KAMALA D. HARRIS,
Attorney General of California
ROBERT MCKIM BELL,
Supervising Deputy Attorney General
State Bar No. 56332
KLINT JAMES MCKAY,
Deputy Attorney General
State Bar No. 120881
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 576 -1327
Facsimile: (213) 897-9395
Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Sept 30, 2011
BY ANALYST

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

In the Matter of the Accusation Against: DAVID MARK GUDEMAN, M.D. 2650 Jones Way, Suite 27B Simi Valley, California 93065 Physician's and Surgeon's Certificate No. G 69799, Respondent.	MBC Case No. 05-2010-204739 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Linda K. Whitney (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California (Board).

2. On or about September 17, 1990, the Board issued Physician's and Surgeon's Certificate Number G 69799 to David Mark Gudeman, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2012, unless renewed.

//

//

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws.

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

5. Section 2234 of the California Business and Professions Code states:

"The Division of Medical Quality[1] shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the

[1] California Business and Professions Code section 2002, as amended and effective January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in the State Medical Practice Act (Cal. Bus. & Prof. Code, §§2000, et seq.) means the "Medical Board of California," and references to the "Division of Medical Quality" and "Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

6. Section 2238 of the California Business and Professions Code provides:

"A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

7. Section 2266 of the California Business and Professions Code provides:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence as to Patient J.C.[2])

8. Respondent is subject to disciplinary action for gross negligence under section 2234(b) of the California Business and Professions Code in that he failed to adequately evaluate, diagnose, and treat the patient's mental state, drug abuse, and chronic pain, failed to properly use opiates for pain, failed to obtain consultation on drug dosages and frequency, failed to terminate treatment when J.C. demanded inappropriate treatment. The facts and circumstances are as follows.

A. J.C. was first seen by Respondent on September 24, 2004, when she was hospitalized at Simi Valley Hospital in Simi Valley, California. Respondent noted that "the patient has pharmaceutical dependence and has been self- adjusting her medication." She had a history of suicide attempts, including shooting herself once in the abdomen.

[2] The patient names are abbreviated for privacy reasons.

B. When she was admitted to the hospital, for surgery to remove leaking breast implants, she was on hydrochlorothiazide, Atenolol, Lisinopril, Norvasc, Prempro, Allegra, Aciphex, Suboxone, Alprazolam, Vicodin, Neurontine, Zyprexa, Topamax, Ambien, Celebrex, and Bextia.

C. J.C. was first seen by Respondent on 10/11/04 in Respondent's private practice, and was evaluated and treated with the primary diagnosis of Bipolar I Depressed with no diagnosis of the substance abuse and dependence. She was seen by Respondent until August 2010 in outpatient treatment. No effort was made to obtain records of past psychiatric treatment or contact her internist to coordinate care, given the multiple chronic medical problems that the then 57-year-old woman had. No request was made for recent laboratory tests prior to pharmacotherapy continuation with Zyprexa and Topamax. No clear treatment plan was documented nor was informed consent obtained for Tegretol initiation nor was clear documentation present for the rationale for its use or for the discontinuation of Neurontine.

D. Respondent never performed a diagnostic work up for chronic pain and did not adequately document the patient's care, although she had a lifelong and well known pain condition. Respondent noted that J.C. had severe family stressors and that he was treating this patient with supportive psychotherapy. However, there is no record of his psychotherapy. There is no documentation of his having clarified the nature of the family problems, getting his patient to work with him on constructive solutions or dealing with any of the major life crises that occurred during the time he was treating J.C., such as the murder of her daughter on January 1, 2005 or her son's suicide on June 4, 2010. There was no evidence of Respondent's psychotherapeutic understanding of his patient.

E. The patient's records are incomplete and inaccurate. Respondent did not fully document what he actually does, and sometimes he documented nothing. Respondent often "infers" from what medications he gave, what his reasoning was for the changes in medications. Respondent did not act on information that requires medical evaluation, such as Respondent being told by his patient that her 14-year-old grandson put his fingers in his little sister's vagina. He did not document his understanding of the context or make a determination about the danger of the family environment on the children to clarify whether notification to Child Protective

Services was required or any other intervention was necessary, such as talking to family therapist (if there was any) or referral for family therapy. Instead, he only focused on "pain" and "function" by which he meant avoiding withdrawals.

