dr. Koskey then referenced Dr. Murphy's report documenting Patient A's extensive psychiatric history, but again, there was no showing respondent was aware of this report or any of the information contained therein.

Dr. Miles's Opinions regarding Inadequate History

55. Dr. Miles opined that respondent's records document the elements of an adequate psychiatric history, including required diagnostic criteria for diagnosing major depressive disorder. Dr. Koskey's criticisms regarding failing to document an adequate psychiatric history were that respondent failed to rule in or rule out substance-abuse problems, and failed to rule in or rule out episodes of bipolar disorder or discuss auditory hallucinations and paranoid delusions. Regarding the first criticism, the LCSW in the Behavior Health Assessment documented that no concern regarding Patient A's use of substances was reported. At his first visit with Patient A, respondent documented that she reported she had never been addicted to alcohol or street drugs. The standard of care did not require respondent to do anything further, other than periodically monitoring Patient A, which he did.

56. As to the criticism that respondent failed to document bipolar disorder/auditory hallucinations, or paranoid delusions, Dr. Miles opined that there is no mention of treatment for these three conditions in the LCSW's notes, physician

assistant notes, or by respondent. Patient A told health care providers at the clinic some of her past psychiatric history, and some of the medications she was previously prescribed, but was not forthright about all of her past psychiatric history and past psychiatric treatment. She denied she was ever hospitalized psychiatrically or that she had mental treatment outside of jail, except for a time 20 years earlier when she was treated for less than a year for depression. The Las Colinas records were never provided to respondent or the clinic while Patient A was receiving treatment there.

57. Thus, Dr. Miles opined it is unlikely Patient A ever had an episode of mania necessary for a diagnosis of bipolar disorder. Although complainant may have learned of Patient A's past psychotic symptoms during discovery, Patient A did not disclose those symptoms to respondent or anyone at the clinic and, likewise, when describing her treatment at Las Colinas, she discussed sertraline, an antidepressant, and Trazodone, a sedating antidepressant, but did not reveal the antipsychotics that had also been prescribed there. Further, Patient A refused to discuss the circumstances that led to her arrest and was only willing to talk about her depression, sleep, and concentration problems. Dr. Miles opined that respondent could not be reasonably blamed for Patient A's failure to adequately report her past history. Based upon Patient A's presentation and disclosures, the standard of care did not require respondent to engage in any further documentation of ruling in or out bipolar disorder, auditory hallucinations, or paranoid delusions.

58. Dr. Miles testified that respondent's records contain the elements of an adequate psychiatric history and met the standard of care. There was enough data in those records to determine that an adequate history had been obtained. While it may not have been the kind of document that a medical student such as those that Dr. Koskey supervises would write, in terms of how clinicians document their findings,

respondent's records were well within the standard of care, and well within the types of records Dr. Miles has seen when reviewing physician records.

59. Dr. Miles disagreed that respondent failed to rule out bipolar disorder, delusions or hallucinations, because respondent reviewed the prior clinic notes which reflected Patient A's denial of substance use or abuse in the past. There was no history of bipolar disorder given, and nothing that would suggest mania in the past. Without manic or hypomanic symptoms, there was nothing in the bipolar spectrum that could be diagnosed. There were no hallucinations or delusions present during the mental status exam. Accordingly, given Patient A's presentation, there was no evidence of psychoses or substance use disorder. The standard of care did not require respondent to engage in additional documentation to rule out bipolar disorder, hallucinations or delusions. It was within the standard of care for respondent to use other providers' notes as sources of information that he integrated into his findings. The psychiatric history respondent took met the standard of care. While it has later been learned that Patient A had an extensive psychiatric history, which she did not disclose to respondent or others at the clinic, that is outside of respondent's control and does not mean he fell below the standard of care. Respondent should not be faulted for not knowing Patient A's non-disclosed history as he is not omniscient and he did ask all the appropriate questions to obtain Patient A's history. Moreover, the standard of care does not require that physicians document every condition they rule out.

Respondent's Testimony regarding Inadequate History

60. Respondent disagreed with Dr. Koskey's opinion that he failed to take an adequate psychiatric history. Respondent went through his records and thought process, explaining the history he took. At the first office visit, respondent had "a good deal of information" regarding Patient A. There was a history of several episodes of

depression, depression experienced over her lifetime, and the only prescriptions she disclosed having been prescribed were antidepressants and sleep aids.

MAJOR DEPRESSIVE DISORDER ALLEGATION

61. Complainant alleged respondent committed gross negligence by diagnosing major depressive disorder without satisfying its diagnostic criteria.

Dr. Koskey's Opinions regarding Major Depressive Disorder

62. Dr. Koskey opined that the DSM-5 establishes the diagnostic criteria for major depressive disorder, including requiring that patients suffer from five of nine depressed symptoms for two weeks or more. Dr. Koskey initially thought the DSM-5 criteria required six symptoms be present, later conceding that only five are required for adults. However this error did not change his opinions because Patient A did not have five of the required criteria. The symptoms must not be attributable to substances, and patients must never have had a manic or hypomanic episode. Bipolar disorder and major depressive disorder can both present with depressed episodes, but antidepressants can exacerbate bipolar symptoms. Substances can cause depressed episodes, so stopping the substances is an important part of treatment. When making a major depressive disorder diagnosis, a psychiatrist needs to assess for both historical and current symptoms major depressive disorder, bipolar disorder, and substance use disorders.

63. At the January 10, 2020, visit, respondent did not inquire whether Patient A's symptoms had lasted two weeks or more, no inquiry regarding whether alcohol or marijuana contributed to her symptoms, and no inquiry of whether another disorder was causing her symptoms. Although respondent noted that Patient A endorsed "several episodes of severe depression," he did not ask her about these in detail, and

did not confirm they met the criteria for a major depressive disorder. Dr. Koskey disagreed that depression and major depressive disorder are synonymous. Patient A had depressive symptoms, but those could have been due to substance abuse or other conditions. Respondent also did not ask Patient A whether alcohol, marijuana, or other substances were contributing to her depressed or anxious symptoms. Patient A disclosed using alcohol and marijuana, but respondent did not ask questions to see if those were causing the symptoms. Respondent did not ask Patient A about symptoms of bipolar disorder. Respondent also did not ask Patient A whether her symptoms of depression were consistent for two weeks or more. He also noted that the LCSW documented "trouble sleeping," not "insomnia," a DSM-5 criterion. Dr. Koskey concluded that respondent's diagnosing major depressive disorder without satisfying the diagnostic criteria was an extreme departure from the standard of care.

Dr. Miles's Opinions regarding Major Depressive Disorder

64. Although Dr. Koskey criticized respondent for not asking about episodes of severe depression in more detail, Dr. Miles opined that at the initial visit on January 10, 2020, respondent noted a review of the electronic health record and that Patient A had depression and concentration problems. Respondent also noted Patient A's depressed mood, rated its severity, listed insomnia as a problem, and put her back on a dose of Trazodone that she had been previously prescribed while incarcerated. At the February 25, 2020, visit, respondent noted Patient A had very low interest, very low motivation, and very low energy. At the first and third visits, respondent identified the following DSM-5 criteria of major depressive disorder: depressed mood, loss of interest, insomnia, fatigue, and decreased concentration. Further, Patient A's BHQ9 scores were consistent for someone with major depressive disorder.

65. Dr. Miles testified that the standard of care does not require that every DSM-5 criterion be satisfied before the diagnosis can be made. He referenced the introduction in the DSM-5 which specifically states it is to be used as a guideline, and its use should be informed by clinical judgment. The specific criteria are "meant to serve as a guideline and not a rigid cookbook....." A diagnosis can be made even if all of the criteria are not met, as long as the symptoms are persistent and severe. The DSM-5 was not meant to separate psychiatry from the rest of medicine regarding how diagnoses are made. As with all medicine, clinical judgment plays a central role.

66. Dr. Miles testified that the records reflect symptoms of major depressive disorder and diagnosing that disorder was appropriate. Patient A had a depressed mood, loss of interest in activities, insomnia, fatigue, and concentration problems, which are all symptoms of major depressive disorder. Respondent's diagnosis met the standard of care.

Respondent's Testimony regarding Major Depressive Disorder

67. At his first visit with Patient A, respondent documented depressed mood and insomnia, low interest, low energy, and difficulty concentrating. Those symptoms satisfied the DSM-5 criteria for depression. Patient A satisfied the DSM-5 Criterion B because she had clinically significant impairment or distress from depression. Patient A satisfied Criterion C because her symptoms were not due to another medical condition, or the physiological effect of substances. Patient A satisfied Criterion D because her symptoms were not better explained by schizophrenia and she had no history of mania or hypomania based on the history she provided. Respondent felt confident that he had satisfied the DSM-5 criteria for diagnosing Patient A with major depressive disorder.

68. As to the claim he did not rule out bipolar disorder, or other mania, respondent testified that based on Patient A's presenting complaints, the history she provided, and what she was willing to disclose, he was not obligated by the standard of care to get any further information of her symptoms or problems. He did rule out substance-abuse, because he learned respondent was not using alcohol or illicit substances, and did not have a history of addiction. Thus, he had no reason to think those had an impact on her depression. Further, respondent documented that Patient A had been on Zoloft beginning in 2019, so this satisfied the DSM-5 criterion that the symptoms last more than two weeks, because they had lasted for more than 12 months. As to other opinions Dr. Koskey expressed regarding respondent's alleged failure to ask Patient A about episodes of past depressive disorders, that is not one of the DSM-5 criterion. More importantly, respondent cited to and read from the DSM-5 introduction that states physicians may have patients who do not meet the full criteria but have symptoms, so not meeting the full criteria does not mean the patients do not have the diagnosis. While he does believe Patient A had all required criteria, even if she did not, this does not mean she does not have the diagnosis.

69. Respondent disagreed with Dr. Koskey's opinion that all elements of DSM-5 must be met to make a diagnosis of major depressive disorder, explaining that this is not the standard of care. "In an ideal world," a psychiatrist could obtain all of these criteria, but in respondent's experience, and his more than 30 years of practicing psychiatry, he has never seen a psychiatrist obtain all the criteria for any diagnosis; this is not the standard of care. The role of clinical judgment plays a part in making the diagnosis. Physicians are not given all the symptoms on a checklist, but evaluate the quality of the information they receive, evaluate the amount of distress and impairment presented, and make diagnoses. Sometimes patients do not meet the entire criteria, but physicians still have to make decisions to treat and those are based

on patients' presentations. In any event, here respondent identified five of the nine symptoms required to make a major depressive disorder diagnosis, and was "totally convinced" that Patient A had major depressive disorder.

ADHD Diagnosis Allegation

70. Complainant alleged respondent committed gross negligence by diagnosing ADHD without satisfying its diagnostic criteria or adequately considering alternatives.

Dr. Koskey's Opinions regarding ADHD Diagnosis

71. The DSM-5 criteria for ADHD includes an onset of symptoms before age 12, symptoms that are present in two or more settings, and symptoms that are not better explained by another psychiatric or medical disorder. Because childhood ADHD symptoms can improve by adulthood, having the diagnosis as a child does not automatically result in the diagnosis being made in adulthood; the patient must meet the criteria in the present.

72. Respondent diagnosed Patient A with ADHD on February 25, 2020, but failed to meet the DSM-5 criteria for making that diagnosis. He did not establish that Patient A had symptoms before age 12, or that her symptoms were not better explained by another diagnosis, or if they occurred in two or more settings. While she was prescribed Ritalin at age six, respondent did not ask whether this was for ADHD, what symptoms were present at the time, or whether those symptoms had resolved by adulthood. Low concentration can also be caused by depression, and marijuana or alcohol use could be responsible for some of the symptoms. He also did not provide a rationale for why ADHD might be responsible for Patient A's presentation as opposed to the depression he had already diagnosed, or her marijuana use. Patient A was also

taking sedating medications which may have dulled her cognitive function. Respondent's failure to satisfy the diagnostic criteria for ADHD, or consider alternatives, was an extreme departure from the standard of care.

