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

In the Matter of the Accusation Against: **Carol Stone Wolman, M.D.** Box 822 Albion, CA 95410 Physician's and Surgeon's Certificate G-17507 Respondent.	Case No. 12-1999-98505 OAH No. N2003 020089

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Division of Medical Quality, Medical Board of California, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective on September 4, 2003.

It is so ORDERED August 5, 2003.

FOR THE DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
RONALD H. WENDER, M.D.
Chair, Panel B

BILL LOCKYER, Attorney General
of the State of California
LAWRENCE A. MERCER, State Bar No. 111898
Deputy Attorney General
California Department of Justice
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5539
Facsimile: (415) 703-5480

Attorneys for Complainant

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

In the Matter of the Accusation Against: **Carol Stone Wolman, M.D.** Box 822 Albion, CA 95410 Physician's and Surgeon's Certificate G-17507 Respondent.	Case No. 12-1999-98505 OAH No. N2003 020089 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Ron Joseph (Complainant) is the Executive Director of the Medical Board of California. He brought this action solely in his official capacity and is represented in this matter by Bill Lockyer, Attorney General of the State of California, by Lawrence A. Mercer, Deputy Attorney General.

2. Respondent Carol Stone Wolman, M.D. (Respondent) is represented in this proceeding by her attorneys, Hassard Bonnington L.L.P., and John Etchevers, Esq., whose address is Two Embarcadero, Suite 1800, San Francisco, CA 94111-3993.

3. On or about October 28, 1969, the Medical Board of California issued Physician's and Surgeon's Certificate No. G-17507 to Carol Stone Wolman, M.D. (Respondent).

Said license is currently valid with an expiration date of June 30, 2005.

JURISDICTION

4. Accusation No. 12-1999-98505 was filed before the Division of Medical Quality (Division) for the Medical Board of California, Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on February 22, 2002. Respondent timely filed her Notice of Defense contesting the Accusation. A First Amended Accusation was filed on January 23, 2003, and respondent's earlier Notice of Defense was deemed to respond to the charges in the amended pleading. A copy of First Amended Accusation No. 12-1999-98505 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 12-1999-98505. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands and agrees that the charges and allegations in Accusation No. 12-1999-98505, if proven at a hearing, constitute cause for imposing discipline upon her license to practice medicine in the State of California.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up her right to contest those charges.

10. Respondent agrees that Physician's and Surgeon's Certificate no. G-17507 is subject to discipline and she agrees to be bound by the imposition of discipline as set forth in the Disciplinary Order below.

RESERVATION

11. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Division of Medical Quality, Medical Board of California, or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

12. This stipulation shall be subject to approval by the Division of Medical Quality. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Division regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Division considers and acts upon it. If the Division fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Division shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Division may, without further notice or formal proceeding, issue and enter the

following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate no. G-17507 issued to Respondent Carol Stone Wolman, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions.

Within 15 days after the effective date of this decision the respondent shall provide the Division, or its designee, proof of service that respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent or at any other facility where respondent engages in the practice of medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to respondent.

1. CONTROLLED DRUGS - PARTIAL RESTRICTION Respondent shall not prescribe, administer, dispense, order, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedule(s) III, IV and V of the Act and the ADD medications Ritalin and Adderal.

2. PHYSICIAN ASSESSMENT AND CLINICAL EDUCATION PROGRAM Within 90 days from the effective date of this decision, respondent, at his/her expense, shall enroll in The Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine (hereinafter the "PACE Program"). The PACE Program consists of the Comprehensive Assessment Program which is comprised of two mandatory components: Phase 1 and Phase 2. Phase 1 is a two-day program which assesses physical and mental health; neuropsychological performance; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to the specialty or sub-specialty of the respondent. After the results of Phase 1 are reviewed, respondent shall complete Phase 2. Phase 2 comprises five (5) days (40 hours) of Clinical Education in respondent's field of specialty. The specific curriculum of Phase 2 is designed by PACE Faculty and the Department or Division of respondent's specialty, and utilizes data

obtained from Phase 1. After respondent has completed Phase 1 and Phase 2, the PACE Evaluation Committee will review all results and make a recommendation to the Division or its designee as to whether further education, clinical training (including scope and length), treatment of any medical and/or psychological condition and any other matters affecting respondent's practice of medicine will be required or recommended. The Division or its designee may at any time request information from PACE regarding the respondent's participation in PACE and/or information derived therefrom. The Division may order respondent to undergo additional education, medical and/or psychological treatment based upon the recommendations received from PACE.

Upon approval of the recommendation by the Division or its designee, respondent shall undertake and complete the recommended and approved PACE Program. At the completion of the PACE Program, respondent shall submit to an examination on its contents and substance. The examination shall be designed and administered by the PACE Program faculty. Respondent shall not be deemed to have successfully completed the program unless he/she passes the examination. Respondent agrees that the determination of the PACE Program faculty as to whether or not she passed the examination and/or successfully completed the PACE Program shall be binding.

Respondent shall complete the PACE Program no later than six months after his initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

If respondent successfully completes the PACE Program, including the examination referenced above, she agrees to cause the PACE Program representative to forward a Certification of Successful Completion of the program to the Division or its designee. If respondent fails to successfully complete the PACE Program within the time limits outlined above, she shall be suspended from the practice of medicine.

Failure to participate in, and successfully complete all phases of the PACE Program, as outlined above, shall constitute a violation of probation.

3. MONITORING Within thirty (30) days of the effective date of this

decision, respondent shall submit to the Division or its designee for its prior approval a plan of practice in which respondent's practice shall be monitored by another physician in respondent's field of practice, who shall provide periodic reports to the Division or its designee.

If the monitor resigns or is no longer available, respondent shall, within fifteen (15) days, move to have a new monitor appointed, through nomination by respondent and approval by the Division or its designee.

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

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

6. PROBATION SURVEILLANCE PROGRAM COMPLIANCE Respondent shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep the Division informed of her business and residence addresses which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall, at all times, maintain a current and renewed physician's and surgeon's license.

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

7. INTERVIEW WITH THE DIVISION, ITS DESIGNEE OR ITS DESIGNATED PHYSICIAN(S) Respondent shall appear in person for interviews with the Division, its designee or its designated physician(s) upon request at various intervals and with reasonable notice.

//

8. TOLLING FOR OUT-OF-STATE PRACTICE, RESIDENCE OR IN-STATE NON-PRACTICE In the event respondent should leave California to reside or to practice outside the State or for any reason should respondent stop practicing medicine in California, respondent shall notify the Division or its designee in writing within ten (10) days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty (30) days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Division or its designee shall be considered as time spent in the practice of medicine. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary order.

9. COMPLETION OF PROBATION Upon successful completion of probation, respondent's certificate shall be fully restored.

10. VIOLATION OF PROBATION If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

11. COST RECOVERY The respondent is hereby ordered to reimburse the Division the amount of $1,500.00 for its investigative and prosecution costs, with the initial payment of $500.00 due within six months of the effective date of this decision and the balance due within three years of the effective date. Failure to reimburse the Division's cost of investigation and prosecution shall constitute a violation of the probation order, unless the Division agrees in writing to payment by an installment plan because of financial hardship. The filing of bankruptcy by the respondent shall not relieve the respondent of her responsibility to reimburse the Division for its investigative and prosecution costs.

12. PROBATION COSTS Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which are currently set at $2,874.00, but may be adjusted on an annual basis. Such costs shall be payable to the Division of Medical Quality and delivered to the designated probation surveillance monitor no later than January 31 of each calendar year, unless the Board upon a showing of financial hardship agrees in writing to a later date. Failure to pay costs within 30 days of the due date shall constitute a violation of probation.

13. LICENSE SURRENDER Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender her certificate to the Board. The Division reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, respondent will not longer be subject to the terms and conditions of probation.

//

//

//

//

//

//

//

//

//

//

//

//

//

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney. I understand the stipulation and the effect it will have on my license to practice medicine in California. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Division of Medical Quality, Medical Board of California.

DATED: 6/13/03.

Carol Stone Wolman, M.D.

CAROL STONE WOLMAN, M.D.
Respondent

I have read and fully discussed with Respondent Carol Stone Wolman, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 6/13/03.

HASSARD BONNINGTON, L.L.P.

JOHN A. ETCHEVERS
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Division of Medical Quality, Medical Board of California of the Department of Consumer Affairs.

DATED: June 13, 2003.