F. Respondent thus justified starting a known addict on Norco "for her pain" and later adding Oxycontin and continuing the use of Benzodiazepines, Alprazolam and Ambien. He prescribed such drugs to J.C. despite her known patterns of alcohol abuse and suicidality. The record clearly demonstrates the pattern of continued increase in dosages of narcotics as tolerance progressed to clearly dangerous levels.

G. In September 2007, Respondent received a FAX from CostCo pharmacy clearly notifying him that his patient was using "multiple pharmacies and multiple doctors" and they indicated that they would not fill any more prescriptions for the patient. Still, Respondent persisted in his "treatment" which amounts to supplying narcotics to a known addict. In 2009, he received an "anonymous" letter expressing concerns about his patient's life from overdose, but still continued to prescribe opiates.

H. Respondent was also treating the patient's son, who committed suicide on June 24, 2010, but there are no details documented. When Respondent saw his patient on July 2, 2010, he did not document this momentous family tragedy. There is no review of treatment to date and the patient's opiate prescriptions were renewed and still more drugs prescribed, including Ambien, Alprazolam, Cymbalta, and Celebrex.

I. By this time in 2010, Respondent was maintaining his diagnosis of "Bipolar I, in full remission" without any documentation, as well as the medical diagnoses of fibromyalgia, hypertension and now chronic pain scoliosis. However, throughout his years of treating the patient, there was no record of any physical exam or lab tests or any attempt to contact patient's internist or any other specialist about these conditions, or consideration of any the possible drug complications such as of Cymbalta on the patient's blood pressure or any concern about liver function, given chronic use of Celebrex. In addition, there is no diagnosis regarding the patient's clear substance dependence with increasing tolerance and overt addict behavior.

J. Respondent's September, 2004, hospital consultation clearly noted that, at 57 years old, his patient suffered from chronic substance and alcohol abuse, problems with anxiety and depression, at least one serious suicide attempt by shooting herself in the abdomen as well as past multiple suicide attempts. Her delirium was due to opiate withdrawal but the diagnoses of substance dependence and alcohol abuse were never made. Instead, this patient was treated without a proper evaluation to confirm the diagnosis and no proper monitoring on follow up. There is no proper documentation of any treatment plan before any medications are used or his reasons for medication changes.

K. The red flag of substance abuse on March 4, 2005 was well documented: "She tried 1,000 mg of Vicodin;" however, this fact was not used to change the diagnosis to evaluate the risk of overdose/suicide or the need for higher level of care such as inpatient treatment for her drug abuse. The family substance abuse and alcohol problems were noted in the record: husband's drinking, and her daughter's use of methamphetamine. However, no therapeutic action was considered, taken or documented such as family treatment, Alcoholics Anonymous, Narcotics Anonymous and consideration for sober living placement.

L. Since the September, 2004 consult and the October, 2004 onset of outpatient psychiatric treatment, this patient was seen in combined pharmacotherapy and supportive psychotherapy. The record of outpatient treatment between October 2004 and November 4, 2005 is consistent with major problems involving the patient and her family, but none of these issues became the focus of treatment. None of them was addressed therapeutically in a problem solving way. This patient was diagnosed as Bipolar but there is no clear basis to justify this diagnosis.

M. On March 7, 2007, the patient returned to treatment. She had not been seen since November 4, 2005. There is no proper evaluation of this patient on her return to treatment. The record states that her daughter (who was a substance abuser) had died at age 25 years, after being missing for two months. There was no further clarification about what this meant for the patient, how the patient coped or why she had not come in all this time. Then there is the strange note out of context: "Her husband is okay with changing to Norco". There is no documentation of any diagnoses or any explanation. This is the beginning of what amounts to an ever increasing

dangerously derailed "treatment" with larger and larger dosages of both Norco and Oxycontin, which was added on December, 17, 2007. The applicable standard of care required that the patient's mourning and all related affects be seen as the real source of her pain.