Dr. Miles's Opinions regarding ADHD Diagnosis

73. The history respondent documented was adequate for a provisional diagnosis of ADHD which warranted treatment, and the prescription of Adderall was reasonable. Respondent noted the presence of five current symptoms and a history of Ritalin being prescribed at age six. A prescription for Ritalin to a six-year-old is most probably for ADHD. Very few adult patients can adequately describe symptoms they had at age six. Dr. Miles disagrees with Dr. Koskey's criticism that respondent violated the standard of care by not providing a rationale for why he thought ADHD, and not depression, marijuana usage, or sedating medication effects, were causing Patient A's symptoms. While those factors could contribute to her concentration problems, it was within the standard of care for respondent to consider the alternate explanation of ADHD given the patient's history.

74. Dr. Miles testified that Dr. Koskey's criticism that an ADHD diagnosis was not made before age 12 is not reasonable. Very few people can describe symptoms they had before age 12 and, if they can, there will be "lots of holes" and "lots of inaccuracies" in those descriptions. Further, being prescribed Ritalin at age six obviated the need to further explore symptoms that were present before age 12.

Respondent's Testimony regarding ADHD Diagnosis

75. Respondent testified he is "totally convinced" Patient A had ADHD. She had more than five of the symptoms, and several occurred before age 12. The symptoms being present in two or more settings is not as important for adults as it is

for children. There was no better explanation for Patient A's symptoms than ADHD. Dr. Koskey's opinion that respondent failed to determine whether the symptoms resolved by the time she was an adult is not a DSM-5 criterion. Moreover, Dr. Koskey opined that a patient could only have depression or ADHD, but both conditions can occur simultaneously, they are not mutually exclusive.

ADDERALL PRESCRIPTION ALLEGATION

76. Complainant alleged respondent committed gross negligence by failing to safely prescribed Adderall to Patient A.

Dr. Koskey's Opinions regarding Adderall

77. Dr. Koskey opined that Adderall is a first-line treatment option for appropriate patients with ADHD. However, it has potentially serious side effects, a potential for abuse and dependence, and a street value. It must be used with caution, or avoided, when patients have a history of substance use. Reasonable precautions include only prescribing one month at a time, with no refills, and conducting initial and random urine drug screens to rule out the use of other substances. Stimulants like Adderall may exacerbate bipolar mania, and work in the opposite way that antipsychotic medications work, making psychosis more likely. Thus, they are contraindicated in patients with a history of psychosis and should be used cautiously in patients with a history of bipolar disorder, when the patient's mood has been stabilized with appropriate medications. Stimulants also pose a risk for causing or exacerbating cardiac arrhythmia which must be screened for before a prescription is written. To minimize the risks of side effects, stimulants should be started at a low dose and only increased if patients do not respond and do not have significant side effects. Prescribing guidelines for Adderall call for starting with 5 mg once or twice

daily for adults, and increasing the 5 mg weekly to a maximum of 40 mg daily. Side effects should be discussed with patients before prescribing stimulants.

78. Respondent started Patient A on 20 mg of Adderall twice daily on February 25, 2020. He did not ask her about any history of cardiac arrhythmia. Dr. Koskey stated 20 mg twice daily is four times the conventional starting dose, and respondent did not discuss potential side effects with Patient A, including the potential to cause dependence or worsen psychotic symptoms. Of note, Dr. Koskey opined that respondent's failure to safely prescribed Adderall harmed Patient A "by causing the psychotic symptoms she reported to her mother before her death" which was an extreme departure from the standard of care. However, it was never established that Patient A disclosed her psychotic history at any time to respondent or that respondent was aware of the psychotic symptoms Patient A reported to her mother.

79. Dr. Koskey opined that respondent did not ask Patient A why Ritalin had been prescribed. Ritalin can also be prescribed for narcolepsy, after a stroke, or for major depression. Dr. Koskey agreed there was no evidence Patient A had narcolepsy or suffered a stroke. He disagreed the reasonable conclusion was the Ritalin has been prescribed for ADHD, testifying he is not a child psychiatrist. Dr. Koskey agreed patients can have ADHD and depression at the same time, but one condition should not be diagnosed if the other diagnosis is the reason for the patient's symptoms.

80. Dr. Koskey opined that respondent's dosage of Ritalin was an extreme departure the standard of care. The psychiatric approach should be to determine the safe medication to prescribe, the safe dosage to prescribe, and inform the patient of possible side effects. Respondent prescribed 20 mg twice a day, which is 40 mg total. Although there are studies about prescribing Adderall for certain weights, those studies do not affect Dr. Koskey's opinions because they were performed in carefully

controlled clinical environments, and were done to study the efficacy of the medication. Even in those studies, the clinicians started Adderall at a lower dose than the weight-based dose they determined was safe to prescribe. Further, Adderall can cause hallucinations and paranoia in patients, which seems to have occurred here based on Patient A's mother's statements that Dr. Koskey reviewed. Again, given that there was no evidence respondent was aware of that information, Dr. Koskey relying on them to formulate his opinions was not persuasive.

Dr. Miles's Opinions regarding Adderall

81. Dr. Miles opined that respondent's prescription of Adderall was reasonable. Respondent discussed the risks and benefits of Adderall with Patient A in accordance with his standard practice and procedures, although this was not documented. While it may be ideal to have these discussions documented, as long as the actual risks and benefits are communicated to the patient, this meets the standard of care. Dr. Koskey also criticized respondent for prescribing a starting dose of 40 mg, instead of 10 mg. While slow titration of the medication using lower dosages is common, there is literature suggesting therapeutic responses in adults to address ADHD symptoms can be 54 or 60 mg per day, and Dr. Miles cited those studies in his report. Given Patient A's weight documented in the chart, respondent prescribing 20 mg twice a day was within the standard of care. Dr. Miles further opined that 10 mg of Adderall is rarely an effective dose. As to any psychotic symptoms that may have been caused by Adderall, neither Patient A nor her mother notified respondent regarding those symptoms, so is unclear if the Adderall caused them, and, even if it did, respondent was unaware of Patient A's past psychotic history or the current symptoms she reported to her mother.

Respondent's Testimony regarding Adderall

82. Respondent discussed the side effects of Adderall with Patient A. Patient A never reported a history of psychosis, or taking antipsychotic medications, and at the last office visit had no presenting symptoms suggesting psychosis. The symptoms Patient A reported to her mother, she never reported to respondent or anyone at the clinic. Had respondent been contacted about them, he would have told Patient A to stop the Adderall. Alternately, Patient A could have gone to an emergency room, or could have decreased or stopped the dose, but she did not. Respondent expressed his great sorrow for her tragic suicide. Had he known about her antipsychotic medications he could have added those to treat her depression, and would not have prescribed Adderall. Additionally, given the chart notations that Patient A found housing and was seeking employment, records respondent reviewed, Patient A was not someone he would expect to commit suicide. Moreover, in the suicide evaluations and surveys administered, Patient A was listed as low risk and no risk for suicide. Respondent testified there was no way he could have known or predicted Patient A's suicide given what she told respondent and other providers at the clinic.

TRAZODONE PRESCRIPTION ALLEGATION

83. Complainant alleged respondent committed negligent acts when treating Patient A by failing to adequately address the potential side effects of describing Trazodone to her.

Dr. Koskey's Opinions regarding Trazodone

84. Dr. Koskey opined that Trazodone is an antidepressant used mainly for its sedating side effects, so patient complaints of fatigue or excessive sedation should be considered potential side effects. Normal outpatient doses of Trazodone start at 25-50

mg at bedtime and range up to 200 mg. A patient on a new dose of Trazodone complaining of being too tired should be considered a side effect until proven otherwise. Respondent prescribed 200 mg of Trazodone on January 10, 2020. Dr. Koskey testified that Stahl's Prescriber Guide recommends an initial starting dose of Trazodone at 25 to 50 mg at bedtime. Respondent prescribed 200 mg at bedtime, which he continued over time. This was a simple departure from the standard of care, although Dr. Koskey acknowledged determining the dosage would depend on when in the past the 200 mg amount was taken.

85. At Patient A's next appointment on January 30, 2020, respondent noted that the Trazodone was helping her sleep but she was sleeping all the time. This should have prompted respondent to consider whether 200 mg of Trazodone, a very high dose, was too high, especially as he never tried lower doses with her. Respondent's failure to address the potential side effects of Trazodone was a simple departure from the standard of care.

Dr. Miles's Opinions regarding Trazodone

86. Dr. Miles testified that Trazodone is an antidepressant used for its sedative features because it is not addictive. Respondent prescribed 200 mg of Trazadone for sleep, the dose Patient A was previously prescribed when incarcerated. When she complained of sleepiness at subsequent visits, respondent attributed this to depression, and did not document the possibility it was a side effect of Trazodone. While it may be common to start a patient on 50 mg of Trazodone as an initial dosage, Patient A had a history taking 200 mg. Respondent's decision to start her at this dosage was not below the standard of care based upon her disclosure that this was an effective dosage for her. While Patient A said she was sleeping all the time, this was attributed to low energy and lack of motivation caused by her depression, rather than

from the Trazadone which she had previously taken with good results. She did not describe morning tiredness or grogginess, but instead an overall fatigue which likely were consistent with depression rather than Trazadone sedation.

87. Further, had respondent provided Patient A with a lower dose that was not effective, this could have diminished the therapeutic alliance between respondent and Patient A, and that may have caused her to leave treatment. Dr. Miles explained in settings like these, it is often useful to provide the patient with the dose the patient finds useful and titrate the dosage up or down at subsequent office visits. Dr. Miles stated 200 mg of Trazodone is not a dangerous dose, as 400 to 600 mg can be prescribed. Dr. Miles was not concerned about respondent continuing to prescribe 200 mg even after the patient reported being tired because respondent and Patient A were involved in the treatment process together, it is a collaborative process, and Patient A was letting respondent know that, for whatever reason, this was a dosage she needed at that time, and respondent was allowing that relationship to continue, accepting the fact that Patient A's judgment had value.

Respondent's Testimony regarding Trazodone

88. At the second office visit after respondent started Trazodone, Patient A reported sleeping all the time. He discussed with her how Trazodone can cause next day tiredness, and suggested decreasing the dose, but she was not willing to do so.

Evidence Regarding Patient B

89. Patient B's medical records, CURES report, the transcript of Dr. Erbe's board interview, the investigation reports,[6] DSM-5 excerpts, the Stahl's Prescriber's Guide, and testimony from Dr. Erbe, and the experts, were received in evidence. The following factual findings are based thereon. Of note, several of respondent's visits with Patient B were not alleged in the accusation, but are included herein for context.

Patient B's Records from Family Health Centers of San Diego

90. Patient B had been a patient at Family Health Centers of San Diego since 2014. The problem list contained an extensive medical history dating back to 2014, including diagnoses of major depressive disorder, persistent depressive disorder, personality disorder, erectile dysfunction, coronary artery disease, heart attack, and stent placement, and listed the numerous medications prescribed.

LCSW Clinic Visits Before Respondent's Treatment

91. Patient B was seen numerous times by LCSWs at the clinic, beginning in October 2017 on a referral from his physician. Records of those visits documented multiple episodes of depression, insomnia, difficulty concentrating, financial difficulties, numerous professional and social difficulties, lack of insight, and fleeting suicidal thoughts. There were diagnoses of anxiety, major depressive disorder, general personality disorder, and rule out bipolar disorder and rule out ADHD notations. Behavioral Health Assessments and Treatment Plans were referenced. Scores on self-reported psychological tests indicated Patient B's symptoms ranged from moderate to

[6] See footnote 3, above.

severe depression. At times, Patient B wanted to cease services, but was eventually referred to respondent for additional psychiatric treatment.