BILL LOCKYER, Attorney General
of the State of California

LAWRENCE A. MERCER
Deputy Attorney General

Attorneys for Complainant

DOJ Docket Number: 03573160-SF2002AD0225

Exhibit A
Accusation No. 12-1999-98505

BILL LOCKYER, Attorney General
of the State of California
VIVIEN H. HARA (State Bar No. 084589)
Supervising Deputy Attorney General
LAWRENCE A. MERCER (State Bar No. 111898)
Deputy Attorney General
California Department of Justice
455 Golden Gate Ave., Suite 11000
San Francisco, CA 94102
Telephone: (415) 703-5539
Facsimile: (415) 703-5480

Attorneys for Complainant

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

In the Matter of the Accusation Against: **CAROL STONE WOLMAN, M.D.** **Box 822** **Albion, CA 95410** **Physician and Surgeon Certificate** **No. G 17507** **Respondent**	**No. 12 1999 98505** **FIRST AMENDED ACCUSATION**

Complainant, Ron Joseph, alleges:

PARTIES

1. He is the Executive Director of the Medical Board of California, Department of Consumer Affairs, State of California and brings this Accusation solely in his official capacity.

2. On or about October 28, 1969, the Medical Board of California ("Board") issued Physician and Surgeon Certificate No. G 17507 to respondent Carol Stone Wolman, M.D. ("respondent"). Said certificate was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on June 30, 2003, unless renewed. There is no Board record of previous discipline having been taken against this certificate.

//

JURISDICTION

3. This Accusation is brought before the Division of Medical Quality (" Division") of the Board under the authority of the following provisions of law:

A. Section 2227 of the Business and Professions Code ("the Code") states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the division.
(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the division.
(3) Be placed on probation and required to pay the costs of probation monitoring upon order of the division.
(4) Be publicly reprimanded by the division.
(5) Have any other action taken in relation to discipline as the division or an administrative law judge may deem proper."

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, or other matters made confidential or privileged by existing law, is deemed public and shall be made available to the public by the board."

B. Section 2234 of the Code states:

"The Division of Medical Quality 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, or 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.
(d) Incompetence.
(e) The commission of any act involving dishonesty or corruption which is substantially related too the qualifications, functions, or duties of a physician and surgeon.
(f) Any act or conduct which would have warranted the denial of a certificate."

//

C. Section 2242(a) of the Code provides that prescribing, dispensing or furnished dangerous drugs as defined in section 4022 without a good faith prior examination and medical indication therefor constitutes unprofessional conduct.

D. Section 2261 of the Code provides, in pertinent part, that it is unprofessional conduct to knowingly make or sign any document related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts.

E. Section 2262 of the Code provides that it is unprofessional conduct to alter or modify the medical record of any person, with fraudulent intent, or to create any false medical record, with fraudulent intent.

F. Section 2266 of the Code provides that the failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to patients constitutes unprofessional conduct.

G. Section 725 of the Code provides, in pertinent part, that repeated acts of clearly excessive prescribing or administering of drugs is unprofessional conduct for a physician and surgeon.

H. Section 125.3 of the Code provides, in pertinent part, that the Division may request the administrative law judge to 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.

4. Section 14124.12 of the Welfare and Institutions Code states, in pertinent part:

> "(a) Upon receipt of written notice from the Medical Board of California, the Osteopathic Medical Board of California, or the Board of Dental Examiners of California, that a licensee's license has been placed on probation as a result of a disciplinary action, the department may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, including any dental surgery or invasive procedure that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim, including any claim for dental

services, as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive procedures for which the licensee was placed on probation."

5. At all times mentioned herein, respondent practiced in the rural community of Albion, California as a psychiatrist.

DRUGS INVOLVED

6. The following dangerous drugs and controlled substances are involved in this matter:

A. **Alupent** is a trade name for metaproterenol sulfate, which is a bronchodilator, a potent beta-adrenergic stimulator indicated for the relief of bronchial asthma and reversible bronchospasm which may occur in association with bronchitis and emphysema. It is contraindicated for patients with cardiac arrhythmias. It is a dangerous drug under Business and Professions Code section 4022 (hereinafter "section 4022").

B. **Ambien** is a trade name for zolpidem tartrate, a non-benzodiazepine hypnotic of the imidasopyridine class. It is a dangerous drug as defined in section 4022, a schedule IV controlled substance as defined by section 1308.14 of Title 21 of the Code of Federal Regulations. It is indicated for the short-term treatment of insomnia. It is a central nervous system depressant and should be used cautiously in combination with other central nervous system depressants. Any central nervous system depressant could potentially enhance the CNS depressive effects of Ambien. It should be administered cautiously to patients exhibiting signs or symptoms of depression because of the risk of suicide. Because of the risk of habituation and dependence, individuals with a history of addiction to or abuse of drugs or alcohol should be carefully monitored while receiving Ambien. The recommended dosage for adults is 10 mg. immediately before bedtime.

C. **Amoxicillin** is a semi-synthetic penicillin antibiotic used in the treatment of bacterial infections and is a dangerous drug under section 4022.

D. **Ativan**, a trade name for lorazepam, a psychotropic drug of the benzodiazepine class indicated for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022, a schedule IV controlled substance as defined by section 11057(d)(13) of the Health and Safety Code. It has a central nervous system depressant effect. Lorazepam can produce psychological and physical dependence and it should be prescribed with caution particularly to addiction-prone individuals (such as drug addicts and alcoholics) because of the predisposition of such patients to habituation and dependence.

E. **Buspar**, a trade name for busprione hydrochloride, is a non-benzodiazepine drug used for short-term management of anxiety. It is a dangerous drug as defined in section 4022.

F. **Celebrex** is a trade name for celecoxib capsules. It is a non-steroidal anti-inflammatory drug (NSAID) used for the relief of signs and symptoms of osteoarthritis or rheumatoid arthritis. It is a dangerous drug under section 4022.

G. **Chloral Hydrate** is a dangerous drug as defined in section 4022 of the Code and a schedule IV controlled substance and narcotic. It is a sedative hypnotic recommended for short term use. Prolonged use may result in psychological and physical dependence.

H. **Dalmane**, a trade name for flurazepam hydrochloride, is a dangerous drug as defined in section 4022 and a schedule IV controlled substance as defined in Health and Safety Code section 11057(d)(5). It is indicated for the treatment of insomnia.

I. **Depakote** is a trade name for divalproex sodium and is indicated for the

treatment of manic episodes associated with bipolar disorder. It is a dangerous drug under section 4022. Depakote is contraindicated for patients with compromised liver function or blood clotting disorders since hepatotoxicity and inhibition of platelet aggregation are known side effects of this medication.

J.. **Erythromycin** is an antibiotic used in the treatment of bronchitis and pneumonia and is a dangerous drug under section 4022.

K. **Imitrex** is a trade name for sumatriptan succinate. It is a dangerous drug under section 4022, and is used to treat migraines. It should only be used when a clear diagnosis of migraine has been established.

L. **Inderal** is a trade name for propranolol hydrochloride, a nonselective beta-adrenergic receptor blocking agent indicated in the treatment of hypertension, and is a dangerous drug as defined in section 4022. Inderal is contraindicated for patients with asthmatic conditions or certain heart conditions, since it can exacerbate asthma and raise blood pressure.

M. **Klonopin** is a trade name for clonazepam, an anticonvulsant of the benzodiazepine class of drugs. It is a dangerous drug as defined in section 4022, a schedule IV controlled substance as defined by section 11057(d)(6) of the Health and Safety Code. It produces central nervous system depression and should be used with caution with other central nervous system depressant drugs. Like other benzodiazapines, it can produce psychological and physical dependence. Withdrawal symptoms similar to those noted with barbiturates and alcohol have been noted upon abrupt discontinuance of Klonopin. The initial dosage for adults should not exceed 1.5 mg. per day divided in three doses.

N. **Lithium carbonate**, indicated in the treatment of manic episodes of Bipolar Disorder, is a dangerous drug within the meaning of section 4022.

///

O. **Lorcet** is a trade name for a combination of hydrocodone bitartrate (10 mg.) and acetaminophen (650 mg.). Hydrocodone bitartrate is a semisynthetic narcotic analgesic, a dangerous drug as defined in section 4022 and a Schedule III controlled substance under section 11056(e)(4). (See "Vicodin" below.)

P. **Marijuana** is a hallucinogenic substance and a Schedule I controlled substance under section 11054(e)(13) of the Health and Safety Code. As such, it cannot be prescribed for a patient for any condition. Under the Compassionate Use Act of 1996 (section 11362.5 of the Health and Safety Code), however, it may be recommended by a licensed physician and surgeon under certain specified conditions.

