REDACTED

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

In the Matter of the Accusation Against:	)	
DOROTHY L. GRAY, M.D. 3048 16th Street, #207 San Francisco, CA 94103	)	Case No. 12-96-70046
Physician & Surgeon's No. A20878	)	OAH No. N 1998050151
Respondent.	)	

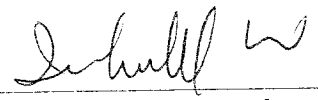
DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Medical Board of California as its Decision in the above-entitled matter.

This Decision shall become effective on December 21, 1998.

IT IS SO ORDERED.

DATE: November 19, 1998



Ira Lubell, M.D., President
Division of Medical Quality

BEFORE THE
DIVISION OF MEDICAL QUALITY
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In the Matter of the Accusation Against:	)	
DOROTHY L. GRAY, M.D. 3048 16th Street, #207 San Francisco, CA 94103	)	Case No. 12-96-70046
	)	OAH No. N 1998050151
Physician & Surgeon's No. A20878	)	
Respondent.	)	

PROPOSED DECISION

This matter was heard before Jonathan Lew, Administrative Law Judge, State of California, Office of Administrative Hearings on September 10, 14 and 15; and on October 6, 1998. The hearings were conducted in San Francisco and Oakland.

Complainant was represented by Susan K. Meadows, Deputy Attorney General.

Respondent Dorothy L. Gray was present. She was represented by Frederick C. Roesti, Esq., Law Gallery, 64 Gough Street, Suite D, San Francisco, California 94102.

FACTUAL FINDINGS

1. Complainant Ron Joseph is the Executive Director of the Medical Board of California (hereinafter the "Board") and he made and issued the accusation solely in his official capacity.

2. On September 16, 1963, physician and surgeon's certificate No. A20878 was issued by the Board to Dorothy L. Gray (hereinafter "respondent"), and at all times

pertinent to this matter, this license has been in full force and effect. The license expired on September 30, 1997, and has not been renewed.[1]

3. Complainant alleges as separate causes for disciplinary action: 1) that respondent's license to practice medicine was revoked in the State of Minnesota, and 2) that respondent has impaired ability to practice medicine with safety to the public and that she requires psychotherapy and clinical supervision in order to practice medicine safely. These allegations will be addressed separately and in same order.

4. Minnesota Revocation. On November 23, 1996, the State of Minnesota, Board of Medical Practice revoked respondent's license to practice medicine and surgery in that state. The Minnesota Board of Medical Practice adopted and incorporated as its own "the Conclusions in the ALJ's Report which supports that Respondent violated Minn. Stat. § 147.091, subd. 1(f), (g), (k), (l), (o), (q), (r), (s), (t) and (u) (1994)."[2]

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[1] Section 118(b) of the Business and Professions Code provides, in part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the time within which the license may be renewed, restored, or reinstated.

[2] Section 147.091 of the Minnesota Statutes 1994 sets forth grounds for disciplinary action by the Board of Medical Practice. The language of the sections under which disciplinary action was taken against respondent's license follow.

1(f) Violating a rule promulgated by the board or an order of the board, a state, or federal law which relates to the practice of medicine, or in part regulates the practice of medicine including without limitation sections 148A.02, 609.344, and 609.345, or a state or federal narcotics or controlled substance law.

1(g) Engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare or safety of a patient; or medical practice which is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established.

1(k) Engaging in unprofessional conduct. Unprofessional conduct shall include any departure from or the failure to conform to the minimal standards of acceptable and prevailing medical practice in which proceeding actual injury to a patient need not be established.

1(l) Inability to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, use of drugs, narcotics, chemicals or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills.

1(o) Improper management of medical records, including failure to maintain adequate medical records, to comply with a patient's request made pursuant to section 144.335 or to furnish a medical record or report required by law

Complainant has submitted a certified copy of the record of the disciplinary action taken against respondent by the Minnesota Board of Medical Practice, and such constitutes conclusive evidence of the events related therein under Business and Professions Code section 141.

5. Business and Professions Code section 2305 provides that the revocation imposed by another state upon a license to practice medicine issued by that state, that would have been grounds for discipline in California, shall constitute grounds for disciplinary action for unprofessional conduct against the licensee in California. It was established that the revocation of respondent's license to practice medicine and surgery in Minnesota gives rise to grounds for disciplinary action for unprofessional conduct against respondent in this state.

6. Respondent did not appear at any of the Minnesota Board proceedings. The Notice of and Order for Hearing were sent to her last known address, and in fact accepted for delivery at 1171 Valencia Street, #4, San Francisco in August 1996. This was two months prior to a prehearing conference. Respondent did not file any Notice of Appearance or make any request for a continuance or for any other relief. The Minnesota hearing proceeded by way of default. A notice was sent to her last known address. It advised her that she was invited to present oral argument to the Board on November 23, 1996. She was not present at the hearing and failed to provide representation on her behalf. She also had an opportunity to appeal any subsequent action taken by the Board and she failed to do so.

Respondent had come to California from Minnesota in June 1993. In March 1996 she moved from the Valencia Street address because she was unable to pay the rent. She was homeless and lived out of her automobile until April 1997. She used an address on Golden Gate Avenue to receive mail, but the Minnesota Board apparently did not know this. Eventually she approached the Patient's Rights Advocacy Project in San Francisco for legal assistance in addressing the Minnesota licensing action. Respondent

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1(q) Engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws.

1(r) Becoming addicted or habituated to a drug or intoxicant.

1(s) Prescribing a drug or device other than medically accepted therapeutic or experimental or investigative purposes authorized by a state or federal agency or referring a patient to any health care provider as defined in section 144.335 for services or tests not medically indicated at the time of referral.

1(t) Engaging in conduct with a patient which is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior which is seductive or sexually demeaning to a patient.

1(u) Failure to make reports as required by section 147.111 or to cooperate with an investigation of the board as required by section 147.131.

made diligent effort to obtain information and necessary advocacy services, including legal counsel. However she was at no time able to raise money or to otherwise arrange transportation back to Minnesota to contest the matter. Correspondence mailed on her behalf to the Minnesota Board was sent in 1997, but this was months after the Board's November 23, 1996 Order revoking her license.

7. Impairment. A psychiatric examination was performed by Richard J. Corelli, M.D. at the request of the Medical Board of California on respondent on November 12, 1997. In conjunction with his psychiatric examination Dr. Corelli referred respondent to Robert J. McIntyre, Ph.D. for psychological testing evaluation. The purpose of the psychological testing was to evaluate her current levels of depression and to assess for character pathology and any cognitive deficits. Psychological testing was performed by Dr. McIntyre on December 13, 1997.

Based on his own psychiatric examination of respondent, the results of the psychological testing performed by Dr. McIntyre and his review of other documents provided to him by the Board, Dr. Corelli prepared a psychiatric examination report on January 2, 1998. He concluded that respondent does have impaired ability to practice medicine with safety to the public at this time and that she requires psychotherapy and clinical supervision in order to practice medicine safely.

8. In reaching this conclusion Dr. Corelli noted several issues of major concern. He observed:

> She has demonstrated a rather persistent and consistent pattern of poor judgment and episodic loss of control around her drinking and depression in the past which are of major proportions. She has had difficulty with boundary issues and professional roles that is of significant concern as to her ability to practice medicine safely. She appears to have difficulties currently being able to stay focused and has attentional and concentration problems that might make it very difficult for her to be effective as a physician or psychiatrist. There are significant issues around her ability to accept responsibility and conversely her tendency to externalize and project blame onto others while at the same time showing evidence of persistent inflation and grandiosity that make her still at risk with regard to her underlying illness of depression and substance abuse.

Dr. Corelli offers the following psychiatric diagnosis:

Axis I:	Major Depression [296.32] R/O Bipolar II Disorder [296.89]
Axis I:	Alcoholism [303.90] Sustained Full Remission
Axis II:	Personality Disorder NOS [301.9]

9. In making recommendations for the future, Dr. Corelli opines that because of the relapsing nature of both major depression and alcoholism, respondent is likely to remain at risk for an indefinite period of time. That is, any relapse into a severe depression and/or recurrence of drinking would pose a significant risk to any patients who were currently in treatment with her at the time. As far as her being able to practice medicine, Dr. Corelli suggests:

> It would appear necessary for her to be separately in psychotherapy and clinical supervision with qualified and experienced psychiatrists well versed in treating and supervising impaired physicians and that the treatment and supervisory periods should extend throughout the time of any probationary period. I would imagine that the training of a qualified psychiatry residency program would be able to provide the necessary and sufficient clinical supervision as long as this was supplemented by her being in individual psychotherapy as well during the course of her training program. Because of the severity of her depressive illness and the severity of her alcoholism as manifested in the past and the usual and customary course of these illnesses as is often seen in clinical practice, it would seem mandatory that she be under psychiatric treatment and clinical supervision for an extended period of time to safeguard her patients in the event of any relapse that would potentially impact her clinical judgment and place her patients at risk.

10. Respondent is in need of intense psychotherapy, once a week minimum. An experienced psychotherapist, preferably a psychiatrist or psychologist, is required. Supportive counseling after the fashion that she has received to date is viewed by Dr. Corelli as grossly insufficient given the complexity of problems she is dealing with. Counseling with a nurse or psychotherapist on a monthly basis is acceptable only if she is not also treating others as a professional. This may be all that she is capable of financially at present. But were she to practice medicine, intensive treatment by one who is credentialed and more experienced with her issues is clearly needed. In sum, intense psychotherapy with a psychiatrist or psychologist is needed to deal with the major psychological issues with which she presents.

Dr. Corelli's recommendations are made in the context of respondent actually being accepted into a psychiatry residency program. He believes clinical supervision would be readily available in a residency program and that she would typically participate in one to four meetings a week with senior clinical faculty members to discuss individual cases. It would be an apprenticeship arrangement. Dr. Corelli suggests that she might also be able to receive affordable psychotherapy through a residency program – possibly through senior faculty on a sliding fee scale, or via insurance. This suggestion by Dr Corelli is made without his knowing whether her being admitted into a residency program is even realistic at this time. He does not recommend that she otherwise be permitted to practice in other restricted settings or under other specified probationary terms and conditions.

11. By reason of the matters set forth above in Findings 7 through 10, it has been established that respondent has impaired ability to practice medicine with safety to the public and that she requires psychotherapy and clinical supervision in order to practice medicine safely.

12. Respondent first began on tricyclic antidepressants in 1982 consisting of Desipramine, Imipramine and Doxepin. She began taking Cytomel in 1986 to improve her energy level, and in 1987 began taking low doses of Lithium. She found the Lithium affected her cognitive performance, and started taking Prozac in 1988 along with Cytomel. At the time of her January 1998 examination she was receiving Prozac 80 mg, Cytomel 45 ug, Paxil 20 mg, Premarin 0.625 mg, Progesterone 1.25 mg and Buspar 60 mg. She is being seen at the San Francisco Department of Health Clinic and the Family Health Clinic at San Francisco General Hospital.

In September she began taking Ritalin, 5 mg three times daily. It was added because it was believed to be effective in conjunction with her depression medications. Respondent reports being able to focus her attention, to concentrate and to read better since starting on this medication.

13. Respondent began psychotherapy with Rebecca Zuckweiler in early 1984 and continued for about nine years through May 1993. Ms. Zuckweiler is a certified clinical specialist in psychiatric/mental health nursing. Psychotherapy focused on childhood issues, poor relationships and inability to maintain employment.

After beginning mental health treatment through San Francisco's Central City Seniors Unit respondent began seeing clinical nurse specialist Florence Rowe, R.N. Ms. Rowe was primarily responsible for dispensing respondent's medications. She reports that respondent was compliant in taking same. Respondent saw Ms. Rowe several times a month when she first started, then once a month after a routine was established. After giving medications, the two would typically meet for up to an hour and a half, much of their session being centered around practical daily problems. It was directed more at issues and supportive counseling arising out of respondent being homeless, unemployed and depressed. Ms. Rowe believes her sessions with respondent were therapeutic, but does not characterize their sessions as being psychotherapy. She was aware that respondent had already been through intensive psychotherapy with Ms. Zuckweiler, and so she chose to focus her attention on respondent's more immediate and daily problems.

14. Work History. Respondent completed her medical education at the University of Texas, Southeastern Medical School, and also completed a masters program in public health at the University of California, Los Angeles. Over the past twenty years she has worked as a staff physician at the Hennepin County Methadone Rehabilitation Program (1978), as clinical director and full time psychiatrist with the

St. Croix Health Center (1979), as medical officer with the Veterans Administration neuro psychiatric hospitals in Tomah, Wisconsin (1979-83), as psychiatric consultant with the Minnesota Department of Jobs and Training (1983-84), and in private practice for a period in St. Paul prior to moving to California. She held herself out to specialize in treatment of Vietnam veterans with post-traumatic stress disorder and of patients with diagnoses of refractory depression.

She came to California in 1992, and in January 1993 explored the possibility of beginning a psychiatry residency program in Fresno through the University of California. The program wanted to start her as a first year resident, and she wanted to start as a second year resident. She decided instead to look for work and applied for positions at Vacaville and Napa State Hospitals. They would not hire her because she had not completed a residency in psychiatry. Other residency programs or positions for which she applied and was rejected included those at California Pacific Medical Center, San Mateo County, Stanford University Hospital and Martin Luther King, Jr. Center in Los Angeles. She also applied for positions in the California State Prisons and Contra Costa County jail; the Tom Waddell Clinic, and in the communities of West Side and Bay View Hunters Point.

Respondent also sought employment in the field of public health, trying to utilize her masters in public health. She applied to various health centers in San Francisco and the East Bay Area without success. She applied for employment outside the health field, but most of her efforts were directed towards positions in psychiatry. Eventually she ran out of energy and hope, and stopped trying. She remains unemployed at this time.

15. To date respondent has not completed a psychiatric residency and is not board certified in psychiatry or any other specialty. Yet, this is the only medical specialty in which she desires to practice. She describes her past work in state institutions as being in psychiatry, and she held herself out to be a psychiatric practitioner when she was in private practice. Her resume lists her professional experience in psychiatry as running from 1968 to present. She describes her position at the St. Croix Health Center as being the "Clinical Director and Full Time Psychiatrist." She explains that the reason she decided not to pursue a psychiatric residency in Minnesota was that the University of Minnesota residency program focused on the biology and neurological bases underlying mental illness, and not on psychotherapy.

16. In addition to reading journal articles in psychiatry, respondent has participated in continuing medical education courses through CME, Inc. For example, between March and August 1998, she has attended continuing education courses on subjects such as Alzheimer's disease, schizophrenia, bipolar disorders and progress in psychoses. She understands that she is required to complete 25 hours per year of continuing education. CME, Inc. offers complimentary seminars on various psychiatric topics and she currently takes advantage of these courses when they are offered in San Francisco.

17. The reasonable costs of investigation and prosecution of this case are detailed below:

Medical Board of California Investigative Services			
January – December 1997	20.5 hours	@ $112/hour	$2,296.00
January – July 1998	5.0 hours	@ $108.80/hour	544.00
Expert Reviewer Services			
Review	1.0 hour	@ $200/hour	200.00
Psych Exam	2.0 hours	@ $200/hour	400.00
Review/report	3.5 hours	@ $200/hour	700.00
Attorney General Time			
1997-98	43.0 hours	@ $100/hour	4,300.00
1998-99	56.6 hours	@ $100/hour	5,650.00
Legal Assistant Time			
1997-98	3.5 hours	@ $53/hour	185.50
1998-99	16.5 hours	@ $53/hour	848.00
		Total	$15,123.50

LEGAL CONCLUSIONS

1. Cause for disciplinary action exists under Business and Professions Code sections 141 and 2305, by reason of the matters set forth in Findings 4 and 5.

2. Cause for disciplinary action exists under Business and Professions Code section 822, by reason of the matters set forth in Findings 7 through 11. Respondent has impaired ability to practice medicine with safety to the public, and she requires psychotherapy and clinical supervision in order to practice medicine safely.

3. The reasonable costs of the investigation and enforcement of this case total $15,123.50, by reason of the matters set forth in Finding 17. Respondent is unemployed, on public assistance and in no position to reimburse the Medical Board of California at this time. The Board should consider cost recovery only in the context of any future petition by respondent for re-licensure, and then take into account any financial hardship demonstrated by respondent at that time.

4. Respondent moves to terminate the disciplinary proceedings and to be referred instead to the Board's diversion program. The Division of Medical Quality of the Board establishes criteria for the acceptance, denial, or termination of physicians and surgeons in a diversion program. (Business and Professions Code section 2350). Physicians who request to participate are evaluated by diversion evaluation committees. The committee determines whether individual physicians may with safety continue to resume the practice of medicine and/or whether they are suitable candidates for participation in a treatment program. It is outside the province of an administrative law judge to make direct referrals of physicians into the Board's diversion program.

Respondent argues that referral by the Chief or Deputy Chief of Enforcement of the Board into the diversion program is mandatory when a physician voluntarily requests evaluation of eligibility, even if the physician is currently under investigation by the Division. But this is true only where the investigation is based primarily on the self-administration of drugs or alcohol and does not involve actual harm to the public or his or her patients. (Business and Professions Code section 2350(b)). This case involves matters beyond the self-administration of drugs or alcohol, and there were determinations in the Minnesota disciplinary action that reference actual harm to the public or patients. (See footnote 2, *supra*.)

5. The matters set forth in Findings 10 through 16 were considered in making the following order. Respondent has not demonstrated that she is an appropriate candidate for probation at this time. For her to be able to practice safely she needs to begin a program of intense psychotherapy, and by one who is a psychiatrist or psychologist experienced in treating practitioners with the types of problems/issues she presents. She also needs to be accepted into a residency program in psychiatry that will afford necessary and sufficient clinical supervision of her work. Respondent presents no evidence that either is likely to occur. She can only hope that she will be accepted into a psychiatry residency program in California, and then further hope that such program will also allow her to begin intense psychotherapy at little or no cost.

She applied to several residency programs without success. She rejected the one program in Fresno that accepted her as a first year resident. There is no evidence that this program remains available to her. Since moving to California in 1992 she has not practiced medicine. She remains unemployed. She has no pending applications to residency programs in psychiatry, and no immediate plans to work in any type of medical position. It would not be wise to place her on probation at this time on the oft chance that she will be successful the second time around she applies for admission into a psychiatry residency.

Respondent should continue taking the responsible and positive steps that she has taken towards full rehabilitation. Though financially beyond her means at this time, she must at some point arrange for more intense psychotherapy as a first step towards treatment and return to the practice of medicine in a manner that will not endanger public

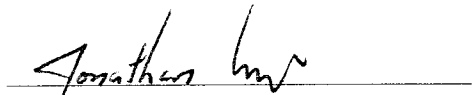
health and safety. Upon successful treatment she can perhaps then pursue reinstatement of her license under Business and Professions Code section 823.

ORDER

1. Physician and surgeon's certificate No. A 20878 issued to Dorothy L. Gray is revoked pursuant to Legal Conclusions 1 and 2, separately and for both of them.

2. The Board's reasonable costs of the investigation and enforcement of this case total $15,123.50. The matters set forth in Legal Conclusion 3 should be considered by the Board in seeking any reimbursement of these costs.

DATED: November 2, 1998



JONATHAN LEW
Administrative Law Judge
Office of Administrative Hearings

REDACTED

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO April 2, 1998
BY [illegible] ANALYST

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

In the Matter of the Accusation Against: **DOROTHY L. GRAY** 276 Golden Gate Ave. San Francisco, CA 94102 Physician & Surgeon's No. A20878 Respondent.	Case No. 12-96-70046 OAH No. **ACCUSATION**

The Complainant alleges:

PARTIES

1. Complainant, Ron Joseph, is the Executive Director of the Medical Board of California (hereinafter the "Board") and brings this accusation solely in his official capacity.

2. On or about September 16, 1963, physician and surgeon's certificate no. A20878 was issued by the Board to Dorothy L. Gray (hereinafter "respondent"), and at all times relevant to the charges brought herein, this license has been in full force and effect. Said license expired on September 30, 1997

and has not been renewed.

JURISDICTION

3. This accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), under the authority of the following sections of the California Business and Professions Code (hereinafter "Code"):

A. Section 2227 of the Code provides that the Board may revoke, suspend for a period not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act.

B. Section 2234 of the Code provides, in pertinent part, that unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

C. Section 125.3 of the Code provides, in part, that the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

D. Section 118(b) of the Code provides, in part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during

the time within which the license may be renewed, restored, or reinstated.

E. Section 2428 provides, in part, that a license which has expired may be renewed any time within five years after expiration.

F. Section 2305 of the Code provides, in part, that the revocation, suspension, or other discipline, restriction, or limitation imposed by another state upon a license or certificate to practice medicine issued by that state, or the revocation, suspension, or restriction of the authority to practice medicine by any agency of the federal government, that would have been grounds for discipline in California of a licensee under this chapter, shall constitute grounds for disciplinary action for unprofessional conduct against the licensee in this state.

G. Section 141 of the Code provides:

> (a) For any licensee holding a license issued by a board under the jurisdiction of the department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or another country shall be conclusive evidence of the

events related therein.

(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by that board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country.

H. Section 822 of the Code provides, in pertinent part, that if the Board determines that the licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the Board may take action by revoking or suspending the licentiate's license, placing the licentiate on probation, or taking such other action as the Board in its discretion deems proper.

I. Section 125.3 provides:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, the board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed

partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge where the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) Where an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licentiate to pay costs.

(f) In any action for recovery of costs, proof of

the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licentiate who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licentiate who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

J. Section 16.01 of the 1997-98 California Budget Act provides as follows:

(a) No funds appropriated by this act may be expended to pay any Medi-Cal claim for any service performed by a physician while that physician's license is under suspension or revocation due to a disciplinary action of the Medical Board of California.

(b) No funds appropriated by this act may be expended to pay any Medi-Cal claim for any surgical service or other invasive procedure performed on any Medi-Cal beneficiary by a physician if that physician has been placed on probation due to a disciplinary action of the Medical Board of California related to the performance of that specific service or procedure on any patient, except in any case where the board makes a determination during its disciplinary process that there exist compelling circumstances that warrant continued Medi-Cal reimbursement during the probationary period.

(c) The State Department of Health Services shall ensure that no Medi-Cal claim is paid in violation of subdivision (a) or (b).

(d) The Medical Board of California shall work with the State Department of Health Services to provide all information necessary to accomplish the purposes of this section. The board and the department shall report to the Legislature, upon the conclusion of each

calendar quarter of the 1996-97 fiscal year, the number of physicians on probation who are not receiving Medi-Cal reimbursement as a result of this section, and the number of physicians on probation who continue to be eligible for Medi-Cal reimbursement as a result of a determination of the board.

FIRST CAUSE FOR DISCIPLINE

(Discipline Imposed by Another State)

4. Respondent is subject to disciplinary action under sections 2305 and 141 of the Code in that on or about November 23, 1996, the State of Minnesota, Board of Medical Practice revoked respondent's license to practice medicine in that state. Among other reasons charged, respondent's license to practice was revoked for excessive and inappropriate prescribing. Attached hereto as Exhibit A and incorporated herein by reference as if fully set forth is a true and correct certified copy of the Order revoking respondent's license and the findings of fact surrounding the revocation of respondent's license in Minnesota.

SECOND CAUSE FOR DISCIPLINARY ACTION

(Impaired Ability to Practice Medicine)

5. On or about August 8, 1997, respondent agreed to undergo a psychiatric examination. The psychiatric examination, which included psychological testing, was concluded on or about November of 1997. Respondent has a history of alcohol related problems coupled with severe depression. The evaluator opined that because of the relapsing nature of major depression and alcoholism respondent is likely to remain at risk for an

indefinite period of time. The evaluator concluded that respondent has impaired ability to practice medicine with safety to the public and that she requires psychotherapy and clinical supervision in order to practice medicine safely.

6. Based on the aforementioned evaluation, cause for disciplinary action is established under Code section 822.

PRAYER

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

1. Revoking or suspending License Number A20878, heretofore issued to respondent Dorothy L. Gray;

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

3. Ordering respondent to pay the Division the actual and reasonable costs of the investigation and enforcement of this case; and, if placed on probation, to pay costs of Probation monitoring;

4. Taking such other and further action as the Division deems necessary and proper.

DATED: April 2, 1998.

Douglas Lane, Deputy Director for

Ron Joseph
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

Dorothy Gray.acc

MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza 2829 University Avenue SE Suite 400 Minneapolis, MN 55414-3246
**Telephone (612) 617-2130 *Fax (612) 617-2166*
MN Relay Service for Hearing Impaired (800) 627-3529

CERTIFICATION OF DISCIPLINARY ACTIONS

ORDER DATED November 23, 1996

IN THE MATTER OF: Dorothy L. Gray, M.D.

CITY AND STATE OF: San Francisco, CA

I, Robert A. Leach, Executive Director of the Minnesota Board of Medical Practice, Do hereby certify that the attached Board Order is a copy of the original official record on file in the office of the Minnesota Board of Medical Practice. As Executive Director, I am the official custodian of such documents and I have personally compared the attached copy with the original and find it to be a true and correct copy thereof.

Robert A. Leach,
Executive Director
Minnesota Board of Medical Practice

(S E A L)

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BEFORE THE MINNESOTA

BOARD OF MEDICAL PRACTICE

In the Matter of
Dorothy L. Gray, M.D.
License No. 19,079
Date of Birth: [redacted]

FINDINGS OF FACT, CONCLUSIONS, AND FINAL ORDER

The above-entitled matter was heard by Administrative Law Judge (ALJ) Barbara L. Neilson on October 3, 1996, in Courtroom 1 of the Office of Administrative Hearings, Minneapolis, Minnesota. The hearing was held pursuant to a Notice of and Order of Hearing issued by the Complaint Review Committee (Committee) of the Minnesota Board of Medical Practice (Board).

Jennifer M. O'Brien Assistant Attorney General, 525 Park Street, St. Paul, Minnesota 55103, represented the Committee. Respondent failed to appear at the hearing and was not represented at the hearing.

On October 11, 1996, the ALJ issued Finding of Fact, Conclusions and Recommendation (ALJ's Report). The Committee did not submit exceptions to the ALJ's Report. Respondent did not submit exceptions to the ALJ's Report.

The Board met to consider the matter on November 23, 1996, at the University Park Plaza, 2829 University Avenue SE, Minneapolis, Minnesota. The following members of the Board were present: Adrienne Breiner; Doris C. Brooker, MD; Sandra Engwall, MD; Patricia A. Jilk; Barbara LeTourneau, MD; Mary Mika; Elliot V. Troup, MD; Joseph Willett, DO; M.J. Martin, MD; Scott Tongen, MD; Craig Stone and James Gaviser, MD. Jennifer M. O'Brien appeared and presented oral argument for the Committee. Neither Respondent or her representative appeared at the hearing. Louis Hoffman, Assistant Attorney General, was present as legal adviser to the Board. Janet Lindquist, MD; Peter Smyth, MD; Zenas Baer

and James F. Knapp, MD were members of the Complaint Review Committee that commenced this proceeding and, therefore, did not participate in deliberations or vote in this matter. Richard D. Mulder, MD, David M. Kidder, DO, Richard J. Ivance and Karen Novak also participated in the commencement of the proceeding, but are no longer members of the Board.

FINDINGS OF FACT

1. On July 25, 1996, the Board served a Notice of and Order for Hearing upon Dorothy L. Gray, M.D. ("Respondent") by certified mail, return receipt requested, at her last known address filed with the Board.

2. On October 3, 1996, a prehearing conference was held.

3. Respondent failed to appear or be represented at the hearing and is in default in this proceeding.

4. The Board hereby adopts and incorporates as its own the Findings in the ALJ's Report, attached hereto and made a part hereof.

Based on the foregoing Findings of Fact, the Board makes the following:

CONCLUSIONS

1. The Minnesota Board of Medical Practice and the Administrative Law Judge have authority to consider the charges made against the Respondent under Minn. Stat. §§ 147.091 and 14.50 (1994), and the Board may take disciplinary action against the Respondent for any charges established as set forth in Minn. Stat. § 147.141 (1994).

2. The Board and the Complaint Review Committee gave timely and proper notice in this matter and have fulfilled all relevant substantive and procedural requirements of law and rules.

3. The Complaint Review Committee has the burden of proof to establish, by a preponderance of the evidence, the charges made against the Respondent under Minn. R. 1400.7300, subp. 5 (1995).

4. The Board hereby adopts and incorporates as its own the Conclusions in the ALJ's Report which supports that Respondent violated Minn. Stat. § 147.091, subd. 1(f), (g), (k), (l), (o), (q), (r), (s), (t) and (u) (1994).

Based on the foregoing Findings of Fact and Conclusions, the Board issues the following:

ORDER

1. NOW, THEREFORE, IT IS HEREBY ORDERED that the license of Respondent to practice medicine and surgery in the State of Minnesota is revoked immediately.

2. IT IS FURTHER ORDERED that Respondent shall pay $23,972.40 in costs to the Board within one (1) year of the date of this Order.

Dated: 23 Nov., 1996

STATE OF MINNESOTA
BOARD OF MEDICAL PRACTICE

M. J. Martin, MD
M.J. MARTIN
President

AFFIDAVIT OF SERVICE BY MAIL

Re: In The Matter of the Medical License of Dorothy L. Gray, M.D.
License No. 19,079

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

MARY L. REUTER, being first duly sworn, deposes and says:

That at the City of St. Paul, County of Ramsey and State of Minnesota, on November 25, 1996, she served the **Findings of Fact, Conclusions, and Final Order** by depositing the same in the United States mail at said city and state, a true and correct copy thereof, properly enveloped with prepaid first class postage, and addressed to:

Dorothy L. Gray, M.D.
1171 Valencia Street, Suite No. 4
San Francisco, CA 94110

Mary L. Reuter
MARY L. REUTER

Subscribed and sworn to before

me this November 25, 1996.

Patti Williams
Notary Public

AFFIDAVIT OF PERSONAL SERVICE

Re: In The Matter of the Medical License of Dorothy L. Gray, M.D.
License No. 19,079

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

MARY L. REUTER, being first duly sworn, deposes and says:

That at the City of St. Paul, County of Ramsey and State of Minnesota, on November 25, 1996, she personally served the **Finding of Fact, Conclusions, and Final Order** by handing to and leaving with Shanon Neary, 525 Park Street, Suite 200, St. Paul, Minnesota, a true and correct copy thereof addressed to:

Jennifer M. O'Brien
Assistant Attorney General
525 Park Street, Suite 200
St. Paul, Minnesota

Mary L. Reuter

Subscribed and sworn to before
me this November 25, 1996.

Patti K. Williams
Notary Public

PATTI K. WILLIAMS
NOTARY PUBLIC

CONTAINS NOT PUBLIC DATA

11-0903-10677-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE MINNESOTA BOARD OF MEDICAL PRACTICE

In the Matter of the Medical License of
Dorothy L. Gray, M.D.
Date of Birth: [redacted]
License Number: 1900079

FINDINGS OF FACT, CONCLUSIONS, AND RECOMMENDATION

This matter came on for hearing before Administrative Law Judge Barbara L. Neilson on Thursday, October 3, 1996, in Courtroom 1 of the Office of Administrative Hearings in Minneapolis, Minnesota. The record closed at the conclusion of the hearing on October 3, 1996.

Jennifer M. O'Brien, Assistant Attorney General, 525 Park Street, Suite 500, St. Paul, MN 55103-2106, appeared on behalf of the Board of Medical Practice ("the Board"). There was no appearance by or on behalf of the Respondent, Dorothy L. Gray, M.D., 1171 Valencia Street, Suite No. 4, San Francisco, CA 94110.

NOTICE

As provided in Minn. Stat. § 147.01, subd. 4 (1994), all records in this proceeding, including this Report, are confidential and privileged and are not public record, subject to certain exceptions. This Report is a recommendation, not a final decision. The Board will make the final decision after a review of the record. The Commissioner may adopt, reject or modify the Findings of Fact, Conclusions, and Recommendations. Under Minn. Stat. § 14.61, the final decision of the Board shall not be made until this Report has been made available to the parties to the proceeding for at least ten days. An opportunity must be afforded to each party adversely affected by this Report to file exceptions and present argument to the Board. Parties should contact Robert E. Leach, Executive Director, Minnesota Board of Medical Practice, Suite 106, 2700 University Avenue West, St. Paul, MN 55114, to ascertain the procedure for filing exceptions or presenting argument.

STATEMENT OF ISSUE

The issue in this matter is whether disciplinary action should be taken against the medical license of Respondent, Dorothy L. Gray, M.D., because of the conduct alleged in the Notice of and Order for Hearing.

Based upon all of the proceedings herein, the Administrative Law Judge makes the following:

FINDINGS OF FACT

1. The Notice of and Order for Hearing was issued in this matter on July 25, 1996, and served upon the Respondent on the same date by certified mail, return receipt requested, at 1171 Valencia Street, Suite 4, San Francisco, CA 94110. The Notice of and Order for Hearing informed the Respondent that a prehearing conference would be held on October 3, 1996, at 1:30 p.m. at the Office of Administrative Hearings in Minneapolis, Minnesota, and further informed the Respondent that "[f]ailure to [appear at the prehearing conference] may prejudice Respondent's rights in this proceeding and any subsequent proceedings related to this matter, may result in the allegations contained herein being taken as true, and may be the basis for disciplinary action against Respondent."

2. Counsel for the Board received a return receipt indicating that the envelope containing the Notice of and Order for Hearing sent to the Respondent was, in fact, accepted for delivery at 1171 Valencia Street, Suite 4, San Francisco, California, on August 5, 1996. The signature of the agent who signed the return receipt card is not legible. (Exhibit 1.)

3. The Respondent did not file any Notice of Appearance with the Administrative Law Judge or make any request prior to the prehearing conference for a continuance or any other relief. She also did not contact counsel for the Board after the Notice of and Order for Hearing was issued or have any attorney contact counsel for the Board on her behalf.

4. The Respondent did not personally appear at the prehearing conference in this matter scheduled for October 3, 1996, or have an appearance made on her behalf.

5. Because the Respondent failed to appear at the prehearing conference in this matter, she is in default.

6. Pursuant to Minn. R. 1400.6000 (1993), the allegations contained in the Notice of and Order for Hearing are hereby taken as true and incorporated into these Findings of Fact.

Based upon the foregoing Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS

1. The Board of Medical Practice and the Administrative Law Judge have jurisdiction in this matter pursuant to Minn. Stat. §§ 14.50, 147.091, 214.10, and 214.103 (1994).

2. The Notice of Hearings issued by the Board was proper and the Board has fulfilled all relevant substantive and procedural requirements of law and rule.

3. The Respondent, having made no appearance at the prehearing conference and not requesting any continuance or other relief, is in default. Pursuant to Minn. R. 1400.6000, the allegations contained in the Notice of and Order for Hearing are hereby taken as true.

4. The Respondent has violated Minn. Stat. § 147.091, subd. 1 (f), (g), (k), (l), (o), (q), (r), (s), (t), and (u) (1994) by virtue of the conduct described in the Notice of and Order for Hearing.

5. As a result of Conclusion 4 above, the conduct described in the Notice of and Order for Hearing constitutes grounds justifying the Board in suspending, revoking, conditioning, or limiting the Respondent's license to practice medicine in the State of Minnesota pursuant to Minn. Stat. §§ 147.091 and 147.141 (1994).

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

RECOMMENDATION

IT IS HEREBY RESPECTFULLY RECOMMENDED: That the Board of Medical Practice take disciplinary action against the medical license of Dorothy L. Gray, M.D.

Dated this 11th day of October, 1996.

Barbara L. Neilson

BARBARA L. NEILSON
Administrative Law Judge

Reported: Tape Recorded (1 tape)

NOTICE

Pursuant to Minn. Stat. § 14.62, subd. 1, the Agency is required to serve its final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

STATE OF MINNESOTA)
) ss
COUNTY OF HENNEPIN)

AFFIDAVIT OF SERVICE BY U.S. MAIL

Margaret K. Isleman, being first duly sworn, hereby deposes and says that on the 11th day of October, 1996, at the City of Minneapolis, county and state aforementioned, she served the attached FINDINGS OF FACT, CONCLUSIONS, AND RECOMMENDATION; OAH Docket No. 11-0903-10677-2 by depositing in the United States mail at said City of Minneapolis, a true and correct copy thereof, properly enveloped, with first class postage prepaid and addressed to the individuals named herein.

Robert E. Leach, Executive Director
Minnesota Board of Medical Practice
Suite 106, 2700 University Avenue West,
St. Paul, MN 55114

Jennifer M. O'Brien
Assistant Attorney General
525 Park Street, Suite 500
St. Paul, MN 55103-2106

Dorothy L. Gray, M.D.
1171 Valencia Street, Suite No. 4,
San Francisco, CA 94110

Margaret K. Isleman
Margaret K. Isleman

Subscribed and sworn to before me
this 11th day of October 1996.

Louise C. Cooper
Notary Public

LOUISE C. COOPER
NOTARY PUBLIC - MINNESOTA
My Comm. Expires Jan. 31, 2000

BEFORE THE MINNESOTA

BOARD OF MEDICAL PRACTICE

In the Matter of the
Medical License of
Dorothy L. Gray, M.D.
Date of Birth: [redacted]
License Number: 19,079

NOTICE OF AND
ORDER FOR HEARING

ALLEGATIONS

The facts alleged as the underlying basis for disciplinary action are as follows:

Introduction

1. On April 21, 1970, the Minnesota Board of Medical Practice (hereinafter Board) issued medical license 19,079 to Dorothy L. Gray (hereinafter Respondent). The Board also directed that a stipulation and order based on Respondent's chemical dependency and mental illness be issued at the same time. As a result, the Board issued a Stipulation and Order dated April 21, 1970, restricting Respondent's practice. On January 4, 1979, the Board issued a modification of the Stipulation and Order based on Respondent's progress in addressing her chemical dependency and mental illness issues. Upon evidence of Respondent's further improvement, the Board issued an unconditional license for Respondent to practice on February 25, 1981.

2. Since Respondent received her unconditional license in 1981, she has engaged in behavior with her patients and in her personal life which demonstrates a continued pattern of chemical dependency and mental illness problems that affect her practice of medicine.

3. Respondent's Minnesota license was placed on inactive/hold status on September 30, 1992.

4. Respondent currently lives and maintains an active medical license in California.

History of Respondent's Licensure

5. On April 18, 1969, Respondent applied for a license to practice medicine in Minnesota. Respondent based her application on reciprocity of her already active license in California.

6. Based on information provided by Respondent in her licensure application, the Board discovered that Respondent had been receiving alcohol treatment at the Willmar State Hospital Alcohol & Drug Addiction Unit pursuant to her history of a psychoneurotic disorder and abuse of alcohol. At the time of her application, Respondent had been employed for approximately one month with the facility as a Medical Trainer under close supervision of the medical staff. In light of the information provided on Respondent's application and by Respondent's treating physicians, Drs. Peterson and Larrabee, the Board asked Respondent and the Medical Director of the Willmar State Hospital, Dr. W. F. Larrabee, Jr., to meet with them to discuss Respondent's condition and its potential impact on her ability to practice medicine.

7. Respondent and Dr. Larrabee met with the Board on April 18, 1969 (April 1969 meeting). During the meeting, Respondent informed the Board she began abusing alcohol approximately four years earlier, when she was undergoing acute anxiety associated with depression. At that time she was hospitalized for her mental condition. In May 1968, Respondent was again hospitalized for psychiatric care at St. Mary's Hospital in Rochester, Minnesota, where she stayed for two and a half months. Following that hospitalization, she was again hospitalized for a week at St. Michael's Hospital in Milwaukee, Wisconsin. Respondent ultimately returned to Minnesota where she entered Winona Community Memorial Hospital for psychiatric care. Subsequently, in October 1968, she transferred to Willmar State Hospital for psychiatric and chemical dependency treatment.

8. During the April 1969 meeting, Dr. Larrabee described Respondent as "defensive" but improving. He stated that he did not feel Respondent was stable enough to engage in private practice, but he would recommend her for a license that restricted her practice to a structured, supervised environment.

9. During the April 1969 meeting, Respondent told the Board that she had no intention of engaging in private practice, but she would be satisfied with no less than a full, unrestricted license.

10. After considering the information provided during the April 1969 meeting, the Board offered Respondent a license restricted to practice in a supervised, structured setting. Respondent rejected the offer of licensure with restrictions, choosing instead to continue working in an unlicensed, "medical trainee" capacity at Willmar State Hospital.

11. In June 1969, Respondent transferred to Rochester State Hospital, where she was employed as a "medical student."

12. On December 27, 1969, Respondent wrote to the Board to ask for full licensure. The Board scheduled the matter for consideration on February 20, 1970.

13. On or about December 25, 1969, Respondent resumed her abuse of alcohol. Her supervisor, Dr. Francis A. Tyce, Medical Director at Rochester State Hospital, confronted Respondent about her drinking. Respondent then began attendance at Alcoholics Anonymous.

14. On February 20, 1970, Respondent and Dr. Tyce met with the Board to discuss Respondent's fitness for licensure in light of her psychiatric and alcohol-related problems. During the meeting, Dr. Tyce told the Board that Respondent continued to have episodes of depression and was under psychiatric care, in addition to being monitored by the Rochester State Hospital's Alcohol Counseling Office. Dr. Tyce believed that Respondent was capable of handling some medical practice, but he believed it essential that her practice be limited to a structured, supervised setting.

15. On April 21, 1970, the Board issued a restricted license to Respondent. Specifically, Respondent was restricted from private practice and allowed to practice only as a member of the Rochester State Hospital or some other state or federal public institution approved by the Board and only under the direction and supervision of the medical director of the institution.

16. From 1970 through 1977, Respondent continued to struggle with her psychiatric and substance-abuse problems, being repeatedly hospitalized and/or treated for those conditions as follows:

a. May 1973 through June 1973 at Rochester Methodist Hospital and the Mayo Clinic;

b. October 1973 through December 1973 at Rochester Methodist Hospital and Mayo Clinic;

c. February 1974 at Willmar State Hospital;

d. September 1976 at Metropolitan Medical Center Chemical Dependency Unit;

e. February 1977 at Metropolitan Medical Center Chemical Dependency Unit; and

f. April 1977 at Hazelden Treatment Center.

17. Between 1970 and 1977, Respondent's chemical abuse affected her employment as a physician. Specifically, in November 1973, the Board received information from Respondent's supervising physician, Dr. Larrabee, that Respondent's employment at the facility was in jeopardy due to her continuing alcohol abuse. Additionally, in February 1977, the St. Cloud Veteran's Administration Hospital dismissed Respondent due to the danger Respondent posed to patients as a result of her chemical abuse problems.

18. In July 1978, after approximately one year of sobriety, Respondent initiated efforts to have the restriction of her license modified by the Board. Specifically, Respondent sought to practice medicine outside the realm of state or federal facilities in any public or nonprofit facility that could guarantee the supervision and structure required by the Board.

19. On January 4, 1979, Respondent entered into a Stipulation and Order with the Board, modifying the restrictions on Respondent's medical license. The Stipulation and Order permitted Respondent to practice in a public or nonprofit institution, office or clinic where Respondent was supervised, had no direct access to controlled substances, and reported quarterly on her status of attendance at meetings, progress, employment and control of chemical dependency. The Stipulation and Order also required Respondent to meet with the Disciplinary Committee of the Board to review her progress under the terms and conditions of

the Stipulation and Order. Exhibit A attached hereto and incorporated by reference is a true and correct copy of the January 4, 1979, Stipulation and Order.

20. On October 31, 1980, Respondent requested Board issuance of an unconditional license. Respondent submitted evidence of her continued sobriety and progress in addressing her chemical dependency problems.

21. On February 25, 1981, the Board issued an Order for Respondent's unconditional license to practice medicine. Exhibit B attached hereto and incorporated by reference is a true and correct copy of the February 25, 1981, Order.

Respondent's Conduct and Practice Subsequent to Receipt of Her Unrestricted License

22. In October 1983, Respondent left her position with the Tomah V.A. Hospital, where she had been a staff physician since July 1979. Respondent returned to the Twin Cities and maintained a private practice from 1983 through 1992.

23. From January 1984 through May 1993, Respondent regularly saw psychotherapist Rebecca L. Zuckweiler. During the time Zuckweiler treated Respondent, Respondent suffered from very severe clinical depression with accompanying panic attacks, thus rendering Respondent unable to attend to her own personal daily living needs or function in an employment capacity. In approximately 1985, Respondent became extremely dependent on an unlicensed therapist, seeing the therapist approximately four times a week. Over Respondent's refusal, the therapist repeatedly encouraged Respondent to address her drug use and to obtain a psychiatrist. Ultimately, upon the unlicensed therapist's threat to end therapy if Respondent did not seek the services of a psychiatrist, Respondent complied. Respondent, however, supplemented the psychiatrist's prescriptions with her own medications.

24. Between 1983 and 1992, Respondent, without ever obtaining formal training in psychiatry, provided psychiatric services and treatment. Respondent prescribed controlled substances to individuals suffering from posttraumatic stress disorder and affective disorders, particularly, depression. An advertisement describing Respondent's practice listed the

following: "abuse," "addiction," "reiki," "loss," "eating disorders," "grief," "relationships," and "guided imagery." Respondent's training in psychiatry consisted of an "Independent in-depth study of scientific literature (from 1965-present) on treatment of Refractory Depression and PTSD, [with] focus on chemotherapeutic augmentation of traditional antidepressant regimens." Respondent's curriculum vitae failed to reflect any formal training in psychiatry.

Respondent's Employment History

25. From approximately 1985 to 1987, Respondent rented space from Associated Resources in Psychology (ARP), Little Canada, Minnesota, to practice medicine, including psychiatry. ARP terminated its lease with Respondent based on Respondent's deteriorating condition of chemical use, depression and the questionable character of her practice. During this time Respondent appeared glassy-eyed, sleepy, shaky, and confused. The foregoing signs were infrequent at first; however, they became almost constant toward the end of her relationship with ARP. Additionally, the following occurred:

a. On more than one occasion, Respondent slept at her desk.

b. On a regular basis, Respondent took a handful of different pills at lunch.

c. Respondent maintained a locked storage closet full of drugs in her office.

d. On one or more occasions, Respondent overtly talked about her suicidal desires, specifically suicide by overdose.

e. On one or more occasions, Respondent implied suicidal desires, specifically speaking about dying and having no reason to live.

26. From 1985 to 1987, Respondent utilized the following prescribing mechanisms:

a. Respondent prescribed thyroid supplements to patients to potentiate the effect of antidepressants like Imipramine and Desyrel and did not perform blood tests on those patients.

b. Respondent treated her own depression with antidepressants, thyroid supplements, and amphetamines.

c. Respondent had been writing prescriptions for fictitious patients and then having the prescriptions filled for her own use.

27. On one or more occasions, Respondent's home revealed the following:

a. The house was filled with debris, preventing visibility of the floor.

b. Respondent owned a pet dog, cat and bird. Each animal defecated throughout the house, and Respondent had not removed the feces.

c. On one occasion, approximately 150 to 200 amber-colored pill bottles and patients' brown pill bottles with patient names on the labels were strewn about Respondent's homestead.

d. Respondent's living room and kitchen were so cluttered that one could not walk through the rooms.

e. Respondent routinely kept a plethora of empty pop cans lying around her living room and kitchen.

f. Respondent's bedroom was filled with boxes of drugs. On more than one occasion, Respondent came out of her bedroom and acknowledged that she had taken pills.

28. In 1989, residents of the Fellowship Club cleaned Respondent's basement and discovered a box containing drugs. One resident returned from Respondent's house under the influence of drugs. The resident reported that he had taken tranquilizers from Respondent's basement and that the drugs were all benzodiazepine samples.

29. Respondent was employed at Tomah VA Medical Center, Tomah, Wisconsin ("Tomah VA"), on the following three occasions:

a. From June 18, 1974, to January 3, 1976;

b. From July 29, 1979, to October 15, 1983; and

c. From February 25, 1990, to May 15, 1991.

30. During Respondent's employment from February 1990 to May 1991 with the Tomah VA, Respondent was the subject of a formal investigation which resulted in her

removal from Psychiatric Services to a general medical position as Officer of the Day. During the investigation the following occurred:

a. In December 1990, the Tomah VA Administration Investigation Board began an investigation of Respondent's performance. The investigation focused on five primary "areas of concern":

1) Polypharmacy;

2) Whether inpatients were receiving inadequate care;

3) Whether Respondent's professional judgment was sound;

4) Whether there were problems with Respondent's communication of treatment plan changes to the Interdisciplinary Team ("Team"); and

5) Whether Respondent's work was being completed in a timely fashion.

b. In a memorandum dated January 4, 1991, the Chairperson of the Investigation Team reported the investigative findings to the Tomah Medical Director. The Team concluded:

1) Polypharmacy was a problem in Respondent's practice. Specifically, the Team discovered Respondent:

a) Prescribed to patients simultaneously multiple tricyclic antidepressants and multiple antipsychotic medications;

b) Prescribed to other patients simultaneously desipramine, imipramine, propranolol, lithium and cytomel without a step-wise addition of drugs given over a proper time trial;

c) Failed to document clinical indications for medication usage;

d) Failed to order serum levels when prescribing desipramine and imipramine; and

e) Prescribed multiple medications on the basis of one patient interview.

2) Respondent's inpatients received less than adequate care because Respondent preferred outpatient care and maintained irregular and inadequate scheduling of hours. In addition, the Team noted that Respondent would often be late for staff meetings, and a number of the meetings were canceled due to her absence.

3) Respondent was not communicating changes in patients' treatment plans to the Interdisciplinary Team.

4) Respondent was considerably behind in her paperwork, even though many medical records needed only her signature for proper disposition.

5) Respondent received no formal psychiatric training during the course of her professional career.

c. On January 31, 1991, Respondent was relieved of her responsibilities on Psychiatric Services and reassigned to a general medical position as Officer of the Day.

31. In 1987, Respondent practiced psychiatry out of her St. Paul, Minnesota, home. From February 1990 to May 1991, while still employed at the Tomah VA, Respondent conducted weekend evaluations of Vietnam veterans residing in Minnesota and Wisconsin. Respondent maintained a reputation for readily diagnosing Vietnam veterans with posttraumatic stress disorder and writing a letter to Social Security recommending that the veteran receive total disability payments.

32. Upon being fired from Tomah V.A. Hospital in May 1991, Respondent returned to private practice full-time, seeing patients at her home in St. Paul, Minnesota. Respondent's behavior deteriorated, becoming more confused and unkempt. In the winter of 1991, Respondent admitted to treating herself for depression with 80 mg. of Prozac, daily.

33. In late 1991 or early 1992, Respondent admitted she was writing Prozac prescriptions for a patient on Medicaid and instructing the patient to get the prescription filled for Respondent's use.

34. Patients who saw Respondent in 1991 and 1992 felt uncomfortable with her behavior, noting that she seemed heavily medicated and withdrawn. During this time, Respondent was taking Prozac as well as a high dose of Trazadone.

35. During interviews on November 10 and 24, 1992, Respondent claimed she had been free of all medication prescribed for depression since February 1990, and she denied ordering any controlled substances (other than Xanax) from pharmaceutical manufacturers, distributors or drug representatives. However, documentation from Eli Lilly and Company, the Upjohn Company, and Interstate Drug Exchange, Inc., showed that Respondent ordered Prozac, Ansaid, Didrex and Prelu-2 (the latter two being amphetamines) to be delivered to her residence between January 1989 and August 1992.

36. During the November 10, 1992, interview, Respondent acknowledged using massage therapy, hypnosis, age regression and Reiki therapy, as well as prescription medication in treating her patients. Respondent described Reiki therapy as "the laying of hands on the head, hands, back and feet of the client." Respondent hypnotized patients, told them they lived "past lives" and talked about the guru, Shakti Gawain, when treating them.

37. During the November 10, 1992, interview, Respondent also stated she did not maintain chart notes regarding patients.

38. During the November 24, 1992, interview, Respondent questioned the veracity of the medication orders attributed to her. On December 15, 1992, Respondent advised that she would arrange a time to provide a handwriting sample to enable an assessment of whether Respondent had placed such orders. On December 21, 1992, Respondent refused to provide any handwriting sample. Respondent made a decision not to keep an appointment scheduled for December 22, 1992, with the investigator.

39. In May 1993, Respondent moved from Minnesota with the stated intent to continue her practice of psychiatric medicine in California. Respondent maintains a current license to practice medicine in the State of California.

Respondent's Treatment of Specific Patients

40. Patient #1 is a female whose diagnoses included depression and anorexia. Respondent provided treatment for patient #1 from 1985 to 1992. Respondent engaged in the following conduct with patient #1:

a. From September 14, 1988, to August 12, 1992, Respondent prescribed Prozac for patient #1, despite the precaution that Prozac could cause significant weight loss in underweight, depressed patients. Respondent's primary diagnosis of patient #1 was major depression with anorexic features. In November 1988, two months after Respondent began prescribing Prozac for patient #1, patient #1's weight fell below 100 pounds. Respondent continued the prescription.

b. Respondent failed to document numerous prescriptions she wrote for patient #1.

c. Respondent disclosed to patient #1 that Respondent had been self-treating her depression since 1982 by self-prescribing Prozac, Imipramine and Desyrel.

d. On one or more occasions, Respondent took her medication in front of patient #1. Shortly after taking the medication, Respondent's eyes rolled up in her head and Respondent fell asleep.

e. Patient #1 observed Respondent take a number of drugs simultaneously.

f. Patient #1 observed boxes of medications in Respondent's home, including samples.

41. Patient #2 is a 49-year-old man whose diagnosis was never charted by Respondent. Respondent provided treatment for patient #2 from May 6, 1991, to July 1992. Respondent engaged in the following conduct with patient #2:

a. Respondent first saw patient #2 on May 6, 1991, to prescribe medication and monitor its effects.

1) Respondent instructed patient #2 to continue seeing his counselor for psychotherapy. Blue Cross Blue Shield payment records indicate Respondent provided both medication management and psychotherapy to patient #2 in 1991 and 1992.

2) Respondent failed to schedule the frequency of patient #2's medication checks, thereby leaving it to the patient's discretion.

3) Respondent continued refilling patient #2's Prozac and Trazodone prescriptions until July 1992 even though patient #2 discontinued his appointments with Respondent in March 1992.

b. Respondent failed to document the following information in patient #2's chart:

1) A diagnosis;

2) A statement of symptoms;

3) A treatment plan;

4) An assessment;

5) An observation; and

6) Notes of visits by the patient.

c. Respondent transgressed physician/patient boundaries, constituting departures from the minimal standards of acceptable and prevailing medical practice as follows:

1) Respondent conducted patient #2's appointments in a back room of Respondent's home.

2) After seeing Respondent for two to three months, patient #2's sessions with Respondent consisted of lengthy discussions between Respondent and patient #2 resulting in the following:

a) Patient #2 felt as if he and Respondent were friends.

b) Respondent disclosed personal information to patient #2 (that Respondent was chemically dependent and had been fired from Tomah VA in

Wisconsin). Respondent also discussed her previous marriage, her relationship with her father, and her lesbianism. Even though the medication check was scheduled to last 10 to 15 minutes, patient #2 frequently spent two to two and one-half hours at his appointments with Respondent.

c) During patient #2's appointments, Respondent acted very fey, overreacted and, on occasion, used faulty logic.

d) In January 1992, patient #2's insurance company sent Respondent a check for $160. Patient #2 previously paid Respondent for appointments. Under their agreement, Respondent would reimburse patient #2 upon receipt of the insurance check. Respondent, however, withheld the insurance money, reimbursing patient #2 only after he became angry and confronted Respondent.

e) Respondent discussed having Christmas dinner with patient #2 in 1991; these plans did not materialize. However, Respondent admitted that she went to dinner with patient #2 on two or three separate occasions.

f) In approximately January 1991, at Respondent's request, patient #2 drove Respondent to Sears so she could pick up her car.

d. Respondent employed therapies with patient #2 which departed from the minimal standards of acceptable and prevailing medical practice as follows:

1) Respondent utilized methods similar to hypnosis in which she put patient #2 in a relaxed state with his eyes closed.

2) Respondent utilized age-regression therapy with patient #2.

3) Respondent performed energy balancing on patient #2.

4) Respondent spoke of a guru named Shakti Gawain and performed "chakra therapy" on patient #2. During chakra therapy, Respondent touched patient #2's "energy points" and "focused the earth energy" to patient #2. Respondent performed "chakra therapy" on patient #2 five or six times, with the first time being in late November 1991.

42. Patient #3 (DOB: [redacted]) is a woman whose diagnosis included anorexia and depression. Respondent provided treatment for patient #3 from June 11, 1985, to September 8, 1992. Respondent engaged in the following conduct with patient #3:

a. From 1985 to 1992, Respondent prescribed medication to patient #3 as follows:

Date	Drug	Quantity
08/23/85	Imipramine 25 mg.	30
09/11/85	Imipramine 50 mg.	60
10/09/85	Imipramine 25 mg.	60
10/09/85	Imipramine 10 mg.	60
11/22/85	Imipramine 50 mg.	60
11/22/85	Imipramine 10 mg.	60
01/03/86	Imipramine 50 mg.	60
01/03/86	Imipramine 10 mg.	60
02/14/86	Imipramine 50 mg.	90
02/14/86	Imipramine 10 mg.	30
04/04/86	Imipramine 10 mg.	60
11/14/86	Desyrel (Trazodone) 50 mg.	15
11/20/86	Desyrel (Trazodone) 50 mg.	25
11/24/86	Desyrel (Trazodone) 50 mg.	30
12/05/86	Desyrel (Trazodone) 50 mg.	60
12/12/86	Desyrel (Trazodone) 100 mg.	60
01/06/87	Desyrel (Trazodone) 100 mg.	120
01/12/87	Norpramin (Desipramine) 10 mg	15
01/19/87	Norpramin (Desipramine) 10 mg	30
01/26/87	Norpramin (Desipramine) 10 mg.	32
01/26/87	Desyrel (Trazodone) 100 mg.	120
02/02/87	Norpramin (Desipramine) 25 mg.	16
02/09/87	Norpramin (Desipramine) 25 mg.	16
02/09/87	Norpramin (Desipramine) 10 mg.	10
02/16/87	Norpramin (Desipramine) 25 mg.	15
02/16/87	Norpramin (Desipramine) 10 mg	21
02/23/87	Norpramin (Desipramine) 25 mg.	45
03/02/87	Norpramin (Desipramine) 25 mg.	30
03/09/87	Desyrel (Trazodone) 100 mg.	120
03/16/87	Norpramin (Desipramine) 25 mg.	60
03/16/87	Norpramin (Desipramine) 10 mg.	30
03/30/87	Norpramin (Desipramine) 50 mg.	60
03/30/87	Norpramin (Desipramine) 10 mg.	90
04/06/87	Desyrel (Trazodone) 100 mg.	120
04/21/87	Norpramin (Desipramine) 50 mg.	30
04/21/87	Norpramin (Desipramine) 10 mg.	40
04/27/87	Norpramin (Desipramine) 50 mg.	30
05/04/87	Norpramin (Desipramine) 50 mg.	90
05/04/87	Desyrel (Trazodone) 100 mg.	120
05/11/87	Norpramin (Desipramine) 10 mg.	60
07/02/87	Norpramin (Desipramine) 50 mg.	120
07/02/87	Desyrel (Trazodone) 100 mg.	120
08/04/87	Norpramin (Desipramine) 50 mg.	120

08/04/87	Norpramin (Desipramine) 50 mg.	120
08/04/87	Desyrel (Trazodone) 100 mg.	90
08/04/87	Desyrel (Trazodone) 50 mg.	30
09/16/87	Norpramin (Desipramine) 25 mg.	60
10/21/87	Norpramin (Desipramine) 25 mg.	90
10/21/87	Norpramin (Desipramine) 50 mg.	120
11/04/87	Desyrel (Trazodone) 100 mg.	90
11/11/87	Imipramine 25 mg.	100
11/11/87	Norpramin (Desipramine) 50 mg.	100
11/18/87	Norpramin (Desipramine) 100 mg.	90
12/01/87	Desyrel (Trazodone) 100 mg.	90
12/09/87	Cytomel 5 mcg.	30
01/19/88	Cytomel 5 mcg.	120
01/19/88	Norpramin (Desipramine) 50 mg.	180
02/03/88	Desyrel (Trazodone) 50 mg.	180
02/15/88	Cytomel 25 mg.	30
02/15/88	Norpramin (Desipramine) 100 mg.	90
03/09/88	Desyrel (Trazodone) 100 mg.	60
04/20/88	Cytomel 25 mg.	30
04/20/88	Cytomel 5 mcg.	120
05/25/88	Cytomel 25 mg.	30
05/25/88	Cytomel 5 mcg.	120
06/08/88	Desyrel (Trazodone) 100 mg.	60
06/29/88	Desyrel (Trazodone) 100 mg.	60
07/13/88	Norpramin (Desipramine) 25 mg.	60
07/13/88	Norpramin (Desipramine) 100 mg.	30
07/27/88	Cytomel 25 mg.	30
07/27/88	Cytomel 5 mcg.	120
08/10/88	Norpramin (Desipramine) 100 mg.	60
09/14/88	Prozac 20 mg.	10
09/28/88	Prozac 20 mg.	100
10/12/88	Cytomel 25 mg.	60
10/26/88	Prozac 20 mg.	90
11/21/88	Prozac 20 mg.	90
11/21/88	Cytomel 25 mg.	60
12/09/88	Cytomel 25 mg.	60
01/18/89	Prozac 20 mg.	120
01/18/89	Cytomel 25 mg.	90
03/01/89	Prozac 20 mg.	120
03/01/89	Cytomel 25 mg.	60
04/26/89	Prozac 20 mg.	120
04/26/89	Cytomel 25 mg.	60
05/24/89	Prozac 20 mg.	120
05/24/89	Cytomel 25 mg.	60
06/02/89	Prozac 20 mg.	120
06/21/89	Cytomel 5 mcg.	60
08/23/89	Prozac 20 mg.	120
08/23/89	Cytomel 25 mg.	60
10/18/89	Cytomel 25 mg.	60
11/29/89	Prozac 20 mg.	90
01/03/90	Cytomel 25 mg.	60
03/24/90	Prozac 20 mg.	120
03/24/90	Cytomel 25 mg.	60
06/16/90	Prozac 20 mg.	120
06/16/90	Cytomel 25 mg.	60

06/16/90	Norpramin (Desipramine) 25 mg.	30
01/27/91	Norpramin (Desipramine) 25 mg.	120
05/19/91	Cytomel 25 mg.	60
10/07/91	Cytomel 25 mg.	60
02/21/92	Cytomel 25 mg.	60
05/09/92	Prozac 20 mg.	120
05/09/92	Cytomel 25 mg.	60
05/19/92	Prozac 20 mg.	120
06/29/92	Prozac 20 mg.	90
06/29/92	Cytomel 25 mg.	60
07/23/92	Cytomel 5 mcg.	60
08/12/92	Prozac 20 mg.	90
08/12/92	Cytomel 25 mg.	60

Respondent repeatedly failed to give patient #3 adequate amounts of medication to last to the next appointment, thus requiring patient #3 to schedule and pay for extra appointments.

b. Respondent failed to keep accurate documentation in patient #3's chart, specifically:

1) Respondent failed to reference patient #3's medication in 152 of 189 chart entries in the patient's chart.

2) On August 23, 1985, Respondent charted as follows: "Aventyl--took as soon as she got home last Wednesday--took two sinus tabs. Wednesday--took Aventyl 25 mg. at 3 p.m. Thursday--took Aventyl 25 mg. at 3-4 p.m." However, Respondent failed to document in the patient's chart that Respondent had prescribed Aventyl.

3) On August 23, 1985, Respondent prescribed Imipramine 25 mg. to patient #3 but failed to document it in the physician's notes.

4) On September 11, 1985, Respondent increased patient #3's Imipramine dosage to 50 mg. but failed to document it in the physician's notes.

5) On October 9, 1985, Respondent increased patient #3's Imipramine dosage to 60 mg. but failed to document it in the physician's notes.

6) On October 23, 1985, Respondent increased patient #3's Imipramine dosage to 75 and 85 mg. but failed to document it in the physician's notes.

7) On March 14, 1986, Respondent failed to chart which drug Respondent dosed at 150 mg. as follows: "Currently on 150 mg. daily. Still thinks about diet pills."

c. Respondent stated the following with respect to patient #3:

1) Respondent prescribed Cytomel to patient #3 because Respondent believed Cytomel enhanced the effects of antidepressants such as the tricyclic or the selective serotonin reuptake inhibitors.

2) Respondent thought patient #3 may have had subclinical hypothyroidism, hypothyroidism that conventional laboratory tests cannot identify. However, Respondent failed to order any thyroid tests on patient #3.

3) On several occasions Respondent took only the patient's blood pressure during an appointment.

4) Respondent failed to order any electrolytes on patient #3.

d. Respondent employed therapies with patient #3 which departed from the minimal standard of acceptable and prevailing medical practice as follows:

1) Respondent gave patient #3 books on Reiki, which involved "opening up chakras and letting energy flow through them."

2) Respondent performed Reiki toward the end of patient #3's treatment.

3) On one or more occasions, Respondent performed past-life regression on patient #3, where Respondent brought patient #3 back to a former life.

e. Respondent transgressed physician/patient boundaries, constituting departure from the minimal standard of acceptable and prevailing medical practice as follows:

1) During the summer and fall of 1991, Respondent dined with patient #3, including a dinner with patients #3 and #4 at the Red Lobster restaurant on Respondent's birthday.

2) Respondent admitted accompanying patient #3 to a doll exhibition.

3) During patient #3's appointments, Respondent disclosed personal information. Respondent told patient #3 that Respondent had depression and anorexia.

4) On one occasion, patient #3 told Respondent that her shoulder hurt. Respondent told patient #3 that she had bursitis in her shoulder and instructed patient #3 to lie down on a table where Respondent massaged the patient's shoulder, back and feet.

5) Respondent and patient #3 shopped together in St. Paul and at Cub Foods.

6) On more than one occasion, at Respondent's request, patient #3 dropped Respondent off at Sears to pick up her car.

7) Respondent visited patient #3 at the patient's house.

8) On one or more occasions, Respondent allowed patient #3 to work off her bill by cleaning Respondent's house and garage.

9) On one occasion, when Respondent and patient #3 shopped at Cub Foods together, Respondent told patient #3 to not call her Dorothy. Respondent then proceeded to pick up a prescription at the pharmacy under the name "Mary."

10) Patient #3 observed boxes of Xanax in Respondent's basement.

43. Patient #4 (DOB: [redacted]) is a woman whose diagnosis included depression. Respondent provided treatment for patient #4 from April 25, 1989, to September 9, 1992.

a. From May 10, 1989, to May 31, 1992, Respondent prescribed the following medications for patient #4:

Date	Drug	Quantity
05/10/89	Prozac 20 mg.	90
05/10/89	Pamelor 25 mg.	59
06/23/89	Prozac 20 mg.	30
07/19/89	Prozac 20 mg.	60
07/26/89	Cytomel 25 mcg.	30
08/11/89	Prozac 20 mg.	60
08/11/89	Cytomel 25 mcg.	30
08/15/89	Cytomel 25 mcg.	90
09/07/89	Prozac 20 mg.	60
09/07/89	Cytomel 25 mcg.	90
10/26/89	Cytomel 25 mcg.	60

12/11/89	Cytomel 25 mcg.	60
01/30/90	Cytomel 25 mcg.	60
04/16/90	Cytomel 25 mcg.	60
05/17/90	Cytomel 25 mcg.	60
07/05/90	Cytomel 25 mcg.	60
08/08/90	Cytomel 25 mcg.	60
09/27/90	Cytomel 25 mcg.	60
11/03/90	Cytomel 25 mcg.	60
12/15/90	Cytomel 25 mcg.	90
01/04/91	Cytomel 25 mcg.	90
02/10/91	Cytomel 25 mcg.	80
02/23/91	Prozac 20 mg.	120
03/17/91	Trazodone 50 mg.	30
04/02/91	Trazodone 50 mg.	30
04/21/91	Cytomel 25 mcg.	30
04/21/91	Trazodone 50 mg.	60
05/22/91	Trazodone 50 mg.	60
07/07/91	Diphenhydramine 25 mg.	50
07/09/91	Diphenhydramine 25 mg.	50
07/20/91	Dimenhydrinate 50 mg.	100
08/19/91	Cytomel 25 mcg.	90
08/19/91	Dimenhydrinate 50 mg.	90
09/17/91	Prozac 20 mg.	60
11/29/91	Trazodone 50 mg.	100
11/29/91	Cytomel 5 mcg.	120
12/10/91	Cytomel 25 mcg.	60
12/10/91	Stelazine 1 mg.	120
12/10/91	Anafranil 25 mg.	120
01/16/92	Cytomel 5 mcg.	120
01/16/92	Stelazine 1 mg.	120
01/16/92	Anafranil 25 mg.	120
01/31/92	Cytomel 25 mcg.	100
02/18/92	Cytomel 5 mcg.	120
02/18/92	Anafranil 25 mg.	240
04/20/92	Prozac 20 mg.	120
04/20/92	Cytomel 5 mcg.	180
04/20/92	Stelazine 1 mg.	120
04/20/92	BuSpar 10 mg.	120
05/31/92	Prozac 20 mg.	120
05/31/92	Cytomel 5 mcg.	120
05/31/92	Anafranil 25 mg.	240
05/31/92	BuSpar	240
07/19/92	Stelazine 1 mg.	120
08/04/92	Prozac 20 mg.	120
08/26/92	Anafranil 25 mg.	240

From July 7 to July 9, 1991, Respondent prescribed 100 doses of Diphenhydramine 25 mg. for patient #4, amounting to an average of fifty tablets per day.

b. Respondent failed to maintain adequate records in patient #4's chart, specifically:

1) Respondent charted twenty-six appointments with patient #4 in 1989. In eighteen of the twenty-six entries, Respondent failed to document prescriptions or medication effects or changes.

2) Respondent charted eighteen appointments with patient #4 in 1990. In sixteen of the eighteen entries, Respondent failed to document prescriptions or medication effects or changes.

3) Respondent charted twenty-six appointments with patient #4 in 1991. In fourteen of the twenty-six entries, Respondent failed to document prescriptions or medication effects or changes.

4) Respondent charted thirteen appointments with patient #4 in 1992. In seven of the thirteen entries, Respondent failed to document prescriptions or medication effects or changes.

5) On April 25, 1989, Respondent prescribed Prozac 20 mg. daily and Nortriptyline 125 mg. daily for patient #4. Respondent failed to document these prescriptions in the physician's notes.

6) On May 22, 1989, Respondent prescribed Prozac 60 mg. to patient #4. Respondent failed to document that she increased the patient's Prozac dosage in the physician's notes.

7) On July 26, 1989, Respondent prescribed Cytomel 25 mcg. for patient #4. On August 2, 1989, Respondent increased the Cytomel dosage to 50 mcg. daily and on August 9, 1989, again increased the Cytomel dosage to 75 mcg. daily. Respondent failed to document the medication increases in the physician's notes.

8) On September 13, 1989, Respondent decreased patient #4's Prozac dosage to 20 mg. Respondent failed to document this change in the physician's notes.

9) On October 18, 1989, Respondent discontinued Prozac for patient #4. Respondent failed to document this change in the physician's notes.

10) On November 21, 1989, Respondent decreased patient #4's Cytomel dosage from 50 mcg. to 37.5 mcg. Respondent failed to document this change in the physician's notes.

11) On January 19, 1990, Respondent increased patient #4's Cytomel dosage from 37.5 mcg to 50 mcg. Respondent failed to document this change in the physician's notes.

12) On March 16, 1991, Respondent documented in patient #4's chart: "Went off Prozac. Got too edgy with the combination of Cytomel 50 mcg. daily and Prozac 20 mg. every other day." Respondent failed to document in the physician's notes that the patient had resumed taking Prozac.

c. Respondent failed to maintain any consultation letters or hospitalization records in patient #4's chart.

d. Respondent dined with patient #4 on at least two occasions.

44. Patient #5 (DOB: [redacted]) is a woman whose diagnoses included depression, anorexia, anxiety and panic attacks. Respondent provided treatment for patient #5 from October 4, 1989, to February 9, 1990, as follows:

a. From January 15, 1990, to May 7, 1990, Respondent prescribed the following medications to patient #5:

Date	Drug	Quantity
01/15/90	BuSpar 10 mg.	90
01/18/90	Elavil (Amitriptyline) 10 mg.	30
01/18/90	Prozac 20 mg.	30
01/24/90	BuSpar 10 mg.	180
01/24/90	Elavil (Amitriptyline) 25 mg.	30
02/01/90	Elavil (Amitriptyline) 25 mg.	30
02/01/90	Benadryl 25 mg.	24
02/14/90	Cytomel 25 mcg.	30
02/19/90	BuSpar 10 mg.	180
02/19/90	Benadryl 25 mg.	24
02/21/90	Pamelor (Nortriptyline) 25 mg.	30
02/27/90	Desyrel (Trazodone) 50 mg.	60
03/05/90	Prozac 20 mg.	30
05/07/90	BuSpar 10 mg.	84

b. Respondent failed to maintain adequate records in patient #5's chart, specifically:

1) On October 4, 1989, Respondent prescribed Cytomel 25 mcg. for patient #5. Respondent failed to document the prescription in the physician's notes.

2) On October 4, 1989, Respondent prescribed Desyrel 50 mg. for two days and on day three an increase to 100 mg. for patient #5. Respondent failed to document the prescription or substantiate the increased dosage in the physician's notes.

3) On October 18, 1989, Respondent increased the dosage of Desyrel from 100 mg. to 180 mg. However, Respondent failed to document the prescription or substantiate the reason the dosage was increased in the physician's notes.

4) On October 18, 1989, Respondent increased the dosage of Desipramine from 50 mg. to 100 mg. Respondent failed to document the prescription or substantiate the increased dosage in the physician's notes.

5) On November 22, 1989, Respondent prescribed BuSpar 10 mg. for patient #5. Respondent failed to document and substantiate the prescription in the physician's notes.

6) On January 18, 1990, Respondent prescribed Prozac 10 mg. for patient #5. Respondent failed to document it in the physician's notes.

7) On January 18, 1990, Respondent prescribed Amitriptyline 10 mg. for patient #5. Respondent failed to document the prescription in the physician's notes until February 1, 1990.

8) On February 1, 1990, Respondent prescribed Benadryl 25 mg. for patient #5. Respondent failed to document the prescription in the physician's notes until February 9, 1990.

9) Although Respondent's last chart entry for patient #5 was on February 9, 1990, the pharmacy continued to fill Respondent's prescriptions under patient #5's name until May 7, 1990.

10) Respondent failed to document any consultant notes in the patient's chart.

11) Although Respondent stated she may have discussed the patient's laxative use and possible electrolyte imbalance with a psychologist, Respondent failed to document the discussion.

45. Patient #6 (DOB: [redacted] is a woman whose diagnosis was never charted by Respondent but provided by the patient and recorded by Respondent as manic depression. Respondent provided treatment from July 27, 1989, to May 7, 1990, as follows:

a. From February 5, 1990, to June 6, 1990, Respondent simultaneously prescribed the following medications to patient #6:

Date	Drug	Quantity
02/05/90	Prozac 20 mg.	60
02/05/90	Lithobid 300 mg.	150
02/05/90	Disobrom 120/6	60
02/28/90	Prozac 20 mg.	60
02/28/90	Lithobid 300 mg.	150
02/28/90	Disobrom 120/6	60
03/12/90	Prozac 20 mg.	120
03/12/90	Lithobid 300 mg.	150
03/12/90	Disobrom 120/6	60
04/02/90	Disobrom 120/6	60
04/18/90	Prozac 20 mg.	120
04/27/90	Disobrom 120/6	60
05/04/90	Lithobid 300 mg.	150
05/18/90	Prozac 20 mg.	120
06/06/90	Lithobid 300 mg.	150

1) Patient #6's average daily intake of Prozac 20 mg. was 4.7 and of Lithobid 300 mg. was 6.2.

2) Although Respondent's last chart entry for patient #6 was on January 22, 1990, the pharmacy continued to fill Respondent's prescriptions under patient #6's name until June 6, 1990.

3) Respondent failed to appropriately manage patient #6's medication, specifically:

a) On July 27, 1989, Respondent prescribed Lithobid 600 mg. PO in a.m. and 900 mg. PO at HS simultaneously with Prozac 20 mg. PO qd. Respondent failed to order a Lithium level and failed to record the prescriptions in the physician's notes.

b) On September 21, 1989, Respondent prescribed Lithobid 600 mg. in a.m. and 900 mg. in p.m. simultaneously with Prozac 40 mg. PO qd. Respondent failed to order a Lithium level and failed to record the prescriptions in the physician's notes.

c) On November 1, 1989, Respondent prescribed Lithobid 600 mg. PO in a.m. and 900 mg. PO in HS simultaneously with Prozac 20 mg. PO BID. Respondent failed to order a Lithium level and failed to record the prescriptions in the patient's chart.

d) In February 1990, Respondent continued to prescribe Lithobid 300 mg. simultaneously with Prozac 20 mg. and failed to order a Lithium level for patient #6.

e) In March 1990, Respondent continued to prescribe Lithobid 300 mg. simultaneously with Prozac 20 mg. and failed to order a Lithium level for patient #6.

f) In May 1990, Respondent continued to prescribe Lithobid 300 mg. simultaneously with Prozac 20 mg. and failed to order a Lithium level for patient #6.

g) From January to June 1990, Respondent continued to prescribe medications for patient #6 without assessing the patient.

b. Respondent failed to maintain adequate records in patient #6's chart, specifically:

1) The only diagnosis in patient #6's chart was provided by the patient: manic depression since 1984.

2) On July 29, 1989, Respondent prescribed Desyrel 50 mg. for patient #6 but failed to document that they met for therapy.

3) On January 22, 1990, Respondent ordered a Lithium level for patient #6; however, Respondent failed to document the result in the patient's chart.

46. Patient #7 (DOB: [redacted]) is a woman whose diagnoses included depression, anxiety and panic attacks. Respondent provided treatment from August 1989 to May 1990 as follows:

a. From February 13 to June 14, 1991, Respondent prescribed the following medications to patient #7:

Date	Drug	Quantity
02/13/91	Desyrel 150 mg.	15
02/13/91	Prozac 20 mg.	90
03/08/91	Prozac 20 mg.	90
04/27/91	Prozac 20 mg.	90
06/14/91	Desyrel 150 mg.	15
06/14/91	Prozac 20 mg.	90

Although Respondent charted appointments for patient #7 from August 1989 to May 19, 1990, the pharmacy continued to fill Respondent's prescriptions under the name of patient #7 until June 14, 1991. For over a year, Respondent continued to prescribe medications without assessing patient #7.

b. Respondent charted that from August 1989 to May 1990, Respondent saw patient #7 on eight occasions, after the initial intake assessment. Respondent failed to adequately document the patient's chart in that:

1) Respondent made only one entry with respect to medication.

2) Respondent failed to document any monitoring procedures.

c. Respondent stated that she focused on patient #7's shame and followed Kaufman's theories regarding self-esteem and the "here and now" (referring to Gershen Kaufman's Shame, The Power of Caring). Respondent stated: "I deal with feelings. It's really important to allow people to have bad feelings and not be judgmental. . . . I helped [patient #7] with her self-esteem. I have a really good knack for seeing the strengths in people."

47. During an interview with the investigator, Respondent made the following statements concerning her practice of medicine:

a. Cytomel boosts the antidepressant effect of Prozac and the tricyclics.

b. Respondent specialized in posttraumatic stress disorder (PTSD) and affective disorders, particularly depression utilizing an "eclectic" theoretical model.

c. "I just work within a patient's belief system. I don't in any way question their belief system. . . . When patients have questions regarding their belief systems, I use the Jungian Collective Unconscious. . . ."

d. Respondent employs solely medication monitoring for some of her patients.

e. Respondent employs the following modalities with her patients:

1) Massage therapy ("on one client");

2) Hypnosis;

3) Age regression (in a "very limited" number of cases); and

4) Reiki therapy. Respondent defined Reiki therapy as therapeutic touch; the laying of hands on the head, hands, back and feet of the client. Respondent stated that she does not perform Reiki on all patients.

f. Respondent frequently uses rational-emotive behavior modification.

g. Respondent teaches some patients relaxation techniques.

h. Respondent has provided psychotherapy and "supportive counseling" for some of her patients.

i. Respondent refers chemically dependent patients to a treatment program but provides supportive therapy.

j. Respondent uses a shame-based dysfunctional family mode with nearly every patient.

k. Respondent may have given "something like Xanax to a patient" for anxiety.

l. Respondent admitted, "I sometimes get a stock bottle and dispense from there. . . . I have old sample bottles and fill them up and label them." Respondent labels each

bottle with the patient name, medication name and directions for use. Respondent declares she "doesn't [dispense] to many patients."

Controlled Substances Received by Respondent

48. From September 1990 to August 1992, Interstate Drug Exchange, Inc. ("IDE"), delivered the following controlled substances to Respondent at her residence:

Dates	Drug	Total
9/6/90-8/7/92	Didrex, 50 mg	1,500
9/6/90-8/7/92	Prelu-2 Timed-Release Capsule	1,300

Respondent paid IDE by personal check for four of her purchases: November 16, 1990; January 30, 1991; March 29, 1991; and October 25, 1991. The following drugs were ordered by Respondent and delivered to Respondent's residence, at Respondent's request, on those dates.

a. On November 16, 1990, Respondent received:

# Units	Unit Size	Drug
2	100	Didrex 50 mg tabs
1	100	Prelu 2 timed caps 105 mg
4	100	Trifluoperazine tabs 1 mg
2	100	Penicillin V tabs 250 mg

b. On January 30, 1991, Respondent received:

# Units	Unit Size	Drug
4	100	Tetracycline caps 250 mg
4	100	Trifluoperazine tabs 1 mg
1	100	Prelu 2 timed caps 105 mg
1	100	Penicillin V tabs 250 mg
2	100	Didrex tabs 50 mg

c. On March 29, 1991, Respondent received:

# Units	Unit Size	Drug
2	100	Prelu 2 timed caps 105 mg

d. On October 25, 1991, Respondent received:

# Units	Unit Size	Drug
2	100	Ampicillin caps 250 mg
2	100	Didrex tabs 50 mg
2	100	Prelu 2 timed caps 105 mg
2	100	Penicillin V tabs 250 mg
1	100	Nystatin ointment
1	100	Nystatin cream

e. From January 1989 through August 1991, Eli Lilly and Company shipped sixteen orders of Prozac samples to Respondent. Twelve of the shipments were sent to Respondent's residence and four were shipped to Respondent at the Tomah V.A. Medical Center. The shipments totaled 2415 tablets of Prozac 20 mg.