JULY 23, 2018, INITIAL VISIT WITH RESPONDENT

Two-Page Note

92. Patient B was first seen by respondent on July 23, 2018. At the time, he was 64 years old. Patient B's vital signs were taken. His blood pressure was 136/85 and his pulse was 90. The subjective section documented that Patient B's history was entered on February 26, 2014, and included coronary artery disease for which a stent had been placed in February 2013. Patient B's social history noted he no longer used tobacco, having quit recently, and he occasionally used alcohol and cannabis.

In the Assessment/Plan section, respondent documented that Patient B reported a history of recurrent episodes of depression lasting two weeks or longer, manifested by sadness the entire day, very low interest, very low appetite, very low energy, very low concentration, very low self-esteem, and "an increase decrease in sleep" [*sic*]. Respondent documented that the depressive episodes "usually include thoughts of death," "generally do not include thoughts of death," that Patient B "had never attempted suicide," "has had more than [blank space] suicide attempts. The most serious suicide attempt [blank space] [*sic*]," and that Patient B denied an intent to harm or kill himself. These inconsistent entries appeared to errors respondent made while using the electronic medical record template, but, were not explained at hearing. Respondent documented further that over the past month, Patient B rated "his mood at [space] on a scale where zero represents no depression and 10 represents the worst depression. The patient today rates his mood at a [space] on the same scale." Again, it

appeared respondent failed to complete the electronic record template. The active problem list contained no diagnoses.

Psychiatric Medication Evaluation

93. Another physician referred Patient B to respondent. Patient B's chief complaint was, "My concentration is really the problem." Respondent took a history, documenting that Patient B reported his career being "in shambles for years," the ageism he experienced, his inability to find work, his lack of success in life, and how his disinterest was the main symptom of his depression. Patient B could not recall specific episodes of sadness or disinterest, had an increase in appetite, low energy, low concentration, low self-esteem, and half the time did not have refreshing sleep. He often did not have a "reason to get up." He had never attempted suicide but had brief episodes of death thoughts.

Patient B reported having significant anxiety and worry, which affected his "level of peace." He described his financial difficulties. Respondent checked the "No" box regarding drug abuse but documented "uses marijuana daily in small quantities." Respondent documented Patient B's past psychiatric and medical history, his social/developmental history, and his family history. Respondent performed a mental status exam, documenting that Patient B was cooperative, his speech was within normal limits, his language was articulate, his thought process was linear, his thought content was normal, and he had no delusions, suicidal ideation, or homicidal ideation. Respondent documented that Patient B's fund of knowledge, attention span/concentration, judgment/insight, and recent/remote memory were all appropriate. Patient B's mood/affect was euthymic. Respondent diagnosed major depressive disorder, and identified two problems. "Problem #1 Depression: Sertraline

'was like being mentally foggy, tired, hot flushes and had difficulty urinating.'"
"Problem #2 Anxiety: Buspirone 'spaces me out the next day.'"

Respondent documented on the Adult Medi-Cal Mental Health Severity Analysis that Patient B's risk was not applicable. Patient B's clinical complexity was mild, meaning adjustment reaction; minor depression/anxiety; grief, job loss, marital distress, relationship difficulty; no cognitive impairment; no prior serious mental illness (SMI) history; and/or limited AOD use (acronym not explained) . Patient B's life circumstances were mild, meaning he had emotional distress arising in the course of normal life stresses, was adequately resourced and supported, and was resilient. The benefit of integrated care was high, meaning already established, effective care in primary care setting for chronic stable medical plus co-occurring mild mental illness/emotional distress.

Respondent's Testimony regarding July 23, 2018, Visit

94. Respondent thought depression might be causing some of Patient B's symptoms. Patient B denied drug abuse and acknowledged taking small amount of marijuana daily. Respondent did not think Patient B was abusing marijuana or was dependent on it.

JULY 30, 2018, LCSW VISIT

Two Page Note

95. Patient B was seen by the LCSW who documented his recurrent major depressive episodes, moderate, on the problem list. She requested he complete a PHQ9. Patient B's PHQ9 score was 16, and he noted that his problems made it extremely difficult for him to do his work, take care of things at home, or get along

with others. Patient B also completed a GAD-7 that was not scored, and it was unclear which provider ordered him to complete this test.

Progress Note

96. The LCSW's July 30, 2018, note documented her discussions with Patient B, and the resources given to him. The LCSW noted Patient B's diagnoses of anxiety, performed a mental status exam, documenting Patient B's anxious mood and limited judgment and insight. The LCSW also conducted a safety assessment, noting Patient B's passive suicidal ideation, but there were no self-injurious behaviors reported. The LCSW documented Patient B's social issues, and his statement about being careful of what he told her as he did not want to be hospitalized. Although the LCSW documented that no substance use was reported, she also documented that Patient B smoked cannabis to calm down. The LCSW recommended that Patient B meet with a psychiatrist.

The LCSW further documented on the Adult Medi-Cal Mental Health Severity Analysis that Patient B's risk was mild, meaning he had passive ideation or fantasy - no danger to self/danger to others (DTS/DTO) history, good impulse control, minimal criminal background, good insight, and/or ego dystonic. Patient B's clinical complexity was moderate, meaning he had schizophrenia, major mood or anxiety disorder - stable on medications, baseline functions, sustained recovery; prior history of effective treatment, uncomplicated management; minimal cognitive impairment; no recent hospitalizations; and/or ADD misuse. Patient B's life circumstances were mild and the benefit of integrated care was high.

JULY 30, 2018, VISIT WITH RESPONDENT

Two-Page Note

97. Respondent next saw Patient B on July 30, 2018. His vital signs were taken. His blood pressure was 153/82, and his pulse was 85. The subjective section remained the same as at prior visits.

Psychiatric Medication Evaluation

98. Respondent saw Patient B on July 30, 2018, on a referral from the LCSW for a chief complaint of "My discouragement." Respondent recorded the history he took, much of which was a repeat of that was documented in the July 23, 2018, note. Respondent noted that "the absence of sadness and disinterest suggests he doesn't have a depressive disorder." Patient B did not have a history of making careless mistakes, did not have a problem with follow-through or forgetfulness, but has had problems with poor attention to detail, difficulty sustaining attention, often losing things, difficulty staying organized and was easily distracted. He reported the theft of his bicycle which caused discouragement, and gave him "some desire to die," but he did not attempt to harm or kill himself, and was "getting better." Patient B reported that he snores, but had no episodes where he stopped breathing which respondent noted "argues against obstructive sleep apnea." Respondent checked the box marked "No" regarding drug abuse and wrote "See my note of 7/23/18." Respondent also referenced his July 23, 2018, note in the Past History section. Respondent documented a mental status exam which was consistent with other visits, noting that at this visit Patient B's mood/affect was improving.

Respondent diagnosed ADHD. He identified the same two problems in the Plan section as he did in the July 23, 2018, note, but added "Problem #3 Poor

Concentration" for which respondent would "start methylphenidate 20 mg at 8 am, 20 mg at Noon." (Methylphenidate, brand name Ritalin, is a central nervous system stimulant used to treat attention deficit disorder, ADHD, and narcolepsy.) Respondent documented on the Adult Medi-Cal Mental Health Severity Analysis that Patient B's risk was not applicable, his clinical complexity and life circumstances were both mild, and the benefit of integrated care was high.

99. Respondent's prescription for 20 mg of methylphenidate, to be taken twice a day, was included in the chart.

CURES 2.0 Note

100. Respondent documented his review of the CURES database for the period of January 30, 2018, through July 30, 2018, with "negative results."

Respondent's Testimony regarding July 30, 2018, Visit

101. Respondent had given Patient B a provisional diagnosis of major depressive disorder at the prior July 23, 2018, visit. An individual needs depressed mood or markedly diminished interest or both for this diagnosis. Patient B did not have either, so respondent removed this diagnosis. Patient B had discussed poor concentration at the first office visit, so respondent explored ADHD as a possibility. Respondent believed this diagnosis explained Patient B's work difficulties. Respondent prescribed nothing more than Ritalin at this visit for Patient B's ADHD diagnosis.

AUGUST 13, 2018, VISIT WITH RESPONDENT

Two-Page Note

102. Respondent next saw Patient B on August 13, 2018. Vital signs were taken, and Patient B's blood pressure was 145/88, and his pulse was 85. The subjective history documented remained the same as at prior visit. No diagnosis or orders were listed.

Psychiatric Medication Follow-Up

103. Respondent documented in the Interval History that Patient B's chief complaint was that he had "every symptom of ADHD, except being late. Now everything is better, but I'm late for things." Patient B reported that his productivity had quadrupled, and he had a marked improvement in concentration. He had been taking 20 mg of methylphenidate once or twice a day. When on the medication, his concentration "has been excellent." The methylphenidate had made him anxious, but only when it was "getting low in his system." He reported getting in a verbal argument with a stranger who yelled at him. Patient B "had fleeting thoughts to kill himself. For several days he was depressed, frustrated and angry." He felt people who act like the stranger acted should have consequences. On a typical day, Patient B's energy level was good. Respondent documented Patient B's prior diagnoses and diagnosed ADHD. Respondent documented Patient B's pertinent medical history, and identified the same three problems listed at the prior visit, but now added a fourth problem of fatigue. Respondent noted that Patient B snores, has recorded his breathing while sleeping with an app on his phone, and there were not any apneic episodes. Respondent "cannot say" if Patient B had sleep apnea and Patient B "does not want to have a sleep study." Patient B denied medication side effects and drug abuse.

Respondent performed a mental status exam, documenting similar results as at prior visits, and at this visit Patient B's mood/affect was euthymic. He was compliant and would follow up in four weeks. Respondent documented on the Adult Medi-Cal Mental Health Severity Analysis that Patient B's risk was not applicable, his clinical complexity and life circumstances were both mild, and the benefit of integrated care was high.

104. Copies of the prescriptions respondent wrote for methylphenidate 20 mg, to be taken twice a day, and Viagra 50 mg were included in the chart.

CURES 2.0 Note

105. Respondent documented his review of the CURES database for the period of August 13, 2017, through August 13, 2018, which only listed the methylphenidate respondent prescribed.

AUGUST 21, 2018, LCSW VISIT

106. Patient B was seen by the LCSW on August 21, 2018. His diagnoses were anxiety and personality disorder. The LCSW documented a mental status exam, a safety assessment, and noted there been no changes in Patient B's substance use information. Patient B had high motivation for treatment and was compliant. The LCSW documented her discussions with Patient B including his being grateful that respondent "clarified his diagnoses and prescribed Ritalin for him." Patient B said many providers had misdiagnosed him in the past. He denied being depressed although admitted having hopeless thoughts and feeling like a failure. Patient B reported an improved ability to concentrate, and that his "productivity has quadrupled." Patient B had a second meeting scheduled with his vocational rehabilitation counselor and had organized a local "over 40 social group." Patient B was "happy with his progress to

date." Patient B would follow up in three weeks. The Adult Medi-Cal Mental Health Severity Analysis documented that Patient B's risk was not applicable, his clinical complexity and life circumstances were moderate, and the benefit of integrated care was medium.

In another note, the LCSW documented that Patient B's problem list included recurrent major depressive episodes, moderate, and recommended a PHQ9 be given. Patient B scored a 9 on the PHQ9, and reported that his problems made it somewhat difficult to do his work, take care of things at home, or get along with others.

SEPTEMBER 6, 2018, LCSW VISIT

107. The LCSW next saw Patient B on September 6, 2018, and noted his diagnoses of anxiety and personality disorder. The LCSW documented a mental status exam, noting that respondent's speech was rapid, his mood was irritable, and his insight was limited. Patient B denied suicidal or homicidal ideation. No substance use was reported. Patient B was taking his medication with the exception of one to three days. He reported he developed hives which he thinks may be due to his use of buspirone. He sometimes takes one half tablet, and sometimes does not take any at all. He plans to discuss this with respondent at his next visit. The LCSW documented her discussions and therapeutic interventions with Patient B, including issues he had with his family. There was minimal progress made towards his treatment goals.