Q. **Paxil**, a trade name for paroxetine hydrochloride, an antidepressant unrelated to tricyclic, tetracyclic or other available antidepressant agents, is a dangerous drug as defined by section 4022 and is used for major depressive disorder.

R. **Promethazine with Codeine** cough syrup is a dangerous drug as defined in section 4022, a Schedule V controlled substance under Health and Safety Code section 11058(c)(1).

S. **Risperidol** is a trade name for risperidone, an antipsychotic medication of the benzisoxazole class and is indicated for the management of manifestations of psychotic disorders. It is a dangerous drug under section 4022.

T. **Ritalin** is a trade name for methylphenidate hydrochloride. It is a dangerous drug under section 4022, and a Schedule II controlled substance. Ritalin is a central nervous system stimulant frequently used for treatment of attention deficit disorders. It is contraindicated for use in patients with marked anxiety

///

U. **Soma** is a trade name for carisoprodol tablets; carisoprodol is a muscle-relaxant and sedative. It is a dangerous drug as defined in section 4022. Since the effects of carisoprodol and alcohol or carisoprodol and other central nervous system depressants or psychotropic drugs may be additive, appropriate caution should be exercised with patients who take more than one of these agents simultaneously. Carisoprodol is metabolized in the liver and excreted by the kidneys; to avoid its excess accumulation, caution should be exercised in administration to patients with compromised liver or kidney functions.

V. **Tranxene**, a trade name for clorazepate dipotassium, is a benzodiazepine. Tranxene is indicated for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022, a schedule IV controlled substance and narcotic as defined by section 11057 (d)(7) of the Health and Safety Code. Tranxene has depressive effects on the central nervous system and patients should be advised against the simultaneous use of other CNS-depressant drugs, and cautioned that the effects of alcohol may be increased. The actions of this and other benzodiazepines may be potentiated by barbiturates, narcotics, phenothiazines, monoamine oxidase inhibitors or other antidepressants.

W. **Tylenol with Codeine #3** is a trade name for a combination of acetaminophen and codeine. It is a dangerous drug under section 4022, a Schedule III controlled substance. It is used for treatment of pain, and can produce drug dependence.

X. **Ultram** is a trade name for tramadol hydrochloride, a centrally acting synthetic analgesic compound, and is indicated for the management of moderate to moderately severe pain. There is a seizure risk in patients who are simultaneously taking selective serotonin reuptake inhibitors (SSRI's), tricyclic antidepressants, monoamine oxidase (MAO) inhibitors,

or neuroleptics. It is a dangerous drug under section 4022.

Y. **Valium** is a trade name for diazepam, a psychotropic drug for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022, a schedule IV controlled substance as defined by section 11057(d)(8) of the Health and Safety Code. Diazepam can produce psychological and physical dependence and it should be prescribed with caution particularly to addiction-prone individuals (such as drug addicts and alcoholics) because of the predisposition of such patients to habituation and dependence. Valium is available in 5 mg. and 10 mg. tablets. The recommended dosage is 2 to 10 mg. 2 to 4 times daily.

Z. **Vicodin and Vicodin ES** are trade names for a combination of hydrocodone bitartrate and acetaminophen. Hydrocodone bitartrate is a semisynthetic narcotic analgesic, a dangerous drug as defined in section 4022, a Schedule III controlled substance and narcotic as defined by section 11056(e)(4), of the Health and Safety Code. Vicodin tablets contain 5 mg of hydrocodone bitartrate and 500 mg of acetaminophen and Vicodin ES tablets contain 7.5 mg of hydrocodone bitartrate and 750 mg of acetaminophen. Alcohol and other CNS depressants may produce an additive CNS depression, when taken with this combination product, and should be avoided. Patients taking other narcotic analgesics, antihistamines, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with Vicodin ES may exhibit an additive CNS depression. The dose of one or both agents should therefore be reduced. Repeated administration of Vicodin or Vicodin ES over a course of several weeks may result in psychic and physical dependence. Patients should take the drug only for as long as it is prescribed, in the amounts prescribed, and no more frequently than

prescribed. In patients with severe hepatic or renal disease, effects of therapy should be monitored with serial liver and/or renal function tests. The total 24 hour dose should not exceed five tablets. The maximum 24 hour dosage of acetaminophen should not exceed 4000 mg. At high levels, acetaminophen can cause liver toxicity and even death. With the ingestion of 10,000 mg to 15,000 mg of acetaminophen, severe liver damage is a significant risk.

AA. **Wellbutrin**, a trade name for bupropion hydrochloride, an antidepressant of the aminoketone class, which is chemically unrelated to tricyclic, tetracyclic or other available antidepressant agents, is a dangerous drug under section 4022. It is indicated in the treatment of depression and contraindicated in patients with a seizure disorder or who are taking MAO inhibitors.

BB. **Zoloft**, a trade name for sertraline hydrochloride, an antidepressant unrelated to tricyclic, tetracyclic or other available antidepressant agents, is a dangerous drug as defined by section 4022. It is used for major depressive disorders. Zoloft interacts with many drugs including cardiac medications, such as digitoxin. It causes decreased clearance of diazepam (Valium). It has side effects including nausea, diarrhea, dyspepsia, tremor, dizziness, insomnia and somnolence.

FIRST CAUSE FOR DISCIPLINE

Patient E.C.[1]

(Gross Negligence/Negligence/Incompetence)

7. In or about 1992, respondent undertook to care for and treat E.C., a 13 year old boy, in a family therapy context. E.C. was seen by respondent approximately every two weeks, individually and with family members, until his death in April of 1998 at age 18.

---

[1]Patients are referred to by initials to protect privacy. Respondent will be provided with the full name of the patients pursuant to any request for discovery.

8. Respondent has no progress notes of her treatment of E.C. or medications she prescribed for him until 1997. Respondent asserts that she lost the records for the "early '90's" during an office move. She did not explain the lack of progress notes or records for her treatment of E.C. after the purported loss of records. The only records respondent was able to produce was a one-page document setting forth the dates she saw E.C. in 1997 and 1998. Respondent has stated that she "reconstructed" records for E.C. after his death, but she made no notation that she had made late entries or had reconstructed the records.

9. Respondent described E.C. as having severe anxiety, depression, muscle spasms, and back pain; additionally, he was described as learning disabled and living in a dysfunctional family. In an SSI report dated September 14, 1996, respondent stated that E.C. suffered from severe anxiety and depression and had been treated with phenothiazines, minor tranquilizers, antidepressants, and sleeping medications; at the time of the report, E.C. was taking Valium and Mellaril. Respondent further stated in the report that E.C. had made two serious suicide attempts warranting hospitalization in 1992 and 1993. On June 5, 1997, E.C. overdosed on Valium and Soma, prompting respondent to arrange that all medications be dispensed by E.C.'s grandfather.

10. In a letter to E.C.'s probation officer dated January 31, 1996, respondent expressed concern about E.C.'s drug usage. In the September 1996 SSI report, respondent had stated that E.C. occasionally drinks to excess and has used drugs, including marijuana, amphetamines, and cocaine. There is no documentation of any evaluation or treatment of this substance abuse problem in respondent's records for E.C.

11. Respondent indicates in her records for E.C. that he refused to take antidepressants or tranquilizers, but there are no reasons for E.C.'s refusal documented. Respondent indicates that E.C. made multiple visits to emergency rooms with somatic complaints, was diagnosed with anxiety/depression and prescribed various muscle relaxants and antibiotics.

12. During 1997, respondent treated E.C.'s "severe" anxiety with Valium or Klonopin, muscle spasms and back pain with Soma and Vicodin ES. Respondent gave E.C. 17

prescriptions for Vicodin ES #20 from November 15, 1997 to April 17, 1998. Respondent prescribed Valium, 10 mg. #100 approximately monthly from October 25, 1997 to April 17, 1998.

13. Respondent apparently also acted as E.C.'s general medical practitioner, at least on some occasions. On December 29, 1997, respondent also prescribed Erythromycin 400 mg. #40 qid and Promethazine with codeine cough syrup, 240 ml., 1 tbsp. Q 4-6 hours. On January 6, 1998, respondent prescribed an Alupent inhaler (no directions specified). On January 15, 1998, respondent prescribed Amoxicillin 260 [sic] mg. #40. Respondent also made referrals as needed to a physical therapist and a dietitian. She also corresponded with ancillary agencies involved in E.C.'s care.