N. Respondent prescribed opiates to his patient from March, 2007 to August, 2010 in violation of the Medical Board's Guidelines for the treatment of Chronic Pain with Opiates: he treated a known addict with opiates and continued with increasing higher dosages as tolerance developed. He did not follow the guidelines by initially conducting a proper evaluation, physical exam, laboratory studies, obtaining past records and contacting the patient's other physicians to determine the medical basis of her pain. There is no proper documentation of informed consent or of follow up. There is no proper review and evaluation before increasing dosages. In September, 2007, there was no proper review when Respondent received a fax from CostCo clearly informing him that the patient had been using prescriptions from multiple physicians and that "We will not fill any more Rx's for her." In 2009, Respondent failed to review and reevaluate when he received an anonymous typed letter in June of that year, with concerns about the patient dying from an overdose and that she recently had a "pacemaker/defibrillator unit implanted by another physician". Finally, no review or reevaluation was done after her son's suicide in 2009 just as there was none when her daughter died.

O. Respondent failed to obtain consultation when he became aware of and "worried" about this patient's increasing dosages, well above his own "limiting amounts".

P. Respondent's records did not reflect what he told the patient, the patient's response, or any problems that were encountered. The records therefore do not truthfully and accurately document the actual problems, the rationale for treatment choices, the informed consent and the warnings given to patients and the patient's responses.

Q. When J.C. did not follow recommendations for care, Respondent compromised the integrity of the treatment by failing to terminate his treatment of the patient. No opiates should ever have been prescribed to this patient and care should have terminated if the patient demanded such treatment. Full documentation was also required but absent.

9. Each of the above actions constitutes gross negligence within the meaning of California Business and Professions Code section 2234(b).

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts as to Patient J.C.)

10. The above actions of Respondent violate California Business and Professions Code section 2234(c) in that they constitute repeated negligent acts.

THIRD CAUSE FOR DISCIPLINE
(Failure to maintain adequate and accurate records as to Patient J.C.)

11. The above actions of Respondent violate California Business and Professions Code section 2266 in that Respondent failed to maintain adequate and accurate records with respect to his treatment of Patient J.C.

FOURTH CAUSE FOR DISCIPLINE
(Gross Negligence as to Patient S.C.)

12. Respondent is subject to disciplinary action for gross negligence under section 2234(b) of the California Business and Professions Code in that he failed to failed to adequately evaluate, diagnose, and treat the patient's mental state, drug abuse, and chronic pain, failed to properly use opiates for pain, and failed to obtain consultation on drug dosages and frequency. The facts and circumstances are as follows.

A. S.C. was a 50-year-old Caucasian woman, a college graduate, twice married, with a daughter who, at time of initial evaluation of S.C. by Respondent, was pregnant and in juvenile hall. S.C. was seen by Respondent from February 28, 2008 to August 31, 2010 in outpatient psychiatric treatment. S.C. had a strong family history of drug and alcohol problems in her father and one brother and depression in her mother. The patient's psychiatric problems date back to age 12 with multiple drug and alcohol abuse. In psychiatric treatment with Alcoholics Anonymous, she was able to overcome heroin addiction by Methadone treatment. She was sober for almost 3 years (1994-1997). She had hepatitis C, hypothyroidism, hypertension, obesity and sciatica. She was on disability for recurrent major depression with no psychosis.

B. S.C. was first seen by Respondent on March 5, 2008 for treatment of anxiety over repeated withdrawals and depression. The initial evaluation form was incomplete, another version from a different computer file was later submitted which was structurally complete as to items listed but incomplete as it did not contain all needed data. On mental status, S.C. presented as intelligent and non-psychotic. There was no mention in Respondent's records as to affect, psychological defenses, suicide risk, personality features, insight into her illness, level of motivation for the long term treatment of her addiction or level of her anxiety. Her primary diagnosis was Opioid Dependence and Major Depression Recurrent, non-psychotic. There was no formulation or treatment plan.

C. S.C. was being treated at the Aegis Center, a drug treatment facility in the same building as Respondent. S.C.'s medical history was not completed on either version of the initial evaluation. But, from the diagnoses and the medication with which she entered treatment, she was being treated by at least two additional physicians in addition to the Aegis program. Respondent never contacted any of this patient's current or former care givers and did not obtain any recent physical exam or laboratory testing, especially as related to liver, thyroid, cardiovascular and kidney function before prescribing any medication or for follow up.