Patient B would follow up in three weeks, the LCSW discussed an action plan with him, and provided him with cognitive behavioral therapy handouts. The Adult Medi-Cal Mental Health Severity Analysis documented that Patient B's risk was not applicable, his clinical complexity and life circumstances were moderate, and the benefit of integrated care was medium. In another note, the LCSW noted that Patient

B's problem list included recurrent major depressive episodes, moderate, and recommended a PHQ9 be given to Patient B to complete. Patient B scored an 8 on the PHQ9, and reported that his problems make it somewhat difficult to do his work, take care of things at home, or get along with others.

Respondent's Testimony regarding September 16, 2018, Visit

108. Respondent testified that one would expect a patient to develop a rash approximately two weeks after using medication if the medication caused the rash. Thus, he would have expected a report of a rash at the August 13, 2018, visit, but there was no such report. Here, Patient B did not report a rash until several weeks after starting Ritalin, making it likely not the cause. Moreover, Patient B denied any medication side effects and asked to continue taking the Ritalin. Further, rashes are typically not manifested by hives, which is what Patient B reported.

SEPTEMBER 17, 2018, VISIT WITH RESPONDENT

Two-Page Note

109. Respondent next saw Patient B on September 17, 2018, with a chief complaint of follow-up for mental health medication, and a comment of "no travel," which was not explained. Patient B's vital signs were taken. His blood pressure was 136/80, and his pulse was 86. The subjective and family history were similar to the other chart entries. There was no assessment, diagnosis, or orders listed.

Psychiatric Medication Follow-Up

110. In the Interval History, respondent documented that Patient B had a rash on his right leg "but now believes this was due to 'being brushed by a stingray.'" Patient B had a non-confluent popular [*sic*] rash on his left arm which went away despite continuation of the Ritalin when the weather was very hot. (Respondent testified this was a typo and should have been "papular" rash. A non-confluent rash is one where the rash lesions are clearly separated from one another, and a papular rash is one with small, elevated bumps or papules.) Respondent wrote further: "I cannot predict if continuation of the Ritalin would lead to a more serious reaction." Patient B reported that after his last appointment, he had reduced the Ritalin dose to one-half of a 20 mg tablet in the morning and one-half of a 20 mg tablet two hours later. Patient B's concentration with Ritalin "has been excellent," he would like to continue the Ritalin, and respondent was "willing to try this."

Respondent noted Patient B's prior diagnoses, diagnosed ADHD, and identified four problems previously documented. In the Medication Side Effects section, respondent referenced his Interval History notes and documented that Patient B denied drug abuse. The Mental Status Exam was similar to others, but at this visit Patient B's mood/affect was euthymic. The Adult Medi-Cal Mental Health Severity Analysis was consistent with other visits, with all categories being moderate, and the benefit of integrated care being medium.

111. A prescription for 20 mg of methylphenidate, to be taken in half-tablet dosages was written by respondent.

CURES 2.0 Note

112. Respondent documented his review of the CURES database for the period of September 17, 2017, through September 17, 2018, which only listed medications prescribed by respondent as documented in Patient B's chart.

SEPTEMBER 20, 2018, LCSW VISIT

113. Patient B was seen by the LCSW on September 20, 2018. His diagnoses were major depressive disorder and personality disorder. He presented with poor hygiene and loose association thought process. His mood was anxious. The LCSW recorded her observations and therapeutic interventions, including ways to assist Patient B with organization and planning. She recommended he follow up with vocational rehabilitation. In the Adult Medi-Cal Mental Health Severity Analysis, the LCSW noted that Patient B's risks were mild, his clinical complexity and life circumstances were moderate and the benefit of integrated care was medium.

114. In another note, the LCSW diagnosed Patient B with recurrent major depressive episodes, moderate, and requested he be given a PHQ9 to complete. Patient B scored a 7 on the PHQ9, and reported his problems made his work, taking care of things at home, and getting along with others "somewhat difficult."

OCTOBER 9, 2018, LCSW VISIT

115. Patient B was seen by the LCSW on October 9, 2018. His diagnoses were major depressive disorder and personality disorder. He was agitated and his mood was anxious and irritable. His judgment and insight were limited. Patient B endorsed feeling hopeless, having passive suicidal ideation "every day," but he strongly denied an intent or plan to harm himself. He stopped taking his psychotropic medications by

choice. He "[t]akes only one tablet of Ritalin daily, otherwise he breaks out in hives." In the narrative/observation section the LCSW wrote:

> PHQ9 –13. [Patient B] reports that he feels like he is "pushing a ball up hill". He has been waiting four months for help from Vocational Rehabilitation; he wrote to his Assemblyman who contacted Voc. Rehab on his behalf; he now has been asked to develop a training plan. He started a social group, PB over 40, and a member moved the postings to a Facebook application and [Patient B] does not want to use Facebook, so he is missing out on social opportunities, he feels left out and angry that she hijacked his group. He talked about positive accomplishments, 5 lb. weight loss through using elliptical machine, updated his resume on Indeed, applied for two jobs, went on a date with [name] which went well unfortunately she moved out of town so he won't see her again.

The LCSW discussed and provided cognitive behavioral therapy handouts to Patient B, and discussed ways of managing his ADHD. He had minimal progress toward his treatment goals. The Adult Medi-Cal Mental Health Severity Analysis noted that his risks were not applicable, his clinical complexity and life circumstances were moderate, and his benefit of integrated care was high, meaning it was already established, effective care in primary care setting for chronic stable medical plus co-occurring mild mental illness/emotional distress. The LCSW diagnosed recurrent major depressive episodes, moderate, and ordered a PHQ9 be given. Patient B's PHQ9 score

was 13, and he noted that his problems made it "somewhat difficult" for him to get along with others, work, or take care of things at home.

OCTOBER 22, 2018, VISIT WITH RESPONDENT

Two-Page Note

116. The October 22, 2018, chief complaint section is blank. Patient B's vital signs were taken, and his blood pressure was recorded as 138/87 with a pulse of 102. The subjective history was the same as documented at other visits. Respondent diagnosed recurrent major depressive episodes, moderate, and prescribed 50 mg of Trazodone, 1 to 4 tablets to be taken at bedtime for insomnia, and 10 mg of Adderall to be taken twice a day was also prescribed, with two refills. A form documenting that the Adderall was a new therapy was completed by respondent, which also identified all of Patient B's diagnoses, as reflected in the records.

Psychiatric Medication Follow-Up

117. In the Interval History, respondent documented Patient B's difficulties with an online group he had created and his being completely blocked from the group. Respondent documented that Patient B "has had 1 episode of rash associated with the methylphenidate." Respondent suggested switching to Adderall, and also discussed adding Trazodone to help Patient B sleep. Patient B believed the buspirone made "it difficult for him to settle down." Twenty minutes of the visit was spent "in supportive psychotherapy." Respondent diagnosed ADHD. He noted Patient B's pertinent medical history and identified the four problems previously identified, now adding a fifth problem of erectile dysfunction for which he prescribed sildenafil (brand name Viagra). However for Problem #3, Poor Concentration, respondent now documented that methylphenidate caused a rash when Patient B took 10 mg in the

morning, 10 mg 90 minutes later, and another 10 mg 60 minutes after the second dose. Respondent stopped the methylphenidate and started Adderall 10 mg to be taken twice a day. For Problem #4, Insomnia, respondent started Trazodone 50-200 mg QHS (at bedtime). The Medication Side Effects boxes were not checked, but the drug abuse box was checked "No." A review of systems was not performed. The mental health status exam was similar to that documented at other visits but Patient B's mood/affect was anxious at this visit.

118. The Adult Medi-Cal Mental Health Severity Analysis was consistent with other visits, with all categories being moderate, and the benefit of integrated care being medium.

NOVEMBER 6, 2018, VISIT WITH LCSW

119. The LCSW documented the numerous insults and complaints she received from Patient B at this visit, including his abruptly ending the session. Patient B accused the LCSW of giving him bad advice and making an improper diagnosis. He believed he did not have depression, but, instead, had ADHD. The LCSW diagnosed Patient B with recurrent major depressive episodes, moderate, and ordered he be given the PHQ9 to complete.

120. The Adult Medi-Cal Mental Health Severity Analysis was consistent with other visits, with all categories being moderate, except for the life circumstances category which the LCSW marked as severe, meaning persistent emotional distress, a manifestation of chronic mental illness, relies on behavioral health system for resources, and/or limited resilience. The LCSW marked the benefit of integrated care as medium.

NOVEMBER 13, 2018, VISIT WITH LCSW

121. On November 13, 2018, Patient B was seen by the LCSW for the presenting problem of "[d]epressed mood, passive SI due to feeling like a failure, social rejection." Patient B had completed an intake, undergone nine individual therapy sessions, and had a medication evaluation. He was requesting that his case be transferred. The LCSW documented that Patient B "is intelligent, however he lacks insight into his interpersonal style, he insults others and is difficult interpersonally keeping him from his desired goal of having friends, business relationships." The LCSW's diagnoses were ADHD, depression, and personality disorder. The LCSW ordered a case closure/transfer.

JANUARY 14, 2019, VISIT WITH RESPONDENT

Two-Page Note

122. This visit was not alleged in the accusation. At the January 14, 2019, visit with respondent, Patient B's vital signs were taken. His blood pressure was 154/95 and his pulse was 92. Patient B's chief complaint was a follow-up on mental health medication and "Comments: no travel," which was not explained. The Nurse Comments also listed a chief complaint of "no travel." The subjective and family histories were the same as documented in other records. Respondent diagnosed erectile dysfunction and prescribed sildenafil.

Psychiatric Medication Follow-Up

123. The chief complaint section on the January 14, 2019, note was blank. In the Interval History section, respondent documented that Patient B "continues to have stress related to the PB40 male group; one of the participants invited members to

switch to Facebook which created a whole set of struggles." Patient B's "concentration has been good most of the day with a 10 mg twice a day Adderall in 4 hour intervals. He has been getting 9 hours of sleep each night." More than 20 minutes of the visit were spent in "supportive psychotherapy."

Respondent diagnosed ADHD. He listed the same five problems documented in the other records. Patient B denied medication side effects and drug abuse. The mental status exam was the same as at other visits, but at this visit Patient B's mood/affect was restricted. Patient B was compliant and respondent requested that two 20-minute appointments be scheduled in late March 2019. Respondent marked all categories of the Adult Medi-Cal Mental Health Severity Analysis as moderate, and the benefit of integrated care as medium.

CURES 2.0 Note

124. Respondent documented his review of the CURES database for the period of January 14, 2018, through January 14, 2019, which only listed medications prescribed by respondent as documented in Patient B's chart.

Prescription

125. A January 14, 2019, prescription for 10 mg of Adderall to be taken twice a day, signed by respondent was consistent with respondent's note in the interval history regarding this prescription.

MARCH 25, 2019, VISIT WITH RESPONDENT

Two-Page Note

126. This visit was not alleged in the accusation. Patient B's vital signs were taken. His blood pressure was 133/78 and his pulse was 100. The subjective and family histories were the same as documented in other records. Respondent diagnosed ADHD, combined type. He prescribed Adderall 10 mg to be taken twice a day, with two refills.

Psychiatric Medication Follow-Up

127. The chief complaint section noted that Patient B did not have any concerns or complaints, and the purpose of the visit was to assess his response to medication. In the Interval History section, respondent documented that Patient B's "concentration has been good to excellent most of the day." More than 20 minutes of the visit was spent in "supportive psychotherapy." The same problems were noted. Patient B denied medication side effects and drug abuse. His mental status examination was similar to other visits but at this one his mood/affect was euthymic. Respondent diagnosed ADHD. Respondent marked all categories in the Adult Medi-Cal Mental Health Severity Analysis as moderate, and the benefit of integrated care as medium.