14. On April 9, 1998, E.C., then 18 years of age, was taken to jail after he became psychotic, disorganized, and belligerent. On April 12, 1998, E.C. was transferred to a psychiatric health facility, and his mental status apparently normalized. Urine toxicology on E.C. revealed methamphetamines; he was discharged on April 14, 1998. E.C. apparently indicated to respondent on April 16, 1998 that someone had put drugs in his drink without his knowledge. Respondent indicated that E.C. was angry at being duped and sounded paranoid, thinking that someone had poisoned him and would try to do so again. Respondent also indicated that E.C. described feeling strange, like something was missing inside of him, that he had severe headaches from head-banging, and muscle spasms from struggling with officers in jail. Respondent refilled E.C.'s medications, making sure that E.C.'s grandfather was holding them. On April 18, 1998, E.C. was found dead; autopsy report states the cause of death as "morphine-type alkaloid and methamphetamine toxicity."

15. Respondent was grossly negligent, negligent, and/or incompetent, jointly, singly, or in any combination thereof with respect to her care and treatment of patient E.C. by reason of the following acts or omissions:

A. Respondent failed to document each patient encounter to the extent that the treatment can be understood by any health care provider who may have needed to treat E.C. concurrently or in the future. She failed to document chief

complaint, medical and psychiatric history, medication history, mental status examination, diagnostic formulation with attention to differential diagnosis, and treatment plan. Respondent saw E.C., prescribed multiple psychoactive medications and even medications to treat medical conditions such as asthma, bronchitis or pneumonia, but did not document any physical examination, or history of the condition.

B. Respondent failed to obtain a detailed substance abuse history from E.C., even though she was aware of his substance abuse and that substance abuse or withdrawal may play a part in psychiatric symptoms. She failed to document the frequency and duration of the use of drugs or refer the patient for concurrent treatment of the substance abuse problem. She failed to obtain a toxicology screen or to arrange for urine testing or to address relapse prevention or to refer out for relapse prevention services. After E.C. had been hospitalized on April 14, 1998 for a drug overdose, respondent continued to fail in this area; she failed to assess his drug abuse, present and past, and failed to refer him for substance abuse treatment.

C. Respondent was treating E.C. with opiates for chronic pain from a physical disorder. She failed to state the medical diagnosis or any treatment plan and failed to do a physical examination. She failed to refer E.C. for further medical evaluation of the pain condition or a second opinion. Respondent wrote 17 prescriptions for Vicodin ES without documenting a medical history or physical history or even documenting that she was relying on another named practitioner's history and physical and coordinating care with that practitioner. She failed to refer E.C. to an appropriate specialist for further evaluation when his chronic pain did not abate but instead just renewed prescriptions for the opiate.

D. Respondent treated E.C., a patient with a history of substance abuse, with benzodiazepines for depression and anxiety and not with antidepressants. She documented that E.C. refused antidepressants but did not state a reason or a medical justification for using benzodiazepines alone for depression and anxiety. Respondent

should have known the addiction potential for benzodiazepines, the danger of rebound anxiety on withdrawal, the potential for causing or exacerbating depression with monotherapy, and the danger for patients who drink alcohol to excess or use illicit depressive drugs in combination with benzodiazepines. Especially with a minor, respondent should have solicited the help of E.C.'s guardians and other caregivers to convince him to take antidepressants and deal with his reasons for refusing them.

E. Respondent failed to ask E.C., a patient with previous serious suicide attempts, about suicidal ideation on a periodic basis. Specifically, respondent failed to inquire about suicidal ideation after E.C. had been hospitalized with a drug overdose and after she noted that he sounded paranoid and felt as if something was missing inside of him.

16. Therefore, respondent's conduct as set forth above, whether singly, jointly or in any combination thereof, constitutes causes for discipline pursuant to section 2234 (b), (c) and/or (d) of the Code.

SECOND CAUSE FOR DISCIPLINE

(Prescribing without Good Faith Prior Examination and Medical Indication)

17. The allegations of paragraphs 7 through 15 above, are incorporated herein by reference as if fully set forth.

18. Respondent's conduct as set forth above constitutes prescribing of controlled substances and/or dangerous drugs without a good faith prior examination and medical indication therefor, and therefore, cause for discipline exists pursuant to sections 2242(a) and 2234 of the Code.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Medical Records/Dishonest or Corrupt Acts)

19. The allegations of paragraphs 7 through 15 above are incorporated herein by reference as if fully set forth.

20. Respondent's conduct as set forth above constitutes the failure to maintain adequate and accurate records with reference to the treatment of E.C., and therefore cause for

discipline exists pursuant to sections 2266 and 2234 of the Code.

21. Respondent's conduct in creating a medical record for E.C. after the fact and failing to disclose or document that fact constitutes gross negligence and/or the commission of an act involving dishonest or corruption which is substantially related to the qualifications, functions or duties of a physician, and therefore cause for discipline exists pursuant to sections 2234(b) and/or 2234(e).

22. Respondent's conduct in failing to take reasonable and appropriate steps to arrange for storage and/or transportation of E.C.'s patient records constitutes gross negligence and/or unprofessional conduct, and therefore cause for discipline exists pursuant to sections 2234 and/or 2234(e).

FOURTH CAUSE FOR DISCIPLINE

(Patient D.L.)

(Gross Negligence/Negligence/Incompetence)

23. On or about March 8, 1996, respondent undertook to care for and treat patient D.L., a 58-year-old man with bipolar affective disorder and chronic pain secondary to a back injury. D.L. had a long history of bipolar illness and was taking Tranxene at the time he first consulted respondent, and he refused mood stabilizers.

24. Respondent's medical records for D.L. are disorganized, at times contradictory, and sketchy. For example, medication notations for 1996 and 1997 do not correlate with progress notes for those years. Also, there are two sets of clinical notes for 2001 that do not correlate with one another and at times, for the same dates, contradict one another. The initial evaluation dated July 9, 1996 does not correlate with a first progress note dated March 8, 1996.

25. Respondent's initial evaluation dated July 9, 1996 documents a psychiatric, medical and social history for D.L. and a notation that a recent physical was normal. She ordered a copy of a lumbar CT, which the patient had evidently described as an MRI report. The lumbar CT indicates degenerative disc disease. Respondent records no formal mental examination for D.L. and does not note the presence or absence of psychotic symptoms or a

history of them. Throughout the record, however, mental symptoms such as mood changes and manic symptoms are noted.

26. For 1996, there are handwritten progress notes for 18 dates, starting on March 8, 1996 and ending on October 18, 1996. A medication page does not correlate in any way with the progress note. Medication entries start on January 26, 1996 and end on December 28, 1996, and progress notes go from March 8, 1996 to October 18, 1996, as follows:

1/26 - Ativan 120	No progress note
2/28 - Ativan 120	No progress note
	3/8 progress note indicates depressed; refused antidepressants
3/20 - Vicodin ES 15	No progress note
	3/22 progress note indicates feeling better
3/24 - Ativan 120	No progress note
	4/5 progress note indicates doing better
4/17 - Ativan 120	No progress note
	4/19 progress note indicates doing OK
	5/3 progress note indicates excited about trip
5/7 - Vicodin ES 100	No progress note
	5/17 progress note indicates sounds hypomanic
5/21 - Ativan 120	No progress note
	5/31 progress note indicates back flare up; has increased Vicodin, advised to cut back.
6/12 - Ativan 120 Vicodin ES 100	No progress note.
	6/14 progress note indicates going East; brother helping financially
	6/28 progress note indicates had a great trip; feeling good
	7/9 no progress note but typed history indicates patient taking Tranxene, not Ativan
	7/12 progress note indicates doing well
7/14 - Ativan 120 Vicodin ES 100	No progress note
	7/26 progress note indicates doing OK
8/7 - Ativan 120	No progress note
	8/10 progress note indicates hypomanic under control
	8/24 progress note indicates OK
9/6 - Ativan 120	9/6 progress note partially illegible - indicates going out less; backache
	9/20 progress note partially illegible - indicates pulling out hair; refused antidepressants
10/4 - Ativan 120	10/4 progress note indicates staying in bed a lot; not eating.
	10/11 progress note indicates still depressed
	10/18 progress note partially illegible - indicates still depressed, not suicidal

11/1 - Ativan 120	No progress note
11/19 - Elavil 50	No progress note
12/1 - Ativan 120	No progress note
12/28 - Ativan 120	No progress note

Respondent notes no indication for the medications given, no physical or mental examination, and no detailed clinical findings. No treatment plan is noted.