D. There is no documentation in Respondent's records of the indications, continuation, addition or changes for the medications used. S.C. was seen from March 5, 2008 through August 31, 2010. According to S.C.'s own self-assessment records, she did not improve but deteriorated. There are repeated discrepancies between Respondent's records and the patient's own self-assessment. Respondent's records are routine "default" entries of his own observations and don't relate or address the patient's own assessment of her state, which was often depressed, helpless and suicidal. There is no clear statement as to the reasoning of the pharmacotherapy that Respondent followed in the care of this patient.

E. At the time of S.C.'s second session, Respondent failed to contact Aegis and/or S.C.'s internist before initiating any medication changes. On this second visit, he prescribed Vicodin ES for pain without any consideration that S.C. was an opiate addict on Methadone and used multiple antidepressants and other medications.

F. On the third visit of April 9, 2008, without any specific monitoring of any medications previously prescribed and without providing any rational justification, Respondent stopped the use of the previously prescribed Vicodin and started this patient on Norco for pain, as the patient requested. Furthermore, he undermined the treatment with her other doctors by prescribing medications that were given by them without justifying such an action. No consideration was ever made for the needed evaluation to work to discontinue this medication in this patient.

G. Respondent's records include copies of x ray studies of S.C.'s neck and spine from 2006, but nothing current that supported the diagnosis of chronic pain due to sciatica or neck problems. Referral to a rheumatologist for further evaluation was necessary before any prescription of medications.

H. Additionally, Respondent did not recognize the deterioration of S.C.'s condition, despite her clear pleadings to get the right medication and stay in the Aegis program, because the program strongly disapproved of the medications he was giving her. None of this was ever addressed or documented.

I. S.C.'s statements in the self reports are neither acknowledged in Respondent's records nor addressed appropriately. There is no consideration of the fact that this patient had been in Alcoholics Anonymous since the 1980s and had actually been sober for an extended period. S.C. had entered treatment with Respondent, anxious about relapse. Respondent gave her opiates. Her anxiety was justified, as she knew she was using opiates again and knew that she had to face withdrawal if she were to get healthy again. No consideration for inpatient detox treatment of her substance abuse was ever made as her condition deteriorated with clear risk of death from suicide or overdose.

J. As the patient continued to deteriorate, there was documentation of reported "conflicts" with the Methadone clinic, Aegis. Respondent never contacted Aegis to clarify issues and coordinate care. Instead he continued with Norco and when S.C. became suicidal he added Prozac, and started her on Neurontine for her increasing depression and anxiety while further increasing her Lamictal on August 19, 2008 and later increased it again. There was no attempt to

therapeutically deal with the drug problem as a primary cause of the patient's dysfunction, nor was her daughter's pregnancy and becoming a grandmother dealt with therapeutically.

H. By April 30, 2009, the patient noted "I had one of those episodes where I feel as though I'm going through heavy withdrawals." Xanax didn't help her but Methadone did. She now had urinary symptoms. Respondent prescribed changes in her Methadone, which was prescribed without contacting Aegis. He decreased her Methadone dose and stopped her Mitrazapine. However, S.C. continued to deteriorate.

I. By February 19, 2010, S.C. was asking for further "cutback on certain meds," so she could work things out at Aegis. She continued suicidal, in pain and in high distress with her dependence on medications. However, Respondent never got in touch with Aegis. Instead, he continued to add medications. While patient was clearly stating her distress, Respondent felt S.C. was "progressing well". At no time did he acknowledge that he undermined S.C.'s Methadone treatment for her addiction to opiates and was causing harm.

13. Each of the above actions constitutes gross negligence within the meaning of California Business and Professions Code section 2234(b).

FIFTH CAUSE FOR DISCIPLINE
(Repeated Negligent Acts as to Patient S.C.)

14. The above actions of Respondent violate California Business and Professions Code section 2234(c) in that they constitute repeated negligent acts.

SIXTH CAUSE FOR DISCIPLINE
(Failure To Maintain Adequate and Accurate Records as to Patient S.C.)