CURES 2.0 Note

128. Respondent documented his review of the CURES database for the period of March 25, 2018, through March 25, 2019, which only listed medications prescribed by respondent as documented in Patient B's chart.

JUNE 24, 2019, VISIT

Two-Page Note

129. At this visit, Patient B's vital signs were taken. His blood pressure was 130/77 and his pulse was 91. His subjective and social histories were the same as at other visits. The problem list noted respondent's diagnosis of ADHD, combined type. Respondent prescribed methylphenidate 10 mg to be taken twice a day, with four hours between doses, and ordered refills through August 2019.

Psychiatric Medication Follow-Up

130. Patient B's chief complaint was that the Adderall was causing constipation. Respondent documented in the Interval History that Patient B's concentration was good with Adderall but it caused constipation, and Patient B wanted to go back on the methylphenidate. Respondent documented: "I ask about the time when methylphenidate caused a rash when he took 10 mg in the morning, 10 mg 90 minutes later, and another 10 mg 60 minutes after the second dose." Patient B replied it was a one-time thing and that he had taken the Ritalin "several times after that - and didn't take the doses too close together - and it didn't happen." Patient B reported that 10 mg of Ritalin twice a day was enough to improve his concentration significantly, and respondent was "willing to try this." Patient B denied medication side effects and drug abuse. The mental health examination was consistent with ones performed at other visits, except at this visit Patient B's mood was euthymic. Patient B was compliant and would follow up in one month. Respondent marked the categories in the Adult Medi-Cal Mental Health Severity Analysis as moderate and the benefit of integrated care as medium.

CURES 2.0 Note

131. Respondent documented his review of the CURES database for the period of June 24, 2018, through June 24, 2019, which only listed medications prescribed by respondent as documented in Patient B's chart.

JULY 22, 2019, VISIT WITH RESPONDENT

132. This visit was not alleged in the accusation. Patient B's vital signs were taken. His blood pressure was 127/74, and his pulse was 72. Respondent documented that Patient B reported the Adderall worked for a longer time period than the Ritalin, and improves his concentration better than the Ritalin. The Adderall causes constipation and makes it more difficult to fall asleep. At the last appointment, respondent had prescribed Ritalin which Patient B has been taking, but then Patient B added back the Adderall. Respondent asked Patient B about his concentration with Ritalin which Patient B said has been good. Respondent documented Patient B's statements regarding how and when he takes his medication. Patient B reported that both medications help him stay on task, and with Adderall his concentration is between good and excellent. Patient B thought the best option would be to take Adderall one day followed by two days of Ritalin. Patient B had enough Adderall from a previous prescription to try this regimen for the next month. Respondent documented that Patient B "also uses cannabis regularly." Patient B "has not had any rash from the methylphenidate since his last appointment." Respondent "did not write any medication orders today." Patient B denied medication side effects and drug abuse. His mental status examination was consistent with other visits except at this visit his mood/affect was euthymic. Patient B was compliant and would return for follow-up in four weeks. Respondent documented all categories of the Adult Medi-Cal

Mental Health Severity Analysis as moderate, and the benefit of integrated care as medium.

AUGUST 26, 2019, VISIT WITH RESPONDENT

133. This date was not alleged in the accusation. In the Interval History section, respondent documented that Patient B's concentration alternating Adderall with the Ritalin had been good, and he "has not had any rash from the methylphenidate since his last appointment." Patient B denied medication side effects and drug abuse. His mental status exam remained consistent with that documented at other visits, except at this visit his mood/affect was restricted. Patient B was compliant and would follow up in four weeks. Respondent documented the risk and life circumstances categories on Adult Medi-Cal Mental Health Severity Analysis as moderate and clinical complexity category as severe, meaning schizophrenia, major mood or anxiety disorder, recent instability or worsening function, precarious recovery, cognitive impairment; recent/repeated hospitals; AOD dependence; or prior history of treatment resistance or complexity. He marked Patient B's benefit of integrated care as a low, meaning already established (or pending) care with County provider for complex SMI, relies on behavioral health system for resources and support, or low recovery.

134. Respondent reviewed CURES from August 26, 2018, through August 26, 2019, and only his prescriptions were identified.

SEPTEMBER 30, 2019, VISIT WITH RESPONDENT

135. The date was not alleged in the accusation, but at this office visit respondent documented that Patient B had started an ADHD group, and that respondent refilled the Adderall prescription for one month, but did not refill the

methylphenidate prescription. Patient B continued to deny medication side effects and drug abuse. Patient B's vital signs were taken and his blood pressure was 133/76 with a pulse of 80. Patient B's mental status examination remained the same except that at this visit, his mood/affect was euthymic. Patient B was compliant and would be followed up in two months.

136. Respondent reviewed CURES from September 30, 2018, through September 30, 2019, and only his prescriptions were identified.

OCTOBER 9, 2019, WITH RESPONDENT

137. Although this date was not alleged in the accusation, an entry in the records from respondent on October 9, 2019, stated the following:

> I talked to [Patient B's] pharmacist yesterday. The Adderall and methylphenidate orders were confusing in that the due dates did not coincide. The pharmacist put a good deal of time looking at this. I appreciate her time and effort. Yesterday I canceled an Adderall order and two methylphenidate orders. According to the pharmacist, [Patient B] will run out of Adderall and methylphenidate on November 19. Meeting with [Patient B] on November 18th would be the perfect date to meet for his refills, but I am not working that day. So, I will now send his pharmacy orders for Adderall and methylphenidate asking the pharmacy to not fill until November 19th. I will meet with [Patient B] next on November 25th.

NOVEMBER 25, 2019, VISIT WITH RESPONDENT

Two-Page Note

138. Patient B was next seen by respondent on November 25, 2019, in a follow-up for mental health medication. His vital signs were taken, and his blood pressure was 137/76, with a pulse of 76. The subjective section was the same as at other visits. The medications prescribed were Adderall 10 mg to be taken twice a day on days 2 and 3, alternated with Methylphenidate 10 mg to be taken twice a day on day 1, with refills through January 2020.

Psychiatric Medication Follow-Up Note

139. Patient B was next seen on November 25, 2019, with a chief complaint of having no concerns or questions. The purpose of the visit was to assess his response to medications based on the problems listed below. In the Interval History, respondent documented that Patient B's concentration when alternating Adderall and Ritalin had been good. Patient B's diagnosis was ADHD. The second dose of Adderall caused constipation, and Patient B thought alternating the Adderall with the methylphenidate such that he will take Adderall on day 1, and methylphenidate on days 2 and 3, and then repeating this regimen, gave him the improvement and concentration he gets with the Adderall without the constipation. Respondent continued the Adderall at 10 mg to be taken twice a day on days 2 and 3, and continued the methylphenidate 10 milligrams to be taken twice a day on day 1. Patient B denied medication side effects and drug abuse. The Mental Status Exam was the same as at other visits, with Patient B's mood/affect being restricted. Patient B was compliant and the plan was to follow up in three months.

In the Adult Medi-Cal Mental Health Severity Analysis, respondent determined that Patient B's risk level, clinical complexity, and life circumstances were moderate, and the benefit of integrated care was "medium."

CURES 2.0 Note

140. Respondent documented his review of the CURES database for the period of November 25, 2018, through November 25, 2019, which only listed medications prescribed by respondent as documented in Patient B's chart.

FEBRUARY 26, 2020, VISIT WITH RESPONDENT

Two-Page Note

141. Respondent saw Patient B on February 26, 2020. His vital signs were taken, and Patient B's blood pressure was noted to be 130/62, with a pulse of 82. The Subjective and history sections were the same as in other records. Respondent prescribed Adderall 10 mg to be taken twice a day on days 2 and 3, alternating with methylphenidate 10 mg to be taken twice a day on day 1. Refills of these two medications through April 2020 were prescribed.

Psychiatric Medication Follow-Up

142. Patient B did not have any concerns or questions today and the purpose of the visit was to assess his response to medications. Respondent noted in the Interval History that Patient B's "concentration alternating the Adderall with the Ritalin has been good" and did "not see a need for any medication changes." Respondent continued the Adderall at 10 mg to be taken twice a day on days 2 and 3, and continued the methylphenidate 10 milligrams to be taken twice a day on day 1. Respondent noted that a Controlled Substance Agreement was signed on February 26,

2020. Patient B denied medication side effects and drug abuse. Patient B's Mental Status Exam was the same as other visits, but his mood/affect was restricted. Patient B was noted to be compliant and a follow-up visit in four months was set. In the Adult Medi-Cal Mental Health Severity Analysis, respondent determined that Patient B's risk level, clinical complexity and life circumstances were "moderate," and the benefit of integrated care was "medium."

CONTROLLED SUBSTANCE AGREEMENT

143. Patient B signed a Controlled Substance Agreement on February 26, 2020, agreeing to comply with Family Health Centers of San Diego's requirements for treatment.

CURES 2.0 Note

144. Respondent documented his review of the CURES database for the period of February 26, 2019, through February 26, 2020, which only listed medications prescribed by respondent as documented in Patient B's chart.

MAY 22, 2020, VISIT WITH RESPONDENT

Two-Page Note

145. This visit was not alleged in the accusation, and was done via telephone because of the COVID-19 pandemic.

Psychiatric Medication Follow-Up

146. Respondent documented that Patient B did not have any concerns or questions, and the purpose of the visit was to assess his response to medication. The

encounter was performed via telephone because of COVID-19. Patient B reported that his concentration most of the time had been good, he was interested in economic development, and had a "work group on unemployment issues." Patient B felt a strong sense of direction, and said the medications made him more effective. He had been busy with his ADHD group, and was battling both the Department of Rehabilitation and another group. Patient B's diagnosis remained ADHD. His pertinent past medical history was documented, and it was noted he continued to have a good response to Adderall and Ritalin. Respondent did not see a need for medication changes, and both Adderall and Ritalin were continued. Patient B's five problems were again documented. Patient B denied medication side effects and drug abuse. His mental status examination was consistent with others performed, and at this visit his mood/affect was restricted. Respondent also noted Patient B's prior rash and how he was alternating between Adderall and Ritalin. Respondent documented that Patient B was compliant and would return in four weeks.

Respondent's Testimony about May 22, 2020, Visit

147. Because of the findings at this visit, respondent remained "completely convinced" that Patient B had ADHD. Patient B had an excellent response to stimulants, and his productivity had quadrupled. Respondent considered and rejected that chronic marijuana use, sleep apnea or depression were the causes of Patient B's concentration difficulties, because Patient B was only using small amounts of marijuana which would have no bearing on his concentration problems, was unwilling to undergo a sleep apnea study even though respondent discussed with him the risks of untreated sleep apnea, recorded himself having no episodes of stopped breathing, and did not have depression. Regarding the DSM-5 criterion that the ADHD symptoms occur before age 12, respondent explained that very intelligent, very driven children,

such as Patient B, based on his history, can overcome ADHD symptoms but later when work demands increase, recognize their ADHD symptoms. Thus, although Patient B did not have a formal diagnosis before age 12, it is very likely he had ADHD.

Opinions Regarding Patient B's Care

INADEQUATE HISTORY ALLEGATION

148. Complainant alleged respondent committed gross negligence on November 25, 2019, and February 26, 2020, by failing to take an adequate subjective history of Patient B.

Dr. Koskey's Opinions regarding Inadequate History

149. Dr. Koskey opined that the standard of care for clinical documentation for outpatient psychiatric providers requires they include the taking of a subjective history, also known as the history of present illness or interim history. It should include, at a minimum, the symptoms of the condition being treated, compliance with medications, and any side effects, as well as any patient concerns. On November 25, 2019, and February 26, 2020, respondent's entire subjective history for Patient B was "his concentration alternating the Adderall with the Ritalin has been good." Respondent particularly failed to inquire about any rashes, other side effects of medications, or the potential overuse of stimulants, as well as Patient B's ongoing depressed and anxious increased symptoms. Respondent's failure to take a standard subjective history at these two appointments did not allow him to accurately diagnose or treat Patient B, which was an extreme departure from the standard of care.

