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

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| In the Matter of the First Amended Accusation Against: | ) | |
| PRATAP LAKSHMI NARAYAN, M.D. | ) | Case No. 08-2010-211824 |
| Physician's and Surgeon's Certificate No. C 52001 | ) | |
| Respondent | ) | |

## DECISION

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

This Decision shall become effective at 5:00 p.m. on September 19, 2014.

IT IS SO ORDERED: August 21, 2014.

MEDICAL BOARD OF CALIFORNIA

Dev Gnanadev, M.D., Chair
Panel B

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General
VLADIMIR SHALKEVICH
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*Attorneys for Complainant*

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

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| In the Matter of the First Amended Accusation Against:<br><br>**PRATAP NARAYAN, M.D.**<br>**P.O. Box 26088**<br>**Fresno, CA 93729**<br>**Physician's and Surgeon's Certificate No. C 52001**<br><br>Respondent. | Case No. 08-2010-211824<br><br>OAH No. 2014010210<br><br>**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. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Vladimir Shalkevich, Deputy Attorney General.

2. Respondent PRATAP NARAYAN, M.D. ("Respondent") is represented in this proceeding by attorney Mitchell Green, whose address is: 50 California Street, 34th Floor, San Francisco, CA 94111-4707

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3. On or about July 2, 2005, the Medical Board of California issued Physician's and Surgeon's Certificate No. C 52001 to PRATAP NARAYAN, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 08-2010-211824 and will expire on July 31, 2015, unless renewed.

JURISDICTION

4. Accusation No. 08-2010-211824 was filed before the Medical Board of California (Board) , Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on November 25, 2013. First Amended Accusation was filed and served on Respondent on or about July 10, 2015. Respondent timely filed his Notice of Defense.

5. A copy of First Amended Accusation No. 08-2010-211824 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 08-2010-211824. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to be represented by counsel at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his 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.

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

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in First Amended Accusation No. 08-2010-211824, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations contained in First Amended Accusation No. 08-2010-211824 and that he has thereby subjected his license to disciplinary action. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in the First Amended Accusation No. 08-2010-211824 shall be deemed true, correct and fully admitted by respondent for purposes of that proceeding or any other licensing proceeding involving respondent in the State of California.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

RESERVATION

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

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board 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 Board shall not be disqualified from further action by having considered this matter.

14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including Portable Document Format (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board 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. C 52001 issued to Respondent PRATAP NARAYAN, M.D. (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. CLINICAL TRAINING PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program"). Respondent shall successfully complete the Program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on Respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. Determination as to whether Respondent successfully completed the examination or successfully completed the program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program have been completed. If the Respondent did not successfully complete the clinical training program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of

licensure.

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

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

3. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

4. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the solo practice of medicine, unless and until a practice monitor is installed as described in Condition 5 herein. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting, within 30 calendar days of the effective date of this Decision, or does not comply with Condition 5 of this Order, whichever is applicable, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established, or a practice monitor is installed pursuant to Condition 5 herein.

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, or install a practice monitor as described in Condition 5 herein, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until he returns to an appropriate practice setting, or a practice monitor is installed as described in Condition 5 herein.

5. MONITORING - PRACTICE. Prior to engaging in solo practice of medicine as described in Condition 4 herein, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the

Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

At any time when Respondent engages in solo practice of medicine, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor prior to engaging in solo practice of medicine, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide the required monitoring.

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

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within

15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

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

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

7. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

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

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

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

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the

probation unit office, with or without prior notice throughout the term of probation.

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

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

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

14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and

carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Mitchell Green. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and

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Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 7/10/14

PRATAP NARAYAN, M.D.
Respondent

I have read and fully discussed with Respondent PRATAP NARAYAN, 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: July 10, 2014

Mitchell Green
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 7/10/14

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

VLADIMIR SHALKEVICH
Deputy Attorney General
*Attorneys for Complainant*

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# Exhibit A

**First Amended Accusation No. 08-2010-211824**

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| In the Matter of the First Amended Accusation Against:<br><br>**PRATAP LAKSHMI NARAYAN, M.D.**<br>**P.O. Box 26088**<br>**Fresno, CA 93729**<br><br>**Physician's and Surgeon's Certificate No. C 52001**<br><br>Respondent. | Case No. 08-2010-211824<br><br>**FIRST AMENDED ACCUSATION** |

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Interim Executive Officer of the Medical Board of California, Department of Consumer Affairs.

2. On or about July 2, 2005, the Medical Board of California issued Physician's and Surgeon's Certificate Number C 52001 to PRATAP LAKSHMI NARAYAN, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2015, unless renewed.

3. At all times alleged herein, Respondent, who is a Board Certified Psychiatrist, served as a Medical Director and treating physician in the Fresno County Jail (FCJ). Respondent served as the Medical Director of the FCJ Psychiatric Services.

JURISDICTION

4. This First Amended Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 2227 of 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, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board 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, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

6. Section 2234 of the Code states:

"The board 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.

"(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 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.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview scheduled by the mutual agreement of the certificate holder and the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

7. Section 2242 of the Code states:

" (a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional

conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

8. Section 2266 of the Code states: "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."

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## FACTUAL ALLEGATIONS

**Patient C.V.**[1]

9. C.V. was a 40 year-old Laotian mother of 9, who was arrested because she allegedly assaulted her husband with a knife in front of her children on or about August 6, 2009. During booking, she made statements that she wanted to kill herself and was taken from Fresno County Jail (FCJ hereafter) to Community Regional Medical Center (CRMC). She was placed in 5 point restraints and administered Haldol and Ativan to calm her.

10. C.V. was returned to FCJ On August 10, 2009, at which time she was seen by Respondent. Respondent, with the assistance of a Hmong interpreter, interviewed C.V. Respondent's clinical assessment was "Rule out Dysthymic Disorder versus Major Depressive Disorder, Methamphetamine Dependence." He elected to prescribe anti-depressant Zoloft 50 mg. p.o.[2] qam[3] and a Vistaril taper 25 mg. p.o. bid[4] for 4 days, then 25 mg. p.o. pm[5] for 4 days, then stop, and scheduled C.V. to be seen by a doctor 12 weeks later. Respondent did not document the thought process behind his clinical decision making with regard to why he ordered a Vistaril taper. No prior documentation indicates that C.V. was on this medication prior to seeing Respondent.