27. For 1997, medication entries start on January 13, 1997 and end on September 2, 1997. Progress notes indicate 30 visits with other medications indicated. Entries are as follows:

1/3 - Ativan 120	No progress note 1/11 progress note indicates feeling better and **refill Tranxene 7.5 mg #120** 2/8 progress note indicates doing OK 2/22 progress note indicates doing OK and **refill Tranxene #120**
3/3 - Ativan 120	No progress note 3/8 progress note indicates doing fine, maybe reduce frequency of visits 3/22 progress note indicates OK **refill Tranxene**
4/1 - Ativan 120	No progress note 4/5 progress note indicates low back pain **Vicodin ES #100 no more than tid**
4/11 - Ativan 120	No progress note 4/19 progress note indicates Vicodin helps; mood good. 5/3 progress note indicates tapering off Vicodin bid. **refill Vicodin ES #100; Tranxene #120**
5/6 - Ativan 120	No progress note
5/8 - Vicodin ES 100	No progress note 5/17 progress note indicates feeling great; cautioned about mania; refusing Lithium. 5/31 progress note indicates over-talkative. Urged to take Lithium. **Refill Tranxene #120**
6/2 - Ativan 120	No progress note 6/14 progress note indicates arrogant tone, argued with landlord; still refusing mood stabilizers.
6/25 - Ativan 120	No progress note 6/28 progress note indicates doing OK; calmer. **Refill Tranxene #120**
7/9 - Ativan 120 Vicodin ES 100	No progress note 7/12 progress note indicates loud, argumentative. Hurt back; still refusing Lithium or

		Depakote; **Refill Tranxene #120 and Vicodin ES #100**
		7/26 progress note indicates calmer; doing OK
	8/3 - Ativan 120 Vicodin ES 100	No progress note
		8/9 progress note indicates calming down; antagonistic but not hostile; back pain. **Refill Tranxene, Vicodin**
		8/23 progress note indicates doing OK, calm
	9/2 - Ativan 120 Vicodin ES 100	No progress note
		9/6 progress note indicates upset with nun on his block. **Refill Tranxene, Vicodin**
		9/22 progress note indicates talked to nun; she yelled at him; refused antidepressants.
		10/4 progress note indicates he is paranoid about the nun. **Refill Tranxene, Vicodin**
		10/18 progress note indicates fearful; agoraphobic; clingy. Refusing antidepressants.
		11/1 progress note indicates paranoid re: nun. **Refill Tranxene**
		11/8 progress note indicates doing better.
		11/15 progress note indicates depressed; worried re: nun.
		11/22 progress note indicates feeling better
		11.20 progress note indicates talked to landlord re: nun; feeling better; relieved.
	12/5 - entry in medication record; no drugs listed	12/5 progress note indicates relieved nun may be leaving. **Refill Tranxene 120; Vicodin ES 100**
		12/12 progress note indicates maintaining.
		12/19 progress note indicates feeling better

There are no indications in the records for 1997 of medical indication for the drugs prescribed, of mental status evaluations, of examinations physical or mental, of any detailed clinical findings, or of any reasons for continuing medications that do not seem to be effective. No reasons are noted for double prescriptions for the benzodiazepines Tranxene and Ativan and no referrals noted for further evaluation of chronic pain for which Vicodin ES is supposedly prescribed. There is no evaluation of the source of pain or any alternative treatment offered.

28.. Beginning in 1998, respondent has no separate medication record for D.L. In 1998, there are 36 entries in respondent's progress notes for D.L. In January 1998, D.L. is described as depressed. Tranxene #120 is prescribed on 1/5/98, and Vicodin ES #20 on 1/5 and 1/19. In February 1998, D.L. is doing better. Tranxene #120 is prescribed on 2/3/98 and 2/28/98; Vicodin ES #50 on 2/3 and 2/28. D.L. is described on 2/3 as using only 1 - 2 Vicodin per day

now. In March 1998, D.L. is described as doing better. Tranxene #120 and Vicodin ES #50 are prescribed on 3/25. In April 1998, D.L. is described as doing well. Tranxene #120 and Vicodin ES #50 are refilled on 4/27. In May 1998, D.L. is described as feeling better and wanting to quit smoking and thinking about taking Wellbutrin. Tranxene #120 and Vicodin ES #50 refilled on 5/25. On 6/8/98, Wellbutrin 75 mg #50 is prescribed. On 6/29/98, D.L. left for Britain for a vacation and Tranxene #120 and Vicodin ES #50 are refilled.

29. After his trip to Britain, D.L. returned to respondent on July 13, 1998 and Wellbutrin was discontinued. D.L. was described as hypomanic after his trip, pressured, not sleeping. He feels better after 7/13. In August 1998, Tranxene #120 and Vicodin ES #50 are refilled on 8/3 and 8/29. D.L. is described as doing better until 8/31/98, when he arrives in crisis, upset after a fight with a neighbor, irate and self-righteous, refusing mood stabilizers. On September 7, 1998, D.L. is very depressed and agrees to try Paxil, 10 mg. #50 and on 9/9 is doing better. On 9/21, however, he wants to try Zoloft instead and 50 mg. #30 is prescribed. On 9/28, Tranxene #120 and Vicodin ES #60 are refilled. D.L. is described as doing well in October 1998. Vicodin ES #60 and Tranxene #120 are refilled on 10/26 and 10/30, with prescriptions called in on 10/30. D.L. is described as doing well in November 1998, with Vicodin ES #60 and Tranxene #120 refilled (called in) on 11/30. In December 1998, D.L. is described as depressed, but not wanting to go back on SSRI's (Zoloft and Paxil are SSRI's). Entries for 11/9 and 11/23 are between entries for 10/26 and 10/30. On December 21, 1998, he reports his back hurting, and Vicodin ES #75 was prescribed.

30. For 1998, there are no indications in the record of medical indication for the drugs prescribed, of mental status examinations, of examinations physical or mental, of any detailed clinical findings, or of any reasons for continuing medications not consistently effective. There is no explanation for the double prescriptions for Tranxene and Vicodin on 10/25 and 10/30; no indication of how long Zoloft and Paxil were taken; no medical reasons noted for the discontinuance of Paxil or the substitution of Zoloft; no reasons were noted for the refusal of antidepressants or for the refusal to continue SSRI's. There is no indication of referrals for further evaluation of back pain and no indication of alternative treatments or further evaluation offered.

31. In 1999, respondent has only 13 entries in her progress notes for D.L. In January 1999, D.L. is described as "down" early in the month and obsessing about cigarettes and taking three Vicodin per day for back pain. On 1/11, he is described as "down to ½ ppd (from2 ppd)" presumably of Vicodin and refusing Wellbutrin. Tranxene #120 and Vicodin ES #100 are prescribed. By 1/18, D.L. is "feeling better," but on 1/25, in a telephone call, he indicates he has bronchitis, fever and is coughing up green sputum. Respondent prescribes Erythromycin, 250 mg. #40. During February D.L. is "doing OK," and Tranxene #120 and Vicodin ES #100 are refilled by telephone on 2/23.

32. In March 1999, D.L. is described as "happy" but he still has back pain. On 3/25, respondent added Ultram 50 mg. tid #100 to his usual medications of Tranxene #120 and Vicodin ES #100. There is also a notation of "mj permit." In April 1999, D.L. is described as happy with a girlfriend, but having urinary frequency and nocturia; respondent notes referral to a urologist who suggested substituting Valium for Tranxene, and so on 4/21, respondent prescribed Valium, 10 mg., #100 and Vicodin ES #100. In May, D.L. is described as having trouble with his girlfriend but working on the relationship. There are no further progress notes for 1999.

33. There is no indication of any medical examination before prescribing Erythromycin for "bronchitis" that was apparently diagnosed over the telephone. There is no indication of the reasons for D.L. refusing Wellbutrin and no examination or reasons indicated for adding Ultram to Vicodin ES for pain control. There is no reason or examination indicated for the substitution of Valium for Tranxene except for the "recommendation" of the urologist.

34. For the year 2000, there are 38 entries in respondent's progress notes for D.L. In January 2000, D.L. is described as feeling "OK" but in pain. Respondent adds Celebrex, 50 mg. #50 to Vicodin ES #100 and Valium #100. In February, Celebrex, Vicodin ES and Valium are refilled. In March, D.L. is described as doing "OK" with mood stable. Celebrex, Vicodin ES, and Valium are refilled on 3/21. In April, D.L. is described as having trouble sleeping, so Dalmane 50 mg. #50 is prescribed on 4/20 along with a refill of Celebrex #50. On May 4, D.L. is described as coughing green sputum and febrile. Respondent prescribes Erythromycin 250 mg. #40 in addition to Valium #100 and Vicodin ES #100. On 5/11,

respondent indicates that the cough and fever have cleared. Dalmane #50 is refilled on 5/25, along with a prescription for Wellbutrin 100 mg. #100. In June, D.L. is described as doing "OK" but still having nocturia, and a recommendation to see the urologist again is indicated. Refills of Vicodin ES #100, Valium #100, and Celebrex #50 are given on 6/5, and on 6/15, refills of Dalmane #50 and Wellbutrin #60 are given. In July, Vicodin ES #100, Valium #100, and Celebrex #50 are refilled on 7/3, and there is an indication of a referral to a pain clinic. There is further reference to trouble sleeping due to nocturia and a refill of Dalmane #50 on 7/14. On 7/19, it is indicated that D.L. still cannot sleep, so Ambien, 10 mg., #30 is prescribed along with a refill of Wellbutrin, 100 mg. #100. On 7/31, Valium #100 and Vicodin ES #100 are called in. D.L. is on Cardura, prescribed by the urologist, for nocturia.