150. Dr. Koskey further opined that Patient B disclosed at prior visits that he was a regular user of cannabis and a binge drinker, and other things that should have

prompted respondent to rule in or out substance use disorders, any history of violence, or a traumatic brain injury. Because regular marijuana use can cause mood, anxiety, and concentration problems, respondent should have explored any historical overlap of the symptoms. However, at the first visit with respondent on July 23, 2018, respondent recorded Patient B's psychiatric history as "none other than the above." Respondent failed to assess for any history of cannabis use disorder, psychosis, or mania which was an extreme departure from the standard of care. Further, a patient not being "addicted" to a substance does not rule out they are not using it.

151. Dr. Koskey testified that at the November 25, 2019, and February 26, 2020, visits, respondent did not perform a proper review of Patient's B rashes, side effects of the rashes, or his overuse of stimulants. Although respondent first diagnosed the rash on in 2018, the June 2019 notes indicated the treatment did not stop, and Patient B was still on Ritalin and alternating with Adderall. Dr. Koskey agreed Patient B was not complaining of rashes at the June 2019 visit, and that as of November 2019, rashes were not an ongoing problem. He also agreed that Patient B denied medication side effects at which point Dr. Koskey conceded and withdrew his opinions that respondent was not inquiring about side effects or the rash, agreeing that the records documented respondent had done so. Dr. Koskey also withdrew this criticism regarding the February 26, 2020, visit when shown that the "Denies" Medication Side Effects box was checked. Dr. Koskey withdrew this entire criticism at hearing, and that allegation is dismissed.

152. Dr. Koskey also agreed that depression did not appear to be an ongoing problem for Patient B. Although it was listed as Problem #1 at the July 23, 2018, office visit, major depressive disorder diagnosis does appear to be a prior diagnosis, and there were no prescriptions given for depression. However, Dr. Koskey opined that just

because no medications were prescribed, that does not mean respondent should not be managing the condition because he listed it as a problem. However, Dr. Koskey conceded that the next visit on July 30, 2018, respondent diagnosed ADHD and prescribed Ritalin, he did not prescribe medication for depression. Of note, at this visit respondent also withdrew depression as a diagnosis as he explained in the chart.

153. Dr. Koskey acknowledged that at the August 13, 2018, office visit where the problems listed identified sertraline and buspirone as having been prescribed, respondent was not the one who prescribed those medications. However, Problem #3, poor concentration, documented "start methylphenidate," which indicates respondent prescribed it, and calls into question whether the other problems listed were histories or contemporaneous findings.

Dr. Miles's Opinions regarding Inadequate History

154. Dr. Miles opined that the allegation respondent did not take an adequate history on November 25, 2019, and February 26, 2020, is incorrect. Respondent previously concluded Patient B's concentration problems were not caused by depression. While sleep apnea and marijuana use may have contributed to them, Patient B did not want to have a sleep study, and his marijuana use remained the same over time. Respondent's conclusion that Patient B's depression, sleep apnea, and marijuana were not the predominant cause for his concentration problems was reasonable and within the standard of care.

While respondent's documentation did not include a statement regarding occurrence of a rash or other side effects of the medication, overuse of stimulants, or symptoms of depression and anxiety, the standard of care does not require notating matters unless they are present in the interim, so issues no longer present need not be

documented and respondent monitoring the prescriptions minimized the risk of overuse. At the July 30, 2018, visit respondent determined Patient B did not have a major depressive disorder. From that point forward, respondent's documentation did not contain a diagnosis of major depressive disorder, depression and anxiety were not active problems, so respondent did not need to document inquiries about them on November 25, 2019, and February 26, 2020.

Respondent's Testimony regarding Inadequate History

155. Respondent testified that at the initial visit, he took an extensive history, obtaining details of Patient B's childhood, his family life, and detailed information regarding his education and work history. Had there been any mania, it would have come up during those discussions. Moreover, Patient B was someone who was "very invested" in trying to figure out why things had not worked out for him in life, and if he had mania, he would have told respondent about it. Respondent disagreed that he failed to inquire about past injuries or events, explaining he did so at length and ruled them out as contributing factors. Respondent also disagreed that he failed to investigate alcohol and drug use, because he did ask questions about those substances, and determined Patient B did not abuse marijuana and was not addicted to marijuana or alcohol. Respondent does not believe Patient B's marijuana use affected his concentration, especially as it did not change over time.

156. At the November 25, 2019, visit, respondent spent 30 minutes in face-to-face time with Patient B, primarily in supportive psychotherapy. Respondent documented how the treatment he was providing was effective because Patient B was improving. At the February 26, 2020, visit, Patient B continued to have a good response to Ritalin and respondent continued his supportive psychotherapy. The only diagnosis Patient B had as of this time was ADHD and an adequate history for that

diagnosis was taken. Moreover, respondent was documenting and keeping track of pertinent information for future appointments.

PRESCRIBING RITALIN ALLEGATION

157. Complainant alleged respondent committed gross negligence when prescribing methylphenidate on July 30, 2018.

Dr. Koskey's Opinions regarding Ritalin

158. Dr. Koskey opined that stimulants like methylphenidate are "first-line treatment options" for "appropriate patients with ADHD." Patients with a history of serious coronary events like heart attacks and stent placements should only have methylphenidate prescribed after consultation with a cardiologist. Substance use disorders are also a relative contraindication for stimulants. To minimize side effects, stimulants should be started at a low dose and only increased if patients do not respond or have significant side effects. Adult prescribing guidelines for Ritalin call for starting with 5 mg twice daily, and increasing by 5-10 mg weekly, to a maximum of 60 mg daily. Stahl's guidelines indicate a starting dose of 5 mg once or twice per day, and respondent's starting dose exceeded that amount. Side effects should also be discussed with the patient.

159. Respondent prescribed methylphenidate to Patient B on July 30, 2018, for "concentration problems," but did not diagnose ADHD. No potential side effects of methylphenidate were discussed with Patient B, and respondent did not consult with a cardiologist. At a prior appointment, respondent documented Patient B was using marijuana daily, but a potential use disorder was not discussed with Patient B when starting methylphenidate, and respondent started the patient on 20 mg twice daily which was four times the usual starting dose. Dr. Koskey opined that respondent's

failure to consider the potential physical and psychiatric consequences of prescribing methylphenidate to Patient B, or to document any conversation with him on its potential side effects, was an extreme departure from the standard of care.

160. Dr. Koskey opined that the standard of care required respondent to consult with a cardiologist before prescribing methylphenidate to Patient B because of his cardiac history of myocardial infarction with stent placement. Stimulants, like methylphenidate, can constrict blood vessels and stents are there to prevent further constrictions. However, Dr. Koskey agreed there was no documentation of any blood pressure medications being given to the patient and does not know the standard of care for documenting the same. He also there were no cardiac issues documented while Patient B was treating with respondent. However, he disagreed that taking vital signs was sufficient because blood pressure measurements will not capture arrhythmias or narrowing of the arteries.

Dr. Miles's Opinions regarding Ritalin

161. Dr. Miles disagreed with Dr. Koskey, because respondent did discuss methylphenidate side effects prior to prescribing it to Patient B. The standard of care requires patients be informed of the risks and benefits, but documentation of that discussion is not required. Respondent reviewed vital signs at each visit to monitor the cardiovascular effects of methylphenidate. The standard of care did not require consultation with a cardiologist before prescribing a stimulant to Patient B. Respondent was aware of Patient B's prior medical history, including his cardiac history, followed the patient, and was regularly able to monitor the patient's cardiac status through his vital signs, which was within the standard of care. Further, Patient B was being treated by a cardiologist, and Patient B was deemed to be a reliable historian who informed respondent of specifics regarding his medical history. Patient B

did not have a structural cardiac defect or severe arrhythmia or cardiac dysfunction. Accordingly, the standard of care did not require a cardiac referral before prescribing Ritalin to Patient B.

Respondent's Testimony regarding Ritalin

162. Patient B's cardiac condition was mild. He did not have significant damage to his heart, as far as respondent knew, other than was reported in the records. Respondent checked to see if Patient B was at high risk for coronary disease, and determined he was not. In the extensive medication list, other than a medication for high cholesterol, there were no medications prescribed for hypertension, blood pressure, or other cardiac symptoms. Accordingly, respondent had no concerns prescribing Ritalin. Additionally, Patient B was followed by a primary care physician at the clinic, so was having his blood pressure taken at both his psychiatric and primary care visits. Patient B only had three instances of an elevated systolic blood pressure and one instance of an elevated diastolic blood pressure, none of which required referral to a cardiologist or discontinuation of Ritalin.

TREATMENT OF PATIENT B'S RASH ALLEGATION

163. Complainant alleged respondent committed gross negligence in his management of Patient B's drug-induced rash.

Dr. Koskey's Opinions regarding Rash

164. Dr. Koskey opined that rashes as side effects of medications are potentially serious and can be fatal in rare cases. Symptoms of drug-induced rashes should be assessed by prescribers, including determining the location, onset, timing, severity, and type of rash, as well as the presence of other symptoms or other possible

contributing allergens or exposures. Medications causing rashes should be recorded as allergies in the medical record, and stopped, except in rare cases where careful consideration determines the benefits outweigh the side effects. It is standard to consult with the dermatologist for these rare cases.

165. After starting the methylphenidate, Patient B reported a rash. Respondent noted the location, nature, and timing of the rash, as well as other potential allergens. He concluded that he could not predict if continuing the Ritalin would lead to more serious reaction. This indicates respondent was still considering methylphenidate as a potential allergen, although no chart allergies were noted and no weighing of the risk of continuing a potential allergen was recorded or discussed. Despite not being able to predict if a more serious reaction was possible, respondent continued to prescribe methylphenidate, albeit at half the prior dose. When Patient B returned for his next therapy appointment, the LCSW noted a more definite relationship between methylphenidate and Patient B's rashes, documenting that he only takes one tablet of Ritalin daily, otherwise he breaks out in hives.

166. Respondent saw Patient B 13 days after that LCSW visit, and noted Patient B had one episode of rash associated with methylphenidate, and suggested switching to Adderall. Respondent failed to record methylphenidate as an allergy in the chart. Approximately eight months later, Patient B requested restarting methylphenidate, saying that in retrospect he did not think he had a rash. Respondent was "willing to try" restarting methylphenidate and did so, again, without discussing with Patient B how serious a drug-induced rash could be. Dr. Koskey concluded that respondent's failure to identify methylphenidate as an allergen, and avoid prescribing it, or to "defend methylphenidate as a necessary medication and explore its risks" with Patient B and a dermatologist, was an extreme departure from the standard of care.

167. Dr. Koskey opined that the standard of care required respondent to follow up about Patient B's rash disclosures at each visit. When Patient B reported an increase in concentration with Adderall, and later that he was alternating Adderall and Ritalin, the "totality of respondent's documentation" of those discussions was his notation that Patient B's concentration alternating the medications was good. Respondent did not document discussing the patient's current symptoms or conditions so as to determine whether the medications needed to be adjusted. Dr. Koskey opined this was an extreme departure and did not even approach what a reasonable psychiatrist would do.

Dr. Miles's Opinions regarding Rash

168. Dr. Miles opined that respondent documented that Patient B had a rash on his left leg that he believed was related to contact with a stingray, and that he had a non-confluent papular rash on his left arm that went away despite continuing to take Ritalin and, also occurred when the weather was hot. Respondent documented his conversation with Patient B wherein he stated he could not predict if continuing Ritalin would lead to a more serious reaction. Patient B wish to proceed with a lower dose of Ritalin. Given the single episode of the appearance of a rash, the standard of care did not require respondent document a methylphenidate allergy. Patient B reported a rash in September or October 2018. There was no reason for respondent to inquire any further regarding the rash as of November 2019.

