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

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| In the Matter of the Accusation Against: | |
| JOANNA ROBERTA LOUIS, M.D. | Case No. 13-2013-231099 |
| Physician's and Surgeon's Certificate No. G 43299 | |
| 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 March 24, 2017.

IT IS SO ORDERED: February 23, 2017.

MEDICAL BOARD OF CALIFORNIA

Jamie Wright, JD, Chair
Panel A

KAMALA D. HARRIS
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
MARTIN W. HAGAN
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P.O. Box 85266
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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 Accusation Against:<br><br>**JOANNA LOUIS, M.D.**<br>**1853 N VULCAN AVE # 5**<br>**LEUCADIA, CA 92024**<br><br>**Physician's and Surgeon's Certificate No. G43299**<br><br>Respondent. | Case No. 13-2013-231099<br>OAH No. 2016031243<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 (Board). 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 Martin W. Hagan, Deputy Attorney General.

2. Respondent Joanna Louis, M.D. ("Respondent") is represented in this proceeding by attorney David M. Balfour Esq., of DiCaro, Coppo & Popcke, whose address is: 2780 Gateway Road, Carlsbad, CA 92009.

3. On or about September 8, 1980, the Board issued Physician's and Surgeon's Certificate No. G43299 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 13-2013-231099, and will expire on April 30, 2018, unless renewed.

## JURISDICTION

4. On January 21, 2016, Accusation No. 13-2013-231099 was filed before the Board, and is currently pending against Respondent. A true and correct copy of the Accusation and all other statutorily required documents were properly served on Respondent on January 21, 2016. Respondent timely filed her Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 13-2013-231099 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. 13-2013-231099. 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 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. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

## CULPABILITY

8. Respondent agrees that, at an administrative hearing, complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 13-2013-231099, and that she has thereby subjected his Physician's and Surgeon's Certificate No. G43299

to disciplinary action. Respondent further agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

9. Respondent further agrees that if she ever petitions for early termination or modification of probation, or if an accusation and/or petition for revocation of probation is filed against her before the Medical Board of California, all of the charges and allegations contained in Accusation No. 13-2013-231099 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 or elsewhere.

10. Respondent agrees that her Physician's and Surgeon's Certificate No. G43299 is subject to discipline and she agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

**CONTINGENCY**

11. 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 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 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.

12. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Settlement and Disciplinary Order, the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Board, any

member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Board does not, in its discretion, approve and adopt this Stipulated Settlement and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Settlement and Disciplinary Order be rejected for any reason by the Board, respondent will assert no claim that the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Settlement and Disciplinary Order or of any matter or matters related hereto.

## ADDITIONAL PROVISIONS

13. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

14. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as 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. G43299 issued to Respondent Joanna Louis, M.D. is revoked. However, the revocation stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. **CONTROLLED SUBSTANCES - PARTIAL RESTRICTION**. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedules IV and V of the Act. The partial restriction discussed herein shall terminate upon Respondent fulfilling, and successfully completing, the terms and conditions of the required Clinical Training

Program, as set forth more fully below in probationary condition number 6.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

Respondent shall immediately surrender Respondent's current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, Respondent shall submit proof that Respondent has surrendered Respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, Respondent shall submit a true copy of the permit to the Board or its designee.

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2. **CONTROLLED SUBSTANCES- MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES**. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

3. **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.

4. **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.

5. **PROFESSIONAL BOUNDARIES PROGRAM**. Within 60 calendar days from the effective date of this Decision, Respondent shall enroll in a professional boundaries program equivalent to the Professional Boundaries Program offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine ("Program"). Respondent, at the Program's discretion, shall undergo and complete the Program's assessment of Respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24 hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the Decision(s), Accusation(s) and any other information that the Board or its designee deems relevant. The

Program shall evaluate Respondent at the end of the training and the Program shall provide any data from the assessment and training as well as the results of the evaluation to the Board or its designee.

Failure to complete the entire Program not later than six (6) months after Respondent's initial enrollment shall constitute a violation of probation unless the Board or its designee agrees in writing to a later time for completion. Based on Respondent's performance in and evaluations from the assessment, education, and training, the Program shall advise the Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that Respondent can practice medicine safely. Respondent shall comply with Program recommendations. At the completion of the Program, Respondent shall submit to a final evaluation. The Program shall provide the results of the evaluation to the Board or its designee. The professional boundaries program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

The Program has the authority to determine whether or not Respondent successfully completed the Program. A professional boundaries 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. If Respondent fails to complete the Program within the designated time period, Respondent shall cease the practice of medicine within three (3) calendar days after being notified by the Board or its designee that Respondent failed to complete the Program.

6. **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.

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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.

7. **PSYCHIATRIC EVALUATION**. Within 30 calendar days of the effective date of this Decision, and on whatever periodic basis thereafter may be required by the Board or its designee, Respondent shall undergo and complete a psychiatric evaluation (and psychological

testing, if deemed necessary) by a Board-appointed board certified psychiatrist, who has not previously evaluated Respondent. The Board-appointed board certified psychiatrist shall consider any information provided by the Board or designee and any other information the psychiatrist deems relevant, and shall furnish a written evaluation report to the Board or its designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not be accepted towards the fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations and psychological testing. Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the Board or its designee.

8. **PSYCHOTHERAPY**. Within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval the name and qualifications of a California-licensed board certified psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, Respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the Board or its designee deems that no further psychotherapy is necessary.

The psychotherapist shall consider any information provided by the Board or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the Board or its designee. Respondent shall cooperate in providing the psychotherapist any information and documents that the psychotherapist may deem pertinent.

Respondent shall have the treating psychotherapist submit quarterly status reports to the Board or its designee. The Board or its designee may require Respondent to undergo psychiatric evaluations by a Board-appointed board certified psychiatrist. If, prior to the completion of probation, Respondent is found to be mentally unfit to resume the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over Respondent's license and the period of probation shall be extended until the Board determines that Respondent is mentally fit to resume the practice of medicine without restrictions. Respondent shall pay the cost of all psychotherapy and psychiatric evaluations.

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

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

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

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

The monitor(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, billing appropriately or both. 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.

10. **PROHIBITED PRACTICE**. During probation, Respondent is prohibited from providing any treatments or prescriptions, including opiate-based prescriptions, to any patient for the purpose of treating his or her pain. Any new patients must be provided this notification at the time of their initial appointment. Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

11. **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.

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

13. **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.

14. **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.

15. **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.

16. **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.

17. **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.

18. **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.

19. **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.

20. **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.

21. **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, David M. Balfour Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. G43299. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Disciplinary Order of the Medical Board of California.

DATED: 12/21/16

JOANNA LOUIS, M.D.
*Respondent*

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

DATED: 12/22/16

DAVID M. BALFOUR ESQ.
*Attorney for Respondent*

## ENDORSEMENT

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

Dated: 12/27/2016

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

MARTIN W. HAGAN
Deputy Attorney General
*Attorneys for Complainant*

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# Exhibit A

**Accusation No. 13-2013-231099**

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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 Accusation Against:**<br><br>**JOANNA LOUIS, M.D.**<br>**1853 N Vulcan Avenue # 5**<br>**Leucadia, CA 92024**<br><br>**Physician's and Surgeon's Certificate No. G43299,**<br><br>**Respondent.** | **Case No. 13-2013-231099**<br><br>**ACCUSATION** |

Complainant alleges:

## PARTIES

1. Kimberly Kirchmeyer (complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 8, 1980, the Board issued Physician's and Surgeon's Certificate No. G43299 to Joanna Louis, M.D. (respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on April 30, 2016, unless renewed.

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## JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. 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."

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5. 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:

". . .

"(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.

". . ."

6. 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."

7. 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."

8. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600),

or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

## FIRST CAUSE FOR DISCIPLINE

### (Gross Negligence)

9. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that she committed gross negligence in her care and treatment of patients A.A., C.H., and G.O., as more particularly alleged hereinafter:

**Patient A.A.**

10. On or about April 2, 2007, respondent began providing care and treatment to patient A.A., then fifty-one years old. Patient A.A., who had a history of alcohol abuse, cocaine abuse, and anorexia nervosa, presented with complaints of chronic pain as a result of cervical spine degenerative joint disease, chronic anxiety, and depressive symptoms without suicidal ideation Patient A.A. was noted to be taking Cymbalta[1] 60 mg, Buprenorphine[2], Imitrex[3] prn, Naprosyn[4] prn, and Alprazolam.[5]

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[1] Cymbalta is a brand name for duloxetine, a selective serotonin and norepinephrine reuptake inhibitor antidepressant (SSNRI) that affects chemicals in the brain that may be unbalanced in people with depression. It is used to treat major depressive disorder and general anxiety disorder in adults. Cymbalta is also used in adults to treat fibromyalgia (a chronic pain disorder), or chronic muscle or joint pain (such as low back pain and osteoarthritis pain).

[2] Buprenorphine is an opioid medication used to treat narcotic addiction. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[3] Imitrex is a brand name for sumatriptan succinate and is a headache and migraine medicine that narrows blood vessels around the brain and reduces substances in the body that can trigger headache pain, nausea, sensitivity to light and sound, and other migraine symptoms.

11. Respondent conducted an initial psychiatric evaluation of patient A.A. Patient A.A. was noted to have a "normal" cognitive exam, was alert with full range affect and no psychotic symptoms. Respondent's diagnoses for patient A.A. were Axis I 296.33 (major depressive disorder, recurrent, severe) and 314.00 (Attention Deficit Disorder, predominately inattentive type); panic disorder with agoraphobia, alcohol dependence in remission, history of polysubstance dependence, and post traumatic stress disorder. Respondent's treatment plan for patient A.A. was to increase Cymbalta to 90 mg per day, check labs and follow-up in two weeks.

12. From on or about April 17, 2007 and continuing through December 31, 2008, respondent saw patient A.A. approximately thirty-three times. During this time, respondent documented that patient A.A. had suicidal ideation, relapse with substance abuse, significant financial and social stressors. Respondent gave patient A.A. a referral for therapists. Respondent's plan was to follow-up with patient A.A. in two weeks. Respondent never conducted and/or documented a full mental status exam at any of these follow-up visits. Respondent failed to document the severity of patient A.A.'s symptoms and current disorder. Respondent did not document a standard suicide risk assessment.

13. On or about January 23, 2009, respondent noted that patient A.A. continued to be ruminative, and was taking Wellbutrin[6] 75 mg/day, Cymbalta 120 mg/day, Adderall[7] 120 mg/day,

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(...continued)

[4] Naproxen is a nonsteroidal anti-inflammatory drug (NSAID). It works by reducing hormones that cause inflammation and pain in the body. Naproxen is used to treat pain or inflammation caused by conditions such as arthritis, ankylosing spondylitis, tendinitis, bursitis, gout, or menstrual cramps.

[5] Alprazolam, a benzodiazepine, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[6] Wellbutrin is a brand name for bupropion which is an antidepressant medication used to treat major depressive disorder and seasonal affective disorder.

[7] Adderall is a brand name for dextroamphetamine and amphetamine, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an amphetamine salts used for attention-deficit hyperactivity disorder and narcolepsy.

and Adderall XR[8] 30 mg bid (twice a day). Respondent did not document a mental status exam at this visit.

14. On or about February 7, 2009, patient A.A. was seen for a follow-up visit. Respondent noted that patient A.A. reported that her insurance company did not approve the prescription for Adderall XR. Respondent did not document a mental status exam at this visit. Respondent prescribed Ritalin ER[9] 20 mg po (by mouth or orally) TID (three times a day) and Adderall 60 mg/day to patient A.A.

15. On or about February 20, 2009, patient A.A. was seen for a follow-up visit. Respondent noted that patient A.A. was "doing ok" on methylin ER.[10] Patient A.A. was noted to have a flat affect and stable mood. Patient A.A. reported having increased headaches. Respondent did not document a mental status exam at this visit. Respondent prescribed methylin ER 20 mg TID #90, and Adderall 120 mg po TID #240 (30 mg tabs) to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

16. On or about March 6, 2009, patient A.A. was seen for a follow-up visit. Respondent noted that patient A.A. "needs rewrite of Rx for methylin ER." Respondent did not document a mental status exam at this visit. Respondent prescribed methylin ER 20 mg TID #90, and Adderall 120 mg po TID #240 (30 mg tabs) to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

17. On or about March 30, 2009, patient A.A. was seen for a follow-up visit. Respondent noted that patient A.A. appeared "mildly depressed...weepiness...affect ok." Respondent did not

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[8] Adderall XR is a brand name for dextroamphetamine and amphetamine, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is indicated for the treatment of attention deficit hyperactivity disorder (ADHD) and is an extended release medication.

[9] Ritalin is a brand name for methylphenidate, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a central nervous system stimulant that affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control. Ritalin is used to treat attention deficit disorder (ADD).

[10] Methylin refers to methylphenidate, the generic name for Ritalin.

document a mental status exam at this visit. Respondent prescribed methylin ER 20 mg TID #90, and Adderall 120 mg po TID #240 (30 mg tabs) to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

18. On or about April 14, 2009, patient A.A. was seen for a follow-up visit. Patient A.A. complained of fatigue and insomnia, and reported running out of Adderall. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60 to patient A.A. Respondent decreased the methylin ER dosage because patient A.A. reported that it was not working well, and told patient A.A. to "continue meds at current doses." The plan was for patient A.A. to follow-up in two (2) weeks.

19. On or about April 27, 2009, patient A.A. was seen for a follow-up visit. Patient A.A. reported having a migraine headache for two (2) days. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 30 mg 2/d and 60 mg 3/d to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

20. On or about May 12, 2009, patient A.A. was seen for a follow-up visit. Patient A.A. reported continuing migraine headaches. Respondent noted "Dx 296.33, 314.00, 300.02." Respondent further noted "f/u 2 weeks, stockpile Imitrex, continue all meds." Respondent did not document a mental status exam at this visit. The plan was for patient A.A. to follow-up in two (2) weeks.

21. On or about May 26, 2009, patient A.A. was seen for a follow-up visit. Respondent noted that patient A.A. reported sleeping excessively and increased sadness. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60 and 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

22. On or about June 8, 2009, patient A.A. was seen for a follow-up visit. Respondent noted that patient A.A. was not seeing her therapist and had continuing migraine headaches that required Imitrex for relief. Respondent did not document a mental status exam at this visit. The plan was for patient A.A. to follow-up in two (2) weeks.

23. On or about June 22, 2009, patient A.A. was seen for a follow-up visit. Patient A.A. complained of two (2) migraine headaches per month. Patient A.A. was provided information about support groups. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, Adderall 60 mg BID #240, and Imitrex 100 mg #9 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

24. On or about July 6, 2009, patient A.A. was seen for a follow-up visit. Respondent noted that patient A.A. lost the prescription for Adderall and a new one was provided. Patient A.A. was provided information about support groups. Respondent did not document a mental status exam at this visit. The plan was for patient A.A. to follow-up in two (2) weeks.

25. On or about July 20, 2009, patient A.A. was seen for a follow-up visit. Patient A.A. complained of excessive sleep and fatigue and reported ongoing financial and home stressors. Respondent documented that patient A.A. was "sleeping well." Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up on August 17, 2009.

26. On or about August 17, 2009, patient A.A. did not show-up for or call to cancel her appointment with respondent.

27. On or about August 24, 2009, patient A.A. was seen for a follow-up visit after failing to keep the appointment for August 17, 2009. Patient A.A. reported having ongoing home and financial stressors, and migraine headache. Respondent did not document a mental status exam at this visit. Respondent prescribed Compazine[11] 10 mg #30, Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

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[11] Compazine is the brand name for prochlorperazine, a dopamine receptor antagonist that is used for the antiemetic treatment of nausea and vertigo. It is also a highly potent typical antipsychotic and is also used to treat migraine headaches.

28. On or about September 15, 2009, patient A.A. was seen for a follow-up visit. Patient A.A. again reported family stressors. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A.

29. On or about October 12, 2009, patient A.A. was seen for a follow-up visit. Patient A.A. reported family stressors, the death of the family dog, and having nightmares and dysphoria. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240, and Imitrex 100 mg #9 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

30. On or about November 9, 2009, patient A.A. was seen for a follow-up visit. Patient A.A. reported ongoing stressors at home. Patient A.A. also reported being upset about relationship with therapist. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

31. On or about December 7, 2009, patient A.A. was seen for a follow-up visit. Patient A.A. reported that her mother had been hospitalized, feeling overwhelmed, and sleeping well. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

32. On or about January 4, 2010, patient A.A. was seen for a follow-up visit. Patient A.A. reported home and financial stressors, feeling hopeless, and sleeping "ok." Patient A.A. denied suicidal ideation. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

33. On or about February 1, 2010, patient A.A. was seen for a follow-up visit. Patient A.A. reported feeling severely depressed, sleeping well and spending an increased amount of time in bed, and continuing home stressors. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to

patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

34. On or about February 15, 2010, patient A.A. was seen for a follow-up visit. Patient A.A. reported feeling severely depressed and increase in sleep. Respondent did not document a mental status exam at this visit. Respondent prescribed Ambien[12] 10 mg daily #30 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

35. On or about March 1, 2010, patient A.A. was seen for a follow-up visit. Patient A.A. reported having lost or thrown away her prescriptions. Respondent noted that patient A.A. appeared lethargic and confused and questioned whether patient A.A. was experiencing "SSRI"[13] withdrawal. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

36. On or about March 15, 2010, patient A.A. was seen for a follow-up visit. Respondent did not document a mental status exam at this visit. Respondent prescribed Cymbalta 60 mg #60, Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

37. On or about April 12, 2010, patient A.A. was seen for a follow-up visit. Patient A.A. reported "inadvertently continued on Celexa and Cymbalta" instead of just Cymbalta. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

38. On or about May 10, 2010, patient A.A. was seen for a follow-up visit. Patient A.A. reported seeing a therapist. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60 and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

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[12] Ambien is the brand name for zolpidem and is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is used for the treatment of insomnia and some brain disorders.

[13] SSRI stands for selective serotonin reuptake inhibitors, which are antidepressants.

39. On or about June 7, 2010, patient A.A. was seen for a follow-up visit. Patient A.A. reported continuing stressors at home, and attending a support group and individual therapy. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

40. On of about July 5, 2010, patient A.A. was seen for a follow-up visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. Patient A.A. was to continue taking Cymbalta, which reportedly helped patient A.A. with migraine symptoms. Respondent did not document a mental status exam at this visit. The plan was for patient A.A. to follow-up in two (2) weeks.

41. On or about July 19, 2010, patient A.A. was seen for a follow-up visit. Patient A.A. reported that her son was arrested for possession of marijuana, her migraines were better, and she saw an unidentified flying object (UFO). Respondent did not document a mental status exam at this visit. Respondent's plan was to continue patient A.A. on current medications. The plan was for patient A.A. to follow-up in two (2) weeks.

42. On or about August 2, 2010, patient A.A. was seen for a follow-up visit. Patient A.A. reported difficulty sustaining relationships with men and a therapist. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. Respondent also provided patient A.A. with samples of Lexapro[14] 10 mg for patient A.A.'s son. The plan was for patient A.A. to follow-up in two (2) weeks.

43. On or about August 16, 2010 patient A.A. was seen for a follow-up visit. Patient A.A. reported that son had body dysmorphic disorder. Respondent did not document a mental status exam at this visit. Respondent provided patient A.A. with samples of Lexapro 20 mg for patient A.A.'s son. The plan was for patient A.A. to follow-up in two (2) weeks.

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[14] Lexapro is the brand name for escitalopram, and is an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class. It is used for the treatment of major depressive disorder (MDD) and generalized anxiety disorder (GAD).

44. On or about August 30, 2010, patient A.A. was seen for a follow-up visit. Patient A.A. stated that she was trying to terminate care with her therapist. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A.

45. On or about September 8, 2010, patient A.A. was seen for a follow-up visit. Patient A.A. reported home stressors. Respondent did not document a mental status exam at this visit. Respondent did not document any prescriptions provided to patient A.A. at this visit.

46. On or about September 27, 2010, patient A.A. was seen for a follow-up visit. Patient A.A. reported that she had not been seeing her therapist and continuing home stressors. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

47. On or about October 25, 2010, patient A.A. was seen for a follow-up visit. Patient A.A. reported being fatigued. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

48. On or about November 22, 2010, patient A.A. was seen for a follow-up visit. Patient A.A. had missed an appointment due to illness. Respondent noted that patient A.A.'s affect was "down." Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

49. On or about December 20, 2010, patient A.A. was seen for a follow-up visit. Patient A.A.'s mother had passed away the previous day. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

50. On or about January 17, 2011, patient A.A. was seen for a follow-up visit. Patient A.A. was attending Alcoholics Anonymous (AA) meetings, working on assertiveness and appeared sad and worried. Respondent did not document a mental status exam at this visit.

Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

51. On or about February 14, 2011, patient A.A. was seen for a follow-up visit. Patient A.A. had increased anxiety and appeared sad and worried. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

52. On or about March 4, 2011, patient A.A. was seen for a follow-up visit. Patient A.A. reported attending AA meetings, and appeared sad and worried. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

53. On or about March 14, 2011, patient A.A. was seen for a follow-up visit. Patient A.A. reported having difficulty in getting prescription for Adderall XR filled. Respondent noted patient A.A.'s affect as "upset" and mood as "mildly depressed." Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg #60 to patient A.A.

54. On or about March 28, 2011, patient A.A. was seen for a follow-up visit. Patient A.A. was noted to be upset and dysphoric. Patient A.A. reported having not taken Cymbalta for ten (10) days. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

55. On or about April 13, 2011, patient A.A. did not show-up for or call to cancel her appointment with respondent. Respondent noted that patient A.A. had been contacted and had forgotten about the appointment. The plan was for patient A.A. to follow-up in two (2) weeks.

56. On or about April 25, 2011, patient A.A. was seen for a follow-up visit. Patient A.A. was noted to have a brighter affect. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

57. On or about May 23, 2011, patient A.A. was seen for a follow-up visit. Patient A.A. was noted to still be grieving her mother's death and seeing a therapist. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

58. On or about June 13, 2011, patient A.A. was seen for a follow-up visit. Patient A.A. reported feeling better and her mood was noted as being "a little sad." Patient A.A. was trying to get her son into a support group. Patient A.A. also reported that her son was not taking the previously prescribed Lexapro properly. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

59. On or about July 11, 2011, patient A.A. was seen for a follow-up visit. Patient A.A. complained of dental pain and respondent advised her to seek treatment. Patient A.A. was trying to get her son into a support group. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #60, and Adderall 60 mg BID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

60. On or about August 2, 2011, patient A.A. was seen for a follow-up visit. Patient A.A. reported having been assaulted by her boyfriend, who was arrested after she pressed charges against him. Respondent did not document a mental status exam at this visit. Respondent prescribed Vicodin[15] #60 for tooth pain and Adderall 30 mg as directed (6/day and BID) #240. The plan was for patient A.A. to follow-up in one (1) month.

61. On or about August 29, 2011, patient A.A. was seen for a follow-up visit. Patient A.A. was noted to be "upset about a lot of things." Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID #90, and Adderall 60 mg TID #240 to patient A.A. The plan was for patient A.A. to follow-up on two (2) weeks.

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[15] Vicodin is the brand name for a Hydrocodone combination product and is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. It is used to treat moderate to severe pain.

62. On or about September 12, 2011, patient A.A. was seen for a follow-up visit. Patient A.A. reported difficulty getting her prescriptions filled. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 60/30 mg BID #90, and Adderall 90/60/90 mg TID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

63. On or about October 10, 2011, patient A.A. did not show-up for or call to cancel her appointment with respondent. Respondent noted that patient A.A. "thought it was a Sunday." The appointment was changed to October 12, 2011.

64. On or about October 12, 2011, patient A.A. was seen for a follow-up visit. Patient A.A. reported having nosebleed, feeling overwhelmed, and having sex with a neighbor who assaulted her. Patient A.A. again reported having difficulty in getting her prescriptions filled. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 60/30 mg BID #90, and Adderall 90/60/90 mg TID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

65. On or about October 31, 2011, patient A.A. was seen for a follow-up visit. Patient A.A. reported having lost her prescription for Adderall XR and was worried about running out of her medication. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg #60 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

66. On or about November 14, 2011, patient A.A. was seen for a follow-up visit. Patient A.A. reported feeling "adrift" without "friends to hang with" and sexual abuse of her son by her sister. Patient A.A.'s mood was "very down," her affect was "sad," and she denied any suicidal ideation. Respondent did not document a mental status exam at this visit. Respondent prescribed Cymbalta 120 mg/d, Prozac[16] 20 mg, Adderall XR 60/30 mg BID #90, and Adderall 90/60/90 mg TID #240 to patient A.A.

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[16] Prozac is the brand name for fluoxetine and is a selective serotonin reuptake inhibitors (SSRI) antidepressant.

67. On or about December 12, 2011, patient A.A. was seen for a follow-up visit. Patient A.A. reported ongoing stressors related to her son and that she was seeing a man who had assaulted her. Respondent did not document a mental status exam at this visit. Respondent prescribed Cymbalta 120 mg/d, Prozac 20 mg, Adderall XR 60/30 mg BID #90, and Adderall 90/60/90 mg TID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

68. On or about January 9, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. reported financial stressors and compulsive shopping. Respondent continued all medications at current doses and prescribed Adderall XR 60/30 mg BID #90, and Adderall 90/60/90 mg TID #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

69. On or about January 30, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. reported having difficulty getting prescriptions filled. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall 30 mg 8/day for 7 days #56 to patient A.A. The plan was for patient A.A. to follow-up in one (1) week.

70. On or about February 6, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. again reported difficulty getting prescriptions filled. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 60/30 mg BID #90, and Adderall 30 mg (6/day and BID) #240 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

71. On or about February 20, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. reported having lost her prescription for Adderall XR. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 60/30 mg BID #90 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

72. On or about March 5, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. appeared confused and reported difficulty getting the Adderall prescription filled. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 60/30 mg BID #90, and Adderall 30 mg (6/day and BID) #240 to patient A.A.

73. On or about April 2, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. reported that she had difficulty getting the Adderall prescription filled, stopping all her prescriptions, and breaking-up with her abusive boyfriend. Patient A.A. was noted as having a sad affect and depressed mood, but no suicidal ideation. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg TID #90, Adderall 30 mg (8/day) #240, and Cymbalta 160 mg/day to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

74. On or about April 10, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. reported ongoing difficulty getting the Adderall prescriptions filled. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg TID #90 and Adderall 30 mg (8/day) #60 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

75. On or about April 23, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. reported that she was working on getting Adderall prescriptions filled, but was not taking Adderall XR or Cymbalta due to an inability to pay the co-pay. Respondent advised patient A.A. to take her medication as directed. Respondent did not document a mental status exam at this visit. The plan was for patient A.A. to follow-up in two (2) weeks.

76. On or about May 7, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. reported pain from an elbow injury and not sleeping well. Respondent noted that patient A.A. looked tired and in pain. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg TID #90, and Adderall 30 mg (6/day and BID) #240 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

77. On or about May 23, 2012, patient A.A. called in for a follow-up visit. Patient A.A. reported not sleeping well and, according to respondent, was "all scrambled."

78. On or about June 4, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. reported being upset about her recent break-up with her boyfriend and being anxious. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg TID #90, and Adderall 30 mg (6/day and BID) #240 to patient A.A. The plan was for

patient A.A. to follow-up in one (1) month.

79. On or about July 2, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. reported being upset about her break-up with her boyfriend, anxiety, and being depressed. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg TID #90, and Adderall 30 mg (6/day and BID) #240 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

80. On or about July 11, 2012, patient A.A. called in to respondent to report problems with her son. Patient A.A. had tried to have her son placed on a psychiatric hold pursuant to Welfares and Institutions Code section 5150, but was unsuccessful. Respondent advised patient A.A. to continue her medications and come-in for her follow-up visit. Patient A.A. was scheduled for a follow-up visit on July 15, 2012.

81. On or about July 15, 2012, patient A.A. called in for a follow-up visit. Patient A.A. reported that she was upset about her recent break-up and was not seeing a therapist. Respondent advised patient A.A. to have no contact with her former boyfriend, to immediately make an appointment to see her therapist, and to continue her medication. Patient A.A. was scheduled for a follow-up visit on July 18, 2012 for management of medications.

82. On or about July 18, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. reported having ongoing difficulty having prescriptions filled and agreed to start seeing a therapist again. Respondent noted that she had located a compounding pharmacy that would fill patient A.A.'s prescription and an increase in the dose of Adderall was being made due to "inadequate coverage with 6/day BID #180." Patient A.A. was going to see a therapist and had attended Alcoholics Anonymous meetings. Respondent did not document a mental status exam at this visit. The plan was for patient A.A. to follow-up in two (2) weeks.

83. On or about July 30, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. was noted to be angry and very upset. Patient A.A. was also noted to be doing better on an increased dose of Adderall (8/d of IR form). Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg TID #90, Adderall 30 mg (90/90/60 TID)

#240, Norco[17] 10/325 mg 120, and Ibuprofen 800 mg QID (four times a day) prn pain to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

84. On or about August 27, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. reported that she was not seeing a therapist, but was attending AA meetings. Patient A.A. was noted to be "very scrambled" and "sad and mad." Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg TID, and Adderall 30 mg (90/90/60 TID) #240 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

85. On or about September 10, 2012, patient A.A. did not call in for a telephonic appointment, nor did she answer respondent's calls.

86. On or about September 24, 2012, patient A.A. was seen for a follow-up visit. Patient A.A.'s affect was noted to be "much better" with flat mood. Patient A.A. was going to schedule an appointment with a therapist. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg TID #90, and Adderall 30 mg (90/90/60 TID) #240 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

87. On or about October 8, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. had not yet met with the therapist. Patient A.A.'s mood was noted to be "OK" with "mixed but appropriate" affect. Respondent did not document a mental status exam at this visit. The plan was for patient A.A. to follow-up in two (2) weeks.

88. On or about October 22, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. was noted to be doing better with increased dose of Adderall (8/d of IR form). Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg TID #90, Adderall 30 mg (90/90/60 TID) #240, and Cymbalta 120 mg/d. The plan was for patient A.A. to follow-up in two (2) weeks.

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[17] Norco Is a brand name for acetaminophen and hydrocodone bitartrate, a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. It is used to treat moderate to severe pain.

89. On or about November 5, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. was noted to have mood fluctuating dysphoria, not exercising, sleeping excessively, and not attending AA meetings regularly. Respondent did not document a mental status exam at this visit. Respondent's plan was to continue patient A.A.'s medications at follow-up doses. The plan was for patient A.A. to follow-up in two (2) weeks.

90. On or about November 19, 2012, patient A.A. was seen for a follow-up visit. Respondent noted that patient A.A. was "no longer able to get Adderall RX's." Respondent did not document a mental status exam at this visit. Respondent gave patient A.A. eight (8) boxes of Cymbalta and prescribed Adderall XR 30 mg TID #90, and Adderall 30 mg (90/90/60 TID) #240 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

91. On or about December 7, 2012, patient A.A. was seen for a follow-up visit. Patient A.A. was noted to be "preoccupied and frustrated" and reported being upset with financial stressors. Respondent did not document a mental status exam at this visit. Respondent's plan was to continue patient A.A.'s medications at current doses. The plan was for patient A.A. to follow-up in two (2) weeks.

92. On or about December 17, 2012, patient A.A. was seen for a follow-up visit. Patient A.A.'s mood was noted to be "up & down." Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg TID #90 and Adderall 30 mg #240 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

93. On or about sometime in January 2013, patient A.A. was seen for a follow-up visit. Patient A.A. was noted to be labile and dysphoric, and denied suicidal ideation. Respondent's plan was to "check labs." Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg TID #90, and Adderall 30 mg #240 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

94. On or about January 29, 2013, patient A.A. was seen for a follow-up visit. Patient A.A. reported being worried about financial stressors. Respondent did not document a mental status exam at this visit. Respondent's plan was to continue patient A.A.'s medications at current doses. The plan was for patient A.A. to follow-up in two (2) weeks.

95. On or about February 11, 2013, patient did not show-up for or call to cancel her appointment with respondent. Respondent noted "[w]ent back to sleep!" in patient A.A.'s chart. The appointment was re-scheduled for February 18, 2013.

96. On or about February 18, 2013, patient A.A. was seen for a follow-up visit. Patient A.A. reported having severe migraine headache and sleeping okay. Respondent did not document a mental status exam at this visit. Respondent prescribed Zofran[18] 4 mg (1-2 prn nausea), Adderall 30 mg #240, and Adderall XR 30 mg #90 to patient A.A. The plan was for patient A.A. to follow-up in one (1) month.

97. On or about March 18, 2013, patient A.A. was seen for a follow-up visit. Patient A.A. reported attending AA meetings and difficulty in getting prescriptions filled. Respondent noted that she reminded patient A.A. "about getting established with a single pharmacy." Patient A.A. also reported some impulses to drink alcohol. Respondent did not document a mental status exam at this visit. Respondent provided patient A.A. with Cymbalta samples for one (1) month given 120 mg/day and prescribed Adderall XR 30 mg TID #90, and Adderall 30 mg (90/90/60) #240 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

98. On or about April 2, 2013, patient called in for a telephone appointment. Patient A.A. reported many financial stressors, increased social withdrawal, and possibly seeing the man who had allegedly abused her.

99. On or about April 15, 2013, patient A.A. was noted to be doing better.

100. On or about April 30, 2013, patient A.A. was seen for a follow-up visit. Patient A.A. reported ongoing stressors. Patient A.A. was noted as having a sad affect and unhappy mood. Respondent's plan was to check labs. Respondent did not document a mental status exam at this visit. The plan was for patient A.A. to follow-up in two (2) weeks.

101. On or about May 13, 2013, patient A.A. was seen for a follow-up visit. Patient A.A. reported difficulty keeping appointments, feeling distractible, and not scheduling appointments with the therapist. Respondent did not document a mental status exam at this visit. Respondent

[18] Zofran is the brand name for ondansetron and is used to prevent nausea and vomiting caused by surgery or cancer medicines.

prescribed Adderall XR 30 mg TID #90, and Adderall 30 mg (90/90/60) #240 to patient A.A. The plan was for patient A.A. to follow-up in two (2) weeks.

102. Respondent committed gross negligence in her care and treatment of patient A.A. including, but not limited to, the following:

a. Respondent failed to document a full mental status examination of patient A.A. at any follow-up visit;

b. Respondent failed to document the severity of patient A.A.'s symptoms and current disorder;

c. Respondent failed to document a standard suicide risk assessment of patient A.A.;

d. Respondent prescribed opiate medication to patient A.A. without documenting a clear indication for prescribing the opiate medication used and the dosages prescribed;

e. Respondent failed to monitor the acetaminophen and opiate medications prescribed, including documentation of doses of opiates and acetaminophen prescribed for patient A.A., labs, vital signs, risk factors and contraindications, possible drug interactions, and signs of possible misuse of medications;

f. Respondent wrote multiple prescriptions for patient A.A. without a clear reason to do so;

g. Respondent failed to document any discussions of the risks and benefits of the high dose acetaminophen containing opiate medications prescribed with patient A.A. and/or informed consent regarding the treatment;

h. Respondent prescribed psycho-stimulant medications to patient A.A. without documenting the medical indication /rationale for the prescriptions and/or keeping track of the dosages and combinations used;

i. Respondent failed to monitor the psycho-stimulant medications prescribed to patient A.A., including documentation of doses of drugs prescribed for patient A,A., labs, vital signs, risk factors and contraindications, possible drug interactions, and signs of possible misuse of medications;

j. Respondent engaged in inappropriate polypharmacy of opioid medications and psycho-stimulants to patient A.A.;

k. Respondent failed to document the rationale for high dose psycho-stimulant treatment for patient A.A.;

l. Respondent failed to document any discussions of the risks and benefits of psycho-stimulant treatment with patient A.A. and/or informed consent regarding the treatment; and

m. Respondent failed to document the criteria for the psychiatric diagnoses given to patient A.A. and the psychiatric diagnoses being treated.

**Patient C.H.**[19]

103. On or about October 27, 2009, respondent began providing care and treatment to patient C.H., then twenty-one years old. Patient C.H., had a history of involuntary psychiatric hospitalization, chronic back pain from bilateral ulnar neuropathy, rapid-cycling bipolar disorder, bulimia, physical abuse by mother, sexual abuse, and post-traumatic stress disorder. Patient C.H. reported chronic anxiety, impulsive behavior, depressive symptoms, prior cutting behaviors and multiple overdoses, and suicidal ideation as recently as two days earlier. Patient C.H. had discontinued all psychiatric medications that had been previously prescribed. Patient was taking Seroquel[20] 25 mg/day and clonazepam[21] 0.5 mg BID. Respondent did not obtain a complete medical and psychiatric history at this visit, including patient C.H.'s history of substance abuse, impulsivity and suicidal behavior. Respondent did not obtain medical records for patient C.H. from other providers or a history of patient C.H.'s chronic pain condition.

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[19] The medical records for patient C.H. are out of order and many of the dates of treatment are indeterminable. Where dates of treatment are known they have been referenced.

[20] Seroquel is the brand name for quetiapine and is an atypical antipsychotic approved for the treatment of schizophrenia, bipolar disorder, and along with an antidepressant to treat major depressive disorder.

[21] Clonazepam (brand name Klonopin or Clonopin) is an anti-anxiety medication in the benzodiazepine family and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

104. On or about October 27, 2009, respondent conducted a mental status examination of patient C.H. Patient C.H. was noted to have normal cognition, insight and judgment, attitude and speech, and affect. Respondent's diagnoses for patient C.H. were Axis I bipolar disorder, rapid cycling, manic psychosis, bulimia nervosa, panic disorder without agoraphobia, alcohol abuse, in remission, and attention deficit hyper-activity disorder (ADHD). Respondent did not give patient C.H. an Axis 2 diagnosis. Respondent's Axis 3 diagnosis for patient C.H. was "probable right cervical radiculopathy (ulnar nerve)," which is not a neurologic diagnosis. Respondent prescribed Topamax[22] 25 mg HS (at bedtime), to be increased to 100 mg HS over three (3) weeks, and clonazepam 1 mg q 4-6 hours prn #120 to patient C.H.

105. On or about November 2, 2009, patient C.H. was seen for a follow-up visit. Patient C.H. reported improvement on Topamax. Respondent noted that patient C.H. appeared "hypomanic." Patient C.H. reported having a new boyfriend and having had an altercation with a teacher at school. It was noted that patient C.H. had taken some clonazepam and Seroquel 12.5 mg to help with sleep. An ADD self-report screen was indicative of possible attention deficit disorder (ADD). Respondent did not conduct further assessment's to corroborate this finding. Respondent did not document a mental status exam at this visit. Respondent's plan was to continue the same medication and follow-up in one (1) week.

106. On or about November 9, 2009, patient C.H. was seen for a follow-up visit. Patient C.H. reported having broken up with her new boyfriend. Patient C.H. was also noted to be taking Topamax 50 mg HS. Respondent did not document a mental status exam at this visit. Respondent's plan was to continue same medication and follow-up in two (2) weeks.

107. On or about November 23, 2009, patient C.H. was seen for a follow-up visit. Patient C.H. reported doing well on Topamax. A mental status examination was noted to be normal. Respondent's plan was to continue same medication and follow-up in three (3) weeks.

108. On or about December 7, 2009, patient C.H. was seen for a follow-up visit. Patient C.H. reported panic attacks for which clonazepam was not helpful. A mental status examination

[22] Topamax is the brand name for topiramate and is an anticonvulsant (antiepilepsy) drug.

was noted to be normal. Respondent provided patient C.H. with a refill for Topamax and also prescribed Ativan[23] 0.5 #120 (1-4/d) prn to patient C.H. Respondent's plan was to follow-up with patient C.H. in two (2) weeks.

109. On or about December 28, 2009, patient C.H. was seen for a follow-up visit. Patient C.H. reported getting intoxicated and experiencing intermittent, recurrent episodes of facial paresthesia after increasing her dose of Topamax to 100 mg. Respondent did not document a mental status exam at this visit. Respondent prescribed Vicodin ES 60 mg #60 to patient C.H. and planned to follow-up with patient C.H. in two (2) weeks.

110. On or about sometime in January 2010, patient C.H. was seen for a follow-up visit. Patient C.H. reported feeling "shitty and lonely," unmotivated, and "very depressed." Patient C.H. denied having suicidal ideation. Respondent did not document a mental status exam at this visit. Respondent increased the dose of Topamax to 125 mg HS and prescribed Topamax #90 100 mg, with three (3) refills, to patient C.H. The plan was for patient C.H. to follow-up in two (2) weeks.

111. On or about January 25, 2010, patient C.H. was seen for a follow-up visit. Patient reported continued back pain and worries about finances. It was noted that patient C.H.'s mood had improved since the Topamax dose was increased to 125 mg. Respondent did not document a mental status exam at this visit. Respondent prescribed Vicodin ES #180 (1-2 q 3-4 hours prn) to patient C.H. The plan was for patient C.H. to follow-up in two (2) weeks.

112. On or about February 8, 2010, patient C.H. was seen for a follow-up visit. Patient C.H. was noted to appear tired, was feeling sad and worried, and having difficulty sleeping. Respondent noted that patient C.H. preferred clonazepam over Ativan, and was taking 2 mg of clonazepam at a time. Respondent did not document a mental status exam at this visit. Respondent's plan was to continue medications and decrease clonazepam to 1.5 mg at a time. The plan was for patient C.H. to follow-up in two (2) weeks.

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[23] Ativan is the brand name for Lorazepam and is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a benzodiazepine used to treat anxiety disorders or anxiety associated with depression.

113. On or about February 22, 2010, patient C.H. was seen for a follow-up visit. Patient C.H. was noted to be having difficulty focusing due to untreated attention deficit disorder (ADD). Respondent also noted that patient C.H.'s affect was bright and animated and mood was "stabilized on current meds." Respondent did not document a mental status exam at this visit. Respondent's plan was to continue medications and follow-up in one (1) month. Patient C.H. was told to call if she "starts to de-stabilize."

114. On or about an undeterminable date in 2010, patient C.H. was seen by respondent. Patient C.H. had graduated from school and was working. Patient C.H.'s mood was noted to be euthymic and her affect bright and animated. Patient C.H. reported having a lot of back pain. Respondent did not document a mental status exam at this visit. Respondent prescribed Vicodin ES #120 prn, with five (5) refills, and Topamax 23 mg #60 to patient C.H. Patient C.H. was to follow-up in one (1) month.

115. On or about an undeterminable date in 2010, patient C.H. was seen for a follow-up visit. Patient C.H. was noted to be upset about work situation and getting "screwed over July 4th!" Patient C.H.'s mood was noted to be "stable" and her affect as "bright and bubbly." Respondent did not document a mental status exam at this visit. The plan was to continue current medications and follow-up in one (1) month.

116. On or about August 17, 2010, patient C.H. was seen for a follow-up visit. Patient C.H. reported that she had had a problem with too much Tylenol in prescription of Vicodin and requested change to Norco and a muscle relaxant for pain related to a coccyx injury. Respondent did not document a mental status exam at this visit. Respondent prescribed Norco 10/325 #150, with five (5) refills, and Robaxin 750 mg 1 TID #90 with five (5) refills to patient C.H. The plan was for patient C.H. to follow-up in one (1) month.

117. On or about an undeterminable date in 2010, patient C.H. did not show-up for or call to cancel a follow-up appointment with respondent.

118. On or about an undeterminable date in late 2010, patient C.H. was seen for a follow-up visit by respondent. Patient C.H. reported that she had moved to Escondido and having significant financial problems. Patient C.H.'s affect was noted to be worried and upset and her

mood was euthymic. Respondent noted that patient C.H.'s mood was stable, and her last instability was in July-August, 2010, however respondent had not been contacted. Patient C.H. denied panic attacks and reported unspecified pain. Respondent did not document a mental status exam at this visit. Respondent prescribed Norco 10/325 #150, Vicodin ES #90, Topamax 100 mg #30, and Topamax 25 mg #180. The plan was for patient C.H. to follow-up in one (1) month.

119. On or about January 21, 2011, patient C.H. did not show-up for or call to cancel her appointment with respondent.

120. On or about February 21, 2011, patient C.H. was seen by respondent. Patient C.H. reported significant financial problems and worsened back pain, which respondent noted might be sciatica. This was not a neurologic diagnosis and respondent did not consider other treatments or therapies for patient C.H. related to her ongoing back pain. Respondent noted patient C.H.'s mood as being stable. Respondent further noted that patient C.H. had previously gone to a physical therapist and her condition had worsened, and that the Norco was not being effective. Respondent did not document a mental status exam at this visit. Respondent's plan was to continue medications in current doses and follow-up in two (2) months.

121. On or about April 18, 2011, patient C.H. did not show-up for or call to cancel her follow-up visit.

122. On or about May 16, 2011, patient C.H. was seen for a follow-up appointment. Patient C.H. was noted to be very irritable and not sleeping well, with affect and mood being worried. Respondent noted that patient C.H. was going to see an orthopedist for chronic back pain problems and should get an MRI. There is nothing in the record to indicate that respondent followed-up with this recommendation. Respondent did not document a mental status exam at this visit. Respondent prescribed Norco 10/325 #180 (6/day prn pain) with five (5) refills, Vicodin ES #90, 1 TID prn pain, Topamax 100 mg QHS (every night at bedtime) #30, with five (5) refills, and 25 mg take 6 per day (150 mg) #180 with five (5) refills to patient C.H. The plan was for patient C.H. to follow-up in two (2) months.

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123. On or about July 15, 2011, patient C.H. was seen for a follow-up visit. Patient C.H. reported worsening back pain, increased irritability and crying spells. Respondent noted that patient C.H. was "now having sx of Radiculopathy" which was worsening and required an MRI. Patient C.H. further reported that she was having tremendous muscle spasm in neck, that Vicodin had been ineffective but that Percocet[24] had helped with the pain. Respondent noted patient C.H.'s affect to be "sad, anxious, weepy" and her mood as "sad, mild acute depression." Respondent did not document a mental status exam at this visit. Respondent prescribed Norco 10/325 #180, Percocet 5 mg #120, Topamax 100 mg QAM (every morning), Topamax 200 mg qhs #60 with five (5) refills, and Topamax 75 mg QAM (150 mg) with five (5) refills to patient C.H. The plan was for patient C.H. to follow-up in two (2) weeks.

124. On or about July 27, 2011, patient C.H. did not show-up for or call to cancel her appointment with respondent.

125. On or about August 24, 2011, patient C.H. was seen for a follow-up visit. Patient C.H. reported having lost her job at the hair salon and working on her resume. Respondent noted patient C.H.'s mood and affect to be "sad, worried." Respondent further noted that patient C.H. had not slept the previous night and found Flexeril to be too sedating. Respondent did not document a mental status exam at this visit. Respondent prescribed Norco 10/325 #180 and Percocet 5 mg #120 to patient C.H. The plan was for patient C.H. to follow-up in one (1) month.

126. On or about September 21 or 22, 2011, patient C.H. was seen for a follow-up visit. Respondent noted that patient C.H. still had her bar job but recently broke up with boyfriend. Patient C.H. was trying to find a new job with a hair salon and was looking for a place to live. Respondent did not document a mental status exam at this visit. Respondent prescribed Topamax 25 mg #90, with five (5) refills, Norco 10/325 #180, and Percocet 5 mg #120 to patient C.H. The plan was for patient C.H. to follow-up in one (1) month.

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[24] Percocet is a brand name for oxycodone and acetaminophen, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

127. On or about October 18, 2011, patient C.H. reported feeling ill with fever and vomiting. Patient C.H. requested refills for Percocet and Norco. The plan was to schedule an appointment when patient C.H. was feeling better.

128. On or about November 7, 2011, patient C.H. was seen for a follow-up visit. Patient C.H. reported being fired from her job on October 19. Patient C.H. denied suicidal ideation, reported that she was sleeping poorly, had high anxiety, and continued to have substantial pain in her back. Respondent did not document a mental status exam at this visit. Respondent prescribed Norco 10/325 #180, and Percocet 5 mg #120 to patient C.H. The plan was for patient C.H. to follow-up in two (2) weeks.

129. On or about November 21, 2011, patient C.H. was seen for a follow-up visit. Patient C.H. had gotten a job and started dating a tattoo artist. Respondent noted that patient C.H.'s mood and affect were "happier." Respondent did not document a mental status exam at this visit. The plan was for patient C.H. to continue medications and follow-up in two (2) weeks.

130. On or about an undeterminable date in late 2011, patient C.H. was seen for a follow-up visit. Patient C.H. reported increased back pain. Respondent noted that patient C.H.'s affect was brighter and mood was euthymic. Patient C.H. reported that she would be having dinner with her father, whom she had not seen since August. Respondent did not document a mental status exam at this visit. Respondent prescribed Norco 10/325 #150, Vicodin ES #90 and #120, and Topamax to patient C.H. The plan was for patient C.H. to follow-up in one (1) month.

131. On or about sometime in early 2012, patient C.H. was seen for a follow-up visit. Patient C.H. reported having moved to be with new boyfriend, recently renewing a relationship with her step-mother, and having had a fight with her biological mother before Christmas. Respondent did not document a mental status exam at this visit. Respondent prescribed Percocet 5/325 #300, and Norco 10/325 #180 to patient C.H. The plan was for patient C.H. to follow-up in one (1) month.

132. On or about an undeterminable date in early 2012, patient C.H. did not show-up for or call to cancel a follow-up appointment with respondent.

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133. On or about February 20, 2012, patient C.H. was seen for a follow-up visit. Respondent noted patient C.H. stating "I'm not fulfilled" with current boyfriend and spending time with another person. It was noted that patient C.H. was sleeping well and that her medications were "OK." Respondent did not document a mental status exam at this visit. Respondent prescribed Norco 10/325 #180 with five (5) refills and Percocet 5 mg #240 to patient C.H. The plan was for patient C.H. to follow-up in one (1) month.

134. On or about April 19, 2012, patient C.H. was seen for a follow-up visit. Patient C.H. was noted to "... feel that I'm not attractive in any way." Respondent noted that patient C.H. possibly had body dysmorphic disorder (BDD). Respondent further noted that patient C.H. had depression and irritability, poor self-image, and dreams of suicidal issues and cutting self, but not killing self. Respondent did not document a mental status exam at this visit. Respondent prescribed Valium 10 mg, Topamax 150 mg HS, with plan to increase dose to 175 mg over 2 weeks, and Percocet 5 mg #300 to patient C.H. The plan was for patient C.H. to follow-up in one (1) week.

135. On or about April 26, 2012, patient C.H. did not show-up for or call to cancel her follow-up appointment with respondent.

136. On or about May 1, 2012, patient C.H. was seen for a follow-up visit. Patient C.H. reported multiple stressors, including living situation. Respondent noted patient C.H.'s affect to be irritable and mood "ok." Respondent did not document a mental status exam at this visit. Respondent prescribed Percocet 5 mg #300 (1-2 tabs q 2-3 hrs prn for nighttime pain), Valium 5 mg #120 (1-2 q 4-6 hrs prn for spasm), with five (5) refills, Ativan 0.5 mg #180 (1-2 prn for panic attack or stress, q 3-4 hrs, mr x 1, NTE 6 tabs/day, with five (5) refills. The plan was for patient C.H. to continue all medications, stay at other people's homes as much as possible and to follow-up in two (2) weeks.

137. On or about May 15, 2012, patient C.H. did not show-up for or call to cancel a follow-up visit with respondent.

138. On or about June 3, 2012, patient C.H. was seen for a follow-up visit. Patient C.H. reported that she was having unprotected sex with a "band guy," planned to break up with her

boyfriend, and had to find a place to live. Patient C.H. was noted to be sleeping better with affect and mood mixed and anxiety as high. Patient C.H. was taking clonazepam 4 mg/day. Respondent did not document a mental status exam at this visit. Respondent prescribed Topamax 75 mg/day with five (5) refills, clonazepam 1 mg #120 (1-4/day for panic attacks) with five (5) refills, and Percocet 5/325 #300 (1-2 tabs q 2-3 hrs prn for pain). The plan was for patient C.H. to follow-up in six (6) weeks.

139. On or about July 18, 2012, patient C.H. did not come for her follow-up visit or call respondent to cancel and/or reschedule the appointment.

140. On or about August 1, 2012, respondent noted prescribing Percocet 5 mg/325 #300 (1-2 q 2-3 hrs prn) to patient C.H., and that patient C.H. was to be seen in one (1) week.

141. On or about August 6, 2012, respondent noted that patient C.H. "got mixed-up re apt time will re-schedule later."

142. On or about August 12, 2012, patient C.H. was seen for a follow-up visit. Patient C.H. reported having had a "TERRIFIC B-d celebration!" Patient C.H. had a new boyfriend who was ten (10) years older. Patient C.H. reported that her primary care physician was continuing to give her the "runaround." Respondent noted that patient C.H. had anxiety, poor sleep, and pain during night. Respondent noted that patient C.H. was having unprotected sex and had a high level of anxiety. Patient C.H. was planning to live with her boyfriend. Respondent did not document a mental status exam at this visit. Respondent prescribed Oxycodone 10 mg #300 (1-2 tabs q 2-3 hrs prn for pain), and Norco 10/325 #180 (6/day prn for pain), with five (5) refills to patient C.H. The plan was for patient C.H. to follow-up in one (1) month.

143. On or about September 24, 2012, patient C.H. was seen for a follow-up visit. Patient C.H. reported multiple stressors, "catastrophic thinking" and being "very scared." Patient C.H. was noted to be irritable, had lost fifteen (15) pounds, and had consumed some alcohol. Patient C.H. was noted to be "eagerly awaiting 'BF' to officially propose." Respondent did not document a mental status exam at this visit. Respondent prescribed Topamax 200 mg HS #60, with five (5) refills, Valium 5 mg #120 with four (4) refills, Baclofen 10 mg #120 (1-2 BID), with five (5) refills, and Percocet 5 mg #300 (2 tabs 5x/day. The plan was for patient C.H. to follow-

up in one (1) month.

144. On or about an October 3, 2012, patient C.H. was seen for a follow-up visit. Patient C.H. reported that she was getting married and that her relationship with her step-mom, Rhonda, was "ok." Respondent noted that the Oxycodone was not effective and was causing patient C.H. to have migraines and would be discontinued. Patient C.H. also reported that the Robaxin was not effective. Respondent noted that patient C.H. was using Valium, but had agreed not to use it with the muscle relaxant. Respondent did not document a mental status exam at this visit. Respondent prescribed Percocet 5/325 #300, and Baclofen 10 mg #30 to patient C.H. The plan was for patient C.H. to follow-up in three (3) weeks.

145. On or about October 22, 2012, patient C.H. was seen for a follow-up visit. Patient C.H. reported that she was planning on getting married. Patient C.H.'s weight loss remained at fifteen (15) pounds. Respondent noted that patient C.H. had lots of problems with her back and had "not yet had MRI" and that she had gotten some relief from meloxicam[25] that she got from a friend. Respondent noted patient C.H.'s affect to be tired and mood to be euthymic. Respondent did not document a mental status exam at this visit. Neither did respondent make a referral for patient C.H. to see a specialist regarding her ongoing back pain. Respondent prescribed meloxicam 15 mg #30, Percocet 5/325 #300, and Norco 10/325 #180 to patient C.H. The plan was for patient C.H. to follow-up in one (1) month.

146. On or about November 21, 2012, patient C.H. was seen for a follow-up visit. Respondent noted that patient C.H. did not want ADHD medications and that caffeine was enough. Patient C.H. reported that she and her boyfriend would be moving at the end of the year to live with Rhonda. Patient C.H. reported that she was going to a friend's house for Thanksgiving Day and was looking forward to the event. Respondent noted patient C.H.'s mood to be "OK" and affect "uncomfortable." Respondent did not document a mental status exam at this visit. Respondent prescribed meloxicam 15 mg #30 with eleven (11) refills, and Percocet 5/325 #300 to patient C.H. The plan was for patient C.H. to follow-up in one (1) month.

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[25] Meloxicam is a nonsteroidal anti-inflammatory drug with analgesic and fever reducer effects.

147. On or about sometime in December in 2012, patient C.H. was seen by respondent. Patient C.H. reported that she had recently been having trouble sleeping and was now taking her medications earlier and "chewing" them. Patient C.H. had recently moved in with "Rhonda." Respondent noted patient C.H. to have "mixed" mood and affect. Respondent did not document a mental status exam at this visit. Respondent prescribed Percocet 5/325 #300, Valium 5 mg #120, with five (5) refills, Baclofen 10 mg #120, Ibuprofen 800 mg #120, Topamax 100 mg #60 and Klonopin 1 mg #120 to patient C.H. The plan was for patient C.H. to follow-up in one (1) month.

148. On or about January 20, 2013, patient C.H. saw respondent for refills of Percocet and Baclofen. Respondent noted patient C.H.'s affect to be bright and animated. Respondent did not document a mental status exam at this visit. Respondent prescribed Baclofen 10 mg #120 (1-4/day) with five (5) refills, and Percocet 5 mg #300 (2 tabs 5x/day) to patient C.H. Patient C.H. was to call respondent for a follow-up visit.

149. On or about February 15, 2013, patient C.H. was seen for a follow-up visit. Patient C.H. was noted to be "very sad and weepy about lots of distressing things in her life." Patient C.H. was having financial problems and difficulty with her job. Respondent noted that patient C.H. was "sad...but not depressed...looks to be in pain." Respondent did not document a mental status exam at this visit. Respondent prescribed Topamax 25 mg at HS (8/day) #240, with eleven (11) refills, OxyContin 10 mg #90 (1 TID prn for severe pain) #90, Baclofen 10 mg #120 (1-2 BID) with five (5) refills, Percocet 5 mg #300 (2 tabs 5x/day), Norco 10/325 #180 (2 tabs TID), Neurontin 100 mg #90 (1 qhs x 2 weeks then per MD), and clonazepam 1 mg #120 (1-4/day) with four (4) refills. The plan was for patient C.H. to follow-up in one (1) week.

150. On or about February 20, 2013, patient C.H. was seen for a follow-up visit. Patient C.H. was noted to be "doing ok with most of new meds." Respondent noted that patient C.H. was using OxyContin three times per day and using less Percocet; had a "paradoxical effect" with Neurontin; and, would use extra Topamax as needed. Respondent did not document a mental status exam at this visit. Respondent's plan was for patient C.H. to discontinue Neurontin and continue other medications. The plan was for patient C.H. to follow-up in three (3) weeks.

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151. On or about March 11, 2013, patient C.H. did not show-up for or call to cancel her appointment with respondent.

152. On or about March 20, 2013, patient C.H. was seen for a follow-up visit. Patient C.H. reported having "extreme panic episodes," fight with boyfriend, variable sleep, and working very little. Respondent did not document a mental status exam at this visit. Respondent prescribed OxyContin 10 mg #90 (1 TID prn for severe pain), Percocet 5/325 mg #300 (2 tabs 5x/day), Norco 10/325 #180 (2 tabs TID), and Valium 5 mg #120 (1-4/day), with four (4) refills. The plan was for patient C.H. to follow-up in two (2) weeks.

153. On or about April 3, 2013, patient C.H. was seen for a follow-up visit. Patient C.H. reported having broken-up with her boyfriend, cutting herself, and violent behavior in home. Patient C.H. was noted to "not [be] keeping straight on her meds," having financial stressors, no suicidal ideation, depressed mood, and tired affect. Respondent did not document a mental status exam at this visit. Respondent prescribed OxyContin 10 mg #90 (1 TID prn, and Percocet 5/325 mg #300 (2 tabs 5x/day) to patient C.H. The plan was for patient C.H. to follow-up in two (2) weeks.

154. On or about April 29, 2013, patient C.H. was seen for a follow-up visit. Patient C.H. reported continued social stressors. Respondent noted patient C.H.'s mood and affect as being good/better. Respondent did not document a mental status exam at this visit. Respondent prescribed OxyContin 10 mg #90 (1 TID), Percocet 5/325 mg #300 (2 tabs 5x/day), and Norco 10/325 #180 (2 tabs TID), with four (4) refills. The plan was for patient C.H. to follow-up in one (1) month.

155. On or about June 3, 2013, respondent wrote to patient C.H. to inform her that respondent would no longer prescribe any non-psychiatric medications, in particular narcotics, to patient C.H. That is the last visit note contained in patient C.H.'s medical record.

156. Respondent committed gross negligence in her care and treatment of patient C.H. including, but not limited to, the following:

a. Respondent failed to complete a medical and psychiatric history of patient C.H. at the initial visit;

b. Respondent provided opioid treatment to patient C.H. when there were numerous contraindications for such treatment for patient C.H.;

c. Respondent failed to obtain relevant medical records for patient C.H. from outside providers, communicate about patient C.H. with them, or refer patient C.H. to appropriate specialists;

d. Respondent failed to monitor patient C.H.'s opiate dosages used or medication levels;

e. Respondent failed to perform a standard psychiatric evaluation of patient C.H., and/or document clinical symptoms and diagnostic criteria on follow-up visits;

f. Respondent failed to document a reasoned treatment plan and/or informed consent for patient C.H.;

g. Respondent failed to consider alternative mood stabilizing treatments for patient C.H.;

h. Respondent failed to document a complete mental status exam for patient C.H. at any follow-up visit;

i. Respondent prescribed a polypharmacy regimen with no clear clinical indication and consideration of side-effects for patient C.H.;

j. Respondent prescribed opiate medication to patient C.H. without documenting a clear indication for prescribing the opiate medication used and the dosages prescribed;

k. Respondent failed to monitor the acetaminophen and opiate medications prescribed, including documentation of doses of opiates and acetaminophen prescribed for patient C.H., labs, vital signs, risk factors and contraindications, possible drug interactions, and signs of possible misuse of medications;

l. Respondent wrote multiple prescriptions for patient C.H. without a clear reason to do so;

m. Respondent failed to document any discussions of the risks and benefits of the high dose acetaminophen containing opiate medications prescribed with patient C.H. and/or informed consent regarding the treatment;

n. Respondent prescribed psycho-stimulant medications to patient C.H. without documenting the medical indication /rationale for the prescriptions and/or keeping track of the dosages and combinations used;

o. Respondent failed to monitor the psycho-stimulant medications prescribed to patient C.H., including documentation of doses of drugs prescribed for patient C.H., labs, vital signs, risk factors and contraindications, possible drug interactions, and signs of possible misuse of medications;

p. Respondent engaged in inappropriate polypharmacy of opioid medications and psycho-stimulants to patient C.H.;

q. Respondent failed to document the rationale for high dose psycho-stimulant treatment for patient C.H.;

r. Respondent failed to document any discussions of the risks and benefits of psycho-stimulant treatment with patient C.H. and/or informed consent regarding the treatment; and

s. Respondent failed to document the criteria for the psychiatric diagnoses given to patient C.H. and the psychiatric diagnoses being treated.

**Patient G.O.**

157. On or about July 14, 2008,[26] patient G.O. saw respondent for an initial visit. Patient G.O. had multiple medical problems including fibromyalgia, ankylosing spondylitis, radial nerve radiculopathy of left arm, carpal tunnel syndrome, and attention deficit hyperactivity disorder (ADHD). Patient G.O. reported that she had run out of her medicine and was sleeping poorly. Respondent noted that patient G.O. appeared sad, fearful, frequently tearful, and psychomotor retarded. Respondent further noted that patient G.O. was alert and oriented but with "significantly impaired" memory and concentration, with fair judgment. Patient G.O. was noted to be taking Adderall 30 mg po TID, Ativan 1 mg po BID, methylin ER 20 mg po BID, Cymbalta 120 mg po daily, and Norco 10/325 #6/day. Respondent did not take steps to corroborate patient

[26] Although the first note in patient G.O.'s medical records is dated July 14, 2008, the medical record provided by respondent for patient G.O. was for 2011 through 2013.

G.O.'s diagnoses of fibromyalgia and ankylosing spondylitis or refer patient G.O. to a specialist for evaluation and management of these conditions.

158. On or about January 11, 2011, patient G.O. was seen for a follow-up visit. Patient G.O. reported that she had lost all of her medications and had contused the front of her mouth on a piece of wood. Respondent did not document a mental status exam at this visit. Respondent prescribed Cymbalta 120 mg/day, Adderall 30 mg po TID #90, and Adderall XR 20 mg BID #60 to patient G.O. The plan was for patient G.O. to follow-up in one (1) month.

159. On or about February 5, 2011 patient G.O. was seen for a follow-up visit. Patient G.O. reported that she could no longer afford Adderall RX, the recent death of her mother, and lack of emotional support. Respondent did not document a mental status exam at this visit. Respondent prescribed methlyn ER 10 mg BID #60, and Adderall 30 mg po TID #90. The plan was for patient G.O. to follow-up in one (1) month.

160. On or about March 17, 2011, patient G.O. was seen for a follow-up visit. Patient G.O. reported numerous social stressors and a denial of her Social Security Administration Disability Application. Respondent noted that patient G.O. had numerous health problems with "pain in hands, pain in left ankle, constant back pain." Respondent also noted that patient G.O. appeared depressed, scared, and worried, but no suicidal ideation. Patient G.O. was not eating enough due to lack of funds and was going to apply for food stamps. Respondent did not document a mental status exam at this visit. Respondent did not document the cause for patient G.O.'s pain, neither did respondent refer patient G.O. to a specialist. Respondent prescribed Cymbalta 120 mg/day, Adderall 30 mg po tid #90, and Adderall XR 20 mg BID #60 to patient G.O. The plan was for patient G.O. to follow-up in one (1) month.

161. On or about April 15, 2011, patient G.O. was seen for a follow-up visit. Patient G.O. reported that she had not completed her application for MediCal. Respondent noted that patient G.O. had decreased all narcotics and was occasionally taking Aleve and Humira. Respondent did not document a mental status exam at this visit. Respondent gave patient G.O. samples of Cymbalta 120 mg/day and prescribed Adderall 30 mg po TID #90, and Adderall XR 20 mg BID to patient G.O. The plan was for patient G.O. to follow-up in one (1) month.

162. On or about an indeterminable date in 2011, patient G.O. was seen for a follow-up visit. Patient G.O. was noted to be having housing problems. Respondent documented that patient G.O. "has been able to tolerate being off narcotics (can't afford them)." Patient G.O.'s affect and mood were described to be sad, tired. Patient G.O. was noted to be experiencing interrupted sleep. Respondent did not document a mental status exam at this visit. Respondent gave patient G.O. 8 boxes of Cymbalta samples and prescribed Adderall 30 mg po TID #90 and methylin ER 20 mg BID to patient G.O.

163. On or about July 1, 2011, patient G.O. was seen for a follow-up visit. Patient G.O. was noted to have severe back pain for one to two weeks with spine and muscle spasm, depressed mood and sleeping poorly. Respondent diagnosed patient G.O. with "flare-up of ankylosing spondylitis, diffuse." Respondent did not document a mental status exam at this visit. Neither did respondent refer patient G.O. to a specialist for her continued pain problems. Respondent gave patient G.O. samples of Cymbalta 120 mg/day and prescribed Adderall 30 mg po TID #90, methylin ER 20 mg BID, Motrin, Robaxin prn muscle spasm, and Norco 10/325 #120 (1 q 3 hr prn pain) to patient G.O. The plan was for patient G.O. to follow-up in one (1) month.

164. On or about July 29, 2011, patient G.O. was seen for a follow-up visit. Respondent noted that "Pt was here for monthly meds." Respondent did not document a mental status exam at this visit. Respondent gave patient G.O. Cymbalta samples and prescribed Adderall 30 mg po TID #90, and methylin ER 20 mg BID to patient G.O. The plan was for patient G.O. to follow-up in one (1) month.

165. On or about August 21, 2011, respondent completed a SSI Questionnaire for patient G.O.

166. On or about August 31, 2011, patient G.O. was seen for a follow-up visit. Patient G.O. was reported to be having financial stressors and experiencing substantial back and joint pain, was very shaky, and had lots of muscle spasms. Respondent noted that patient G.O. had been sleeping poorly, had paresthesias of left hand, and her "affect looks to be in pain." Respondent did not document a mental status exam at this visit. Respondent did not refer patient G.O. to a specialist regarding her ongoing pain problems. Respondent gave patient G.O.

Cymbalta samples and prescribed Adderall 30 mg po TID #90, methylin ER 20 mg BID #60, Motrin, Robaxin prn for muscle spasm, Norco 10/325 #180 (1 q 3 hr prn for pain), and Clonazepam 0.5 mg #30 (1 QHS prn) with two (2) refills to patient G.O. The plan was for patient G.O. to follow-up in one (1) month.

167. On or about September 29, 2011, patient G.O. was seen for a follow-up visit. Respondent noted that patient G.O. had applied for SSI. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall 30 mg #90 TID, and methylin ER 30 mg #60 BID to patient G.O. Patient G.O. was to return in one week for a refill of Cymbalta and to follow-up in one (1) month.

168. On or about October 24, 2011, patient G.O. was seen for a visit. Respondent noted patient G.O.'s sleep to be poor and affect as ill. Patient G.O. was noted to be coughing up greenish/yellowish sputum. Respondent did not document a mental status exam at this visit. Respondent gave patient G.O. Cymbalta samples and prescribed Adderall 30 mg po TID #90 and methylin ER 20 mg BID to patient G.O. The plan was for patient G.O. to follow-up in one (1) month.

169. On or about November 21, 2011, patient G.O. was seen for a follow-up visit. Patient G.O. complained of severe paresthesias in right hand for several days via, neck, upper back, and right shoulder. Patient reported that taking Clonazepam at bedtime had been effective. Respondent noted patient's mood to be 6/10, anxiety to be 8/10, and energy to be 6/10. Respondent did not document a mental status exam at this visit. Respondent did not refer patient G.O. to a specialist for her ongoing pain problems, but continued to prescribe high dose stimulants. Respondent gave patient G.O. Cymbalta samples, advised patient G.O. to use Voltaren Gel, and prescribed Clonazepam 0.5 mg #60 with five (5) refills, Lyrica 150 mg #30, with five (5) refills, Adderall 30 mg po TID #90, and methylin ER 20 mg BID #60 to patient G.O. The plan was for patient G.O. to follow-up in one (1) month.

170. On or about December 26, 2011, patient G.O. was seen for a follow-up visit. Patient G.O. reported increased pain that was not helped with current dose of Norco and conflict with roommate. Respondent noted that patient G.O.'s affect looked depressed and mood was

depressed and anxious. Respondent did not document a mental status exam at this visit. Respondent gave patient G.O. Cymbalta samples and prescribed Adderall 30 mg po TID #90, methylin ER 20 mg BID, and Oxycodone 10 mg #90 (1/2-1 q 3 hr prn for pain) to patient G.O.

171. On or about January 23, 2012, patient G.O. was seen for a follow-up visit. Patient G.O. reported severe social stressors and severe pain due to fibromyalgia "on top of ankylosing spondylitis." Respondent described patient G.O.'s affect as sad and her mood as sad and weepy. Respondent noted that the methylin ER had caused patient G.O. to have severe headache and the Oxycodone had caused patient G.O. to have nausea and vomiting. Respondent did not document a mental status exam at this visit. The plan was to continue medications at current doses. Respondent prescribed Adderall 30 mg po TID #90, and Cymbalta 60 mg #60 to patient G.O.

172. On or about February 22, 2012, patient G.O. was seen for a follow-up visit. Patient G.O. reported feeling sick with intermittent fever and continuing pain due to living situation, including horrible situation with roommate. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall 30 mg po TID #90, Adderall XR 20 mg BID, clonazepam 0.5 mg (1-2 QHS prn for anxiety), and Cymbalta 120 mg/day with eleven (11) refills, to patient G.O.

173. On or about March 14, 2012, patient G.O. was seen for a follow-up visit. Respondent noted that patient G.O. was in great distress due to ongoing problems with roommate and lack of support from family, and looked "exhausted & abused." Patient G.O. reported that she was sleeping poorly, pursuing a restraining order against her roommate and planned to move from her apartment. Respondent noted patient G.O.'s affect as "...very ill & exhausted; many lesions on face; no make-up. Frequent crying spells; appears hopeless; frightened." Respondent noted patient G.O.'s mood to be "[d]epressed (pt. is on adequate & proper anti-depressants – situational problems are currently overwhelming her meds); Angry." Respondent did not document a mental status exam at this visit. The plan was for patient G.O. to get out of current living situation and continue anti-depressants. Respondent prescribed Adderall XR 20 mg #60 BID, and Adderall 30 mg #90 TID. Patient G.O. was to call to schedule a follow-up appointment.

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174. On or about April 13, 2012, patient G.O. was seen for a follow-up visit. Patient G.O. reported that she was doing better since moving and was living in motels while looking for a place to live. Respondent noted that patient G.O.'s affect was "a little brighter" and mood was "less depressed." Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall 30 mg po TID #90, and Adderall XR 20 mg BID to patient G.O. The plan was to continue Cymbalta and for patient G.O. to call to schedule a one (1) month follow-up appointment.

175. On or about May 7, 2012, patient G.O. was seen for a follow-up visit. Patient G.O. reported finding a new place to live, being upset about a friend not contacting her, and dating someone. Respondent noted patient G.O.'s affect to look better, mood as 4/10, and anxiety as 5/10. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 20 mg #60 BID, and Adderall 30 mg #90 TID to patient G.O. The plan was for patient G.O. to follow-up in one (1) month.

176. On or about June 4, 2012, patient G.O. was seen for a follow-up visit. Patient G.O. reported worsening dreams and night-terrors, and that the Clonazepam she was taking at bedtime was ineffective. Respondent noted that patient had been referred for therapy but had yet to see the therapist. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall 30 mg po TID #90, Adderall XR 20 mg BID, and Klonopin 0.5 mg #60 with five (5) refills.

177. On or about sometime in July, 2012, patient G.O. was seen for a follow-up visit. Patient G.O. was noted to be doing well and was "NOT DEPRESSED any longer," and was sleeping better on new Klonopin regimen. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 20 mg #60 BID and Adderall 30 mg #90 to patient G.O. The plan was for patient G.O. to follow-up in one (1) month.

178. On or about August 2, 2012, patient G.O. was seen for a follow-up visit. Patient G.O. was noted to be "very weepy," having social problems, denied any suicidal ideations but reported feeling overwhelmed. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall 30 mg po TID, and Adderall XR 20 mg BID to patient G.O. The

plan was for patient G.O. to follow-up in two weeks or one (1) month.

179. On or about August 15, 2012, patient G.O. was seen for a follow-up visit. Respondent noted that patient G.O.'s "[l]ife continues to OVERFLOW [with] CHAOS." Patient G.O. reported having car problems; a theft of items, including medications; disrupted sleep; and, swollen joints. Respondent noted patient G.O.'s affect to be mixed, and mood to be euthymic. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 20 mg #60 BID, Adderall 30 mg #90 TID, and Flexeril 10 mg #60 to patient G.O. The plan was for patient G.O to follow-up in one (1) month.

180. On or about September 10, 2012, patient G.O. was seen for a follow-up visit. Patient G.O. reported that she was sleeping well, having car problems, and family was trying to help her. Respondent noted that patient G.O.'s affect was mixed and her mood was euthymic. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 20 mg #60 BID, and Adderall 30 mg #90 to patient G.O. The plan was to follow-up in one (1) month.

181. On or about October 8, 2012, patient G.O. was seen for a follow-up visit. Patient G.O. reported that she was sleeping okay, the heat was making things worse, and she was experiencing migraine headaches again. Respondent noted that patient G.O.'s mood was "getting more hopeful less panic-stricken" and her affect "looks puzzled." Patient G.O. reported that she was not getting enough of an effect form the Adderall XR. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg BID, Adderall 30 mg 1 TID #90, and Imitrex 100 mg #9 (1/4-1/2 at onset of headaches, not to exceed 2 doses/day) to patient G.O. The plan was for patient G.O. to follow-up in two (2) weeks.

182. On or about November 5, 2012, patient G.O. was seen for a follow-up visit. Respondent noted that patient G.O. was continuing to have car problems, and that patient G.O.'s affect was bright and mood was "less depressed than usual." Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg #30, and Adderall 30 mg #90 TID to patient G.O. The plan was for patient G.O. to follow-up in a month.

183. On or about November 28, 2012, patient G.O. was seen for a follow-up visit. Patient G.O. reported running out of Adderall XR as she was only able to obtain thirty (30) pills for 30

days with a higher amount being approved by the insurance company for after November 18. Respondent's notes do not mention patient G.O.'s mood or affect. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg #60 BID, and Adderall 30 mg #90 TID to patient G.O. The plan was for patient G.O. to follow-up in a month.

184. On or about December 19, 2012, patient G.O. was seen for a follow-up visit. Respondent noted that patient G.O. had "lots of chaos." Respondent documented patient G.O.'s mood as depressed and affect as "mixed." Respondent did not document a mental status exam at this visit. Respondent prescribed Cymbalta 60 mg #60 TID, with eleven (11) refills, Adderall XR 30 mg #60 BID, and Adderall 30 mg #90 TID to patient G.O. The plan was for patient G.O. to follow-up in one month.

185. On or about January 2, 2013, patient G.O. was seen for a follow-up visit. Respondent noted that patient G.O.'s affect was flat and mood sad. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg #60 BID, Adderall 30 mg #90 TID, and Cymbalta 60 mg #60 TID. The plan was for patient G.O. to follow-up in one month.

186. On or about January 30, 2013, patient G.O. was seen for a follow-up visit. Respondent noted that patient G.O. was unable to get approval for a Cymbalta prescription, so respondent gave samples of Cymbalta 120 mg to patient G.O. Respondent documented that patient G.O.'s mood was euthymic and affect brighter. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg #60 BID, and Adderall 30 mg #90 TID to patient G.O. The plan was for patient G.O. to follow-up in one month.

187. On or about February 26, 2013, patient G.O. was seen for a follow-up visit. Respondent noted that patient G.O.'s affect was bright and animated and things were going well for patient G.O. Patient G.O. was planning to see a primary care physician and get referrals to see a Rheumatologist and a Pain Management Specialist, and have lab work done with the results to be sent to respondent. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg #60 BID, and Adderall 30 mg #90 TID to patient G.O. The plan was for patient G.O. to follow-up in one month.

188. On or about March 26, 2013, patient G.O. was seen for a follow-up visit. Patient G.O. had reportedly seen the primary car physician but had yet to get lab work completed. Patient G.O. was noted to have developed pain and weakness in her right wrist, with the pain getting worse each day. Respondent documented patient G.O.'s mood as good, affect as mixed, and mental energy as low. Respondent also noted that patient G.O. was encouraged to go to Alanon. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg #60 BID, and Adderall 30 mg #90 TID to patient G.O. The plan was for patient G.O. to follow-up in one month.

189. On or about April 23, 2013, patient G.O. was seen for a follow-up visit. Respondent noted patient G.O. was "upset," "feels like crap," and has aching knees and right wrist. Respondent documented patient G.O.'s mood as euthymic and affect as bright and animated. Respondent did not document a mental status exam at this visit. Respondent gave samples of Cymbalta 60 mg #60 to patient G.O. and prescribed Adderall XR 30 mg #60 BID, Adderall 30 mg #90 TID, and Klonopin 0.5 mg #60 prn for anxiety, with four (4) refills, to patient G.O. The plan was for patient G.O. to follow-up in one month.

190. On or about May 21, 2013, patient G.O. was seen for a follow-up visit. Respondent noted that patient G.O. had "major problems" with roommate and found a new living situation, pain was under control, sleep was good, mood was euthymic and affect was bright and animated. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall XR 30 mg #60 BID, other medications, and Adderall 30 mg #90. The plan was for patient G.O. to follow-up in one month.

191. On or about June 18, 2013. Patient G.O. was seen for a follow-up visit. Respondent noted that patient G.O. was to see a new pain management doctor to take over narcotics, NSAIA (nonsteroidal anti-inflammatory analgesic) and muscle relaxant prescriptions; and, that respondent would continue to prescribe patient G.O. with psychotropic medications only. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall 30 mg po TID #90, Adderall XR 30 mg BID #60, and Cymbalta 120 mg per day. The plan was for patient G.O. to follow-up in three weeks.

192. On or about July 12, 2013, patient G.O. was seen for a follow-up visit. Respondent noted that patient G.O. was having difficulty getting the health plan to take over prescriptions for pain medications. Respondent did not document a mental status exam at this visit. Respondent prescribed Norco 10/325 #240, 2 q 3-4 hrs prn for pain with no refills and Adderall 30 mg po TID #90. The plan was for patient G.O. to follow-up in two (2) weeks.

193. On or about July 23, 2013, patient G.O. did not show-up for or call to cancel her appointment with respondent.

194. On or about July 30, 2013, respondent prescribed Adderall XR 30 mg #60 BID to patient G.O., and noted that patient G.O. had an appointment scheduled for August 1, 2013.

195. On or about August 1, 2013, patient G.O. was seen for a follow-up visit. Respondent noted that patient G.O. was still having problems with health insurance and needs pain management and rheumatologist. Respondent further noted that patient G.O. had "[n]o way to get pain meds." Patient G.O.'s affect and mood were noted to be mixed with restless sleep. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall 30 mg #90 TID, and Percocet 5/325 #120 for severe pain to patient G.O. The plan was for patient G.O. to follow-up in three (3) weeks.

196. On or about August 14, 2013, patient G.O. was seen by respondent. Patient G.O. was noted to be "feeling worse on 10 mg Percocet than she did (with) 10/325 of Norco." Respondent prescribed Norco 10/325 #240 for severe pain with no refills. Respondent did not document a mental status exam at this visit. The plan was for patient G.O. to follow-up in 2 weeks, at the previously scheduled appointment.

197. On or about August 20, 2013, patient G.O. was seen for a follow-up visit. Respondent noted that patient G.O.'s affect was bright and animated, mood was substantially better than it had been on the last several visits, and sleep was terrific. Patient G.O. reported that she was still waiting to see the Rheumatologist. Respondent did not document a mental status exam at this visit. Respondent prescribed Adderall 30 mg po TID #90, Adderall XR 30 mg BID #60, and (to prescribe) "narcotics per Rheumatologist" to patient G.O. The plans was for patient G.O. to follow-up in one (1) month.

198. On or about May 27, 2015, respondent was interviewed by an investigator with the Division of Investigation, Health Quality Investigations Unit, regarding her care and treatment of patient G.O. Respondent stated that she did not keep track of the prescriptions that patient G.O. was receiving from her primary care physician. Respondent did not recall if she checked patient G.O.'s liver function tests. Respondent stated that she did not follow her own agreement with patient G.O. that patient G.O. would obtain narcotics from patient G.O.'s primary care physician. Respondent further stated that she did not have a pain contract with patient G.O. Respondent also stated that she did not request and/or obtain patient G.O.'s records from any other treating physicians, including a rheumatologist and/or a pain management specialist.

199. Respondent committed gross negligence in her care and treatment of patient G.O., including, but not limited to, the following:

a. Respondent failed to corroborate the diagnoses of ankylosing spondylitis and possible fibromyalgia for patient G.O.;

b. Respondent failed to make referrals to specialists for G.O.'s ongoing pain related problems;

c. Respondent failed to make clear psychiatric diagnoses for patient G.O.;

d. Respondent did not have a pain medication treatment contract or agreement with patient G.O., even after patient G.O. reported having lost medications;

e. Respondent prescribed opiate medication to patient G.O. without documenting a clear indication for prescribing the opiate medication used and the dosages prescribed;

f. Respondent failed to monitor the acetaminophen and opiate medications prescribed, including documentation of doses of opiates and acetaminophen prescribed for patient G.O., labs, vital signs, risk factors and contraindications, possible drug interactions, and signs of possible misuse of medications;

g. Respondent wrote multiple prescriptions for patient G.O. without a clear reason to do so;

h. Respondent failed to document any discussions of the risks and benefits of the high dose acetaminophen containing opiate medications prescribed with patient G.O. and/or

informed consent regarding the treatment;

i. Respondent prescribed psycho-stimulant medications to patient G.O. without documenting the medical indication /rationale for the prescriptions and/or keeping track of the dosages and combinations used;

j. Respondent failed to monitor the psycho-stimulant medications prescribed to patient G.O., including documentation of doses of drugs prescribed for patient G.O., labs, vital signs, risk factors and contraindications, possible drug interactions, and signs of possible misuse of medications;

k. Respondent engaged in inappropriate polypharmacy of opioid medications and psycho-stimulants to patient G.O.;

l. Respondent failed to document the rationale for high dose psycho-stimulant treatment for patient G.O.;

m. Respondent failed to document any discussions of the risks and benefits of psycho-stimulant treatment with patient G.O. and/or informed consent regarding the treatment; and

n. Respondent failed to document the criteria for the psychiatric diagnoses given to patient G.O. and the psychiatric diagnoses being treated.

## SECOND CAUSE FOR DISCIPLINE

**(Repeated Negligent Acts)**

200. Respond is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that she committed repeated negligent acts in the care and treatment of patients A.A., C.H. and G.O., as more particularly alleged in paragraphs 9 through 199, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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## THIRD CAUSE FOR DISCIPLINE

**(Incompetence)**

201. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that she was incompetent in her care and treatment of patient A.A., C.H. and G.O., as more particularly alleged in paragraphs 9 through 199, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

## FOURTH CAUSE FOR DISCIPLINE

**(Excessive Prescribing)**

202. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 725, subdivision (a), of the Code, in that respondent repeatedly prescribed clearly excessive amounts of opioid and psycho-stimulant medications for patients A.A., C.H. and G.O., as more particularly alleged in paragraphs 9 through 199, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

## FIFTH CAUSE FOR DISCIPLINE

**(Prescribing Without An Appropriate Examination and Medical Indication)**

203. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2242, of the Code, in that without performing an appropriate prior examination and medical indication, respondent prescribed opioids and psycho-stimulant medications to patient A.A., C.H., and G.O., as more particularly alleged in paragraphs 9 through 199, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

## SIXTH CAUSE FOR DISCIPLINE

**(Failure to Maintain Adequate and Accurate Records)**

204. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that respondent failed to maintain adequate and accurate records regarding her care and treatment of patients A.A., C.H. and G.O., as more particularly alleged in paragraphs 9 through 199, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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## SECTION 822 CAUSE FOR ACTION

205. Respondent's Physician's and Surgeon's Certificate No. G43299 is subject to action under section 822 of the Code in that she suffers from mental illness and/or physical illness affecting competency, as more particularly alleged hereinafter:

A. Respondent has been under the nearly continuous care of a psychiatrist and/or psychotherapist since approximately 1998 for treatment of her various mental conditions which have been diagnosed as including, but not limited to, bipolar disorder and attention deficit disorder with a reported history of depressive and hypomanic episodes, alcohol abuse, occupational problems, interpersonal problems, impulse control issues, and difficulties in maintaining proper boundaries in both her personal and professional life. Additionally, respondent suffers from chronic pain attributed to, among other things, multiple surgeries for disc degeneration, neuropathic pain, and arthritis with respondent's treating medical professionals expressing concern over respondent self adjusting and escalating her opioid medications and the potential for addition to her opioid medications.

B. On or about June 1, 2015, respondent was asked, and agreed, to voluntarily undergo both a physical and a psychiatric evaluation to determine whether she has a mental illness and/or physical illness affecting competency, that impaired her ability to safely practice medicine.

C. On or about November 13, 2015, respondent underwent a psychiatric evaluation with A.A., M.D., a Board Certified Psychiatrist. Upon completion of that psychiatric examination, which included psychological testing and a review of respondent's relevant treatment records and other pertinent documentation, Dr. A.A. determined respondent's ability to safely practice medicine is impaired due to her unresolved mental diagnoses, and associated symptoms, which result in respondent's over-identification with patients, and failure to maintain proper boundaries which patients, which makes her unsafe to practice medicine.

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## 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 No. G43299, issued to respondent Joanna Louis, M.D.;

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

3. Ordering respondent Joanna Louis, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Taking action as authorized by section 822 of the Code as the Board, in its discretion, deems necessary and proper; and

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

DATED: January 21, 2016

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

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