35. In August 2000, there is an indication that Cardura is helping, and a refill of Ambien 10 mg #30 on 8/10. On 8/24, D.L. is described as doing well, and refills of Valium #100, Vicodin ES #100, Celebrex #60, and Wellbutrin 100 mg. #60 are given. In September, he is described as in pain and spasm, and respondent prescribes Lorcet "10/650." D.L. is given lumbar epidural steroid injections at the pain clinic for his pain on 9/14 and describes an increase in pain; respondent prescribes Lorcet #25 and refills Ambien #30, Celebrex #15. On 9/18, respondent calls in prescriptions for Valium 10 mg. #30, Lorcet #25, and Celebrex #30. On 9/21, D.L. has another injection which he describes as making him feel worse; on 9/25, respondent prescribes Lorcet #25, Valium #50, Ambien #30, and Wellbutrin 100 mg. #60. On 9/28, respondent describes D.L. telephoning in a rage with lots of pain and indications that he is overusing Lorcet. Respondent indicates she referred him to the emergency room. On October 3, 2000, respondent called in prescriptions for Lorcet #50 and Valium #50; on 10/13, respondent describes D.L. as angry because he cannot take more than 3 Lorcet tablets per day; D.L. apparently indicated he would go to the VA for more; on 10/16, respondent called in prescriptions for Lorcet #50 and Ultram #100 tid. On 10/23 D.L. is described as doing better, keeping Lorcets down to tid, and refills for Valium 10 mg. #50 and Ambien 10 mg. #50 are given. In November, D.L. is described as better; Valium #50 and Lorcet #50 refills are called in on 11/14, and Ultram #100, Valium #50, and Lorcet #50 are refilled on 11/28. In December, D.L. is still described as

doing well, with pain and nocturia better. Refills for Valium #50 and Lorcet #50 on 12/15 and 12/28 along with Ultram #100 and Celebrex #30 on 12/28.

36. Respondent added Celebrex and Lorcet for back pain and continued to treat D.L. with Valium, Vicodin ES, and added sleep medications. Prescriptions were incomplete as to strength and directions for administration. No physical examination or vital signs were indicated before prescribing Erythromycin for cough and fever on 5/4/00. Respondent indicated that D.L. had had a manic reaction when taking Wellbutrin before, but there is no indication of reasons for again prescribing this medication, nor did respondent indicate the administration or other directions. She referred D.L. to a pain clinic but continued to prescribe pain medications for D.L.

37. For the year 2001, respondent's progress notes for D.L. are confusing. Notes for January indicate D.L. is depressed, and Wellbutrin is increased. D.L. is described as still having back pain and urinary frequency. Lorcet #50, Valium #50, Ultram #100 and Wellbutrin #60 were prescribed. In February, depression continued. "Usual winter bronchitis" was indicated on 2/12, and Erythromycin, 250 mg. #40 was again prescribed with no physical examination indicated in the chart. In addition, Lorcet #50, Valium #50, and Ambien #30 were prescribed. On 2/21, Paxil, 20 mg/day, #50 was added, and on 2/28, D.L. was described as doing better; on 2/28, medications were refilled: Lorcet #50, Valium #50, Ultram #50, and Wellbutrin, #50; indication that D.L. was referred for pain management.

38. In March 2000, D.L. is described as doing better and in pain management with a Dr. Graham, who is described as continuing Lorcet and Valium. In April, D.L. is described as stable, and refills of Paxil 20 mg. #50, Wellbutrin 100 mg. #60, Ambien 10 mg. #30, and Celebrex 100 mg. #30 are given on 4/9.

39. From May 2000 through October 2000, respondent has two sets of progress notes for D.L., and the entries are not consistent with each other. Entries are as follows:

	Set I	**Set II**
May 2000		
5/8	Called in Ambien, Celebrex and and Wellbutrin refills	
5/11	Doing OK - urinary problem	
5/24		Doing OK; Refill Vicodin ES Valium; RTC 2 weeks

RTC 2 weeks

5/28 Doing well; RTC 1 month

June 2000

6/5 Called in Ambien, Celebrex

6/9 Meds stolen-refill Vicodin ES Valium

6/23 Spending money on girlfriend; RTC 2 weeks

July 2000

7/3 Called in Ambien, Celebrex

7/9 Doing OK. Stopped Wellbutrin. Graham prescribing Paxil; RTC 3 wks.

7/5 Unhappy with girlfriend. Concerned about use of Vicodin. Refill Vicodin #25 Valium #100; RTC 1 week

7/12 Girlfriend leaving. Refill Vicodin #25; RTC 2 weeks

7/29 Refill Vicodin #25, Valium #25

August 2000

8/1 Med call in Ambien #30.

8/13 Mildly depressed; RTC 2 wks.

8/27 Mildly depressed; refuses Wellbutrin Friends stole from him. Refill Ambien. RTC 2 weeks.

8/2 Doing OK. Refill Vicodin #25, Valium #25. RTC 2 weeks.

8/9 Refill Vicodin #25; Valium #25

8/16 DUI arrest. Refill Vicodin #25, Valium #25

8/23 Refill Vicodin #25; Valium #25

8/30 Wants to go back on Wellbutrin 75 mg #60. Refill Vicodin #25, Valium #25. RTC 2 wks.

September 2000

9/10 Doing well; getting lots of sun; RTC 3 weeks

9/26 Med call in Celebrex

9/? Cut off entry

9/13 DUI case dismissed. Heavily in debt from manic episode. Filling out disability forms. Refill Vicodin #25, Valium #25. RTC 1 week

9/23 Increased back pain. Resp. refuses more Vicodin. Declines Ultram. Talk about mania and overspending. Refill Vicodin #25; Valium #25. RTC 1 week.

October 2000

10/1 Very upset. Daughter wants money. Depressed. Refill Ambien. RTC 1 wk.

10/8 Calmer, talked to daughter. RTC 2 weeks

10/19 Doing better. RTC 2 weeks

10/1 Doing OK. Refill Vicodin #25; Valium #25 RTC 2 weeks.

10/8 Med Refill. Vicodin #25; Valium #25

10/25 Forms. Doing OK, refill meds.

10/31 Investigating bankruptcy. Bitter; disenchanted. Refill Vicodin #25; Valium #25. RTC 1 week.

40. Respondent has stated that one set of records actually relates to treatment rendered in 1999, and that she did not initially write the year at the top of the page. Respondent

stated that she made an error in the dates when she added dates to the documents at the time she provided records to the Board. It is not possible to discern from respondent's records, coupled with her explanation for the discrepancy, whether the records reflect different years or not.

41. Set II of the records then goes on in November 2000 to indicate depression on 11/8 and referral to credit counselor; refusing antidepressants; suggested Depakote. Refills of Vicodin #25 and Valium #25. On 11/15, Depakote was prescribed, 250 mg. #100 bid, and refills of Valium #25 and Vicodin ES #25 were given. On 11/22, D.L. was described as doing better and feeling he could handle one month supply of medications, so Vicodin ES #100 and Valium #100 were prescribed. On 11/29, D.L. was described as feeling better. On 12/5, D.L. was described as feeling better and philosophical about his affair. On 12/21/2000, D.L. was described as feeling much better, and refills of Depakote 250 mg. #100, Vicodin ES #100, and Valium #100 were given. Respondent's notes end at this point, although it is indicated that she continued to see D.L.

42. Respondent was grossly negligent, negligent and/or incompetent, singly, jointly, or in any combination thereof with respect to her care and treatment of patient D.L. by reason of the following acts or omissions:

A. Respondent did not perform and/or did not document a formal mental status examination in a patient with a history of major psychiatric illness, bipolar affective disorder. Although she document brief components of a mental examination throughout her sparse progress notes, she at no time recorded an examination in a systematic fashion. She failed to record a history of, or apparently inquire about, the presence or absence of psychotic symptoms that commonly occur in both depression and mania.