169. Dr. Miles opined that respondent's discontinuation of Ritalin, prescribing Adderall, and subsequently resuming Ritalin, with alternating days, reflected his involvement in a therapeutic alignment with shared decision-making with Patient B. This meets the stated of care.

170. Further, the rash was not a bolus rash, it was not hives which are dangerous rashes which require referral to a dermatologist. Patient B did not complain of any side effects from medications at subsequent visits, and told respondent he wanted to continue with the Ritalin. Patient B took lower doses, and never had a rash again. It was within the standard of care for respondent to proceed in this manner, and observe Patient B to see if the rash returned.

171. However, as described in the records, Dr. Miles believes Patient B's rash was contact dermatitis, a heat rash, and not the dangerous type of rash that would require emergency treatment. Dr. Miles had no concerns regarding respondent initially discontinuing Ritalin and adding Adderall when the rash was first reported. Thereafter, he has no concerns with both medications being used in an alternating fashion. Using medications in this way was within the standard of care. Respondent's documentation regarding the rash in the records also met the standard of care, and when it did not occur weeks and months later, it was not necessary to continue documenting it.

Respondent's Testimony regarding Rash

172. Patient B did not report a rash until several weeks after beginning Ritalin. He also reported an encounter with a stingray. Thus, respondent did not think Ritalin was causing the rash. Further, because it was a non-confluent papular rash, which would not be hives since hives are confluent, and given that it was summer, it was possible the rash was a heat rash. However, respondent did document that he could not be sure it was not due to Ritalin as he did not know what could happen in the future. Since respondent could not entirely exclude Ritalin as a cause, he discussed discontinuing Ritalin, but Patient B had increased the Ritalin dose after developing the rash, and his preference was to continue with Ritalin as his concentration was improving.

173. Thereafter at the October 22, 2018, visit where the rash was again reported, respondent suggested switching to Adderall. Later when Patient B wanted to return to using Ritalin, because Adderall was causing constipation, respondent reminded him that taking the doses too close together could cause a rash, and they came up with a plan to alternate Ritalin and Adderall. Patient B reported his concentration was better with Adderall, he had not had a rash since his last appointment, and he did not have any rash at subsequent appointments, which supported respondent's initial belief that Ritalin did not cause the rash.

DIAGNOSING ADHD ALLEGATION

174. Complainant alleged respondent committed gross negligence when diagnosing Patient B with ADHD.

Dr. Koskey's Opinions regarding ADHD

175. Dr. Koskey referenced his standard of care opinions expressed regarding Patient A. Up until the August 13, 2018, office visit, respondent had not satisfied the DSM-5 criteria for diagnosing Patient B with ADHD. Respondent did not document that he considered and rejected the possibility that chronic marijuana use, untreated sleep apnea, or depression might be responsible for Patient B's concentration problems, and did not establish that symptoms were present before age 12. Respondent's failure to document criteria sufficient to satisfy the diagnoses of ADHD was a simple departure from the standard of care.

176. Dr. Koskey opined that chronic marijuana use has been linked to poor concentration. Respondent did not document that Patient B's marijuana use may be the cause of his concentration problems. Dr. Koskey noted Patient B was noted to be taking buspirone, which can cause "foggy headed" side effects for some people.

Dr. Miles's Opinions regarding ADHD

177. Dr. Miles disagreed with Dr. Koskey's opinion, noting that respondent documented a number of ADHD symptoms in his July 30, 2018, note. Respondent's records also include the LCSW's October 23, 2017, notes documenting symptoms that reasonably suggested a diagnosis of ADHD in an adult. Patient B's subsequent report of improved concentration, increased productivity, and his expressions of gratitude are evidence of the correctness of this diagnosis.

178. Dr. Miles opined that respondent did not need to document his monitoring of the appropriate use of the stimulants he prescribed. Respondent could see they were not being overused since Patient B never ran out early and never requested early refills. Additionally, respondent reviewed the CURES data which showed no issues. Respondent documented ADHD symptoms in the chart, including noting a prior psychiatrist had observed concentration difficulties. The symptoms documented suggested an ADHD diagnosis. Respondent's diagnosis was within the standard of care. Further, Patient B's reported improvement with the prescribed treatment suggests the diagnosis was correct.

179. Dr. Miles disagreed that the standard of care required respondent to consider that Patient B's poor concentration was due to depression, sleep apnea, or another condition. Respondent had ruled out depression at the second office visit. It was possible Patient B had sleep apnea that could have contributed to his concentration problems, but he was unwilling to do a sleep study and advised that recordings on his cell phone did not show any sleep issues. There was no indication that Patient B's minimal marijuana use had changed, so was likely not the cause of his concentration issues. Further, Patient B had ADHD symptoms.

Character References

MARK BALAS, M.D.

180. Mark Balas, M.D., testified and wrote a letter on respondent's behalf, which was consistent with his testimony. Dr. Bala's testimony and statements are summarized as follows: Dr. Balas has been a psychiatrist since 2008. He began working at Donovan in February 2017, providing psychiatric treatment for the prison population. Respondent joined the staff in late 2020, and had an adjoining office. He and respondent formed a collegial relationship, and respondent frequently came by to ask questions regarding nuances of providing psychiatric treatment within the prison system, and how to navigate the environment in general. Respondent treats patients with various behavioral problems in the Restricted Housing Unit of the prison, and the two often work with the same patients at different points in time.

Dr. Balas reviews respondent's progress with patients "nearly every day," and has a sense of respondent's patient interactions. Respondent's progress notes are "remarkably reliable because of their thoroughness and detail. Respondent "is one of the best notetakers because he remains clinically focused in his patient care." Respondent spends "a significant amount of time researching patient cases and investigating often overlooked issues." Respondent "is known to be both thorough and efficient. Despite the high volume of very complex patients that respondent treats, respondent "still provides a higher level of reliability and detail in his care notes than other clinical psychiatrists." Respondent and Dr. Balas often consult one another and collaborate on patients, and respondent provides updates on shared patients. Dr. Balas described respondent as "professional, diligent, and intentional in his work in patient care." Dr. Balas was aware of the accusation, but is of the opinion that respondent "is a competent and skilled psychiatrist, and he had "no reservations" supporting him.

181. Dr. Balas testified about his education and employment history. He has known respondent since 2020 when respondent joined the staff at Donovan. He and respondent regularly engage and discuss patients. Respondent treats patients at Donovan who have the most severe mental health issues. Respondent is "very reliable, very thorough, very detailed," and has "a lot of precision in his work." Respondent is "very effective and very thorough, a combination I do not see very often."

Dr. Balas and respondent discuss cases regularly, and review each other's chart notes. Dr. Balas "can tell the big or little picture very easily" when reading respondent's records. He and respondent collaborate on the most complex and behaviorally dysregulated patients at the prison, and respondent can always be counted upon to assist his colleagues. Respondent always takes concerns seriously. He is professional, sets strong boundaries, has a strong knowledge, and always does a very professional job. Respondent will also research cases, and often discovers information about patients of which others were not aware. Dr. Balas knows about the board's accusation, although he has not reviewed it, but has no reservations supporting respondent.

PARMALEE TOWB, M.D.

182. Parmalee Towb, M.D., a Senior Psychiatrist, Supervisor at Donovan, testified and wrote a letter on respondent's behalf, which was consistent with his testimony. Dr. Towb's testimony and statements are summarized as follows: Dr. Towb has worked at Donovan since 2020 where he supervises psychiatrists with a focus on improving the prison psychiatric program. In 2023, respondent was assigned to treat patients in the Restrictive Housing Unit, where inmates are housed separately from the general prison population due to violent behavior or other concerns. Working in his position is "high visibility" and "demands high stress tolerance and good decision-

making, more so than in many other placements." Respondent "is exceptional in the sense that he was chosen" from 20 other psychiatrists to be on that unit.

183. Respondent "has proven to be a good fit, and psychologists and social workers on his unit team report that they enjoy working with him." Dr. Towb cannot recall any inmate psychiatric grievances directed towards respondent. On a "daily to weekly basis," he reviews respondent's work and "preferentially" reviews respondent's notes "because they are more thorough and I can expect good information." Respondent's "decision-making process on which medications he prescribes and which diagnoses he is treating are reflected in detail" and he will seek second opinions "further demonstrating his thoughtfulness and commitment to patient care. Overall, [respondent] is honest, scrupulous, pleasant, a team player, and has good rapport with patients." Dr. Towb understands the board has filed an accusation alleging deviations from the standard of care but, despite that, he has no reservations with respect to respondent's qualifications, competence or professionalism as a psychiatrist. "Over the last several years the services he has provided that I have been aware of are in stark contrast any of the allegations by the medical board."

184. Dr. Towb testified about his education and employment history. He is respondent's supervisor at Donovan. The Restrictive Housing Unit houses the most difficult and dangerous prisoners. Respondent was selected to treat those patients because of his overall clinical competence, decision-making abilities, abilities to assess and appropriately diagnose patients, and create appropriate treatment plans, including prescriptions. Respondent performs very thorough patient assessments. Dr. Towb described respondent as kind, thoughtful, whose reasoning is measured and contemplative, and as one who thinks through all aspects of a patient's presentation, coming up with an appropriate treatment plan. Respondent is very conscientious and

concerned with doing the right thing. When presented with problems, he comes to well-reasoned decisions. He is very competent.

185. Dr. Towb reviews respondent's records on a weekly basis, and finds them to be thorough, complete, well-reasoned, well documented, and to demonstrate respondent's observations, thinking process, and reasoned treatment plan. His records clearly reflect his decision making process. Dr. Towb supports respondent's diagnosis and prescriptions in the documents he has reviewed, and his records are "always a good reflection of his decisions and how he came to those decisions." Respondent has an extremely high character, which Dr. Towb described as "the highest moral character," and Dr. Towb would trust respondent with his life. Dr. Towb would be "quite happy" to have respondent as his psychiatrist. At Donovan, respondent is "held in very high regard" and other physicians have greatly appreciated having him on staff. Dr. Towb has heard "snippets" of the accusation but never reviewed it.

JOHN LYSZCZARZ, M.D.

186. Dr. Lyszczarz testified about his education and employment history. He is the chief psychiatrist at Donovan where he oversees respondent's work. Respondent is employed as a registry staff psychiatrist, he is not a civil service employee, although Dr. Lyszczarz has tried to recruit him to be one on multiple occasions. He described respondent as an especially conscientious psychiatrist. He is a very strong team player, very mission oriented, and very reliable. Dr. Lyszczarz regularly reviews respondent's records, and can clearly see his medical decision-making documented therein.

Dr. Lyszczarz was "challenged" finding someone willing to work in the Restrictive Housing Unit because of the extremely difficult prisoners housed there, and their extreme psychiatric issues. This unit has the highest suicide rate and admission to

crisis beds. Respondent was assigned to this unit, and the team there "could not be happier with him." Respondent is referred to as a "rockstar" by his colleagues.

Respondent is someone who "performs at a very high level without complaint." Dr. Lyszczarz holds respondent in the highest esteem. He is a man of integrity, an honest person, a humble individual, and able to reflect upon situations that do not go well and be receptive to feedback. He makes changes to improve, and his commitment to the psychiatric field is "beyond question." Dr. Lyszczarz spoke with respondent about the accusation, and has no reservations testifying on his behalf. Dr. Lyszczarz fully supports respondent.

Costs of Investigation and Enforcement

187. Complainant seeks recovery of the investigation and enforcement costs pursuant to Business and Professions Code section 125.3.

188. The Department of Consumer Affairs representative designated to certify the investigation costs provided a declaration identifying the investigator, the total number of hours spent, the hourly rate, and attached the investigator's log which set forth the number of hours spent performing specific tasks. Total investigation costs incurred were $12,588.