11. C.V. requested to see a psychiatrist to have her medications adjusted on or about September 7, 2009, complaining to a Jail Psychiatric Services worker (JPS Staff hereafter) that she "cannot sleep at night." JPS Staff noted that she "wants sleeping pills ... medication does not

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[1] Patients' initials are used herein to protect their privacy. The patients' complete identifying information will be furnished to Respondent in response to an appropriate Request for Discovery.

[2] The abbreviation "p.o." stands for the Latin phrase "per os" or "per orem," which means "by mouth."

[3] The abbreviation "qam" stands for the Latin phrase "quaque die ante meridiem," which means "every day before noon."

[4] The abbreviation "bid" stands for the Latin phrase "bis in die," which means "twice daily."

[5] The abbreviation "pm" stands for the Latin phrase "post meridiem," which means "afternoon or evening."

help" and reported C.V. saying: "I think too much I cannot sleep at night." JPS Staff also noted "Not in any acute psychiatric distress."

12. On or about September 7, 2009, without a face to face interview, and without documenting any evaluation, Respondent changed the time C.V. was given Zoloft from a.m. to p.m. Respondent did not document his thought process for doing so, as anti-depressants, such as Zoloft, have no measurable sedative effect to help a patient sleep. Respondent did not document the thought process behind his clinical decision making with regard to this order.

13. C.V. was referred to CRMC for an involuntary 5150 hold on or about November 26, 2009, and returned to FCJ from CRMC on or about December 1, 2009. C.V. had demonstrated psychotic behavior and clinical response to antipsychotic Risperdal during her treatment at CRMC. However, without any examination, a face to face clinical interview, or any other in-person interaction with C.V., Respondent elected on December 2, 2009 to taper and discontinue Risperdal over a 4 week period and to continue Zoloft at 50 mg. in a.m. Respondent did not document the thought process behind his clinical decision- making with regard to this order. Even though C.V. had recently demonstrated psychotic symptoms and shown response to an anti-psychotic medication, when Respondent did not continue C.V.'s Risperdal, he scheduled her next follow-up appointment with a psychiatrist 12 weeks later.

14. On or about January 19, 2010, C.V. was flooding her cell at the FCJ and smearing feces and urine. Without any examination, a face to face clinical interview, or any other in-person interaction with C.V., Respondent ordered Depakote 1,000 milligrams per day, and Risperdal 2 mg. per day. In his note, Respondent suggested that C.V.'s "primary problem appears to be personality disorder." He further noted: "Don't expect improvement until milieu is changed." Respondent's documentation does not explain Respondent's thought process or any reason why he ordered the medications apparently intended to treat C.V.'s psychosis, while at the same time clearly discounting a psychotic process. Respondent did not document the thought process behind his clinical decision making with regard to this order.

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15. On or about April 7, 2010, without any prior examination, a face to face clinical interview, or any other in-person interaction with C.V., Respondent ordered to continue Risperdal 1 mg. p.o. bid and Depakote 500 mg. p.o. bid for 30 days with 2 refills. Respondent did not document the thought process behind his clinical decision making with regard to this order.

16. On or about April 10, 2010, C.V. was found incompetent to stand trial and was admitted to Patton State Hospital. She returned to FCJ on or about July 20, 2010.

17. On or about July 31, 2010, without performing any examination, a face to face clinical interview, or any other in-person interaction with C.V., Respondent ordered to continue Depakote and Prozac in the same dose as C.V. was receiving at Patton State Hospital. However, at the same time he also elected not to continue all other medications, which were formulary antipsychotic drug Zyprexa, Ambien and Ativan. Respondent did not document the thought process behind his clinical decision making with regard to this order.

18. C.V. returned to Patton State Hospital on or about August 19, 2010, where she remained until approximately March 28, 2011. Upon return to FCJ, C.V. was on Depakote 500 mg. p.o. bid, fluoxetine 40 mg. p.o. qam, and Zyprexa 20 mg. p.o. qam.[6] Her hospital diagnosis included Major Depression, Recurrent, Severe with psychotic features and Opioid and Amphetamine Abuse.

19. On or about March 28, 2011 without any prior examination, a face to face clinical interview, or any other in-person interaction with C.V., Respondent ordered that C.V. be given Prozac 40 mg. qam, Zyprexa 10 mg. p.o. qhs and Depakote 500 mg. bid. Respondent scheduled no follow-up. Respondent did not document the thought process behind his clinical decision making with regard to this order.

20. On or about May 27, 2011, without any prior examination, a face to face clinical interview, or any other in-person interaction with C.V., Respondent ordered that C.V. be given Prozac 40 mg. qam, Zyprexa 10 mg. p.o. qhs and Depakote 500 mg. bid. Respondent scheduled

[6] The abbreviation "qam" stands for the Latin phrase "quaque die ante meridiem," which means "every day before noon."

no follow-up. Respondent did not document the thought process behind his clinical decision making with regard to this order.

**Patient M.M.**

21. M.M., a male born in 1984, had a long history of mental health treatment. He had attended the Turning Point program until October 10, 2010, when his grandmother took him to Arizona to participate in an alternative treatment program for mental illness called "Alternative to Meds." This clinic was an holistic and alternative treatment program where no psychotropic medications were provided. He was asked to leave there on November 25, 2010, as his yelling in response to auditory hallucinations was disturbing to neighbors at night.

22. When MM was arrested, he was initially treated at Good Samaritan Hospital. M.M. arrived at FCJ on or about April 30, 2011. That same day, Respondent, without any prior examination, a face to face clinical interview, or any other in-person interaction with the patient, prescribed Haldol 10 mg. qhs and Congentin .5 mg. p.o. bid to M.M. Respondent also elected not to continue all other medications prescribed to M.M. at Good Samaritan. Respondent did not document the thought process behind his clinical decision making with regard to this order.

23. Respondent saw M.M. for about 20 minutes on or about May 2, 2011. Respondent wrote that no history of symptoms of psychosis, mania, or hypomania elicited, and noted that personal history and past medical history were not elicited because M.M. terminated the interview.

24. Respondent saw M.M. on or about June 21, 2011.

25. On or about June 30, 2011, without seeing M.M. again, and without making any record of his clinical thought process, or scheduling a follow up with a psychiatrist, Respondent ordered that M.M. be given Haldol, 10 mg. qhs and Cogentin 0.5 mg. bid.

**Patient D.A.**

26. D.A. came to FCJ on or about May 23, 2007, after being charged with multiple criminal counts, including attempted murder. It was alleged that D.A. had previously gone to his neighbor's residence intoxicated and with a knife, claiming he was suspicious that someone was entering his property. He claimed that someone had drained the oil from his truck in an act of

sabotage. He complained to the trailer park manager and to the police. When he came back from a trip he noticed that the locks on his doors were "misaligned," and again called the police. He began calling his neighbors and accusing them of harassing him. He thought his neighbor was laughing at him, so he decided to confront him. He took a gun with him. He knocked on his neighbor's door. When no one came out, D.A. shot off the locks to the door and kicked it in. The victim said that D.A. had been rambling and not making much sense. On the day of the shooting, the victim woke up to gunshots and went to the living room. He heard D.A. yelling and cursing and said that he "was not making any sense, as he continued to shoot into the house."

27. D.A. was seen by Respondent on or about August 30, 2007. In his documentation of the August 30, 2007, visit, Respondent did not document any reason for the prolonged delay in seeing this patient, or his clinical thought process in making a plan to discontinue a mentally ill inmate's medication for being non-cooperative. Respondent did not document the fact that the patient may have had complaints about the specific JPS Staff member and did not want to discuss those in front of her, nor did Respondent consider/or document the patient's non-cooperation as being an issue to be addressed by treatment, choosing instead to plan on discontinuing the patient's psychotropic medication.

28. On or about October 26, 2007, without attempting to meet with or interview D.A. in person, Respondent wrote in D.A.'s chart: "I/M reportedly refused to be seen by us today per c.o. Lopez. Plan: JPS flu as needed." No further follow up was scheduled, and D.A. was not provided with any psychiatric services for approximately the following five months. Respondent did not document the reason for the patient's non-adherence and did not identify the patient's lack of cooperation as an issue to be addressed by treatment.

29. On or about March 3, 2008, FCJ received a note from D.A.'s brother, which summarized D.A.'s experience at FCJ, including changes and discontinuance of D.A.'s medications and care. Respondent then saw D.A. on or about March 21, 2008. Respondent recorded his interaction with D.A. as follows:

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"Inmate stated 'Id like to have some privacy;' Stated he did not want Ms. Hancock present during the interview despite being informed that she was part of the mental health staff. He stated, 'I object to her presence,' and left the interview room."

Respondent, therefore, had no opportunity to interview D.A., but documented an examination as follows:

"On exam he was adequately groomed, dressed in red jumpsuit. Psychomotor activity was normal. In no apparent distress. No hallucinatory behavior observed. Speech within normal limits. No evidence of behavior or verbalization suggestive of imminent danger to others or danger to self. Appeared entitled and demanding, but affect was euthymic with diminished reactivity. No loosening of associations identified. Possible persecutory thinking, but unclear whether delusional or not, secondary to inmate's lack of cooperation with the interview"

Respondent recorded his assessment of D.A. on that date as follows: "Psychosis by history. No evidence of symptomatic decompensation at present. Primary problem appears to be Cluster B Personality Disorder. Respondent's plan was to continue to monitor, with a follow up scheduled every two weeks." Respondent concluded: "no psych meds appear indicated at present." Respondent did not document any consideration of the defining factors or symptoms in diagnosing D.A. with a Personality Disorder.

30. On or about April 1, 2008, D.A. was again examined by Respondent. Respondent ordered a resumption of psychotropic medication for D.A. without clearly documenting his clinical thought process for doing so, and without scheduling a timely follow up.

31. D.A. was seen again by Respondent on or about June 20, 2008. Respondent's plan was to increase Effexor to 112.5 mg. p.o. bid, nearly a doubling of the dose, and to follow-up with a psychiatrist in 12 weeks. Respondent did not document his clinical thought process or reasons to increase D.A.'s Effexor, and did not schedule a timely follow up after significantly increasing D.A.'s psychotropic medication.

32. D.A. was seen by another psychiatrist at FCJ on or about September 17, 2008,

to whom he told that another psychiatrist had evaluated him and he was told that he was to be given an order to receive quetiapine. No physician's orders were made at that time. On or about that date Respondent ordered a refill of Effexor 112.5 mg. p.o. bid and made no note and scheduled no follow up.

33. D.A. was hospitalized at Metropolitan State Hospital, for restoration of his competency to stand trial, between May 28, 2009, and November 23, 2009

34. On D.A.'s first day back at FCJ, on or about November 24, 2009, Respondent noted that he did not have paperwork from the Metropolitan State Hospital. Without seeing D.A., without attempting to conduct a face to face interview, and without documenting any evaluation, of D.A., and without seeking out information about D.A.'s hospital course, Respondent elected to not continue the antipsychotic Abilify, but prescribed Cymbalta 30 mg. p.o. hs for 30 days with 2 refills.

35. Respondent's decision to not continue antipsychotic medication that was provided to D.A. at Metropolitan State Hospital was never revisited or reconsidered, even though D.A.'s FCJ medical records contain a copy of the Discharge Summary from Metropolitan State Hospital that was faxed to FCJ on or about January 8, 2010. On or about January 19, 2010, D.A. was once again complaining to JPS Staff of psychotic symptoms, increased voices. Mood is depressed, affect flat. D.A. express concern that he was not receiving Abilify, saying it helped him. On or about May 31, 2010, D.A. was complaining of auditory and visual hallucinations and asking for Abilify. D.A., however, was never seen by Respondent again, but Respondent did renew Cymbalta, without any patient contact whatsoever, and without making any medical record or note, for 90 days on April 28, 2010, on July 14, 2010, October 11, 2010, December 28, 2010, and February 2, 2011.

**Patient G.B.**

36. G.B., a 42-year-old Hispanic male, was arrested on allegations of inflicting a corporal injury on a spouse or a cohabitant, and booked into FCJ and placed in general housing on or about August 31, 2010. G.B. had been previously diagnosed at Fresno County Mental Health with depressive disorder, personality disorder, Amphetamine Dependence and Psychotic Disorder

NOS, for which he was prescribed Seroquel 200 mg. bid and Cymbalta 30 mg. At the time of his booking interview G.B. related a prior attempted suicide in 2009 and claimed that he had not taken his medication for the last week or two.

37. On or about October 11, 2010, without ever seeing G.B. in person and without documenting any evaluation or informed consent, Respondent noted that G.B. still complains of symptoms, and ordered for him an increase of Paxil from 10 mg. to 20 mg. at night, with a follow up as previously scheduled.

38. On or about November 9, 2010, without ever seeing G.B. in person and without documenting any evaluation or informed consent, Respondent noted that G.B. was complaining of problems with Paxil, and ordered that Paxil be discontinued and that G.B. be started on Zoloft 50 mg. at night. In his notes, respondent did not explain and did not document the reasons for his conclusion that the symptoms of which the patient was complaining were caused by Paxil.

39. On or about December 29, 2010, without ever seeing G.B. in person and without documenting any interview, evaluation or informed consent, Respondent noted that G.B. was complaining that symptoms are not improving with Zoloft, and noted that G.B. was previously on Cymbalta 30 mg. qam and a "sub-clinical" dose of Seroquel, prior to his arrest. In fact, at the time of his detention G.B. was being prescribed Seroquel 200 mg. twice per day, a total of 400 mg. per day, which is not a "sub-clinical" dose. Respondent ordered that Zoloft be discontinued and that G.B. be given Cymbalta 30 mg. qam.

40. On or about January 26, 2011, Respondent, without ever seeing G.B. in person and without documenting any interview, evaluation or informed consent, noted that G.B. asked for Cymbalta to be dosed in the evenings, although no record other than Respondent's note, made without speaking to the patient, indicates that this request was made. Respondent ordered a change in medication to provide Cymbalta 30 mg. qhs. In his notes, Respondent did not explain and did not document the reasons for his conclusion that the symptoms of which the patient was complaining were caused by taking Cymbalta in the mornings. Respondent did not document his thought process on how changing Cymbalta from qam to qhs would assist the patient.

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41. On or about June 15, 2011, Respondent, without ever seeing G.B. in person and without documenting any evaluation or informed consent, wrote in G.B.'s medical record that G.B. still complaints of some symptoms persisting, though it is not clear from Respondent's or JPS Staff members' notes what those symptoms are. Respondent then increased Celexa to 20 mg. daily. Respondent did not consider, inquire, document or comment in regard to discontinuation of Cymbalta which he previously prescribed to this patient.

42. On or about September 14, 2011, Respondent wrote an order to continue Celexa 20 mg. p.o. am for 30 days with 2 refills, without seeing G.B.

**Patient E.K.**

43. E.K. is an attorney in the Fresno area who was arrested for cutting tires, aggravated assault, corporal injury to his spouse and vandalism. He was brought to the Fresno County Jail in December of 2008. He arrived with verified prescriptions for lithium carbonate, 900 mg. daily and Seroquel 200 mg. at night, which were prescribed to him by Dr. M., who has been E.K.'s outpatient psychiatrist. E.K. was being treated for bipolar disorder for over seventeen years. These medications were dropped off by his wife, together with family verification sheet on or about December 18, 2009. E.K., however, refused to discuss anything about his medications with JPS Staff until Staff knew "of his wife's name and about this 'so called [Dr. M.].'" E.K. refused to sign any releases or consent for treatment.

44. Because E.K. refused to take any medications at the FCJ, he was given no medications for his condition. On December 24, 2008, E.K. gave two letters to a jail officer, who read the letters and noted that a lot of the content was nonsensical, jumping from subject to subject, with words out of context. E.K. refused to speak with the officer and stated that he would only talk if he had legal representative present. E.K. denied suicidal or homicidal ideations and indicated he did not want treatment.

45. On January 22, trial proceedings were suspended as the issue of E.K.'s competency to stand trial was questioned by the court. Doctors H. S., M.D. and R. T., Ph.D. were assigned to perform the competency for trial evaluations.

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46. E.K. was seen by Respondent on April 20, 2009. Respondent did not enter E.K.'s isolation cell, noting that E.K. had previously refused psychiatric care.

47. In his note of April 20, 2009, concerning E.K., Respondent did not document a sufficient mental status examination, did not include any remarks about suicidality or homicidality, even though the patient required special housing. Respondent made no notations in the record to suggest how he arrived at his conclusions pertaining to E.K.

48. E.K. was admitted to Atascadero State Hospital on May 13, 2009 and was discharged on July 22, 2009. The hospital course was uneventful. Upon his return from Atascadero State hospital, E.K. was receiving Lithium Carbonate 1200 mg. p.o. daily and Olanzapine 5 mg. p.o. daily. Without ever seeing E.K. again, Respondent ordered those same medications refilled on or about July 22, 2009.

**Patient N.P.**

49. N.P. had a history of arrests that included prior threats of suicide and psychotic behavior. He was being treated by a private psychiatrist with the medications Lexapro, lorazepam and Seroquel when N.P. was arrested and placed in Fresno County Jail on or about March 7, 2008. He was arrested because he placed a barricade consisting of 12 gallon drums and a 2x4 in front of a driveway, explaining that he did this to keep people from driving over a broken bottle. At that time, he made statements that indicated a suicide risk.

50. Respondent saw N.P. for the first and only time on or about March 13, 2008.

51. On exam, Respondent observed that N.P. was in safety cell, poorly kempt but wrapped in safety cell garment. Respondent noted that N.P.'s psychomotor activity was normal and that N.P. appeared to be in no apparent distress. Respondent noted that N.P.'s speech was within normal limits and that N.P. had told him that he had no plan to harm himself or others. Respondent noted that N.P. was suffering from ideas of persecution, but in Respondent's opinion these were not of delusional proportion and non-bizarre. Respondent noted that N.P. reported no auditory or visual hallucinations and no delusions. N.P.'s affect was dysthymic with positive reactivity. Respondent noted no looseness of associations.

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52. Respondent's assessment of N.P. was depressive disorder NOS rule out dysthymic disorder, no evidence of psychosis or bipolarity; rule out paranoid traits (PDO). Respondent's plan was to prescribe Paxil 20 mg. daily. Respondent noted that N.P. was willing to take Paxil instead of Lexapro. Respondent also ordered "Klonopin on a taper from 0.5 mg. bid x 3 day, to 0.5 mg. p.o. qhs x 3 days then stop." Respondent scheduled a follow up with JPS Staff in six weeks, and a follow up with a physician in 12 weeks.

## DISCIPLINARY ALLEGATIONS

**Patient C.V.**

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligence)

53. Respondent is subject to disciplinary action pursuant to section 2234, subdivision (c), in that he was repeatedly negligent in the care and treatment of patient C.V. The circumstances are as follows:

54. Allegations of paragraphs 9 through 20 are incorporated by reference herein.

55. Respondent's discontinuing C.V.'s previously prescribed Risperdal on or about December 2, 2009, without any examination, a face to face clinical interview, or any other in-person interaction with C.V. was an extreme departure from the standard of care.

56. Respondent's failure to schedule a timely physician follow up after stopping an C.V.'s antipsychotic medication on or about December 2, 2009, without any examination, a face to face clinical interview, or any other in-person interaction with C.V., was an extreme departure from the standard of care.

57. Respondent committed an extreme departure from the standard of care in his care and treatment of patient C.V. when, on or about January 19, 2010, he prescribed to her Depakote and Risperdal, to treat her psychotic behavior, while at the same time changing C.V.'s diagnosis from psychosis to Personality Disorder, without any examination, a face to face clinical interview or any other in-person interaction with C.V.

58. Respondent committed an extreme departure from the standard of care when, on or about July 31, 2010, without any examination, a face to face clinical interview or any other in-

person interaction with C.V. and without documenting the clinical thought process behind his actions, he abruptly discontinued Ativan, Ambien and Zyprexa that were previously prescribed to C.V. at Patton State Hospital.

59. On or about March 28, 2011, when he prescribed Prozac, Zyprexa and Depakote to C.V. without any prior examination, a face to face clinical interview, or any other in-person interaction with the patient, and scheduling no follow up with a psychiatrist, Respondent committed an extreme departure from the standard of care.

60. On or about May 27, 2011, when he renewed C.V.'s prescriptions for Prozac, Zyprexa and Depakote without any prior examination, a face to face clinical interview, or any other in-person interaction with the patient, and scheduled no follow up with a psychiatrist, Respondent committed an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Prescribing Without Prior Exam)

61. Respondent is subject to disciplinary action under section 2242 in that he prescribed dangerous drugs to patient C.V. as defined in Business and Professions Code section 4022 without an appropriate prior examination. The circumstances are as follows:

62. Allegations of paragraphs 9 through 20 are incorporated by reference herein.

63. Respondent's prescription of Depakote and Risperdal without any examination, a face to face clinical interview or any other in-person interaction with C.V. on or about January 19, 2010 was unprofessional conduct pursuant to section 2242.

64. Respondent violated section 2242 on or about March 28, 2011, when he prescribed Prozac, Zyprexa and Depakote to C.V. without any prior examination, a face to face clinical interview, or any other in-person interaction with the patient, and scheduled no follow up with a psychiatrist.

65. Respondent violated section 2242 on or about May 27, 2011, when he prescribed Prozac, Zyprexa and Depakote to C.V. without any prior examination, a face to face clinical interview, or any other in-person interaction with the patient, and scheduled no follow up with a psychiatrist.

THIRD CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)

66. Respondent is subject to disciplinary action pursuant to section 2266 in that he failed to keep adequate and accurate records of his care and treatment of patient C.V. The circumstances are as follows:

67. Allegations of paragraphs 9 through 20 are incorporated by reference herein.

68. Respondent failed to adequately document his clinical thought process when he ordered a Vistaril taper for C.V. on or about August 10, 2009.

69. Respondent failed to adequately document his clinical thought process when he ordered change in administration of C.V.'s Zoloft from a.m. to p.m. on or about September 7, 2009.

70. Respondent failed to adequately document his clinical thought process when he discontinued C.V.'s previously prescribed Risperdal on or about December 2, 2009.

71. Respondent failed to adequately document his clinical thought process when he prescribed Depakote and Risperdal for C.V., while documenting a diagnosis that is inconsistent with such an order, on or about January 19, 2010.

72. Respondent failed to adequately document his clinical thought process when, on or about July 31, 2010, he abruptly discontinued Ativan, Ambien and Zyprexa that were previously prescribed to C.V. at Patton State Hospital.

73. Respondent failed to adequately document his clinical thought process when, on or about March 28, 2011 he failed to document any clinical thought process when he prescribed Prozac, Zyprexa and Depakote to C.V.

**Patient M.M.**

FOURTH CAUSE FOR DISCIPLINE

(Repeated Negligence)

74. Respondent is subject to disciplinary action pursuant to section 2234, subdivision (c), in that he was repeatedly negligent in the care and treatment of patient M.M. The circumstances are as follows:

75. Allegations of paragraphs 21 through 25 are incorporated by reference herein.

76. Respondent's significant and abrupt changes in M.M.'s psychotropic medications on or about April 30, 2011, without any prior examination, a face to face clinical interview, or any other in-person interaction with the patient was an extreme departure from the standard of care.

77. Respondent's failure on or about June 21, 2011, to assess and document whether M.M. continued to present a risk of self harm, and whether M.M. should have remained confined in the safety cell, was an extreme departure from the standard of care.

78. Respondent committed an extreme departure from the standard of care on or about June 30, 2011, when he prescribed Haldol to M.M. without any prior examination, a face to face clinical interview, or any other in-person interaction with the patient, and scheduled no follow up with a psychiatrist.

FIFTH CAUSE FOR DISCIPLINE

(Prescribing Without Prior Exam)

79. Respondent is subject to disciplinary action pursuant to section 2242 in that he prescribed a dangerous drug to patient M.M., as defined in Business and Professions Code section 4022, without an appropriate prior examination. The circumstances are as follows:

80. Allegations of paragraphs 21 through 25 are incorporated by reference herein.

81. Respondent violated section 2242 on or about June 30, 2011, when he prescribed Haldol to M.M. without any prior examination, a face to face clinical interview, or any other in-person interaction with the patient, and scheduled no follow up with a psychiatrist.

SIXTH CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)

82. Respondent is subject to disciplinary action pursuant to section 2266 in that he failed to keep adequate and accurate records of his care and treatment of patient M.M. The circumstances are as follows:

83. Allegations of paragraphs 21 through 25 are incorporated by reference herein.

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84. Respondent failed to adequately document his clinical thought process when, on or about April 30, 2011, he failed to adequately document his clinical thought process when he made changes in M.M.'s psychotropic medications without seeing him in person.

85. Respondent failed to adequately document his clinical thought process when, on or about June 21, 2011, he failed to adequately document his clinical thought process when despite documenting that M.M. was not suicidal he did not document whether M.M. continued to present a risk of self harm, and whether M.M. should have remained confined in the safety cell.

86. Respondent failed to adequately document his clinical thought process when, on or about June 30, 2011, he did not document his clinical thought process when ordering Haldol for M.M. without seeing him in person.

87. Respondent violated section 2266 when, on or about August 30, 2007, he failed to adequately document his clinical thought process when Respondent did not document any reason for the prolonged delay in seeing this patient, or his clinical thought process in making a plan to discontinue a mentally ill inmate's medication for being non-cooperative. Respondent did not document the fact that the patient may have had complaints about the specific JPS Staff member and did not want to discuss those in front of her, nor did Respondent document the patient's non cooperation as being an issue to be addressed by treatment.

**Patient D.A.**

SEVENTH CAUSE FOR DISCIPLINE

(Repeated Negligence)

88. Respondent is subject to disciplinary action pursuant to section 2234, subdivision (c), in that he was repeatedly negligent in the care and treatment of patient D.A. The circumstances are as follows:

89. Allegations of paragraphs 26 through 35 are incorporated by reference herein.

90. Respondent committed an extreme departure from the standard of care on or about March 21, 2008, when Respondent did not document any consideration of the defining factors or symptoms in diagnosing D.A. with a Personality Disorder.

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91. Respondent committed an extreme departure from the standard of care on or about April 1, 2008, when Respondent did not document any consideration of the defining factors or symptoms in diagnosing D.A. with a Personality Disorder.

92. Respondent committed an extreme departure from the standard of care on or about November 24, 2009, when Respondent disregarded the fact that D.A. had just returned from the hospital, and did not seek to obtain any additional information by examining this patient. Therefore, without seeing D.A., without even attempting to conduct a face to face interview, and without documenting any evaluation, of D.A. whatsoever, and without seeking out information about D.A.'s hospital course, Respondent abruptly discontinued the antipsychotic Abilify prescribed to D.A.

EIGHTH CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)

93. Respondent is subject to disciplinary action pursuant to section 2266 in that he failed to keep adequate and accurate records of his care and treatment of patient D.A. The circumstances are as follows:

94. Allegations of paragraphs 26 through 35 are incorporated by reference herein.

95. Respondent failed to adequately document his clinical thought process on or about March 21, 2008, when he failed to document any defining factors or symptoms in diagnosing D.A. with a Personality Disorder.

96. Respondent failed to adequately document his clinical thought process on or about April 1, 2008, when he failed to document any defining factors or symptoms in diagnosing D.A. with a Personality Disorder.

97. Respondent failed to adequately document his clinical thought process on or about June 20, 2008, when he decided to treat D.A. for dysthymic disorder without adequately documenting his clinical thought process in making such a diagnosis and significantly increasing the dose of Effexor prescribed to D.A.

98. Respondent violated business and professions code section 2266 on or about November 24, 2008, when he failed to adequately document his clinical thought process in

abruptly discontinuing Abilify that was prescribed to D.A. at the hospital, while prescribing Cymbalta.

99. Respondent kept inadequate records on January 24, 2010, October 11, 2010 and December 28, 2010, when he failed to document any clinical thought process, and wrote no note in renewing D.A.'s prescription for Cymbalta.

**Patient G.B.**

NINTH CAUSE FOR DISCIPLINE

(Repeated Negligence)

100. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he was repeatedly negligent in the care and treatment of patient G.B. The circumstances are as follows:

101. Allegations of paragraphs 36 through 42 are incorporated by reference herein.

102. Respondent's order of increase of psychotropic medication Paxil prescribed for G.B. without a face to face interview, and without documenting any examination or evaluation of the patient G.B. and scheduling no follow up on about October 11, 2010 was an extreme departure from the standard of care.

103. Respondent's failure to schedule a timely follow-up after he ordered a significant change in psychotropic medication for G.B. on or about October 11, 2010, was an extreme departure from the standard of care.

104. Respondent's order changing psychotropic medication for G.B. without a face to face interview, and without documenting any examination or evaluation of the patient G.B. about November 9, 2010 was an extreme departure from the standard of care.

105. Respondent's failure to schedule a timely follow-up after he ordered a significant change in psychotropic medication for G.B. on or about November 9, 2010, was an extreme departure from the standard of care.

106. Respondent's order to discontinue Zoloft and begin Cymbalta for G.B. without a face to face interview, and without documenting any examination or evaluation of the patient G.B. about December 29, 2010 was an extreme departure from the standard of care.

107. Respondent's failure to schedule a timely follow-up with a psychiatrist after he ordered a significant change in psychotropic medications for G.B. on or about December 29, 2010, was an extreme departure from the standard of care.

108. Respondent's order increasing the dose of psychotropic medication Celexa for G.B. without a face to face interview, and without documenting any examination or evaluation of the patient G.B. on about June 15, 2011 was an extreme departure from the standard of care.

TENTH CAUSE FOR DISCIPLINE

(Prescribing without examination)

109. Respondent is subject to disciplinary action under section 2242 in that he prescribed dangerous drugs, as defined in Business and Professions Code section 2022 without an appropriate prior examination, during his care and treatment of patient G.B. The circumstances are as follows:

110. Allegations of paragraphs 36 through 42 are incorporated herein by reference.

111. Respondent prescribing of Zoloft, a dangerous drug as defined in section 2022, to G.B. on or about November 9, 2010, without conducting a prior examination was a violation of section 2242.

112. Respondent prescribing of Cymbalta, a dangerous drug as defined in section 2022, to G.B. on or about December 29, 2010, without conducting a prior examination was a violation of section 2242.

ELEVENTH CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)

113. Respondent is subject to disciplinary action pursuant to section 2266 in that he failed to keep adequate and accurate records of his care and treatment of patient G.B. The circumstances are as follows:

114. Allegations of paragraphs 36 through 42 are incorporated by reference herein.

115. Respondent failed to adequately document his clinical thought process when, on or about October 11, 2010, he ordered an increase in psychotropic medication prescribed to G.B. without seeing him in person.

116. Respondent's lack of documentation with regard to his clinical decision making on or about November 9, 2010, was an extreme departure from the standard of care and unprofessional conduct in violation of Business and Professions Code section 2266.

117. Respondent's lack of documentation with regard to his clinical decision making on or about December 29, 2010, was unprofessional conduct in violation of Business and Professions Code section 2266.

118. Respondent's lack of documentation with regard to his clinical decision making on or about January 26, 2011, when Respondent did not document the reasons for his conclusion that the symptoms of which G.B. was complaining were caused by taking Cymbalta in the mornings. Respondent did not document his thought process on how changing Cymbalta from qam to qhs would assist the patient, and Respondent inaccurately documented that G.B. requested Cymbalta be dosed in the evenings, when G.B. was, in fact, asking to see Respondent and to revisit what medication he was taking. Respondent's inadequate and incomplete record keeping on or about January 26, 2011 constitutes unprofessional conduct in violation of Business and Professions Code section 2266.

119. Respondent's lack of any documentation with regard to his clinical decision making on or about June 15, 2011, when Respondent ordered an increase in Celexa, constitutes unprofessional conduct in violation of Business and Professions Code section 2266.

**Patient E.K.**

TWELFTH CAUSE FOR DISCIPLINE

(Repeated Negligence)

120. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he was grossly negligent in the care and treatment of patient E.K. The circumstances are as follows:

121. Allegations of paragraphs 43 through 48 are incorporated by reference herein.

122. Respondent's diagnosis of E.K., a patient with a well established prior diagnosis and treatment of bipolar disorder as a malingerer on or about April 20, 2009, while failing to

document any consideration of the defining factors or symptoms in diagnosing E.K. was an extreme departure from the applicable standard of care.

123. Respondent's prescribing of Lithium and olanzapine on or about July 22, 2009, without a face to face examination, or any other interaction with E.K. and without scheduling or conducting a timely follow up was an extreme departure from the standard of care.

THIRTEENTH CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)

124. Respondent is subject to disciplinary action pursuant to section 2266 in that he failed to keep adequate and accurate records of his care and treatment of patient E.K. The circumstances are as follows:

125. Allegations of paragraphs 43 through 48 are incorporated by reference herein.

126. Respondent's sparse documentation of his examination and clinical thought process regarding E.K. on or about April 20, 2011, when Respondent did not document a sufficient mental status examination, did not include any remarks about suicidality or homicidality, even though the patient required special housing, made no notations in the record to suggest how he arrived at his conclusions pertaining to E.K., constitutes unprofessional conduct in violation of Business and Professions Code section 2266.

127. Respondent's failure to make any record or to document his clinical decision making on or about July 22, 2009, when he prescribed Lithium and olanzapine without a face to face examination, or any other interaction with E.K. and without scheduling or conducting a timely follow up, was unprofessional conduct in violation of Business and Professions Code section 2266.

**Patient N.P.**

FOURTEENTH CAUSE FOR DISCIPLINE

(Repeated Negligence)

128. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he was repeatedly negligent in the care and treatment of patient N.P. The circumstances are as follows:

129. Allegations of paragraphs 49 through 52 are incorporated by reference herein.

130. Respondent's failure to document an appropriate assessment of N.P.'s suicide risk when examining N.P. in a safety cell on or about March 13, 2008 was an extreme departure from the standard of care.

131. Respondent's failure to schedule a timely follow up with a psychiatrist, after making significant changes in N.P.'s psychotropic medication on or about March 13, 2008 was an extreme departure from the standard of care.

FIFTEENTH CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)

132. Respondent is subject to disciplinary action pursuant to section 2266 in that he failed to keep adequate and accurate records of his care and treatment of patient N.P. The circumstances are as follows:

133. Allegations of paragraphs 49 through 52 are incorporated herein by reference.

134. Respondent's documentation on March 13, 2008, did not provide adequate information to determine whether N.P. was making progress, and did not describe Respondent's thought process or consideration of safety surrounding self-harm or choice of diagnosis in his care for N.P. As such, Respondent's documentation regarding his clinical decision making on or about March 13, 2011, was unprofessional conduct in violation of Business and Professions Code section 2266.

SIXTEENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

135. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he committed repeated acts of negligence in the care and treatment of patients C.V., E.K., G.B., D.A., N.P. and M.M. The circumstances are as follows:

136. Allegations of paragraphs 9 through 52 are incorporated herein by reference.

137. Each of the following is a departure from the standard of care.

A. Respondent's discontinuing C.V.'s previously prescribed Risperdal on or about December 2, 2009, without any examination, a face to face clinical interview, or any other in-person interaction with C.V. was a departure from the standard of care.

B. Respondent's failure to schedule a timely physician follow up after stopping an C.V.'s antipsychotic medication on or about December 2, 2009, without any examination, a face to face clinical interview, or any other in-person interaction with C.V., was a departure from the standard of care.

C. Respondent departed from the standard of care in his care and treatment of patient C.V. when, on or about January 19, 2010, he prescribed to her Depakote and Risperdal, to treat her psychotic behavior, while at the same time changing C.V.'s diagnosis from psychosis to Personality Disorder, without any examination, a face to face clinical interview or any other in-person interaction with C.V. and without documenting factors or symptoms necessary to establish a diagnosis of Personality Disorder.

D. On or about March 28, 2011, when he prescribed Prozac, Zyprexa and Depakote to C.V. without any prior examination, a face to face clinical interview, or any other in-person interaction with the patient, and scheduling no follow up with a psychiatrist, Respondent departed from the standard of care.

E. On or about May 27, 2011, when he renewed C.V.'s prescriptions for Prozac, Zyprexa and Depakote without any prior examination, a face to face clinical interview, or any other in-person interaction with the patient, and scheduled no follow up with a psychiatrist, Respondent departed from the standard of care.

F. Respondent's failure to schedule a timely follow up after prescribing a psychotropic medication to C.V. on or about August 10, 2009 was a departure from the standard of care.

G. Respondent's significant and abrupt changes in M.M.'s psychotropic medications on or about April 30, 2011, without any prior examination, a face to face clinical interview, or any other in-person interaction with the patient was a departure from the standard of care.

H. Respondent's failure to address on or about May 25, 2011, symptoms of M.M.'s severe mental disorder, even though Respondent described such symptoms in detail in his note of M.M.'s examination on that date, was a departure from the standard of care.

I. Respondent's failure on or about June 21, 2011, to assess and document whether M.M. continued to present a risk of self harm, and whether M.M. should have remained confined in the safety cell, was a departure from the standard of care.

J. Respondent departed from the standard of care on or about June 30, 2011, when he prescribed Haldol to M.M. without any prior examination, a face to face clinical interview, or any other in-person interaction with the patient, and scheduled no follow up with a psychiatrist.

K. Respondent departed from the standard of care on or about March 21, 2008, when Respondent did not document any consideration of the defining factors or symptoms in diagnosing D.A. with a Personality Disorder.

L. Respondent departed from the standard of care on or about April 1, 2008, when Respondent did not consider document any consideration of the defining factors or symptoms in diagnosing D.A. with a Personality Disorder.

M. Respondent departed from the standard of care on or about November 24, 2009, when without seeing D.A., without attempting to conduct a face to face interview, and without documenting any evaluation, of D.A. and without seeking out information about D.A.'s hospital course, Respondent discontinued the antipsychotic Abilify prescribed to D.A.

N. Failure to schedule a timely follow up after renewing Effexor for patient D.A. on or about April 1, 2008 was a departure from the standard of care.

O. Respondent's failure to schedule a follow up and to make any record when renewing D.A.'s Effexor on or about September 17, 2008, was a departure from the standard of care.

P. Respondent's failure to schedule a timely follow up with a psychiatrist after stopping D.A.'s Abilify on or about November 24, 2009 was a departure from the standard of care.

Q. Respondent's failure to schedule any follow up with a psychiatrist when renewing D.A.'s Cymbalta on or about January 24, 2010 was a departure from the standard of care.

R. Respondent's failure to schedule any follow up with a psychiatrist when renewing D.A.'s Cymbalta on or about October 11, 2010 was a departure from the standard of care.

S. Respondent's failure to schedule any follow up with a psychiatrist when renewing D.A.'s Cymbalta on or about December 28, 2010 was a departure from the standard of care.

T. Respondent's order of increase of psychotropic medication Paxil prescribed for G.B. without a face to face interview, and without documenting any examination or evaluation of the patient G.B. and scheduling no follow up on about October 11, 2010 was a departure from the standard of care.

U. Respondent's failure to schedule a timely follow-up after he ordered a significant change in psychotropic medication for G.B. on or about October 11, 2010, was a departure from the standard of care.

V. Respondent's order changing psychotropic medication for G.B. without a face to face interview, and without documenting any examination or evaluation of the patient G.B. about November 9, 2010 was a departure from the standard of care.

W. Respondent's failure to schedule a timely follow-up after he ordered a significant change in psychotropic medication for G.B. on or about November 9, 2010, was a departure from the standard of care.

X. Respondent's order to discontinue Zoloft and begin Cymbalta for G.B. without a face to face interview, and without documenting any examination or evaluation of the patient G.B. about December 29, 2010 was a departure from the standard of care.

Y. Respondent's failure to schedule a timely follow-up with a psychiatrist after he ordered a significant change in psychotropic medications for G.B. on or about December 29, 2010, was a departure from the standard of care.

Z. Respondent's order increasing the dose of psychotropic medication Celexa for G.B. without a face to face interview, and without documenting any examination or evaluation of the patient G.B. on about June 15, 2011 was a departure from the standard of care.

AA. Respondent's failure to conduct a face to face examination or any in-person interaction with G.B., when Respondent ordered that G.B. take Cymbalta in the evening instead of in the morning, on or about January 26, 2011, was a departure from the standard of care.

AB. Respondent's failure to schedule any follow up with a psychiatrist when changing the time of administration of G.B.'s Cymbalta on or about January 26, 2011 was a departure from the standard of care.

AC. Respondent's failure to schedule any follow up with a psychiatrist when renewing G.B.'s Celexa on or about June 15, 20011 was a departure from the standard of care.

AD. Respondent's diagnosis of E.K., a patient with a well established prior diagnosis and treatment of bipolar disorder as a malingerer on or about April 20, 2009, while failing to document any consideration of the defining factors or symptoms in diagnosing E.K. was a departure from the applicable standard of care.

AE. Respondent's prescribing of Lithium and olanzapine on or about July 22, 2009, without a face to face examination, or any other interaction with E.K. and without scheduling or conducting a timely follow up was a departure from the standard of care.

AF. Respondent's failure to document an appropriate assessment of N.P.'s suicide risk when examining N.P. in a safety cell on or about March 13, 2008 was a departure from the standard of care.

AG. Respondent's failure to schedule a timely follow up with a psychiatrist, after making significant changes in N.P.'s psychotropic medication on or about March 13, 2008 was a departure from the standard of care.

SEVENTEENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

138. Respondent is subject to disciplinary action under section 2234 in that he engaged in in unprofessional conduct in his care and treatment of patients C.V., E.K., G.B., D.A., N.P. and M.M. The circumstances are as follows:

139. Allegations of paragraphs 9 through 52 are incorporated herein by reference.

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 C 52001, issued to Pratap Lakshmi Narayan, M.D.;

2. Revoking, suspending or denying approval of Pratap Lakshmi Narayan, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. If placed on probation, ordering Pratap Lakshmi Narayan, M.D. to pay the Medical Board of California the costs of probation monitoring; and

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

DATED: July 10, 2014

FOR

KIMBERLY KIRCHMEYER
Interim Executive Officer
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*

LA2013609437