15. The above actions of Respondent violate California Business and Professions Code section 2266 in that Respondent failed to maintain adequate and accurate records with respect to his treatment of Patient S.C.

SEVENTH CAUSE FOR DISCIPLINE
(Gross Negligence as to Patient D.P.)

16. Respondent is subject to disciplinary action under section 2234(b) of the California Business and Professions Code in that he failed to adequately evaluate, diagnose, and treat the patient's mental state, drug abuse, and chronic pain, failed to properly use opiates for pain, and

failed to obtain consultation on drug dosages and frequency. The facts and circumstances are as follows.

A. Patient D.P. was seen in outpatient psychiatric treatment from June 19, 2007 through September 10, 2010. The last prescription from Respondent filled by D.P. which was written by Respondent was in November of 2010.

B. In his initial evaluation of this 20 year old in June of 2007, Respondent noted that patient had a motorcycle accident in April 2007, with injuries involving his clavicle, the clavicular cervical joint, wrist and thumb. No surgery was recommended and he was recovering.

C. There is no history or details about his drug or alcohol use. While it is documented under present history that the patient is clearly in trouble, on probation, depressed, anxious and "overwhelmed", under chief complaint the notation is: "He is doing well." There is no clarification of any of the history noted above most importantly regarding his probation status.

D. The diagnosis was Opiate Abuse and Major Depressive Disorder, recurrent, severe, without psychosis, and chronic pain due to trauma in sternoclavicular joint. The medications with which the patient came to treatment were not listed in the intake evaluation, but, in the May 4, 2007 consultation by an orthopedic surgeon, the patient was noted to be taking Oxycontin. In the Medication Consent dated June 27, 2007, D.P. was treated with Ambien, Celexa, Xanax for anxiety and no opiates. There is no documentation of any treatment plan for patient's drug abuse.

E. There is no documentation in the chart of any reason for prescribing Oxycontin to someone who already had a substance problem. There was no attempt to refer D.P. to any other physician for a second opinion before continuing the use of opiates and no documentation of any physical examination or baseline lab tests before any medications were prescribed or during the years of follow up.

F. On July 6, 2007, Respondent changed the diagnosis to Opiate Dependence, without any discussion or change in treatment plan and no documentation of any relevant concerns stemming from that change in diagnosis, such as recommendation for detox and/or specific treatment for drug abuse. The documentation is a "default" type which appeared to be a form entry and not tailored to the specific patient.

G. This method of documentation is repeated in most of the records reviewed. This patient received both Oxycontin and Norco for pain from 2007 to 2010. This type of "treatment" was continued by Respondent despite warning letters from the patient's insurance and pharmacies repeatedly raising concerns about the use of narcotics for pain and warnings of the risks involved with the chronic use of acetaminophen.

H. There was no concern raised in the records about the fact that the patient was obtaining narcotics from several pharmacies/physicians and that he was at high risk for injury, since he was working with machinery in construction.

I Although Respondent acknowledged in his interview that he was trying to terminate treatment and refer the patient and that he "worried" and "was drained" by the patient's demands for drugs which "made for a very difficult interaction," none of these concerns were documented and no supervision or consultation with another physician was obtained.

J. Respondent's records include only portions of his patient's February, 2010 discharge from a detoxification program at the Vista del Mar inpatient treatment facility. Respondent did not request the complete record of that hospitalization, and no attempt was made to contact the involved doctors. There is no documentation in the patient's record as to what was the reason for the admission or of the treatment given and the patient's response.

K. The session of April 22, 2010 is similarly silent. The documentation is the same stylized "default" type throughout. Respondent noted that by 2010, he was concerned by the ever-increasing opiate use, especially when the patient had a drunken driving charge and was using heroin. Respondent's records did not reflect the dosages of narcotics he was actually prescribing, as documented in a prescription history obtained by the Medical Board. This history clearly documents the increase in opiate use to dangerous levels. The treatment was terminated after the patient reported Respondent to the Medical Board.

L. D.P. had a history of drug abuse and parental divorce. However, during the entire course of treatment, there were no details in Respondent's records which clarify what the family life was before, during and after the divorce, what the impact of the divorce was on him, or whether the drug abuse preceded or followed the parental divorce. These details are essential for

proper treatment planning. There is no detailed drug/alcohol history that clarifies age of onset, type or course of drug or alcohol abuse. There are no details about the April, 2007 accident, such as the drugs which were used at that time or the circumstances of the accident.

M. There is no evaluation of suicide risk given the family stressors, the drug use and mood disorder. There is no developmental history to clarify behavioral or mood problems, no family history about the presence of drug/alcohol and depression in other family members. There is no detailed medical history, no details on social adjustment and function in school and with peers, no sexual history and no history of childhood abuse or neglect. There is no clarification of the probation status of the patient at the initial evaluation. Respondent failed to use the court to maintain motivation for treatment and compliance. Respondent's recitation of the patient's mental status is very superficial and incomplete, with no details as to vegetative and depressive symptoms, affect or thought disturbances, cognitive function, defenses, relevant character traits, insight or motivation for treatment and change. The treatment plan did not fit the realities of the case and was not modified in the course of the treatment, but was a formulaic default entry.

N. The applicable standard of care required treatment of the drug and alcohol abuse with referral for detox treatment and the involvement of both parents in an effort to reach a treatment alliance for change and commitment to drug treatment for sobriety. Respondent's treatment supported this patient's addiction while he was pharmacologically "treating" the associated depression and anxiety that was caused by the drug addiction. The presence of current addiction to opiates is an absolute contraindication to the use of opiates for pain.

O. Respondent failed to properly and truthfully document care given. This makes the records useless, since what is recorded is generally contradictory, and lacks the documentation of any steps, actions or advice regarding sobriety.

P. Respondent failed to properly evaluate and diagnose the chronic pain. D.P.'s drug abuse was the central problem, and should have been addressed from the very first contact. Instead, Respondent responded by steadily increasing the prescribed opiates to the end of treatment in 2010.

R. Respondent failed to obtain consultation with other physicians on D.P.'s drug use and repeatedly failed to assess his own performance, to acknowledge his difficulties or to obtain help to solve problems constructively.

S. Respondent failed to properly terminate the patient by documenting the treatment impasse and by offering alternatives for continued care to both patient and family. With outpatient care clearly failing and the patient deteriorating, Respondent failed to intervene and stop this type of "treatment" at numerous junctures when he was confronted with severely escalating addict behavior. Instead, he kept prescribing.

17. Each of the above actions constitutes gross negligence within the meaning of California Business and Professions Code section 2234(b).

EIGHTH CAUSE FOR DISCIPLINE
(Repeated Negligent Acts as to Patient D.P.)

18. The above actions of Respondent violate California Business and Professions Code section 2234(c) in that they constitute repeated negligent acts.

NINTH CAUSE FOR DISCIPLINE
(Failure To Maintain Adequate and Accurate Records as to Patient D.P.)

19. The above actions of Respondent violate California Business and Professions Code section 2266 in that Respondent failed to maintain adequate and accurate records with respect to his treatment of Patient D.P.

TENTH CAUSE FOR DISCIPLINE
(Gross Negligence as to Patient J.P.)

20. Respondent is subject to disciplinary action for gross negligence under section 2234(b) of the California Business and Professions Code in that he failed to adequately evaluate, diagnose, and treat a patient's mental state, drug abuse, and chronic pain, failed to properly use opiates for pain, and failed to obtain consultation on drug dosages and frequency. The facts and circumstances are as follows.

A. J.P. was first seen in consultation on March 26, 2008. He was seen in outpatient treatment until January 6, 2009. He died on January 12, 2009. The autopsy report stated the cause of death as "Narcotic Drug Intoxication".

B. Mr. P. presented as a 42-year-old manager, college graduate, divorced father of three adolescents. Details of his history were not documented. The details of his drug and alcohol use are not clear. Following a neck injury in 2004, he had been using Vicodin for pain and was suffering from depression. He had been tried on a variety of antidepressants and had side effects. There is no record of the patient being on any antidepressant at the time of initial evaluation. The mental status was incomplete and did not refer to assessment of the crucial aspects such as mood, range of affect, anxiety, suicide risk, character style, recognition of drug dependence or motivation for treatment for his drug problem.

C. The diagnosis given was Major Depressive Disorder, Recurrent-Severe without psychotic features and facet joint disease in neck. There was no formulation of the case, no discussion and no treatment plan. Respondent's records lack documentation of evaluation of critical aspects of this patient's evaluation (as noted above) or of the treatment prescribed. There is no initial treatment plan, and no changes in treatment were documented on follow-up visits, even when medications were changed. No documentation or specific assessments were made, such as a physical exam, EKG and baseline lab tests prior to prescribing any medication. The drugs prescribed by Respondent also require periodic assessments with lab tests with monitoring during follow-up visits, such as blood pressure, liver function, and suicide risk, but these were not done.

D. On April 24, 2008, Respondent added the diagnosis of Alcohol Dependence but did not document or change any treatment plan. He did not question his continued prescription of opiates and did not recognize or act on the clear, potentially lethal risks that his treatment with Emsam, Depakote, benzodiazepines and opiates presented for this depressed, suicidal, and alcohol abusing patient.

E. Starting with the first session and onward, Xanax was prescribed. Respondent specifically stated that he did not consider the increasing suicidality (thoughts and behavior) of his patient as a possible side effect of Emsam. He did not regularly document the clear suicide risk in his patient. He did not contact any of his patient's physicians who were also prescribing opiates to J.P., nor did he deal with his patient's clear, progressing deterioration with persistently

increasing suicide risk as his life was deteriorating and he began to have medical symptoms of edema and complaints of fatigue. With the increasing suicide risk in his patient, he failed to involve any member of this patient's family to alert them to the risk or modify the treatment to provide safeguards, including any recommendation for inpatient care and drug rehabilitation to address both the depression and the drug and alcohol problems.

F. Respondent failed to properly evaluate, diagnose and treat J.P. with combined psychopharmacology and supportive psychotherapy, and failed to evaluate and diagnose Substance Abuse. This patient acknowledged from the first visit that since the neck surgery in 2004 and nose surgery later, he had been using Vicodin, his family history of alcoholism, and that he had been using alcohol and marijuana since his adolescence. Ongoing, assessment of suicide risk from the first session and during all subsequent follow-up sessions was required, but not done. Respondent also never made the diagnosis for opiate dependence and multiple substance abuse.

G. While alcoholism was diagnosed, no assessment of its details was ever done and no treatment was considered or offered. While suicide was the main feature of this patient's depression, complicated by drug and alcohol use, J.P.'s real risk for a successful suicide was never recognized. In the presence of active drug and alcohol abuse with severe depression and high suicide risk, the use of opiates and benzodiazepines is absolutely contraindicated. As the patient was deteriorating, at no time was any consideration given for the need for a higher level of care.

H. Respondent failed to psychotherapeutically and psychopharmacologically treat chronic, recurrent depression with high suicide risk, in view of serious, chronic multiple substance and alcohol abuse. The use of Xanax as the first choice medication for anxiety in the absence of assessing alcohol and substance use is an extreme departure from the applicable standard of care.

I. The use of both Xanax and Emsam in the absence of assessment and treatment of alcohol and substance use, is an extreme departure from the applicable standard of care, because of the possible lethality of such a drug combination in a patient who can't be trusted to have

reliable self-monitoring and self-care, while being driven by urges to use. The death of this patient was a foreseeable risk, given the severity of his chronic depression with past suicide attempt and the combination of medications with the chronic drug and alcohol abuse. None of these clear signs were addressed.

J. The applicable standard of care required that the alcohol abuse be evaluated and treated in a structured program and that before any medications were prescribed, a physical and base line laboratory tests were performed. In addition, liver function must be tested prior to prescribing Depakote and thereafter periodically.

K. In addition, the known, increasing risk of suicide associated with Emsam should have been specifically assessed, carefully monitored and the medication be discontinued and other antidepressant medications, such as Cymbalta, be prescribed.

L. A physical exam and a baseline blood pressure should have been obtained prior to prescribing Emsam and the patient's blood pressure should have been monitored by the internist (or psychiatrist) thereafter. Psychotherapy should have been based on an assessment of the total reality of the patient's life and functional status. Respondent should have recognized the apparent drug and alcohol abuse in the presence of suicide attempts by slitting his wrists, the high suicide risk.

21. Each of the above actions constitutes gross negligence within the meaning of California Business and Professions Code section 2234(b).

ELEVENTH CAUSE FOR DISCIPLINE
(Repeated Negligent Acts as to Patient J.P.)

22. The above actions of Respondent violate California Business and Professions Code section 2234(c) in that they constitute repeated negligent acts.

///

///

///

///

TWELFTH CAUSE FOR DISCIPLINE
(Failure to maintain adequate and accurate records as to Patient J.P.)

23. The above actions of Respondent violate California Business and Professions Code section 2266 in that Respondent failed to maintain adequate and accurate records with respect to his treatment of Patient J.P.

THIRTEENTH CAUSE FOR DISCIPLINE
(Gross Negligence as to Patient D.A.)

24. Respondent is subject to disciplinary action for gross negligence under section 2234(b) of the California Business and Professions Code in that he failed to adequately evaluate, diagnose, and treat patient D.A.'s mental state, drug abuse, and chronic pain, failed to properly use opiates for pain, and failed to obtain consultation on drug dosages and frequency. The facts and circumstances are as follows.

A. Respondent treated patient D.A. for chronic pain with Methadone and with psychotropic medications for co morbid psychiatric conditions (ADHD, bipolar depression, anxiety and hypothyroidism) as an outpatient from February 27, 2007 to August 2, 2010. On August 3, 2010, this patient died from a Methadone overdose, with the toxicology report noting presence of additional substances (benzodiazepines, Oxycodone) .

B. Respondent failed to evaluate, diagnose and treat opiate addiction in this patient at the time of initial evaluation. This failure was compounded by Respondent's decision to treat this patient as a chronic pain patient with Methadone. Methadone increased the risk of drug abuse and death, because it is long acting thus causing higher side effects (respiratory depression). While Methadone is used in the treatment of chronic pain, there is a specific contraindication for its use in patients with current opiate addiction.

C. Respondent failed, on a continuing basis, to follow the applicable standard of care and Medical Board guidelines in his use of Methadone for chronic pain. The applicable standard of care required that he follow the Medical Board Guidelines for pain management with opiates and Guidelines for the use of controlled substances. The required steps for proper history and

physical examination for diagnosis and treatment planning or for a clear, specific, informed consent and periodic review were not followed.

D. Respondent continued to prescribe increasingly higher dosages of Methadone in violation of the guidelines and the applicable standard of care. He renewed the patient's Methadone prescriptions without seeing the patient for an evaluation and review on numerous occasions and continuously.

E. Respondent's initial evaluation documented a series of serious psychiatric, medical, behavioral and social aspects that required further explanation, clarification and follow-up throughout the course of treatment, since these issues are crucial to proper diagnosis, treatment and management of the case. He failed to properly evaluate these factors, and to properly evaluate, diagnose and treat the patient with pharmacotherapy and psychotherapy.

25. Each of the above actions constitutes gross negligence within the meaning of California Business and Professions Code section 2234(b).

FOURTEENTH CAUSE FOR DISCIPLINE
(Repeated Negligent Acts as to Patient D.A.)

26. The above actions of Respondent violate California Business and Professions Code section 2234(c) in that they constitute repeated negligent acts.

FIFTEENTH CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Records as to Patient D.A.)

27. The above actions of Respondent violate California Business and Professions Code section 2266 in that Respondent failed to maintain adequate and accurate records with respect to his treatment of Patient D.A.

///

///

///

///

///

///

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 69799 issued to David Mark Gudeman, M.D.

2. Revoking, suspending or denying approval of his authority to supervise physician assistants, pursuant to section 3527 of the Business and Professions Code;

3. Ordering him, if placed on probation, to pay the Medical Board of California the costs of probation monitoring;

4. Taking such other and further action as deemed necessary and proper.

DATED: September 30, 2011

LINDA K. WHITNEY
Executive Director,
Medical Board of California,
Department of Consumer Affairs,
State of California,
Complainant

LA2011503409
50958928