189. A certification of costs detailing the expert costs incurred and an attached Statement of Services documented that Dr. Koskey billed complainant $5,950 for his time spent reviewing records and preparing his report.

190. The Deputy Attorney General who prosecuted the case was extremely well prepared, and signed a declaration requesting costs for legal work billed through September 13, 2024, totaling $47,096. Attached to the declaration was the "Matter

Time Activity by Professional Type." That document identified the tasks performed, the dates legal services were provided, who provided the services, the time spent on each task, and the hourly rate of the individuals who performed the work.

191. California Code of Regulations, title 1, section 1042, subdivision (b), requires that any declaration seeking costs include "specific and sufficient facts to support findings regarding actual costs incurred and the reasonableness of the costs." The declarations with the attachments for the costs complied with the regulation and those costs of $65,634 are found to be reasonable.

192. No evidence regarding respondent's ability to pay costs was offered, although he is employed as a registry staff psychiatrist in the prison system, so presumably does not make a substantial amount of money.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of administrative discipline is not to punish, but to protect the public by eliminating those practitioners who are dishonest, immoral, disreputable or incompetent. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

2. Business and Professions Code section 2229 states: "Protection of the public shall be the highest priority" for the board.

The Burden and Standard of Proof

3. Complainant bears the burden of establishing that the causes pled in the accusation are true. (*Martin v. State Personnel Medical Board* (1972) 26.Cal.App.3d 573, 582.)

4. The standard of proof in an administrative action seeking to suspend or revoke a physician and surgeon's certificate is "clear and convincing proof to a reasonable certainty." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

5. Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; it must be sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.) The requirement to prove by clear and convincing evidence is a "heavy burden, far in excess of the preponderance sufficient in most civil litigation. [Citation.]" (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

Applicable Code Sections

6. Business and Professions Code section 2227 authorizes the board to discipline physicians who violate applicable laws and regulations. Subdivision (a)(1) authorizes revocation; subdivision (a)(2) authorizes suspension; subdivision (a)(3) authorizes probation; subdivision (a)(4) authorizes public reprimand which may include a requirement the licensee complete relevant board-approved educational courses; and subdivision (a)(5) authorizes any other action as part of a probation order the board or administrative law judge may deem proper.

7. Business and Professions Code section 2234, authorizes discipline for physicians who commit gross negligence (subdivision (b)) or repeated negligent acts (subdivision (c)).

The Board's Disciplinary Guidelines

8. The board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th Edition 2016) are intended to be used in the physician disciplinary process but "are not binding standards." Further,

> The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

Evaluation of the Causes for Discipline Regarding Patient A

9. Complainant did not establish by clear and convincing evidence that respondent failed to take an adequate psychiatric history of Patient A. Respondent's records were replete with his documentation of the past history Patient A revealed; Patient A's failure to disclose her prior psychotic history or other matters was not respondent's fault and he cannot be held responsible for not knowing what Patient A

refused to disclose. Respondent's records documented the information he obtained which allowed him to rule in and rule out diagnoses. He testified consistent with those records at this hearing, explaining his thought processes. Dr. Miles's opinions regarding this allegation were more reliable and persuasive than those rendered by Dr. Koskey to the contrary.

10. Complainant did not establish by clear and convincing evidence that respondent diagnosed major depressive disorder without satisfying its diagnostic criteria. Respondent documented in the records the symptoms Patient A had which satisfied the diagnostic criteria for a major depressive disorder diagnosis. Even if, arguendo, Patient A did not have all of the required symptoms, the DSM-5 does not require all criteria to be present for a diagnosis to be made if the symptoms of the diagnosis are present, as they were here. Dr. Miles's opinions regarding this allegation were more reliable and persuasive than those rendered by Dr. Koskey to the contrary.

11. Complainant did not establish by clear and convincing evidence that respondent diagnosed ADHD without satisfying the DSM-5 diagnostic criteria or adequately considering alternatives. As previously found, the DSM-5 does not require all criteria to be present for a diagnosis to be made. However, as clearly documented in respondent's records, Patient A did present with symptoms that satisfied the DSM-5 ADHD criteria. The assertion that respondent did not establish that her ADHD symptoms arose before age 12 was not persuasive, as the evidence did not establish any other logical explanation for Ritalin to have been prescribed to her at age six other than for ADHD. Dr. Miles's opinions regarding this allegation were more reliable and persuasive than those rendered by Dr. Koskey to the contrary.

12. Complainant did not establish by clear and convincing evidence that respondent committed gross negligence with his starting dose of Adderall at 40 mg.

Dr. Miles's testimony that starting dosages at higher levels for adults to address their symptoms was within the standard of care is accepted over Dr. Koskey's contrary opinions. No evidence refuted respondent's assertion he discussed risks of treatment with Patient A. Moreover, Dr. Koskey seemed to have factored in as a part of his opinion Patient A's psychotic history, something of which respondent was not aware, and which cannot be considered when evaluating this allegation.

13. Complainant did establish by clear and convincing evidence that respondent committed gross negligence with his starting dose of Trazodone at 200 mg. While it may be true that Patient A reported this was a dose she used in the past that worked, respondent, without the benefit of reviewing her prior records, had no way to verify that dosage. Given Patient A's recent incarceration which she refused to discuss, respondent would have been wise to start her at a standard starting dose. The studies on which he and his expert relied were not persuasive for the reasons noted above. Given Patient A's report of sleeping all the time and for many hours after being prescribed Trazadone, respondent should have lowered the dosage at subsequent visits as Dr. Koskey opined. Keeping that dosage at that level because Patient A wanted that dosage made it appear as if respondent abdicated his responsibility to monitor and titrate the dosage. Further, the level of sleep Patient A reported after starting Trazodone far exceeded sleep levels she previously reported, and were not better explained by other conditions or diagnoses. Given her reported sleep levels, respondent should have lowered Patient A's Trazadone dose.

Evaluation of the Causes for Discipline Regarding Patient B

14. Complainant did not establish by clear and convincing evidence that respondent failed to take an adequate psychiatric history of Patient B. Respondent's records were replete with his documentation of Patient B's past history and prior

treatment. Respondent's records documented the information he obtained which allowed him to rule in and rule out diagnoses. He testified consistent with those records at this hearing, explaining his thought processes. Dr. Miles's opinions regarding this allegation were more reliable and persuasive than those rendered by Dr. Koskey to the contrary.

15. Complainant did not establish by clear and convincing evidence that respondent should have obtained a cardiac consult before prescribing Ritalin. Patient B's cardiac symptoms were mild, he was not on any cardiac medications nor exhibiting any cardiac symptoms. His vital signs were within normal limits and respondent monitored Patient B's responses to Ritalin at the visits. No evidence refuted respondent's assertion he discussed risks of treatment with Patient B. Dr. Miles's opinions regarding this allegation were more reliable and persuasive than those rendered by Dr. Koskey to the contrary.

16. Complainant did not establish by clear and convincing evidence that respondent failed to properly monitor the rash Patient B developed. It was unclear if the rash was caused by the Ritalin prescription, and respondent documented that he could not rule out that possibility. His notes indicated he was monitoring it. Moreover, Patient B developed the rash in the summer, indicating it could likely be a heat rash. Patient B claimed it might be hives. He also attributed the rash to a stingray encounter. The rash was a non-confluent papular rash, suggesting it was likely not caused by the Ritalin. Patient B continued taking the Ritalin at lower doses, spacing out his doses, and alternating with Adderall, all of which helped his ADHD symptoms and, more importantly, his rash resolved. Dr. Miles's opinions regarding this allegation were more persuasive than those rendered by Dr. Koskey to the contrary.

17. Complainant did not establish by clear and convincing evidence that respondent diagnosed ADHD without satisfying the DSM-5 diagnostic criteria or adequately considering alternatives. ADHD symptoms that satisfied the DSM-5 criteria were clearly documented in Patient B's records. The assertion that respondent did not establish that the ADHD symptoms arose before age 12 was not persuasive, as it is possible, given Patient B's report being a high achiever while a child, and his reported difficulties and lack of life successes, that he did have this condition before age 12. Even if he did not, as previously found, the DSM-5 does not require all criteria to be present for a diagnosis to be made. Dr. Miles's opinions regarding this allegation were more reliable and persuasive than those rendered by Dr. Koskey to the contrary.

Evaluation of the Appropriate Discipline

18. Having found one cause to discipline respondent because he committed gross negligence in his care and treatment of Patient A when he prescribed her initial Trazodone dose of 200 mg and thereafter did not lower that dosage, the issue is the appropriate discipline for that violation. While the board's disciplinary guidelines set forth a maximum penalty of revocation and a minimum penalty of revocation, stayed, five years' probation, with various terms and conditions, when gross negligence is found, the guidelines also allow deviation in appropriate cases. This case is one where deviation is appropriate. Respondent has been a licensed physician since 1990 with no history of discipline or complaints. He holds medical licenses in three states and has served in numerous leadership capacities and on several utilization/quality control committees. His medical records were extremely detailed, easy to read, and he presented as a sincere and credible witness. Colleagues who work with him, including those who supervise him, testified on his behalf and highly sang his praises. They described his extensive knowledge, excellent record keeping, and commitment to

psychiatric care, serving the most dangerous prison population at Donovan. Although it has been found that respondent's Trazodone dose initially prescribed to Patient A fell below the standard of care, respondent's testimony regarding why that dose was prescribed was not so out of line as to be unreasonable, and his records documented, consistent with his testimony, that he discussed this dose with the patient at the initial prescribing and subsequent visits. Moreover, respondent successfully defended himself against complainant's multiple gross negligence allegations, repeatedly demonstrating why his care and treatment of the two patients at issue was well within the standard of care.

On this record, public protection is satisfied by issuing respondent a public reprimand and ordering him to take a board-approved education course regarding prescribing medications, possibly one addressing Trazodone prescriptions. While respondent's testimony about losing his job should he be placed on probation cannot be considered, it also cannot be ignored that public safety will not be furthered should society lose the excellent skills and treatment respondent currently provides to extremely dangerous prisoners.

A public reprimand is not a "free pass." It constitutes the board's formal criticism and censure of respondent, who engaged in the conduct outlined above. It warns him that engaging in the same or similar conduct in the future will likely result in more serious consequences. A public reprimand gives notice to the public and others of the nature and extent of respondent misconduct.

The Reasonable Costs of Investigation and Enforcement

19. Business and Professions Code section 125.3 permits complainant to request that an administrative law judge "direct a licentiate found to have committed a

violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case."

20. In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court decided that in order to determine whether the actual costs of investigation and prosecution sought by a regulatory board under a statute substantially identical to Business and Professions Code 125.3 are "reasonable," the agency must decide: (a) Whether the licensee has been successful at hearing in getting charges dismissed or reduced; (b) the licensee's subjective good faith belief in the merits of his or her position; (c) whether the licensee has raised a colorable challenge to the proposed discipline; (d) the financial ability of the licensee to pay; and (e) whether the scope of the investigation was appropriate to the alleged misconduct.

21. Complainant established only one of the nine causes for discipline discussed at hearing, and respondent was successful in having Dr. Koskey retract some of his opinions. Accordingly a rejection of the $65,634 costs sought is warranted. Based upon the evidence of record, costs shall be reduced to $2,000.

ORDER

Respondent Edward Joseph Erbe, M.D., is reprimanded for committing gross negligence with his starting dose of 200 mg of Trazodone for Patient A. This decision shall serve as respondent's Public Reprimand. The following terms are ordered:

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.

Costs

Respondent shall pay the costs associated with the enforcement of this matter in the amount of $2,000. Respondent may negotiate a payment plan with the Board.

DATE: October 29, 2024

Mary Agnes Matyszewski (Oct 29, 2024 15:54 PDT)

MARY AGNES MATYSZEWSKI

Administrative Law Judge

Office of Administrative Hearings