B. At no time did respondent set forth a treatment plan for this patient or any change in diagnosis or treatment plan through evaluation.

C. Respondent failed to document each patient encounter to the extent that the treatment can be understood by any health care provider who may have needed to treat D.L. concurrently or in the future. Her progress notes and medication records are not consistent with one another, and the two sets of progress notes for the period of 1999-

2001 are not consistent with one another and can't be reconciled. There is no way to determine which records, if any, accurately reflect the treatment rendered.

D. Respondent repeatedly failed to state tablet strength or directions for dosing when recording her prescriptions for D.L. At no time did respondent state the tablet strength for the Ativan prescribed; though Valium is sometimes specified as a 10 mg. tablet, there are no daily dosing directions stated. There are numerous instances of other medications prescribed where key prescribing information is not present.

E. Respondent repeatedly prescribed two benzodiazepines, Tranxene and Ativan, simultaneously over a long period of time with no explanation or justification. She provided no treatment plan concerning this combination benzodiazepine treatment, which can be dangerous, as they are both central nervous system depressants.

F. Respondent failed to consider or offer or failed to document consideration of other treatments for D.L.'s depression when he refused to continue to take SSRI-type antidepressants.

G. When respondent treated D.L. for what she diagnosed as bronchitis on several occasions, she failed to take or failed to document a medical history and a physical examination before prescribing antibiotics or bronchodilators. Other diagnoses such as tuberculosis or lung cancer with recurrent infection would not have been unreasonable to rule out.

H. Respondent prescribed Depakote without ordering baseline laboratory monitoring and ongoing monitoring of liver function and platelet aggregation since hepatic failure resulting in death and thrombocytopenia have been reported in patients receiving this medication.

I. When respondent prescribed Wellbutrin for D.L. initially, she discontinued its use because D.L. had had a manic episode on the drug. When she prescribed it again later on, she failed to specify or did not consider dosage reduction or any other precautions, such as the prescribing an additional agent, to minimize the chance of a manic episode recurring in response to this medication.

43. Therefore, respondent's conduct as set forth above, whether singly, jointly, or in any combination thereof, constitutes causes for discipline pursuant to section 2234(b), (c), and/or (d) of the Code.

FIFTH CAUSE FOR DISCIPLINE

(Prescribing without Good Faith Prior Examination and Medical Indication)

44. The allegations of paragraphs 23 through 42, above, are incorporated herein by reference as if fully set forth.

45. Respondent's conduct, as set forth above, constitutes the prescribing of controlled substances and/or dangerous drugs without a good faith prior examination and medical indication therefor, and therefore, cause exists for discipline pursuant to sections 2242(a) and 2234 of the Code.

SIXTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

46. The allegations of paragraphs 23 through 42, above, are incorporated herein by reference as if fully set forth.

47. Respondent's conduct, with reference to the simultaneous prescriptions for Ativan and Tranxene and repeated prescriptions for pain medication for D.L. without treatment plan or examination, constitutes excessive prescribing under section 725 of the Code and therefore, cause exists for discipline pursuant to section 2234 of the Code.

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Medical Records)

48. The allegations of paragraphs 23 through 42, above, are incorporated herein by reference as if fully set forth.

49. Respondent's conduct, as set forth above, constitutes failure to maintain adequate and accurate records with reference to the treatment of D.L., and therefore, cause exists for discipline pursuant to sections 2266 and 2234 of the Code.

///

///

EIGHTH CAUSE FOR DISCIPLINE

(Creating a False Medical Record/Dishonest Act)

50. The allegations of paragraphs 23 through 42, above, are incorporated herein by reference as if fully set forth.

51. Respondent's conduct in having inconsistent medical records for D.L. and two inconsistent sets of medical records for D.L. for the year 2001, and/or in altering her records for D.L. without disclosing that fact, constitutes the creation of false medical records, the making of documents related to the practice of medicine which falsely represent the existence or non-existence of a state of facts, and/or a dishonest act substantially related to the qualifications, functions and duties of a physician and surgeon, and therefore cause exists for discipline pursuant to sections 2261 and/or 2262 and/or 2234(e) through section 2234 of the Code.

NINTH CAUSE FOR DISCIPLINE

(Patient M.W.)

(Negligence/Incompetence)

52. From on or about July 22, 1999 through April 25, 2000, a period of nine months, respondent undertook to care for a treat patient M.W., a fifteen year old boy with a history of attention deficit disorder, impulse control disorder, and bipolar disorder. During that time, respondent had ten appointments for M.W. , and he failed to appear for five of those appointments. M.W. had been held by juvenile detention authorities on many occasions before his mother brought him to respondent requesting a recommendation for the use of marijuana for M.W.'s psychiatric symptoms. M.W. reported to respondent that he had used Ritalin, Dexedrine, Depakote, Cylert, Clonidine, Imipramine, Wellbutrin, Zoloft and other psychoactive medications in the past and could not tolerate the side effects of these medications; he had used marijuana, and this had alleviated his symptoms with fewer side effects and greater acceptance by his peer group.

53. Respondent conducted an initial psychiatric evaluation, but did not include in that evaluation any information concerning previous psychiatric hospitalizations or prevoius outpatient psychiatric treatment. Respondent's psychoactive medication history did not have information regarding duration of medication trials, dosages, efficacy, and any side effects of

concern that may have caused the drugs to be discontinued. Respondent's medication history did not indicate whether M.W. was currently taking any prescribed psychoactive medication. There was no medical history included in the evaluation. Following this evaluation, respondent wrote a recommendation for marijuana on July 22, 1999, but with the condition that M.W. keep regular appointments and refrain from the use of illicit drugs. When M.W. failed to keep his next appointment and it was reported to respondent on September 21, 1999 that M.W. had "stopped Depakote" and was using methamphetamines and abusing marijuana, and respondent immediately revoked her marijuana authorization for M.W.

54. On October 11, 1999, respondent convinced M.W. to try Depakote and wrote a prescription which was refilled until January 28, 2000, when a combination of lithium and Inderal was substituted because M.W. refused to continue on Depakote. Respondent did not perform or did not record any medical examination, medical history, or baseline laboratory blood or liver function tests before prescribing Depakote, Inderal, or lithium. M.W. was psychiatrically hospitalized in February 2000 and was discharged on or about February 16, 2000 on Depakote and Risperidol, which respondent subsequently refilled. M.W. did not appear for several appointments during his treatment with respondent, and in March 2000, he was truant from school and hiding from his probation officer. On April 25, 2000, respondent withdrew as M.W.'s psychiatrist by reason of his repeated failure to appear for evaluation.

55. Respondent was negligent and/or incompetent in her treatment of patient M.W. by reason of the following acts or omissions:

A. Respondent failed to do a medical history on M.W. as part of her initial evaluation.

B. Respondent failed to include information in her psychiatric evaluation about previous psychiatric hospitalizations or outpatient psychiatric treatment.

C. Respondent failed to include information in her psychoactive medication history concerning medication trials, dosages, efficacy, and side-effects that may have caused discontinuance of the drugs. She failed to record any current psychoactive or other medications.

D. Respondent failed to perform or record a medical history before prescribing psychoactive medications and failed to do a medical examination, including baseline liver function, heart function, and other tests before prescribing Depakote, Inderal, and lithium, all of which may have significant medical side effects.

56. Therefore, respondent's conduct as set forth above constitutes causes for discipline pursuant to sections 2234(c) and/or (d) of the Code.

TENTH CAUSE FOR DISCIPLINE

(Patient R.N.)

57. Respondent first saw Patient R.N., in June, 1998. Respondent describes R.N. as a 40 year old woman with a long history of severe alcohol abuse, extreme anxiety, anorexia and physical problems, which included a severe leg infection at the site of a bullet wound and chronic bronchitis. R.N. was also reported to have legal problems, having been deprived of custody of her children.

58. Although respondent states that she first saw R.N. in June, 1998, her records contain no documentation of her initial treatment of R.N. The first progress note for R.N. is dated July 18, 1998, and a typed note of October 15, 1998 appears to be respondent's initial evaluation note for R.N.

59. Respondent's records for R.N. show that she had regular, generally weekly, contact with R.N. between July, 1999 and January, 2001. The records do not state whether the entries are for an office visit or reflect a telephone consultation, but it appears that they address both types of contact. During this time, respondent's records reflect ongoing prescriptions for a number of drugs, including Dalmane, Klonopin, Tylenol with Codeine #3, Chloral Hydrate, Buspar, Ultram, Valium, Promethazine with Codeine syrup, and Alupent. The records do not contain any reflection of a full physical or mental status examination of patient R.N.

60. Although respondent's July 18, 1998 progress note states that R.N. had been clean and sober for one month, none of respondent's progress notes or records for R.N. document referral to or attendance at an alcohol treatment program. At no time did respondent document a standard alcohol history setting forth the amount of alcohol consumed, the duration of

drinking, whether R.N. had experienced significant alcohol withdrawal, whether she had been hospitalized for complications of her alcoholism, whether she had received treatment for alcoholism. She also failed to document any plan to address relapse prevention. Correspondence in respondent's file indicates that R.N. did relapse at some time between July 18, 1998 and November, 1998, but respondent's progress notes for R.N. make no mention of this fact.

61. Respondent's records for R.N. describe her as suffering from severe anxiety and chronic depression. Over the course of treatment, respondent prescribed various benzodiazepines for R.N.'s anxiety, including Klonopin, Valium and Dalmane. At no time did respondent fully or adequately evaluate R.N.'s anxiety, and there is no indication that she considered the potential problems associated with prescribing benzodiazepines to an alcoholic who was attempting to stay sober. She failed to consider alternative treatment for R.N.'s anxiety, including treatment options not utilizing medication. Respondent failed to obtain a detailed medical history regarding R.N.'s depressive episodes and she failed to assess and document the symptoms and severity of depressive episodes prior to making a diagnosis of depression.

62. Although respondent's notes indicate that a different physician was treating R.N.'s leg wound and prescribing pain medication, respondent prescribed Tylenol with Codeine #3 for pain on the July 18, 1998 visit. Respondent's record contains no explanation why she prescribed pain medication to R.N. on this occasion. She prescribed Tylenol with Codeine #3 on a number of occasions between September 1999 and April 2000, again without an explanation, treatment plan or risk/benefit evaluation .

63. Respondent's record for R.N. contains a progress note dated October 15, 1998. That note states that Dalmane was not working for sleep, and that Chloral Hydrate and Buspar were prescribed. Another chart entry, also dated October 15, 1998 bears no resemblance to the progress note for the same date. In fact, the content and medications described in the two entries are entirely different, and do not correlate in any way with one another.

64. Respondent wrote more than 40 prescriptions for promethazine with codeine syrup, which would be sufficient to provide up to 16 teaspoons per day for the period within which the prescriptions were issued. Respondent's record indicates that she undertook to

treat R.N.'s cough; However, her record contains a single reference to a physical examination for the cough, dated September 23, 1999. Respondent later admitted that she had excessively prescribed Promethazine with Codeine syrup, and that she was not aware what alcohol was an ingredient in the medication when she prescribed it.

65. Respondent treated R.N. for insomnia. She prescribed Dalmane four times, for a total of 150 tablets, without any evaluation of R.N.'s insomnia. Between October and December, 1998, respondent also prescribed high doses of Chloral Hydrate without any evaluation of the insomnia. Respondent at no time conducted an insomnia evaluation, including the type of insomnia, associated symptoms, drug/alcohol and caffeine history or sleep hygiene. Her records contain no treatment plan for the insomnia, and no assessment of the risks of prescribing Chloral Hydrate and Dalmane to an alcoholic patient.

66. Respondent prescribed Imitrex for R.N.'s recurrent headaches. However, respondent failed to take a detailed history, to perform a focused physical examination or to obtain a medication history regarding past treatment for the headaches.

67. Respondent diagnosed and treated anorexia nervosa in R.N. She failed to obtain the clinical information necessary to make this diagnosis, including a history of the onset of the weight loss, a menstrual history, an assessment of R.N.'s body image assessment, or to consider the weight loss in connection with R.N.'s alcoholism, depression and anxiety.

68. On or about April 25, 2000, respondent began prescribing Ritalin to R.N. for "low energy" without conducting a clinical evaluation of the complaint, or conducting an assessment of other conditions associated with low energy.

69. Respondent was grossly negligent, negligent and/or incompetent, jointly, singly or in any combination thereof with respect to her care and treatment of patient R.N. by reason of the following acts or omissions:

A. Respondent failed to document each patient encounter to the extent that the treatment can be understood by other health care providers who may have need to treat R.N. concurrently or in the future. She failed to adequately or completely document R.N.'s chief complaint, medical history, psychiatric and substance abuse history, medication history, mental

status examination, diagnostic formulation, and treatment plan. Respondent failed to record adequate information, including medical indications therefor, regarding the prescriptions she issued to R.N. Moreover, respondent failed completely to document her initial treatment of R.N. Further, respondent's progress note and evaluation for October 15, 1998 do not correlate in any way with one another, making it impossible to discern what treatment occurred on that date, what R.N.'s condition was on that date, or even whether the records accurately reflect anything that occurred on that date.

B. Respondent failed to obtain a detailed, specific substance abuse history from R.N. Respondent failed to adequately evaluate R.N.'s alcohol problem, or to document previous treatment efforts. She failed to evaluate R.N. for abuse of other substances. Respondent failed to formulate a plan for alcohol abuse treatment.

C. Respondent prescribed benzodiazepines to R.N., despite of her history of severe alcoholism. Respondent failed to discuss or consider that benzodiazepines can be addicting, that they can precipitate alcohol craving and a drinking relapse in some patients, and that they can exacerbate depression. Moreover, respondent prescribed three different benzodiazepines to R.N., a severe alcoholic in early remission, without attention to the risks of such prescriptions in this clinical setting. She failed to consider or document non-pharmacological treatment for anxiety.

D. Respondent diagnosed recurrent depression in R.N. without conducting an adequate clinical evaluation of R.N.'s symptoms, including obtaining a past history of depressive episodes, the symptoms and severity of the current depressive episode. She failed to consider a differential diagnosis, including alcohol-related depressive symptoms.

E. Respondent failed to fully and adequately evaluate R.N.'s complaints of insomnia. She failed to evaluate the type of insomnia, associated symptoms, drug/alcohol and caffeine history and sleep hygiene. Respondent inappropriately treated R.N.'s insomnia with high doses of benzodiazepines without a risk/benefit analysis.

F. Respondent diagnosed migraine-type headaches in R.N. and prescribed Imitrex without documenting a clinical or medication history. She failed to perform a focused

physical examination, or to consider other explanations for R.N.'s headache.

G. Respondent at no time conducted an adequate mental status examination for R.N., an extremely ill and symptomatic patient.

H. Respondent diagnosed anorexia nervosa in R.N. without obtaining the clinical information to make the diagnosis. She failed to obtain an adequate history of R.N's reported weight loss, or to consider whether R.N's weight loss was associated with her chronic alcoholism, depression and anxiety.

I. Respondent prescribed large amounts of cough syrup containing Codeine and alcohol without having conducted a relevant examination and history. She failed to inform herself, let alone R.N., that the prescription contained alcohol, and she prescribed promethazine with codeine in excessive amounts over a large period of time.

J. Respondent prescribed Ritalin for "low energy" without clinically evaluating R.N.'s complaints of low energy, without evaluating the possibility that prescribed medication, alcohol relapse or other medical conditions could have contributed to a loss of energy, and without considering the possibility that Ritalin could exacerbate R.N.'s anxiety.

70. Therefore, respondent's conduct as set forth above, whether singly, jointly or in any combination thereof, constitutes causes for discipline pursuant to section 2234(b), (c) and/or (d) of the Code.

ELEVENTH CAUSE FOR DISCIPLINE

(Prescribing Without Good Faith Prior Examination and Medical Indication)

71. The allegations of paragraphs 57 through 68, above, are incorporated herein by reference as if fully set forth.

72. Respondent's conduct as set forth above constitutes prescribing of controlled substances and/or dangerous drugs without a good faith prior examination and medical indication therefor, and therefore, cause for discipline exists pursuant to sections 2242(a) and 2234 of the Code.

//

//

TWELFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Medical Records)

73. The allegations of paragraphs 57 through 68 above are incorporated herein by reference as if fully set forth.

74. Respondent's conduct constitutes the failure to maintain adequate and accurate records with reference to the treatment of R.N., and therefore cause for discipline exists pursuant to sections 2266 and 2234 of the Code.

PRAYER

WHEREFORE, complainant requests that a hearing be held on the matters herein alleged, and that following that hearing, the Division issue a decision:

1. Revoking or suspending Physician and Surgeon Certificate No. G 17507, heretofore issued to Carol Stone Wolman, M.D.;

2. Prohibiting respondent from continuing to be or becoming a supervisor of physician assistants;

3. Ordering Carol Stone Wolman, M.D. to pay the Division the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring; and

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

DATED: January 23, 2003

RON JOSEPH, Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant