



LEGAL AFFAIRS
 1625 North Market Blvd., Suite S 309
 P (916) 574-8220 F (916) 574-8623



MEMORANDUM

DATE	December 15, 2010
TO	Members Medical Board of California
FROM	Anita L. Scurl Supervising Sr. Counsel Department of Consumer Affairs 
SUBJECT	PROPOSED PRECEDENTIAL DECISION – <i>In the Matter of the Accusation Against Jill Siren Meoni, M.D.</i>; Case No. 10-2007-185857; OAH No. 2008100753

In accordance with the procedure adopted by the Division of Medical Quality in July 2004 (Exhibit 1), the Office of the Attorney General has recommended that one portion of the above-captioned decision be designated as precedential. The executive director, chief of enforcement and I all agree with this recommendation.

Procedural Background

Dr. Meoni (“respondent”) was the recipient of an Accusation. The matter was heard before Administrative Law Judge Donald P. Cole, who submitted a Proposed Decision to the Medical Board of California (“Board”) on July 7, 2009. A panel of the board non-adopted that decision and later granted reconsideration to change several footnotes to ensure consistency in all parts of the decision.

Facts/Findings of the Case

The facts of the case are not themselves relevant to the current request since the portion of the decision sought to be designated as precedential relates to the interpretation of Business and Professions Code Section 2334. Section 2334 governs the exchange of information regarding expert witnesses and provides as follows:

“(a) Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless the following information is exchanged in written form with counsel for the other party, as ordered by the Office of Administrative Hearings:

- (1) A curriculum vitae setting forth the qualifications of the expert.

- (2) A brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis.
 - (3) A representation that the expert has agreed to testify at the hearing.
 - (4) A statement of the expert's hourly and daily fee for providing testimony and for consulting with the party who retained his or her services.
- (b) The exchange of the information described in subdivision (a) shall be completed at least 30 calendar days prior to the commencement date of the hearing.
- (c) The Office of Administrative Hearings may adopt regulations governing the required exchange of the information described in this section.

The key issue relates to a motion by complainant (the Board's executive director) to exclude expert testimony for violation of section 2334. The administrative law judge found that respondent had violated the requirements of section 2334 by failing to provide the expert witness disclosure within 30 calendar days prior to the commencement of the hearing and by failing to provide "a brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis." Nonetheless, the administrative law judge declined to apply the statutory remedy of excluding the expert testimony. The administrative law judge construed section 2334 as affording both OAH and the administrative law judge a measure of discretion with regard to the remedy for noncompliance to be applied in a given case, depending on the totality of the circumstances.

Portions of Decision to be Designated as Precedential

The recommendation is that only the following portion of the decision be designated as precedential:

Motion in Limine to Exclude Expert Testimony (Conclusions of Law Nos. 5 through 14, inclusive)—pages 36 to 45.

If the Board approves the request to designate the above portion of the decision as precedential, those portions not accepted for publication will be redacted and replaced with asterisks. Exhibit 2 is the redacted version of the decision and is what those viewing the precedent decision would see. Exhibit 3 is the decision in its entirety.

Rationale

16 Cal. Code Regs. 1364.40(a) authorizes the division to designate, as a precedent decision, "any decision or part of any decision that contains a significant legal or policy determination of general application that is likely to recur."

Expert witnesses are necessary in every quality of care case; therefore the issue presented in this case is very likely to be a recurring issue. In its decision (Conclusion of Law No. 9,

page 39), the board agreed with both the administrative law judge and with complainant about the critical need for guidance in interpreting section 2334 in order to carry out the purpose for which that section was enacted. The board further stated that it "intends to convey its interpretation of that section in this decision." That interpretation is not binding on administrative law judges unless it is designated as a precedential decision.

The portion of the decision proposed to be designated as precedent contain significant legal determinations and would provide guidance to counsel for respondent and complainant as well as guidance to the Office of Administrative Hearings.

Attachments

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

In the Matter of the Accusation
Against:

JILL SIREN MEONI, M.D.

Physician's and Surgeon's
Certificate No. A 55229

OAH No. 2008100753

MBC Case No. 10-2007-185857

PRECEDENTIAL DECISION
No. MBC-2011-01 DMQ

DESIGNATION AS PRECEDENTIAL DECISION

Pursuant to Government Code Section 11425.60, the Medical Board of California hereby designates as precedential that portion of the decision listed below in the Matter of the Accusation against Jill Siren Meoni:

Motion in Limine to Exclude Expert Testimony (Conclusions of Law Nos. 5 through 14, inclusive)—pages 36 to 45

This precedential designation shall be effective January 28, 2011.

IT IS SO ORDERED this 28th day of January, 2011.

BARBARA YAROSLAVSKY, President
Medical Board of California

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

In the Matter of the Accusation Against:

JILL SIREN MEONI, M.D.,

Physician's and Surgeon's Certificate No.
A 55229,

Respondent.

Case No. 10-2007-185857

OAH No. 2008100753

DECISION AFTER RECONSIDERATION

Motion in Limine to Exclude Expert Testimony

5. On May 7, 2009, complainant filed a motion in limine seeking "to exclude the expert testimony of each of respondent's six expert witnesses, on the grounds that respondent has violated the mandatory expert witness disclosure requirements of [Business and Professions Code] section 2334." The motion was based primarily on the following arguments: (i) Contrary to the requirements of section 2334, respondent's expert witness disclosure did not occur at least 30 calendar days before the commencement of the hearing; and (ii) the mandatory penalty for the failure to comply on a timely basis with the requirements of section 2334 is the automatic exclusion of the offending party's expert testimony. Complainant also contended that: (iii) Respondent's expert disclosures failed to comply with the requirements of section 2334 in other respects than timeliness (e.g., the description of the expected testimony of respondent's experts); and (iv) respondent's various failures to comply with the requirements of section 2334 were highly prejudicial to complainant's ability to prepare for the hearing.

6. Respondent has violated the requirements of section 2334 in two respects. First, respondent failed to provide its expert witness disclosure within 30 calendar days prior to the commencement of the hearing. On March 5, 2009, OAH granted respondent's motion to continue the hearing, and set the hearing to commence on May 14, 2009. Based on that hearing date, and pursuant to section 2334, subdivision (a), expert witness disclosure was to be made no later than April 14, 2009. Respondent did not, however, make her formal disclosure until April 30, 2009.¹ For purposes of the motion in limine, respondent's disclosure is deemed to have been

¹ The analysis that follows focuses on respondent's formal expert witness disclosure of

16 days late.² It is thus concluded that respondent's disclosure was untimely.

Second, respondent failed, as to two of its experts, to provide "a brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis." Complainant argued essentially that the descriptions provided in respondent's disclosure were not adequate to meaningfully inform complainant of the actual substance of the expected testimony of respondent's experts, including the experts' actual opinions and the bases therefor. Complainant's argument is rejected with regard to William Umansky and Luis Becerra. The description of the expected testimony of these individuals as set forth in respondent's disclosure did not constitute the kind of testimony that is typically considered "expert testimony," i.e., as described, it did not consist of formal expert opinions, but instead involved the physician's course of care of respondent.³ As such, such testimony is properly characterized as percipient witness testimony, not expert testimony per se.⁴ On the other hand, the description of the expected testimony of Frank Tiffany and David Sheffner clearly involved, at least in part, the rendering of genuine expert opinions. The description of their testimony adequately set forth the general substance of the testimony, including opinion testimony,⁵ but did not set forth any "basis" for such opinion testimony, and thus fails to comply with section 2334.⁶

April 30, 2009. On April 16, 2009, respondent served a Final Witness and Exhibit List. This list may be viewed as constituting respondent's initial expert witness disclosure. Under either view, based on the reasoning set forth below, violations of section 2334 would be found, though the violations would differ to a certain extent. For example, respondent did not disclose the fee to be charged by all of her experts until April 30.

² On April 16, 2009, Presiding Administrative Law Judge Alan R. Alvord issued a prehearing conference order, in which the parties were ordered to exchange the information required by section 2334 by April 30, 2009. Complainant objected to that portion of the order and contended in her in limine motion that OAH lacked the authority to grant additional time within which to make a section 2334 disclosure after the 30-day deadline had already passed. For the purposes of ruling on the in limine motion, it is assumed *arguendo* that the disclosure was to be made on April 14, 2009, notwithstanding the prehearing conference order.

³ Indeed, the testimony of these two physicians, as described above, was limited to issues directly relating to the course of care, and did not constitute expert opinion testimony.

⁴ In the absence of any statutory, regulatory or judicial guidance as to the meaning of "expert testimony," recourse is taken to the somewhat analogous use of expert testimony in civil cases pursuant to Code of Civil Procedure section 2034.

⁵ Complainant's contention that the disclosures provide insufficient detail to permit complainant to prepare to meet the testimony of respondent's experts at the hearing was unpersuasive. Absent any guidance—both for respondent and for the administrative law judge—as to how "brief" the required narrative statement may be, it is not appropriate to construe that adjective in an unduly narrow fashion that would in effect constitute a trap for the unwary.

⁶ Since respondent's other two experts, Christine Baser and Steven Rudolph, did not testify at the hearing, it is not necessary to address the adequacy of respondent's disclosures of their testimony.

7. In light of the conclusion that respondent has violated section 2334, the remedy for respondent's violations must now be addressed. The Administrative Law Judge denied the motion in limine and rejected exclusion of the expert testimony on the grounds that section 2334 affords both OAH and the administrative law judge a measure of discretion with regard to the remedy for non-compliance to be applied in a given case, depending on the totality of the circumstances.

8. The administrative law judge determined that exclusion of respondent's expert witness testimony would not further the apparent legislative purpose of the statute, but would instead undermine the interests of justice, and based this conclusion on the following considerations.

First, with regard to the timeliness of disclosure, even though formal disclosure did not occur until April 30, the identity of respondent's six experts, and at least a short description of the subject matter of their expected testimony, was provided on April 16, 2009, i.e., just two days after the April 14 deadline.

Second, in the absence of clear guidance as to what level of detail satisfies the "brief narrative statement" requirement of section 2334, great caution and restraint is appropriate before excluding expert testimony based on a finding that a proffered description did not constitute an adequate "brief narrative statement."

Third—and closely related to the preceding point—complainant did not place respondent on notice prior to filing the motion in limine of the alleged inadequacy of respondent's disclosure.

Fourth, complainant did not establish prejudice by virtue of either the untimeliness or the inadequacy of respondent's disclosures.

Fifth, no evidence was presented that respondent's failure fully to comply with section 2334 was in bad faith, i.e., constituted a conscious attempt to "hide the ball" or otherwise circumvent proper disclosure.

Sixth, the administrative law judge presumed that the ultimate decision maker in this case, the Medical Board of California, would desire to have all relevant evidence available for its consideration, so that it can make the most well-informed and appropriate decision possible in this very important matter.

9. In her written argument and during oral argument, complainant asked the board to reverse the decision denying the motion in limine, exclude expert testimony as a result of that reversal, and, in the decision itself, designate its decision as a precedent decision. The board denies these requests for the following reasons.

First, as required by law, the board has read all of the expert testimony in question as part of its review of the record and therefore does not believe it is appropriate, fair or equitable at this

stage of the proceedings to attempt to “unring the bell.”

Second, there is a process set out in regulation (Title 16 CCR section 1364.40) for designating precedent decisions and complainant’s request is inconsistent with that process. Complainant may certainly renew her request in the manner prescribed in that regulation.

The board does agree with both the administrative law judge and with complainant about the critical need for guidance in interpreting Business and Professions Code Section 2334, in order to carry out the purpose for which that section was enacted, and intends to convey its interpretation of that section in this decision.

10. Business and Professions Code section 2334 provides as follows:

“(a) Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless the following information is exchanged in written form with counsel for the other party, as ordered by the Office of Administrative Hearings:

“(1) A curriculum vitae setting forth the qualifications of the expert.

“(2) A brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis.

“(3) A representation that the expert has agreed to testify at the hearing.

“(4) A statement of the expert's hourly and daily fee for providing testimony and for consulting with the party who retained his or her services.

“(b) The exchange of the information described in subdivision (a) shall be completed at least 30 calendar days prior to the commencement date of the hearing.

“(c) The Office of Administrative Hearings may adopt regulations governing the required exchange of the information described in this section.”
(Stats. 2005, c. 674 (S.B. 231), § 14.)

11. The board finds that Section 2334 governs the entire subject of expert witness disclosures in Medical Board cases, including the penalty to be imposed for failure to comply with the disclosure requirements by the statutory production deadline and therefore Section 2334 prevails over any other provision of law, including provisions of the Administrative Procedure Act (APA). Evidence of this is found in the first sentence of section 2334, subdivision (a), which begins with the phrase: “Notwithstanding any other provision of law . . .” This phrase is indicative of the Legislature’s intent to have the provisions of section 2334 control notwithstanding the existence of other laws that might otherwise govern the subject. (See *People*

v. DeLaCruz (1993) 20 Cal.App.4th 955, 963 [phrase “has been read as an express legislative intent to have the specific statute control despite the existence of other law which might otherwise govern.”].)

12. A review of the legislative history of section 2334 confirms both the problem section 2334 was specifically enacted to address, as well as the legislative intent to place a mandatory obligation on the parties to make the required disclosures by the statutory deadline in order to promote, rather than defeat, its underlying public policy. In her Initial Report to the Legislature, the Medical Board’s Enforcement Monitor⁷ described the problems that result from defense counsel’s failure to disclose the opinions of their experts as follows:

“As described above, MBC requires its experts to reduce their expert opinions to writing – and those expert opinions are immediately discoverable by the defense. However, defense counsel frequently instruct their experts not to reduce their opinions to writing so the HQE DAG has no idea of the substance of defense counsel’s expert opinion until that expert takes the stand at the evidentiary hearing.

“This practice results in the unfair ‘sandbagging’ of the DAG at the hearing, and stifles the possibility of prehearing settlement. Although true bilateral discovery is not a feature of administrative hearings under the Administrative Procedure Act, the general discovery principle of eliminating undue litigation surprise is a public policy with important application here. The expert medical opinions in these MBC administrative hearings go to the heart of the Board’s case and are partly or entirely dispositive of the result. Litigation surprise regarding this central element of the administrative action disserves all parties to the process and the public interest as a whole.”

(Initial Report, Medical Board of California Enforcement Program Monitor, prepared by Julianne D’Angelo Fellmeth and Thomas A. Papageorge, dated November 1, 2004, at pp. 160-161.)

In the wake of the Enforcement Monitor’s Initial Report, Senate Bill 231, as amended, included a new statute specifically designed to address this problem. That statute, as originally introduced, provided that:

“2334. Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert

⁷. Business and Professions Code section 2220.1 provided for the appointment of a “Medical Board Enforcement Program Monitor” to monitor and evaluate “the disciplinary system and procedures of the board, making as his or her highest priority the reform and reengineering of the board’s enforcement program and operations and the improvement of the overall efficiency of the board’s disciplinary system.” (Added by Stats. 2002, c. 1085, (Sen. Bill No. 1950), § 18; repealed by Stats. 2004, c. 909 (Sen. Bill No. 136), § 3, operative Jan. 1, 2006.)

testimony shall be permitted by any party unless a detailed written report by the expert witness, including findings and conclusions of the expert witness, is exchanged by the parties in advance of the hearing. The Office of Administrative Hearings shall adopt regulations in consultation with the Medical Board of California governing the required exchange of expert testimony in these proceedings.” (Sen. Bill No. 231 (2005-2006 Reg. Sess.) § 11, as amended in Assembly on June 13, 2005.)

Thus, as original introduced, the Legislature only required that the disclosure be made “in advance of the hearing.” As the bill moved through the legislative process, the Legislature amended section 2334, never losing sight of its objective to compel the timely production of information regarding expert witnesses. For example, the Legislature eliminated the requirement that “a detailed written report” be produced and, instead, required only that the expert testimony be “reduced to writing by the expert witness, including findings and conclusions of the expert witness, . . .” Thus, as later amended in the Assembly, section 2334 then provided:

“2334. Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless ~~a detailed written report~~ *it is reduced to writing* by the expert witness, including findings and conclusions of the expert witness, is exchanged by the parties in advance of the hearing. The Office of Administrative Hearings shall adopt regulations in consultation with the Medical Board of California governing the required exchange of expert testimony in these proceedings.” (Sen. Bill No. 231 (2005-2006 Reg. Sess.) § 11, as amended in Assembly on July 11, 2005.)

Then, on August 30, 2005, the Legislature abandoned the requirement that the disclosure simply be made “in advance of the hearing” and, instead, established a specific statutory deadline for the production. In this regard, section 2334, as amended, stated:

“2334. (a) Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless ~~it is reduced to writing by the expert witness, including findings and conclusions of the expert witness, and it is exchanged by the parties in advance of the hearing.~~ The Office of Administrative Hearings shall adopt regulations in consultation with the Medical Board of California governing the required exchange of expert testimony in these proceedings. *the following information is exchanged in written form with counsel for the other party, as ordered by the Office of Administrative Hearings:*

- (1) *A curriculum vitae setting forth the qualifications of the expert.*
- (2) *A brief narrative statement of the general substance of the testimony the expert is expected to give, including any opinion testimony and its basis.*
- (3) *A representation that the expert has agreed to testify at the hearing.*

(4) *A statement of the expert's hourly and daily fee for providing testimony and for consulting with the party how retained his or her services.*

(b) *The exchange of the information described in subdivision (a) shall be completed at least 30 calendar days prior to the commencement date of the hearing.*

(c) *The Office of Administrative Hearings may adopt regulations governing the required exchange of the information described in this section.* ”

(Sen. Bill No. 231 (2005-2006 Reg. Sess.) § 12, as amended in Assembly on August 30, 2005.)

This would remain the statutory production deadline throughout the remainder of the legislative process (see Sen. Bill No. 235 (2005-2006 Reg. Sess.) § 11, as amended on September 2, 2005) and ultimate approval by the Governor on October 7, 2005 (see Bus. & Prof. Code, § 2334). Thus, subsequent amendments to Senate Bill 231 confirm the Legislature's explicit rejection of the requirement that the expert witness disclosures be made simply "in advance of the hearing" and, instead, its intention that such disclosures shall be made "at least 30 calendar days prior to the commencement date of the hearing." (Cf. *Cooper v. Swoap* (1974) 11 Cal.3d 856, 864-865 [Legislature's direct consideration and explicit rejection of proposal to reduce grants of AFDC recipients sharing housing with an adult aid recipient an "unambiguous indicant of legislative intent"]; see also *Martin v. Szeto* (2004) 32 Cal.4th 445, 450 [subsequent amendments to bill cited as clarifying legislative intent].)

Permitting OAH to order the required expert witness disclosures to be made *less than 30* calendar days prior to commencement of the hearing was included in an earlier version of Senate Bill 231 that was explicitly rejected by the Legislature and, thus, to permit it now would be entirely inconsistent with legislative intent. (Cf. *Cooper v. Swoap* (1974) 11 Cal.3d 856, 864-865 [Legislature's direct consideration and explicit rejection of proposal to reduce grants of AFDC recipients sharing housing with an adult aid recipient an "unambiguous indicant of legislative intent"].)

13. The board finds that the obligation of both parties to make the required exchange of expert witness information by the statutory deadline set by the Legislature in section 2334 (b), is mandatory, not merely directory. (Business and Professions Code Sections 8, 19) This is also consistent with case law:

"... 'Time limits are usually deemed to be directory unless the Legislature clearly expresses a contrary intent.' (*Id.* at p. 1145.) For example, if the statute attaches consequences or penalties to the failure to observe time limits, the statute is construed as mandatory. (*County of Sacramento v. Insurance Co. of the West* (1983) 139 Cal.App.3d 561, 565-566; see also *Edwards v. Steele, supra*, 25 Cal.3d at p.410.)" (*Matus v. Board of Administration* (2009) 177 Cal.App.4th 597, 608-609.)

14. In the proposed decision, the administrative law judge construed section 2334 as

affording both OAH and the administrative law judge a measure of discretion with regard to the remedy for non-compliance to be applied in a given case, depending on the totality of the circumstances.

(a) The board finds, using well-settled rules of statutory construction, that an interpretation granting discretion as to whether to impose the statutory remedy of exclusion is inconsistent with the legislative intent underlying the statute, would defeat (rather than promote) the statute's general purpose and would lead to absurd consequences.

“In construing a statute, our fundamental task is to ascertain the Legislature’s intent so as to effectuate the purpose of the statute. (*Day v. City of Fontana* (2001) 25 Cal.4th 268, 272.) We begin with the language of the statute, giving the words their usual and ordinary meaning. (*Ibid.*) The language must be construed ‘in the context of the statute as a whole and the overall statutory scheme, and we give ‘significance to every word, phrase, sentence, and part of an act in pursuance of the legislative purpose.’” (*People v. Canty* (2004) 32 Cal.4th 1266, 1276.) In other words, “we do not construe statutes in isolation, but rather read every statute ‘with reference to the entire scheme of law of which it is part so that the whole may be harmonized and retain effectiveness.’ [Citation.]” (*In re Marriage of Harris* (2004) 34 Cal.4th 210, 222.) If the statutory terms are ambiguous, we may examine extrinsic sources, including the ostensible objects to be achieved and the legislative history. (*Day, supra*, 25 Cal.4th at p. 272.) In such circumstances, we choose the construction that comports most closely with the Legislature’s apparent intent, endeavoring to promote rather than defeat the statute’s general purpose, and avoiding a construction that would lead to absurd consequences. (*Ibid.*)” (*Smith v. Superior Court* (2006) 39 Cal.4th 77, 83.)

Section 2334, subdivision (a), states that:

“(a) Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless the following information is exchanged in written form with counsel for the other party, *as ordered by the Office of Administrative Hearings: . . .*” (Italics added.)

The board finds that section 2334 is a self-executing statute in the sense that it applies in all Medical Board cases, regardless of whether OAH orders the parties to comply with its provisions or not.⁸ In this regard, section 2334 is similar to a statute of limitations (see, e.g., Bus. & Prof. Code, § 2230.5) which applies whether or not the parties are ordered to comply with its provisions.

⁸. While OAH has reportedly begun the practice of routinely issuing orders requiring the parties to comply with the provisions of section 2334, issuance of such orders are not required since section 2334 is otherwise applicable in Medical Board cases, regardless of whether OAH orders the parties to comply or not. Such orders do, however, serve a useful purpose by helping to ensure that section 2334 does not become a trap for the unwary.

To interpret the phrase “as ordered by the Office of Administrative Hearings” as requiring an OAH order before the statute could apply in Medical Board cases would violate the general rules of statutory construction cited above. It would also lead to the absurd consequence of section 2334 applying in those Medical Board cases where OAH has issued an order requiring compliance with its provisions but not to those cases where OAH has not issued such an order.

Here, the phrase “as ordered by the Office of Administrative Hearings” is more appropriately read as referring to an order from OAH prohibiting expert testimony offered by a party whenever it has been determined that the party has failed to comply with the expert witness disclosure requirements of section 2334 by the statutory deadline. Without such an order from OAH, the statutory penalty fixed by the Legislature for violation of section 2334 could never be imposed. This reading is also consistent with other prescribed duties and responsibilities of administrative law judges under the APA, including those provisions requiring an administrative law judge to issue orders and decisions. (See, e.g., Gov. Code, §§ 11511.5, subd. (e) [“The administrative law judge shall issue a prehearing conference order incorporating the matters determined at the prehearing conference.”]; and 11517 [“If a contested case is originally heard by an administrative law judge alone, he or she shall prepare . . . a proposed decision in a form that may be adopted by the agency as the final decision in the case.”].) The Legislature was presumed to be aware of existing law (here, the authority of an administrative law judge to issue orders) when it required an order from OAH to impose the statutorily required penalty for failure to comply with the requirements of section 2334. (*People v. Cruz* (1996) 13 Cal.4th 764, 775)

(b) “The most basic principle of statutory construction is that courts must give effect to statutes according to the ordinary import of the language used in framing them.” (*People v. Herman* (2002) 97 Cal.App.4th 1369, 1380-1381, internal quotes and citation omitted.) “If there is no ambiguity in the language of the statute, then the Legislature is presumed to have meant what it said, and the plain meaning of the language governs.” (*Id.*, at p. 1381, internal quotes and citations omitted.) Here, there is no ambiguity regarding the penalty to be imposed for a violation of section 2334. The Legislature has made a policy choice to fix that penalty as exclusion of the expert testimony.

The board finds that OAH lacks the authority to refuse to impose the legislatively mandated penalty of exclusion where a party has failed to comply with the requirements of section 2334. Whenever it has been determined that a party in a Medical Board case has violated the expert witness disclosure requirements of section 2334, either by failing to disclose the information specified in section 2334, subdivision (b), and/or failing to make the required disclosures by the statutory deadline contained in section 2334(c), section 2334(a) requires that an order be issued prohibiting that party from presenting the proffered expert testimony in the case.⁹

⁹. Administrative disciplinary proceedings that are commenced by the issuance of an interim order of suspension (ISO) under Government Code section 11529 constitute an exception to the otherwise applicable provisions of section 2334. In ISO cases, the filing of the accusation and subsequent hearing are necessarily expedited (Gov. Code, § 11529, subd. (f)) and, as a result, the hearing may be scheduled such that is impossible for the parties to comply with the expert witness disclosure requirements of section 2334 by the statutory deadline set

The board notes that the conclusion expressed above applies equally to both complainant and respondent. Based upon its review of the record (Exh. 29 in particular), the board urges both parties in future cases to be diligent in fully complying with Section 2334 in order to fulfill the purposes of the statute.

What constitutes compliance with Section 2334(a)(2)? Merely listing topics or subjects that the expert witness will testify about, without disclosing the general substance of the expert's anticipated testimony, the actual expert opinions he/she will testify to, and the basis for each of those opinions, is plainly insufficient and would clearly violate the statutory requirements of section 2334. A "brief narrative statement" of the "general substance" of the expert's testimony means a short narrative statement that provides the main features of the testimony—the essential nature of the testimony to be proffered. The statement must include any opinion to be presented and the basis for that opinion. By way of example as to what is not acceptable, taken from the record in this matter: A party merely states (see Exh. 29) that an expert will testify "whether Respondent can practice medicine safely, and whether the circumstances surrounding Respondent's use of medication constituted general unprofessional conduct as alleged." This narrative does not state what expert opinion will actually be proffered (i.e. that respondent can practice medicine safely and that respondent's use of medication is not general unprofessional conduct). Nor does it describe whatsoever the basis for that opinion. This is simply insufficient.

This decision shall become effective at 5 p.m. on June 7, 2010.

IT IS SO ORDERED this 6th day of May, 2010.

HEDY CHANG, Chairperson
Panel B, Medical Board of
California

by section 2334, subdivision (c). Compliance with section 2234 is excused when it is impossible to comply. (See e.g., *McKenzie v. City of Thousand Oaks* (1973) 36 Cal.App.3d 426, 430 [compliance with procedural statute may be excused when it is "impracticable, impossible or futile" to comply].)

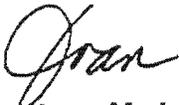
State of California

Department of Consumer Affairs

Memorandum

To : Carlos Ramirez, Asst. DAG
Tom Rellly, DAG
Mary Agnes Matyszewski, DAG
Health Quality Enforcement Section
Office of the Attorney General

Date: July 28, 2004

From : 
Joan M. Jerzak
Chief, Enforcement Program

Subject: Precedential Decisions Revised Procedures

As a follow-up to our meeting on July 21, 2004, with DCA Legal Counsel Anita Scuri, Board Counsel Nancy Vedera, Interim Executive Director Dave Thornton and me, the attached Precedent Decision Procedure was revised. I believe it incorporates all the offered suggestions and will serve as a guide for Board staff as decisions are selected for precedential designation.

Thank you all for your assistance.

Exhibit 1

PRECEDENT DECISION PROCEDURE

July 2004

Introduction

The purpose of this policy is to establish a procedure for identifying potential precedential decisions and reviewing and acting upon recommendations to designate decisions as precedential. Under the Administrative Procedure Act (APA) a decision that contains a significant legal or policy determination of general application that is likely to recur may be designated as precedential. (See Government Code (GC) Section 11425.60; Attachment 1) Once a decision is designated as precedential, the Division of Medical Quality (hereinafter "Division") may rely on it, and parties may cite to such decision in their argument to the Division and courts. Furthermore, it helps ensure consistency in decision-making by institutionalizing rulings that the Board feels reflects its position on various issues. The Division has adopted section 1364.40, Title 16, California Code of Regulations, to implement its authority to designate decisions as precedential.

Step 1: Identifying Potential Precedential Decisions

A decision or part of a decision that contains significant legal or policy determination of general application that is likely to recur may be recommended for designation as a precedential decision. Section 11425.60 does not preclude the Board from designating as precedential a decision that is already in effect. The recommendation shall be made to Board Counsel, giving the reasons why the person believes the decision meets the criteria to be designated as a precedential decision. Their recommendation shall be accompanied by a copy of the decision.

Step 2: Review of Recommendation

If the Executive Director, after consultation with the Chief of Enforcement and the Board Counsel, concludes that the Division should consider the decision for precedential designation, the matter will be placed on the Division's agenda for action. The agenda serves as public notice that the Division will consider the decision as a precedential decision.

Step 3: Preparation for Board Review

Board Counsel will then prepare or will arrange with the appropriate staff to prepare the precedential designation proposal for presentation to the Division for review and consideration.

The Board's Discipline Coordination Unit shall maintain a log of the decisions proposed to the Division for precedential designation. The log shall show the date of the Board meeting, decision number, respondent's name, a general description of the legal or policy issue, and whether the precedential decision was approved or not. A copy of the Board Counsel memorandum and minutes of the Board meeting (when the decision was discussed) will be maintained with the log.

If the Division adopts a decision as precedential, it will be assigned a precedential designation number. The precedential designation number shall begin with "MBC" and uses the calendar year and sequential numbering beginning with "01" for each year, followed by lettering for the Division designating the decision, DMQ (Division of Medical Quality) and DOL (Division of Licensing), (i.e., MBC-2004-01-DMQ for year 2004).

Step 4: Designation of a Precedential Decision

Board Counsel will prepare an order designating the decision, or portion(s) of the decision, as precedential for signature by the Division President. The effective date is the date the decision was designated as a precedential decision. (See Attachment 2 for an example of a Designation as Precedential Decision.)

Board Counsel will send a copy of the signed Designation as a Precedential Decision, including a copy of the decision, to the Office of Administrative Hearings. (The Office of Administrative Hearings maintains a file of precedential designations for reference by Administrative Law Judges.)

Step 5: Indexing

Under Government Code section 11425.60(c), the Division is required to maintain an index of significant legal and policy determinations made in precedential decisions. The Board's Discipline Coordination Unit will maintain the index.

The index shall be divided into three sections (Attachment 3) :

- 1) Decisions by fiscal year, including: the precedential designation number, the respondent's name, the MBC case number, the OAH case number and the precedential designation date (effective date).
- 2) Subject matter, followed by a general description of legal and/or policy issue, the precedential designation number and the respondent's name.
- 3) Code section number, followed by a general description of the section, the precedential designation number and the respondent's name.

NOTE: As decisions are added to the index, an asterisk will be entered after the cases, showing if they were appealed to the Superior Court, Court of Appeals or Supreme Court. Two asterisks following the case, will reflect the case was reversed as a precedential decision by the Board.

A copy of each precedential designation shall be maintained with the index and on the Board's website. The index shall be updated every time a decision is designated as precedential. The index is a public record, available for public inspection and copying. It shall be made available to the public by subscription and its availability shall be published annually in the California Regulatory Notice Register. Each January, Board staff will submit the index to the Office of Administrative Law for publication in the California Regulatory Notice Register.

Step 6: Reversal of Precedential Designation

The Executive Director, after consultation with the Chief of Enforcement and Board Counsel, may recommend that the Division reverse its designation of all or portion(s) of the precedential designation on a decision. The matter will then be placed on the agenda for action. Board Counsel will prepare or arrange with the appropriate staff to prepare the order, "Reversal of Precedential Designation," (Attachment 4). Board Counsel will then send a copy of the signed Reversal of Precedential Designation, including a copy of the decision to the Office of Administrative Hearings.

§ 11425.60. Decisions relied on as precedents

(a) A decision may not be expressly relied on as precedent unless it is designated as a precedent decision by the agency.

(b) An agency may designate as a precedent decision a decision or part of a decision that contains a significant legal or policy determination of general application that is likely to recur. Designation of a decision or part of a decision as a precedent decision is not rulemaking and need not be done under Chapter 3.5 (commencing with Section 11340). An agency's designation of a decision or part of a decision, or failure to designate a decision or part of a decision, as a precedent decision is not subject to judicial review.

(c) An agency shall maintain an index of significant legal and policy determinations made in precedent decisions. The index shall be updated not less frequently than annually, unless no precedent decision has been designated since the last preceding update. The index shall be made available to the public by subscription, and its availability shall be publicized annually in the California Regulatory Notice Register.

(d) This section applies to decisions issued on or after July 1, 1997. Nothing in this section precludes an agency from designating and indexing as a precedent decision a decision issued before July 1, 1997.

HISTORY:

Added Stats 1995 ch 238 §21 (SB 523), operative July 1, 1997; Amended by Stats 1998 ch 390 §8 (SB 794), operative July 1, 1997.

Added "and indexing" in subd (d).

Law Revision Commission Comments:

1995 Section 11425.60 limits the authority of an agency to rely on previous decisions unless the decisions have been publicly announced as precedential.

The first sentence of subdivision (b) recognizes the need of agencies to be able to make law and policy through adjudication as well as through rulemaking. It codifies the practice of a number of agencies to designate important decisions as precedential. See Sections 12935(h) (Fair Employment and Housing Commission), 19582.5 (State Personnel Board); Unemp. Ins. Code 409 (Unemployment Insurance Appeals Board). Section 11425.60 is intended to encourage agencies to articulate what they are doing when they make new law or policy in an adjudicative decision. An agency may not by precedent decision revise or amend an existing regulation or adopt a rule that has no adequate legislative basis.

Under the second sentence of subdivision (b), this section applies notwithstanding Section 11340.5 ("underground regulations"). See 1993 OAL Det. No. 1 (determination by Office of Administrative Law that agency designation of decision as precedential violates former Government Code Section 11347.5 [now 11340.5] unless made pursuant to rulemaking procedures). The provision is drawn from Government Code Section 19582.5 (expressly exempting the State Personnel Board's precedent decision designations from rulemaking procedures). See also Unemp. Ins. Code 409 (Unemployment Insurance Appeals Board). Nonetheless, agencies are encouraged to express precedent decisions in the form of regulations, to the extent practicable.

The index required by subdivision (c) is a public record, available for public inspection and copying.

Subdivision (d) minimizes the potential burden on agencies by making the precedent decision requirements prospective only.

Attachment 1

SAMPLE

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

In the Matter of the Accusation)	
Against:)	OAH No.
NAME)	
)	
)	MBC Case No.
)	
Physician's and Surgeon's)	PRECEDENTIAL DECISION
Certificate No.)	No. MBC-2004-01-DMQ
)	
Respondent.)	
_____)	

DESIGNATION AS A PRECEDENTIAL DECISION

Pursuant to Government Code Section 11425.60, the Division of Medical Quality, Medical Board of California, hereby designates as precedential Decision No. MBC-2004-01-DMQ (or those sections of the decision listed below) in the Matter of the Accusation Against NAME.

- 1) Findings of Fact Nos. 3-6; and
- 2) Determination of Issues No. 5.

This precedential designation shall be effective July 30, 2004.

LORIE RICE, President
Division of Medical Quality
Medical Board of California

Attachment 2

SAMPLE

2004

**Medical Board of California
Precedential Decisions**

Index

MBC-2004-01-DMQ *Ridgill, Edward*, MBC Case No. 06-1997-78021,
OAH Number E-123545, July 30, 2004

*Attachment 3
1 of 2 pages*

SAMPLE

**Medical Board of California
Precedential Decisions**

Index 2004

by Subject Matter

Petition for Penalty Relief

Evidence of rehabilitation, or
lack of, 2004-01-DMQ

Rehabilitation

Petitioner's burden, 2004-01-DMQ

by Code Section

Business and Professions Code

Section 2307 - Modification or

Termination of Probation –

2004-01-DMQ, *Ridgill*

2 of 2 pages

SAMPLE

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

In the Matter of the Accusation)	
Against:)	OAH No.
NAME)	
)	
)	MBC Case No.
)	
Physician's and Surgeon's)	PRECEDENTIAL DECISION
Certificate No.)	No. MBC-2004-01-DMQ
)	
Respondent.)	
_____)	

WITHDRAWAL OF PRECEDENTIAL DECISION

Pursuant to Government Code Section 11425.60, the Division of Medical Quality, Medical Board of California, hereby orders the withdrawal of precedential Decision No. DMQ-2004-01-DMQ (or those sections of the decision listed below) in the Matter of the Accusation Against NAME.

- 1) Findings of Fact Nos. 3-6; and
- 2) Determination of Issues No. 5.

The withdrawal of this precedential designation shall be effective July 30, 2005.

 LORIE RICE, President
 Division of Medical Quality
 Medical Board of California

Attachment 4

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

In the Matter of the Accusation Against:

JILL SIREN MEONI, M.D.,

Physician's and Surgeon's Certificate No.
A 55229,

Respondent.

Case No. 10-2007-185857

OAH No. 2008100753

DECISION AFTER RECONSIDERATION

Donald P. Cole, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on May 14, 18, 19, 20, 26, 27, 28, 29 and June 1, 2009, in San Diego, California.

Michael S. Cochrane, Deputy Attorney General, Department of Justice, State of California, represented complainant Barbara Johnston, Executive Director, Medical Board of California (board or medical board), Department of Consumer Affairs, State of California.

Steven H. Zeigen, Esq., Rosenberg, Shpall & Associates, APLC, represented respondent Jill Siren Meoni, M.D., who was present throughout the hearing.

The matter was submitted on June 10, 2009.¹

The proposed decision of the Administrative Law Judge was submitted to the Medical Board of California on July 7, 2009. After due consideration thereof, Panel B of the Board (hereafter "Board") declined to adopt the proposed decision and thereafter on October 5, 2009, issued an Order of Nonadoption and subsequently issued an Order Fixing Date for Submission of Written Argument. On December 29, 2009, the Board issued a Notice of -Hearing for Oral Argument. Oral argument was heard on January 28, 2010, and the Board voted on the matter that same day.

The Board issued its Decision After Nonadoption on February 17, 2010, to become effective March 22, 2010. On March 12, 2010, complainant filed a Petition for Reconsideration seeking a change to several footnotes to ensure consistency in all parts of the decision. An order staying the decision until April 1, 2010, was issued. A Nunc Pro Tunc Order was issued granting reconsideration and staying the effective date of the decision until the board issues its Decision

¹ See footnote to Finding 3.

After Reconsideration. Neither party requested oral argument. The time for filing written argument in this matter having expired, written argument having been filed by complainant and such written argument, together with the entire record, including the transcript of said hearing, having been read and considered, pursuant to Government Code Section 11517, the board hereby makes the following decision and order:

FACTUAL FINDINGS

Jurisdictional Matters

1. On November 15, 1995, the board issued to respondent Physician's and Surgeon's Certificate No. A 55229. The certificate is renewed and current, with an expiration date of October 31, 2009.

2. On September 15, 2008, complainant signed the accusation in her official capacity. The accusation and other required jurisdictional documents were served on respondent. On September 24, 2008, respondent executed and thereafter filed a notice of defense.

3. On May 14, 2009, the record was opened and jurisdictional documents were received. On May 14, 18, 19, 20, 26, 27, 28, 29, and June 1, 2009, sworn testimony was given and documentary evidence was introduced. On June 1, 2009, closing arguments were presented. On June 10, 2009, the record was closed and the matter was deemed submitted.²

Introductory Matters

4. Respondent served in the United States Navy Medical Corps from July 1990 to August 2003. She received several honors during her service. Respondent was discharged from the Navy in 2003, under circumstances set forth below.

Respondent received her medical degree in 1994 from the Uniformed Services University of the Health Sciences in Bethesda, Maryland. She completed her internship at the Naval Hospital, Camp Pendleton, California in family practice in 1995, and her residency in radiology at the Naval Medical Center, San Diego, California, in 2002, where she served as Chief Resident in 2001 to 2002 and was an annual instructor of Radiology for the General Practitioner. Respondent was certified by the American Board of Radiology in 2002.

² During the hearing, the ALJ requested the parties to meet and confer in an effort to reach a written stipulation on certain specified matters. The record was left open at the conclusion of the hearing to permit the parties additional time to reach the requested stipulation. By letter dated June 10, 2009, counsel for complainant advised the administrative law judge that the parties were unable to reach any factual stipulations. Based on the parties' asserted inability to reach such stipulations, the record was closed and the matter deemed submitted on June 10, 2009.

In the fall of 2003, after her discharge from the Navy, respondent began working part-time at Promise Hospital in San Diego as a contract physician. In June 2005, she was promoted to Director of Radiology, a position she held until August 2008, when she left Promise due to the facility's emerging practice of diverting work to an outside radiology company.

In March 2004, respondent began working at Sharp Rees-Stealy in San Diego on a per diem basis. By the time the accusation was filed (September 2008), respondent was working at Sharp two days per week on a regular basis, and also covered for other radiologists when they were unable to work due to illness or for other reasons. Respondent now works at Sharp on an irregular, as-needed basis.

As a radiologist, respondent is engaged primarily in the review and interpretation of medical radiological images, produced by such processes as radiography and magnetic resonance imaging. At times, she also performs "semi-invasive procedures," such as anthrograms and superficial biopsies.

5. The accusation set forth one cause for action and two causes for discipline. The cause for action alleged pursuant to Business and Professions Code section 822³ that respondent has a mental illness and/or physical illness affecting her ability to practice medicine safely. The first cause for discipline alleged pursuant to section 2239, subdivision (a) that respondent used prescription medication and/or alcohol to the extent, or in such a manner, as to be dangerous to herself, to others, or to the public, or to the extent that such use impaired her ability to practice medicine safely. The second cause for discipline alleged pursuant to section 2234 that respondent engaged in unprofessional conduct by breaching the rules or ethical code of the medical profession, or by engaging in conduct unbecoming to a member in good standing of the profession, so as to demonstrate her unfitness to practice medicine.

All allegations arose out of events occurring primarily in the periods from December 2002 to April 2003 and from January to August 2007, and related to physical and mental conditions of respondent (in particular migraine headaches, anxiety, and depression), and the prescription medications respondent used in an effort to alleviate the symptoms of those physical and mental conditions.

December 2002 to April 2003

6. During the period from December 2002 to April 2003, when the events described below took place, respondent was not practicing as a physician.

7. Kathleen Flanigan, L.C.S.W., has been a California licensed clinical social worker for about 25 years. Since 2000, she has worked at Sharp Mesa Vista Hospital (Mesa Vista) in that facility's Cognitive Intensive Outpatient Program (CIOP), as either a staff therapist or on a part-time per diem basis.

³ All statutory references are to the Business and Professions Code, unless otherwise noted.

The CIOP is a program for persons with mood disorders (primarily anxiety and depression), and includes both a group therapeutic and an educational component. The focus of the program is to help people learn cognitive behavior techniques to help them control their moods. During the time period in question, Flanigan worked with Dr. Michael Ricciardi, a Mesa Vista staff psychiatrist.

Respondent was in the CIOP for about three months, attending on 62 dates from January 5 to April 11, 2003.⁴ As far as Flanigan could recall at the hearing, respondent's diagnosis was major depression.

During the course of respondent's participation in the CIOP, Flanigan at times observed respondent to sleep through class sessions.⁵ On January 29, 2003, respondent appeared "somnolent & appeared sedated. She denied (when screened) taking any extra or unprescribed meds. [She was] minimally participative." Respondent stated, "I had another bad night last night." Flanigan, together with the nurse (RN), determined that respondent should not be permitted to drive home that day. On February 3, 2003, respondent was "alternately attentive & drowsy." On February 19, 2003, respondent "explored her catastrophic thinking the day prior, after beginning to ruminate on elements of the diversion program for impaired physicians." As of February 12, 2003, it was Flanigan's overall evaluation that "Jill's progress in program has been quite rocky."⁶ On March 18, 2003, respondent "presented as somewhat sedated" and stated that she did not sleep well the previous night. Flanigan did not know whether respondent's sedation was the result of medication.

8. Flanigan was aware that respondent's outpatient psychiatrist, Dr. Howard Hicks, believed that respondent was abusing her pain medication, and that respondent did not agree with Dr. Hicks' assessment. Flanigan did not offer an opinion as to whether respondent did or did not abuse her medication. She testified that if she had had concerns about respondent's ability to practice medicine, she would have recorded that in her chart notes. No such concern is there recorded.

9. Flanigan testified in a professional, direct, objective, and careful manner. She did not appear to have any bias, or to overstate any of the matters about which she testified.

⁴ Respondent was admitted to the CIOP several times in December 2002; on each such occasion, she was discharged from the program upon her inpatient admission to the hospital in connection with the episodes discussed below in this Proposed Decision.

⁵ This paragraph is based on both Flanigan's testimony at the hearing and her therapy notes and other medical records she prepared.

⁶ Flanigan referred in connection with respondent's December 2002 inpatient hospitalizations to "the context of intense suicidal ideation and [that] patient at points took excessive medication." Flanigan testified that she did not recall what she meant by "excessive medication," and that nothing more may have been involved than the taking of one pill in excess of what was prescribed.

10. Howard Hicks, M.D., has been a psychiatrist since 1981. He is not Board certified. Respondent was his patient from September 29, 1998 to April 10, 2003.

Dr. Hicks testified that respondent first came to him with a diagnosis of general anxiety disorder, which Dr. Hicks confirmed. Later, it became apparent to him that she had a major depressive disorder as well.

In March 2003, Dr. Hicks diagnosed respondent with "polysubstance abuse."⁷ He made this diagnosis on the basis of a series of events occurring during the period from December 2002 to March (and, eventually, April) 2003, including: (i) that respondent came to his office impaired on two or three occasions,⁸ i.e., with slurred speech, unsteady gait, forgetfulness, needing to have questions repeated, and appearing to fall asleep; (ii) her reporting of a couple of minor automobile accidents; (iii) her lack of truthfulness about what medications she was prescribed and taking, which Dr. Hicks viewed as a desperate attempt to cling to narcotics and benzodiazepines, her "drugs of choice";⁹ (iv) her husband's phone call to Dr. Hicks, which Dr. Hicks understood to reflect her husband's concern that respondent was impaired at home, and his related concern for the safety of their son; (v) that her family planned an intervention on her behalf relating to her drug and alcohol problems; and (vi) respondent's several hospital admissions, one of which, in late December 2000, resulted from an incident when she phoned him and expressed a concern she may have taken too much Xanax.¹⁰

Because of the events described above and Dr. Hicks' polysubstance abuse diagnosis, Dr. Hicks told respondent that she would have to address her chemical dependency before she could address other problems (i.e., anxiety, depression). Respondent disagreed with Dr. Hicks, who then told her that he could not treat her if they had such a fundamental difference in approach. As a result, their therapeutic relationship was terminated in April 2003.

11. Dr. Hicks testified that respondent's above-described impairment could but was unlikely to have resulted from taking her medications as prescribed.¹¹ He added that under the

⁷ "Polysubstance Abuse" is not identified as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR). Instead, substance abuse mental disorders are identified by categories, e.g., Cannabis Abuse, Hallucinogen Abuse, Opioid Abuse. Additionally, the disorder of "Polysubstance Dependence" is recognized.

⁸ Respondent had 17 sessions with Dr. Hicks during this period.

⁹ Dr. Hicks also testified that at one point he suggested that respondent stop taking Xanax, and she protested "vociferously." This caused Dr. Hicks to believe that Xanax was a drug of choice and was hurting her.

¹⁰ Xanax is a benzodiazepine used to treat anxiety and panic attacks.

Dr. Hicks testified about what was possibly a distinct incident, when, on December 16, 2002, respondent called and told him that she had taken over 50 Xanax tablets, as well as two Vicodin tablets and two wine coolers to "knock her out."

¹¹ In addition to Xanax and narcotics, which Dr. Hicks was aware that respondent was

totality of the described circumstances, he did not believe that her impairment could reasonably be explained in that way.

Dr. Hicks testified that once an individual is diagnosed with polysubstance abuse, the diagnosis in some sense follows or remains with the patient, even during periods when the patient is not using the drugs in question, and even though the patient is not impaired during periods of non-use. This is especially the case if a chemical dependence is "primary," i.e., genetic. If, on the other hand, the dependence is "secondary," i.e., arises out of an attempt to address a particular primary problem such as depression, migraine headaches or anxiety, and if the primary issue is successfully addressed, the likelihood of relapse into drug abuse is substantially less, though not "zero." He added that if respondent did not undergo a "downward spiral" within the past six years, he would think that she had managed to get "clean and sober."

12. Since respondent left Dr. Hicks' care in April 2003, Dr. Hicks has had no contact with respondent's other health care providers or colleagues.

13. During his testimony, Dr. Hicks exhibited a palpable degree of hostility toward respondent and toward members of her family who were present at the hearing. At times he seemed inclined to assume the worst about respondent. For example, he did not contact her colleagues because he "knew" that she would not have given him permission to do so.

14. Michael Ricciardi, M.D., is a staff psychiatrist at the Naval Medical Center of San Diego. From 2001 to 2006, he practiced at Mesa Vista. Respondent came under Dr. Ricciardi's care in late November 2002, on referral from Dr. Hicks, and remained under Dr. Ricciardi's care until mid April 2003.¹² Dr. Ricciardi testified with regard to some of his medical records, but he had practically no independent recollection of respondent or his treatment of her. Mesa Vista (and other) records reflected that respondent underwent four acute psychiatric inpatient hospitalizations in December 2002 and early January 2003, precipitated by a crisis relating to her employment with the Navy.

a. *December 11, 2002.* In a Mesa Vista admission history dated December 11, 2002, Dr. Ricciardi referred to respondent's problems with the Navy, and in particular to the recent issuance of a 1,000 page EEO report, which essentially exonerated everyone but her in connection with a sexual harassment claim she had filed against a fellow radiology resident.¹³ On the evening of December 11, 2002, respondent "began to have thoughts of suicide and of self-injury. She was uncomfortable with remaining at home, fearing that to do so would allow opportunity for her to hurt herself or her children. She sought counsel with . . . Dr. Hicks, who

taking, respondent at some point advised him that she was taking pursuant to prescription Neurontin, another pain medication, initially 900 mg, but later 1,200 mg. Dr. Hicks testified that at the 1,200 mg level, Neurontin can also cause impairment.

¹² Respondent was under Dr. Ricciardi's care in connection with her several admissions into the CIOP and one or more of her inpatient admissions at Mesa Vista.

¹³ This incident is described below.

recommended referral to the inpatient unit.”¹⁴ Dr. Ricciardi described respondent as “awake, tired, alert, and oriented to person, place, time, and situation,” and also “depressed and dejected.” Her speech was described as “spontaneous and regular in rate, rhythm, modulation, and volume. Thought processing is logical, linear, and goal directed.” Respondent expressed “concern for her own safety at home given the frequency of the suicidal ideas and the safety of her children as well. When she considers suicide she is burdened with guilt of leaving her children and has commented more than once that she would have to take the children with her.”¹⁵ Dr. Ricciardi’s “psychiatric impression” included major depression, chronic, severe, without psychosis and anxiety disorder not otherwise specified. He referred as well to respondent’s migraine headaches. He made no reference to substance abuse. Respondent was discharged on December 13, 2002.

b. *December 16, 2002.* In a Mesa Vista CIOG discharge summary dictated on February 3, 2003, Dr. Ricciardi stated that respondent was discharged from the CIOP on December 17, 2002,¹⁶ and admitted to the inpatient unit, because she “was expressing suicidal ideas.” From there, respondent was referred to the Naval Medical Center San Diego (NMCS D).¹⁷

According to NMCS D records, respondent stated that at about 6:00 p.m. on December 16, 2002, she took 45 Xanax tablets,¹⁸ two Vicodin,¹⁹ and three wine coolers, explaining that she felt “very stressed” and “wanted to go to sleep” or “take a break.”²⁰ She later corrected herself, stating she had taken “closer to 10 mg” Xanax. Respondent denied suicidal intent. After taking the medication, respondent called her psychiatrist, Dr. Hicks, who told her to go to the hospital. She went to the Sharp Coronado Hospital emergency room, and, after she was medically cleared from her Xanax overdose, she was transferred to NMCS D. Respondent related to NMCS D staff some of the details concerning her sexual harassment complainant, as well as several other Navy-related “stressors” with which she was trying to cope. She described semi-weekly panic attacks, which she treated with Xanax. She stated that she had been diagnosed with major

¹⁴ Dr. Ricciardi testified that the information recited here came from respondent herself.

¹⁵ Dr. Ricciardi testified that he thought respondent meant by this last comment that if she killed herself, she would kill her children as well. He did not explain the basis for his opinion. Respondent testified that she did not make this comment at all.

¹⁶ Respondent’s inpatient admission was the prior evening, December 16. She was discharged from the CIOP on December 17, after program staff called respondent’s home and learned from respondent’s husband of her inpatient admission the night before.

¹⁷ NMCS D was respondent’s duty station, and her transfer there caused her substantial additional anxiety and embarrassment. It was not claimed, however, and the evidence did not suggest, that the transfer to NMCS D was other than coincidental.

¹⁸ NMCS D documents variously record respondent claiming to have ingested 45, 50, or 60 Xanax.

¹⁹ Vicodin is an opioid used to treat pain.

²⁰ As set forth below, respondent denied that she ingested any alcohol or Vicodin. Lab test results from later in the evening of December 16 were negative for opiates and alcohol, thus supporting her testimony.

depression, general anxiety disorder, and post-traumatic stress disorder. Respondent was given a mental status exam. Her level of consciousness “was alert and nonfluctuating and the patient was oriented in four spheres.” Her speech “was characterized by normal rate and rhythm.” Her memory “appeared intact,” and her “[a]ttention and concentration skills appeared unimpaired.” Respondent’s discharge diagnoses included major depressive disorder, panic disorder, general anxiety disorder, migraines, and occupational problems. Respondent was discharged on December 17, 2002.²¹

c. *December 27, 2002.* In an admission history dated December 31, 2002, Dr. Ricciardi referred again to the EEO report. He stated that after returning home earlier that day from the CIOP, respondent “found herself becoming more agitated, anxious and depressed” and went to her parent’s home. “There she continued to experience worsening of her depressed mood and emergence of suicidal ideas in the form of taking an overdose of medications with the hope of sleeping through the weekend.” Her parents then drove her to the hospital. Respondent was “drowsy, awake, and alert,” and “fully oriented to person, place, time, and situation. Her speech is responsive, low in volume, somewhat slow, but otherwise regular in rate and modulation.” Her “thought processing is slow but linear and goal directed.” He added, “The patient’s cognitive functions are mildly impaired with deficits of concentration and short-term memory.” Dr. Ricciardi’s psychiatric impressions included major depression, chronic severe without psychosis and anxiety disorder not otherwise specified. He also referred to her migraine headaches. No reference was made to substance abuse. Respondent was discharged on December 30, 2002.

d. *January 5, 2003.* In an admission history dated January 6, 2003, Dr. Ricciardi referred to respondent’s four recent “acute episode[s] of depression with suicidal ideation,” resulting in admissions at Sharp Mesa Vista and Balboa Naval Hospital. Dr. Ricciardi noted that respondent “does not take lethal overdoses as a suicide act,²² but has now twice overdosed on prescribed medications, the first time Xanax and currently Vicodin.”²³ Dr. Ricciardi described respondent’s present mental status as, inter alia, “drowsy, awake and alert. She is oriented to person, place, time, and situation. . . . Cognitive functions are mildly impaired with deficits of concentration and short term memory.” His psychiatric impressions included major depression, chronic severe without psychosis, anxiety disorder not otherwise specified, and migraine headaches. Substance abuse was not included among Dr. Ricciardi’s impressions. Respondent was discharged on January 6, 2003.

²¹ The matters set forth in this paragraph are based primarily on NMCSO medical records, not those of Dr. Ricciardi.

²² However, according to a nursing admission assessment dated January 5, 2003, respondent stated that she had tried to commit suicide in December 2002.

²³ Dr. Ricciardi testified that the reference to a “current” Vicodin overdose pertained to the then-current hospitalization. His report did not provide any details as to what this overdose involved. It is possible that the “overdose” in question was respondent’s taking of two Vicodin tablets on one occasion within a shorter time interval than prescribed (see Finding 35).

15. In a chart note dated January 22, 2003, Dr. Ricciardi wrote that respondent “had an argument with her mother yesterday afternoon because mother questioned the safety of the children with her.” In a note dated January 29, 2003,²⁴ respondent was noted to be lethargic, with “affect blunt, pupils pinpoint, reacting equally to light, speech slurred, gait steady. Stated felt very tired. Was up last night with baby and relates, feeling [illegible] groggy with Neurontin.”

In an outpatient progress note dated April 3, 2003, Dr. Ricciardi noted respondent’s statement that “she has not acted on [suicidal ideation] however has missed Dilaudid²⁵ prescribed for headache.” Dr. Ricciardi cautioned respondent “to not misuse medication—either analgesics, anxiolytics and other psychotropics.” In his assessment, Dr. Ricciardi wrote, “Pt at this time is functioning poorly and in a regressed state of dependency.” This statement was made in the context of respondent’s service in the Navy, not medications.

In an outpatient progress note dated April 7, 2003, Dr. Ricciardi’s “impression” was Depression, Anxiety and Benzodiazepine abuse. Dr. Ricciardi testified in somewhat unclear terms to the distinction between an “impression” and a formal “diagnosis.” Dr. Ricciardi’s note did not explicitly state the basis for his impression of substance abuse. However, the note states, “Girlfriend and parents now saying they think she has become drug dependent.” Further, the note refers to a conversation Dr. Ricciardi had with Dr. Hicks. It thus appears likely that Dr. Ricciardi’s impression of substance abuse was based primarily on the perceptions of respondent’s family members and the opinion of Dr. Hicks.

In Dr. Ricciardi’s April 11, 2003, discharge summary, he identified major depression, chronic, severe, without psychosis and post-traumatic stress disorder as respondent’s diagnoses. He also made reference to anxiety, to “vague suicidal ideas,” and to respondent’s migraine headaches. He also noted, “At the time of discharge, the patient was able to accept and tolerate active duty service in the Navy” He made no reference to substance abuse.

16. Luis Becerra, M.D., is a board-certified neurologist, a Commander in the United States Navy, and an Assistant Clinical Professor of Surgery at the Uniform Services University. Respondent was one of Dr. Becerra’s neurology students, and she was also his patient, from August 2001 to September 2003, when he treated her for migraine headache pain at the regional Navy headache clinic he headed as part of his duties as Head of the Neurology Division at NMCSO.

Dr. Becerra testified that among the medications he prescribed for respondent were beta blockers and, in late 2002 to early 2003, Neurontin and Topomax. These medications, even when taken as prescribed, can have significant side effects, such as diminished attention and concentration, and apparent impairment. With regard to Neurontin, significant side effects are possible at the 300 mg level (the “starting” dose), but the usual dose is much higher, from 900 to

²⁴ The identity of the person who prepared this chart note is not known. It is, however, a Sharp Mesa Vista team progress note; Dr. Ricciardi is listed as the assigned physician.

²⁵ Dilaudid is an opioid spray used for pain relief.

1200 mg. He started respondent out at 300 mg, then later increased her dosage to 900, and then finally to 1200 (around early summer 2002).

Dr. Becerra testified that he never suspected respondent of abusing her medications, and never thought she was a drug-seeking patient. He added that between 2001 and 2003, he was the Chair of the Pharmacy and Therapeutics Committee, i.e., the narcotics "Czar." In that capacity, he had to know who was and who was not dependent on medications.

Dr. Becerra testified that he was aware of respondent's allegations of sexual harassment; he counseled her to address them by following the chain of command. Based on that harassment and respondent's physical condition, Dr. Becerra felt that she should leave the Navy. With regard to her headaches, respondent was found fit for duty by the Central Physical Evaluation Board. She was, however, later discharged as unfit for duty due to depression. Her migraines were a "factor" in her discharge.

January to August 2007

17. Rene Endow-Eyer, Pharm.D., is employed at the VA Hospital in San Diego as a psychiatric clinical pharmacist. She sees patients one-on-one (as a psychiatrist would) and prescribes medication under protocol. She is engaged, inter alia, in medication management, i.e., the prescribing, adjusting, and changing of medications. Dr. Endow treated respondent from October 2005 to February 6, 2007. Respondent was formally released from Dr. Endow's care on March 13, 2007.

During respondent's first visit with Dr. Endow, respondent denied alcohol use. Respondent identified Triazolam, a benzodiazepine, for insomnia, and Bupropion (Wellbutrin)²⁶ as the medications she was currently taking. Respondent did not advise Dr. Endow concerning any prescriptions for Dilaudid spray or Norco/Vicodin.²⁷ Dr. Endow testified that she would have wanted to know if respondent were taking other medications (e.g., for pain management), so as to avoid unintended duplication of therapy and to guard against unintended drug interactions. Dr. Endow prescribed Temazepam, also a benzodiazepine, for respondent's insomnia. Dr. Endow testified that it was her understanding that respondent would no longer be receiving Triazolam or any other benzodiazepine. Dr. Endow's prescription of Temazepam was also based on her understanding that respondent was not drinking alcohol—if she had known otherwise, it would have affected her continued prescription of a benzodiazepine.

In March 2006, Dr. Endow issued a prescription to respondent for Wellbutrin.

In May 2006, Dr. Endow increased respondent's Temazepam prescription from 30 to 45 mg. She did so based on the belief that respondent was not receiving benzodiazepines from any

²⁶ Wellbutrin is an antidepressant.

²⁷ Norco is an opioid, used to treat pain. It is very similar to Vicodin, but each Norco tablet contains 10 mg of the opiate hydrocodone, whereas each Vicodin tablet contains only 5 mg of that drug.

other source. Dr. Endow testified that she was not sure she would have increased the dosage had she known that respondent was receiving benzodiazepines from another source. At this time, according to Dr. Endow's notes, respondent again denied alcohol use.²⁸

On January 9, 2007, respondent expressed concern that "at times anxiety is too much for her while driving, stutters while speaks." On that date, Dr. Endow first issued to respondent a prescription for Lorazepam (Ativan), another benzodiazepine used to treat anxiety.

On January 23, 2007, at least in part based on respondent's suggestion, Dr. Endow increased the dosage of that prescription. At the same time, Dr. Endow discontinued respondent's prescription for Temazepam. Respondent advised Dr. Endow at this time that she had seen psychiatrist Laura Vleugels the preceding week, and that respondent had received Ambien CR²⁹ from that source. Respondent did not mention receiving benzodiazepines or Wellbutrin from any other source. Dr. Endow testified that if she had known respondent was receiving Wellbutrin from Dr. Vleugels, she would not have continued prescribing it, due to the danger of seizures at high doses. Dr. Endow also noted, "pt seems to minimize her symptoms and this is the first time she's been honest with her symptoms with writer."

On February 6, 2007, with respondent's agreement, Dr. Endow decreased respondent's Lorazepam prescription because respondent was noted to have "slurring speech." Dr. Endow also noted respondent was "somewhat unsteady walking down the hallway." Dr. Endow testified that if respondent were getting this medication elsewhere, that could also cause slurred speech, as could taking too high a dosage of the medication.³⁰ Dr. Endow also noted at this time that respondent "seems to minimize her symptoms."

On February 27 and March 7, 2006, respondent executed medical releases so that Dr. Endow and Dr. Vleugels could communicate with each other about her. On March 13, 2007, Dr. Endow phoned Dr. Vleugels. Dr. Endow and Dr. Vleugels discussed medications that each had prescribed to respondent. Dr. Endow learned that both she and Dr. Vleugels were prescribing

²⁸ On several other occasions, Dr. Endow's notes reflected respondent's denial of alcohol use. Dr. Endow testified that it is her practice to manually enter (type) this information into each electronic chart note; she admitted, however, that she had no independent recollection of having done so in this case, or of her conversations with respondent about alcohol use. Dr. Endow's numerous references to respondent's alcohol and drug use consisted of the following identical language. "Denies ETOH/drug use. Denies tobacco use. Drinks occ caffeinated soda 3-4x/wk. Is being followed in FIRM [i.e., medical providers]." The conclusion seems inescapable that, whatever Dr. Endow's standard practice, in this case she in fact copied and pasted the quoted language into her notes on each occasion. Dr. Endow's claim that respondent repeatedly told her that she did not drink alcohol is thus rendered somewhat questionable. It is rendered more questionable by the undisputed fact (see below) that respondent freely told Dr. Vleugels that she drank alcohol.

²⁹ Ambien is used to treat insomnia.

³⁰ Dr. Endow testified that slurred speech can also be a side effect when the medication is taken as prescribed.

Wellbutrin XL to respondent.³¹ As a result of her conversation with Dr. Vleugels, and because it would create a conflict for a patient to see two different providers for medications, as well as a risk of duplication of services and unintended drug interactions, Dr. Endow discontinued all medications she had prescribed to respondent. Further, Dr. Endow and the VA “team” determined that it was not in respondent’s best interest to receive treatment and medication management from two providers, and that respondent should therefore be given the option to choose between the VA and Dr. Vleugels. It was respondent’s decision to terminate her treatment with Dr. Endow.

Dr. Endow never had a concern that respondent had a drug abuse or dependence problem. She never observed respondent impaired and she never believed that respondent was taking excessive medications.³²

Dr. Endow testified in an objective, fair manner. She did not come across as attempting to advocate for or against respondent.

18. Laura Vleugels, M.D., is a psychiatrist, licensed in California since 2003. She treated respondent from January 2007 to October 2008. From the outset, it was Dr. Vleugels’ understanding that respondent was transferring her psychotherapeutic treatment from Dr. Endow to herself.

Dr. Vleugels stated³³ that at her initial session with respondent on January 12, 2007, respondent identified her symptoms as including “very poor concentration medical school—on (i.e. CME lectures),” “worried about catching pedestrians (driving),”³⁴ “exhaustion all the time,” and “fatigue – wants to go to bed as soon as she gets home.” Respondent told Dr. Vleugels that she had suffered from migraine headaches since she was in her early twenties. Among the medications respondent told Dr. Vleugels she was taking were Citalopram (Celexa), Fioricet,³⁵ and Dilaudid spray. Respondent stated that her alcohol use was “rare.” Dr. Vleugels did not note in her chart that respondent identified Vicodin as one of her pain medications; she thus did not believe that respondent told her she was taking that drug. Dr. Vleugels’ assessment included diagnoses of major depressive disorder (MDD), general anxiety disorder (GAD), and post traumatic stress disorder (PTSD). With regard to her plan, she noted, “No change in meds at this time—will send for VA records [and] Gifford records.”

On January 17, 2007, respondent brought two VA medications to show Dr. Vleugels, Wellbutrin and Citalopram. Dr. Vleugels prescribed Lorazepam for respondent’s anxiety. Dr.

³¹ As found below, Dr. Vleugels was already aware of this fact, since respondent had told her so.

³² These facts are inferred from the absence of any such notations in Dr. Endow’s chart.

³³ The Factual Findings relating to Dr. Vleugels are based both on Dr. Vleugel’s testimony and on her chart notes.

³⁴ Dr. Vleugels was not certain but believed this chart note referred to respondent’s anxiety, not to any substance abuse issues.

³⁵ Fioricet is a barbiturate used to treat headache pain.

Vleugels did not know at the time that respondent had already been prescribed a benzodiazepine from another source—though that knowledge would not have affected her decision to prescribe Lorazepam to respondent. Dr. Vleugels' assessment and plan remained unchanged. On January 24, 2007, Dr. Vleugels prescribed Clonazepam (Klonopin), another benzodiazepine, used to treat anxiety, and continued two prescriptions, for Wellbutrin and Citalopram,³⁶ which respondent had received from the VA. Dr. Vleugels noted that respondent's sleep had "markedly improved on Ambien CR."³⁷ Her diagnosis remained unchanged. On January 31, 2007, respondent advised Dr. Vleugels that a pharmacist at the VA told her two weeks before that "Celexa wasn't for me." Dr. Vleugels did not know at this time that the VA pharmacist had been prescribing benzodiazepines to respondent. Dr. Vleugels' assessment at this time was major depressive disorder (MDD), general anxiety disorder (GAD), and "panic."

On February 7, 2007, respondent told Dr. Vleugels that she had one drink per night. Dr. Vleugels "encouraged" respondent not to drink alcohol while taking benzodiazepines, due to the "additive effect," and noted that respondent "verbalized understanding." Dr. Vleugels' diagnosis remained unchanged.

On February 14, 2007, respondent told Dr. Vleugels that she had consumed two drinks during the preceding week. Dr. Vleugels again "cautioned [respondent] @ use of ETOH [i.e., alcohol] w/benzos given additive effect." Dr. Vleugels' diagnosis was MDD, GAD and post-traumatic stress disorder (PTSD). As of that date, respondent had still not told Dr. Vleugels that she had been prescribed Ativan from the VA.

On February 26, 2007, respondent told Dr. Vleugels about a conflict she had had with her husband while on vacation. According to Dr. Vleugels' chart note, respondent's husband expressed concern "about medicines combining and leading to" side effects. Specifically, respondent woke up with a headache one day after drinking two piña coladas the previous evening, and took dilaudid nasal spray.³⁸ Respondent's husband "felt she was unsteady on her feet, confused (per pt). He took away her meds" for one day. Respondent explained to Dr. Vleugels that she took Dilaudid spray, albeit rarely, and that her husband "has always had concern about dilaudid." Respondent made reference to a Dr. Tiffany, whom she saw every three months, and from whom she received "pain control" medications for her headaches. Dr. Vleugels' diagnosis was "MDD recurrent severe," "GAD w/panic," and PTSD. Dr. Vleugels "[d]iscussed importance of not drinking w/combo of benzos/narcotics." She noted that respondent "agrees not to drink," and "not to use nasal spray/dilaudid." Dr. Vleugels noted that

³⁶ Like Wellbutrin, Citalopram is an anti-depressant.

³⁷ Dr. Vleugels testified that she did not know how or where respondent received this medication. Dr. Vleugels believed that she may have given respondent samples; her chart notes did not reflect this, however.

³⁸ Dr. Vleugels testified that if respondent used the Dilaudid spray "a number of hours" after she consumed the drinks, there would not have been an additive effect. Dr. Vleugels believed that in fact the alcohol respondent had consumed the preceding evening would have been out of her system by the time she took the Dilaudid spray.

she had phoned and left a message for Dr. Endow at the VA, and that respondent told her she was no longer seeing Dr. Endow.

On February 26, 2007, after her session with respondent, Dr. Vleugels received a phone message from respondent's husband, Mark. According to Dr. Vleugels, she called respondent, who "gave me permission to return his call but preferred that I not release info w/o her being present." According to her chart notes, Dr. Vleugels called Meoni, who expressed concern "that Jill is not presenting a clear picture of her medications. He notes she was extremely sedated last week 'this isn't the first time . . . ' 'She is in denial.'" Meoni felt that Dr. Vleugels did not have a clear picture of what respondent was taking and the impact of her medication on her. Dr. Vleugels did not recall at the hearing whether Meoni's concern was about medications in general, or about Dilaudid in particular.

On March 7, 2007, respondent advised Dr. Vleugels that she had "had a bad [headache] the other night—husband had taken her Dilaudid & not given it back. Husband rubbed her head. Took Fioricet—didn't help." Respondent told Dr. Vleugels she was very upset that Meoni had called Dr. Vleugels, and that Meoni's lack of understanding of respondent's depressive and anxiety disorders was causing some conflict between them. Dr. Vleugels' diagnosis at this time was MDD, GAD, and PTSD. Dr. Vleugels discussed her recommendation that respondent decrease her use of benzodiazepines, and reviewed the side effects, including "mental clouding, sedation, care with driving potential for abuse/dependence, risks of combing with other meds—esp narcotics. No ETOH." Dr. Vleugels noted that respondent "agrees not to drink ETOH" and "[n]o longer plans to take Dilaudid for migraine pain."

On March 13, 2007, Dr. Endow phoned Dr. Vleugels, and they spoke concerning the various medications that each had prescribed for respondent. Dr. Endow told Dr. Vleugels that she had prescribed Lorazepam to respondent. Dr. Endow told Dr. Vleugels that she had terminated her care of respondent and would no longer be providing further treatment or medications for respondent. Until her conversation with Dr. Endow, Dr. Vleugels was unaware that respondent had been prescribed a benzodiazepine from another provider.

On March 14, 2007, Dr. Vleugels "confronted [respondent] with my concerns about her taking benzos from 2 sources, her having had at least 3 episodes of oversedation,³⁹ her continued use of ETOH, her need for narcotics." Respondent denied that she took more benzodiazepines than had been prescribed, and explained that she "felt badly about terminating with [Dr. Endow] and that the VA mailed refills." Dr. Vleugels stated that respondent had never disclosed to her that she was receiving benzodiazepines from the VA on an on-going basis, and that this raised a "red flag," as one indication of substance dependence is securing medication from multiple sources. Further, Dr. Vleugels was concerned that if respondent took too many benzodiazepines, this could result in oversedation, as could her taking benzodiazepines in combination with alcohol. Dr. Vleugels noted, "While [respondent] is not accepting of my concerns of substance dependence, she agrees with my plan to taper her off benzodiazepines. She agrees not to obtain

³⁹ Dr. Vleugels testified that the source of this information was respondent herself, as well as Mark's more general concern that respondent was oversedated.

benzos from other sources.” Dr. Vleugels felt that respondent minimized Dr. Vleugels’ concerns about respondent’s securing benzodiazepines from two sources, offering as an explanation that she continued to receive these drugs from the VA, because they were shipped to her automatically. Regarding respondent’s narcotic use, Dr. Vleugels was concerned that such use might lead to drug interactions with the medications she (Dr. Vleugels) was prescribing or to side effects that could impair respondent. Dr. Vleugels’ diagnosis was MDD, GAD, PTSD, and, for the first time, “benzo dependence?”⁴⁰ Dr. Vleugels’ plan included “No ETOH” and that respondent “agrees for all benzos to come from me.”

On April 25, 2007, Dr. Vleugels noted that respondent complained of “difficulty w/focus at work.” She also stated, however, that “concentration has improved—i.e. @ CME.” Respondent told Dr. Vleugels that she was not taking Dilaudid spray, but instead Fioricet as needed, for her headaches. Dr. Vleugels’ diagnosis was MDD, GAD, PTSD, and “Benzo abuse?”

On May 9, 2007, Dr. Vleugels’ diagnosis was PTSD, GAD, MDD and “benzo abuse.” No other information noted in the chart explains or suggests why the question mark was deleted from the “benzo abuse” reference. Dr. Vleugels testified that at this point, she had still not made a formal diagnosis of benzodiazepine abuse, but was keeping it on her list as something she was considering.

On May 30, 2007, respondent informed Dr. Vleugels of her May 24-25 hospitalization, “secondary to altered mental state.”⁴¹ Respondent admitted to using alcohol and headache medications on the date she was hospitalized, but denied any intentional overdose. She agreed to sign a release so that Dr. Vleugels could secure the relevant medical records. Dr. Vleugels’ diagnosis remained unchanged. She cautioned respondent with regard to the use of alcohol and opioids.

On June 6, 2007, Dr. Vleugels reviewed certain medical records relating to respondent’s recent hospitalization. She testified that the statement in one document (a narrative summary of respondent’s hospitalization) that respondent had had “a couple drinks of ETOH daily over the past several days to help her sleep” was inconsistent with respondent’s statements to Dr. Vleugels that she was not consuming any alcohol. Based on her review of the records, Dr. Vleugels understood that altered mental state was one of the diagnoses of respondent, and that respondent underwent a psychological evaluation. Dr. Vleugels’ diagnosis was MDD, GAD, and PTSD; benzodiazepine abuse was no longer mentioned. No explanation for its absence was provided, but Dr. Vleugels testified that its removal meant that it was no longer an ongoing concern for her. On no subsequent occasion during her treatment of respondent did Dr. Vleugels identify substance abuse as a possible or actual diagnosis of respondent.

⁴⁰ Dr. Vleugels testified that this note (in particular the question mark) meant that possible benzodiazepine dependence was becoming a concern to her, but was not at this point a formal diagnosis.

⁴¹ 41 This hospitalization is described below.

On June 13, 2007, respondent informed Dr. Vleugels that she had had a rum and Coke the previous evening. Dr. Vleugels testified that doing so was contrary to respondent's agreement not to consume alcohol. Dr. Vleugels' diagnosis was unchanged.

On July 18, 2007, respondent reported increased anxiety, and "Had feeling crossing the bridge this am—had intrusive thought of driving off the bridge." Dr. Vleugels did not recall that this intrusive thought was a recurring one. Respondent reported "no significant use" of headache medication. Respondent did not report that she had taken Vicodin as prescribed by Dr. Umansky in connection with any plastic surgical procedure.⁴² Dr. Vleugels' diagnosis remained unchanged.

On August 1, 2007, respondent told Dr. Vleugels that she was "just a basketcase,"⁴³ that she had "really bad anxiety—all day, everyday. Trouble thinking clearly." Respondent was experiencing "horrible" headaches, and was taking "round the clock Fioricet."⁴⁴ Dr. Vleugels' diagnosis remained unchanged.

19. On August 8, 2007, Dr. Vleugels submitted a complaint to the medical board about respondent. She wrote:

"This physician struggles with chronic severe headaches and an anxiety disorder. She is on multiple medications. She was recently admitted to the hospital for altered mental status. She was under the influence of prescribed medications and admitted to recent alcohol use. I have concerns about this physician—she is a radiologist who is on call at all times to read images. Her prescription drug use, alcohol use may impair her ability to work."

Dr. Vleugels testified that she initially contacted the medical board because of three "red flags": (i) Respondent's receipt of benzodiazepines from two sources; (ii) Mark Meoni's phone call reflecting that respondent was having problems relating to medication; and (iii) respondent's May 2007 hospitalization. Her purpose in placing the call was to ascertain whether she was required to report respondent to the board. The board's representative told her that she "might want to file" the complaint, for "ethical reasons." Based on this statement, Dr. Vleugels felt compelled to file the complaint.

20. On November 28, 2007, respondent and Dr. Vleugels discussed a letter respondent had received from the medical board informing her that a complaint had been filed against her. Respondent "firmly believes someone in radiology reported her." Dr. Vleugels did not tell respondent that she herself was the reporting party. Substance use was discussed. Respondent told Dr. Vleugels she was decreasing her use of Dilaudid spray, and denied "obtaining from other sources."⁴⁵ Respondent acknowledged receiving benzodiazepines from two sources (i.e.,

⁴² Dr. Umansky's care of respondent is described below.

⁴³ This phrase is in quotation marks in Dr. Vleugels' chart notes.

⁴⁴ Again, the phrases are in quotation marks in Dr. Vleugels' notes.

⁴⁵ Dr. Vleugels testified that she did not recall ever hearing about a Dr. Umansky or the

Dr. Vleugels and the VA), and explained that this was because “she didn’t want to tell VA she had a new care provider.” Respondent further pointed out that “she tapered off without protest when evident they were not effective.” Respondent also acknowledged having one drink per night on occasion. Respondent did not believe substance use was “problematic.” Dr. Vleugels discussed with respondent the possibility of consulting with an addiction specialist, to which respondent replied, “That would be like my telling them [i.e., the medical board] they’re right!”

21. Dr. Vleugels continued to treat respondent for over a year after filing the medical board complaint. Dr. Vleugels did not disclose to respondent that she was the individual who had filed the complaint until October 2008. Her disclosure effectively ended the therapeutic relationship. Dr. Vleugels testified that she did not tell respondent sooner because she did not want such a disclosure to interfere with their working relationship. In February 2009, respondent sent Dr. Vleugels an intent to sue letter.

Dr. Vleugels testified in an objective manner. She did not seem defensive when asked pointed questions. She did not exhibit any hostility toward respondent, but seemed to answer questions honestly. On the other hand, the pending lawsuit constitutes a substantial source of potential bias.

22. On March 18, 2007, respondent was treated by Dr. John Berry at Midway Urgent Care for acute ear pain secondary to earplug impaction. After cleaning respondent’s ear, Dr. Berry discharged her with a prescription for Vicodin (16 tablets), which respondent filled the following day.

23. At about 3:00 a.m. on May 24, 2007, respondent was admitted to NMCS D with a complaint of ear pain. At that time, according to nursing notes, respondent “appears to be staggering and is in tears. Pt appears altered. Left ear pain. Pt slow to respond and answer questions.” At 3:30 a.m., it was noted that respondent had “slurred speech, not appropriately answering questions. Pt anxious, tearful & stating ‘my ear hurts.’” A note at 4:50 a.m. stated, “unable to maintain consent d/t [due to] AMS.”⁴⁶ A note at 7:30 a.m. stated, “Pt continues to be irrational, tangential, weepy emotional.” A psychological assessment was done at about 9:00 a.m. A blood alcohol test conducted at 11:30 a.m. reflected a blood alcohol content of 0.005 percent, i.e., a barely measurable amount. Lab tests were positive for barbiturates and opioids. As part of her treatment, respondent was administered morphine, which normally implies significant pain on the part of the patient. On physical examination at 1:00 p.m., respondent was found to be “awake, alert and oriented to time, person, place, and situation.” Respondent was discharged on May 25 at 11:50 a.m. to the ENT clinic for further management of her mastoiditis.⁴⁷ At the time of discharge, respondent’s diagnoses were “acute mastoiditis without complications,” “depressive disorder, not elsewhere classified,” and “migraine without intractable migraine.”⁴⁸

prescription of Vicodin by Dr. Umansky to respondent.

⁴⁶ AMS refers to altered mental state.

⁴⁷ Mastoiditis is an inflammation (i.e., infection) of a bone behind the ear.

⁴⁸ The “admission diagnosis” had been identified as “altered mental status, Otitis Externa,

24. Frank Tiffany, M.D., is an internist. He is not Board certified. From 2004 to 2008, he was a staff physician at Dr. David Smith's San Diego Comprehensive Pain Management Center (PMC). He was terminated in February 2008,⁴⁹ and has since practiced as an independent contractor, engaging in internal medicine and pain management. He has no special training in pain management aside from what he has learned on the job.

Respondent was a patient at the PMC from early 2003 to at least December 2007. During most of this time, it was Dr. Tiffany who treated respondent for migraine headache pain. Dr. Tiffany testified that a number of different medications were tried to address respondent's severe migraine headaches, and she was eventually stabilized on a combination of Dilaudid, Fioricet, and Norco.

On April 9, 2003, respondent signed an "Informed Consent For Opioid Maintenance" agreement. The agreement stated, inter alia, that "I consent to receive prescriptions for all opioid medication(s) exclusively from Dr. David James Smith, at SDCPMC."

Dr. Tiffany tells patients to take whatever medication they need when they need it, so long as they don't exceed the total amount prescribed during the prescription period, i.e., he warns them that they only have a certain amount of medication that must last a certain period of time.

In 2005, respondent was prescribed Dilaudid spray to be used up to four times per day. From March 2005 to May 2007, respondent underutilized the spray. According to Dr. Tiffany, she used only nine spray bottles, though she could have gone through 17 bottles and still been "within the correct framework." Norco was also prescribed during much of this period.

In August 2007, Dr. Tiffany discontinued Dilaudid, since respondent wanted to try a different medication. Dr. Tiffany discussed Actiq (i.e., Fentanyl "pops")⁵⁰ with respondent, and he gave her a two-week supply, as a trial, with instructions that she take one pop twice per day. Dr. Tiffany also gave respondent a Norco refill, but asked her to hold off on taking it, to see if the Actiq was effective. In September 2007, Dr. Tiffany noted in his progress notes that respondent had been having some severe headaches recently. Further, "She states she cont[inues] to utilize the Actiq pops which she states at times is not as eff[ective] so she ends up using two pops at a time. She would like to discuss with MD what the next strength of the pop is." By January 2008, Dr. Tiffany's prescription to respondent was now two Actiq pops at a time, twice a day. In other words, at some point Dr. Tiffany modified his prescription of Actiq to coincide with the level of the medication that respondent was in fact taking.

Respondent never advised Dr. Tiffany of other medications she was taking as prescribed by other physicians. He was not aware whether any other doctor prescribed headache medications at the same time that he himself did. More specifically, he was unaware in June

URI."

⁴⁹ Dr. Tiffany has sued Dr. Smith with regard to his termination.

⁵⁰ Fentanyl is an opioid, used to treat pain.

2007 that respondent was receiving Fioricet from a Naval hospital, at a time when he himself was prescribing to respondent another barbiturate, Fiorinal.⁵¹ In a January 17, 2008 chart note, Dr. Tiffany stated, "Pt reports that she was prev[iously] obtaining fiorinal from Balboa Hospital. However states that she would like to obtain at this facility vs. Balboa. Pt denies any medication refills."

Dr. Tiffany testified that he would want to know if another physician were prescribing benzodiazepines. A failure to disclose these matters would "raise a red flag" for him. He explained that it is important for a physician to have this kind of information, to be sure that there is no unintended drug interaction. It could be dangerous if a patient does not inform her physician of all of her medications.

Dr. Tiffany testified that he had no indication that respondent used any medications inappropriately. He has never seen her somnolent and has never seen her impaired.

25. William Umansky, M.D., is a board-certified plastic and reconstructive surgeon. In November 2005, Dr. Umansky performed an abdominoplasty on respondent. Respondent had a post-operation serroma (fluid collection), lasting a little longer than average, so Dr. Umansky saw respondent for about three months post-surgery for that condition. His prescription of Vicodin in November 2005 for post-operative pain was within his usual custom and practice. Dr. Umansky was aware at the time that respondent was being treated elsewhere for migraine pain. He did not know she was receiving Dilaudid; he testified that even if he had known this, it would not have changed his own prescription.

Dr. Umansky performed two more surgical procedures on respondent in 2007, a liposuction (in July) and a second, related procedure (in September). In both instances, Dr. Umansky prescribed Vicodin for post-operative pain. Dr. Umansky was unaware that respondent was receiving Norco elsewhere at the time of his own Vicodin prescriptions. He testified that had he been so aware, he would have discussed the matter with respondent and, depending on the outcome of that discussion, may or may not have changed his Vicodin prescription. He might possibly, for example, have prescribed a stronger dose of Vicodin, if he concluded respondent's need for pain medication was greater than he originally thought to be the case.

Dr. Umansky testified that at no time did he believe that respondent was impaired, was abusing medication, or was engaging in drug-seeking behavior.

26. A Controlled Substance Utilization Review and Evaluation System (CURES) patient prescription history⁵² reflected, inter alia, the following prescription-filling history of

⁵¹ Fiorinal is very similar to Fioricet and is used to treat headache pain.

⁵² CURES patient prescription histories are compiled from information maintained by the Department of Justice, which consists of "Schedule II and Scheduled III prescription information that is received from California pharmacies and is therefore only as accurate as the information provided by the Pharmacies." Fioricet and Fiorinal, as well as benzodiazepines, are Schedule IV

respondent:

a. Between November 7 and 18, 2005, respondent filled three prescriptions for Vicodin, for a total of 110 tablets, prescribed by Dr. Umansky in connection with the plastic surgical procedural she underwent that month. She did not fill any other prescriptions for Vicodin or Norco during November 2005. However, she did during that month fill prescriptions for Fiorinal and Dilaudid spray, prescribed by PMC's Dr. Tiffany.

b. Between December 2005 and January 2007, respondent filled one prescription for Norco (20 tablets), four for Dilaudid spray, and two for Fiorinal (120 tablets), all prescribed by Dr. Tiffany.

c. In February and March 2007, respondent filled one prescription for Dilaudid spray and, on March 11, one for Norco (60 tablets), prescribed by Dr. Tiffany. On March 19, 2007, respondent filled one Vicodin prescription (16 tablets), prescribed by Dr. Berry for her ear pain. Between February 21 and March 7, she also filled three prescriptions for benzodiazepines prescribed by Dr. Vleugels (60 1 mg tablets of Clonazepam, 30 1 mg tablets of Lorazepam,⁵³ and 45 0.5 mg tablets of Lorazepam), as well as one prescription for Ambien CR (30 12.5 mg tablets), also prescribed by Dr. Vleugels.

d. Between May 10 and August 9, 2007, respondent filled one Dilaudid spray prescription and four Norco prescriptions (300 tablets), prescribed by Dr. Tiffany. In addition, respondent filled four Vicodin prescriptions (120 tablets), prescribed by Dr. Umansky in connection with the liposuction he performed in July 2007. Respondent did not fill any of the Dr. Tiffany prescriptions during the period she filled the Dr. Umansky prescriptions (i.e., July 12 through August 1).⁵⁴

e. Between August 29 and December 13, 2007, respondent filled one Norco prescription (90 tablets) and five Fentanyl prescriptions (270 pops), prescribed by Dr. Tiffany. Respondent also filled one Vicodin prescription (30 tablets), prescribed by Dr. Umansky, in connection with the November 2007 procedure.

depressants (Health & Saf. Code, § 11057, subd. (d)), and thus would not necessarily be identified in CURES histories, though at times, for reasons apparently not known to the parties, they do. Drugs prescribed by the VA (e.g., by Dr. Endow) also do not appear on CURES reports.

⁵³ This particular prescription was filled on February 24, 2007. Though not reflected on the CURES report, two days later respondent filled a Lorazepam prescription (60 2 mg tablets) that had been prescribed by Dr. Endow.

⁵⁴ It appears that respondent filled another Vicodin prescription, not reflected on the CURES report, 15 tablets on May 25, 2007, in connection with her discharge from the hospitalization of the previous day.

Respondent's Testimony

27. Respondent and her husband Mark were married in 1994. The couple has four children, presently 13, 12, 7 and 4 years old.

28. Respondent began her residency in radiology at NMCS D in 1998. She was the only female in her class.

Respondent testified that during the course of her residency, one of her male colleagues acted in inappropriate ways. Matters became more serious, despite respondent's attempts to talk to her colleague about his conduct, and during her second year respondent went to her program director. Finally, in March 2002, respondent filed a formal sexual harassment complaint. Shortly after filing the complaint, respondent was removed from her residency at NMCS D and placed elsewhere for further radiological training. Eventually, she was reassigned to NMCS D, where she completed her residency. In November 2002, she became Board certified, passing the exam on her first attempt. At some point during this period, respondent decided to seek a medical discharge from the Navy. The Navy initially refused the discharge, finding her fit for duty (in early 2003). Later, in August 2003, the Navy discharged her, based on findings of depression and anxiety.⁵⁵

29. Respondent testified concerning her four inpatient hospitalizations in December 2002 and January 2003.

a. *December 11, 2002.* Respondent testified that several days before she was admitted inpatient on December 11, 2002, she received her copy of the 1,000-page EEO report pertaining to her sexual harassment complaint. While she had concerns before the report was released about how objective or fair it would be, she nonetheless hoped that the report would vindicate her. When she reviewed it, however, she felt that it was unfair and biased. She became discouraged and disillusioned. She referred to the report as a "traumatic event." She felt that she needed some time alone to process the report, away from her family, and from her family responsibilities. She denied suicidal ideation. She stated that she did have thoughts about how the people who had hurt or betrayed her would feel if she were gone, i.e., if she killed herself, but she had no thoughts of actually ending her life, as that would leave her children without their mother.

b. *December 16, 2002.* Respondent testified that she was very stressed, was not sleeping well, and was continuing to think about the EEO report and the implications of that report for her Naval career. She was exhausted. She wanted to take a nap, get some rest, and let her husband take care of the children. To that end she took a "handful" of (about six to ten)

⁵⁵ The record was unclear with regard to whether respondent formally sought the discharge, or whether the Navy alone can institute discharge proceedings. In either case, the evidence was clear that it was respondent's desire and intention to be discharged. It is also clear that her discharge was for medical reasons, and not on the basis of any improper conduct on her part.

Xanax. “The instant I took that Xanax, I knew I had made a mistake.” She called Dr. Hicks to make sure that the amount she had taken would not be dangerous. She did not tell Dr. Hicks that she had taken 50 to 60 tablets.⁵⁶ Dr. Hicks advised her to go to the emergency room. She had her husband take her to the Sharp Coronado Hospital emergency room, where she spent several hours before being transferred to NMCS D. The transfer to her duty station upset her. Respondent denied that she took the Xanax in order to hurt, much less kill, herself—she just wanted to get some sleep. She in fact denied that admission on an inpatient basis was even medically necessary, though she felt it provided a therapeutic benefit to her.

c. *December 27, 2002 and January 5, 2003.* Respondent testified that the reasons for these two hospitalizations were the same as for the previous two, i.e., the enormous stress she was under in connection with the release of the EEO report, and the desire to have some time away from her family so that she could take care of herself without having to focus on other people.

Respondent testified that she has not had any inpatient hospitalizations for psychological reasons since the January 5, 2003 incident.

30. Respondent testified concerning the CIOG. She stated that the program was very helpful to her in three ways. First, it got her out of the Navy library, where she had been temporarily assigned during the pendency of her EEO complaint, and where she was getting hate mail. Second, it taught her a healthy pro-active way to deal with a life-altering event in her life (i.e., the EEO matter). Third, she missed having structure in her life—a goal, a purpose, a way to be productive.

Respondent testified with regard to the January 29, 2003, CIOP session that she had taken Neurontin the day before in the prescribed manner. She told CIOP personnel about the effects of Neurontin. Respondent thus attributes any perceived or actual impairment on January 29 to this prescription medication.

31 Respondent testified that she sought counseling from Dr. Vleugels as a result of the rescission of an offer of acceptance into a breast imaging fellowship at UCSD in late 2006. When respondent met Dr. Vleugels, respondent told her “about” Dr. Endow and signed a release so that Dr. Vleugels could secure records from the VA. Respondent also told Dr. Endow about Dr. Vleugels and signed a release so that Dr. Endow could secure Dr. Vleugels’ records. Respondent acknowledged that she did not advise Dr. Vleugels about all of the medications (specifically Ativan) she was receiving from Dr. Endow, and vice versa; respondent explained that she was preoccupied at the time with the rescission of her UCSD fellowship and was also trying to determine which of the two providers (Dr. Endow or Dr. Vleugels) she was going to stay with. She stated she never intended to deceive either provider. During the three-week

⁵⁶ Respondent testified that she never told anyone that she had taken Vicodin or wine coolers. Negative lab test results for opiates and alcohol confirmed respondent’s testimony.

“transition period” (i.e., between January 12 and February 6, 2007),⁵⁷ respondent expected that the two providers would be communicating with each other.

32. Respondent testified that during a Disneyland trip at the end of February 2007,⁵⁸ she had two piña coladas during dinner one evening, woke up the next morning with a headache, and took Dilaudid spray in an effort to abort the headache. Respondent did not take any benzodiazepines during the Disneyland trip. Respondent was using Dilaudid about twice per week at this time under Dr. Tiffany’s care, in contrast to four times per day that she was previously using that medication under Dr. Smith. She added that Dr. Vleugels never instructed her not to drink alcohol. Indeed, on the occasions when respondent told Dr. Vleugels that she had consumed alcohol, Dr. Vleugels did not show much of a reaction.

33. With regard to the May 24, 2007 incident, respondent testified that she went to the emergency room because of an ear infection that was resisting treatment and whose symptoms were recurring and becoming very severe. She had taken Norco earlier in the day, but not benzodiazepines and not Dilaudid. She had a rum and Coke that day as well, around 7:00 p.m. She may also have had one the previous day. At the time she checked into the hospital, she had various pains in her head, e.g., ear ache, a migraine. She did experience a degree of altered mental state that day, but not through abuse of medications, i.e., she took them as prescribed. Respondent testified that she did not tell Dr. Vleugels that she had been hospitalized secondary to altered mental state—instead, respondent had a secondary diagnosis of altered mental state.

Respondent denied that she ever gave Dr. Vleugels permission to speak to her husband Mark. At some point in late February or March 2007, Dr. Vleugels informed respondent that Meoni had called her; Dr. Vleugels asked respondent whether she could speak to Meoni, or at least listen to what Meoni had to say. Respondent explicitly told Dr. Vleugels, “No,” explaining that she had trust issues and did not want anyone to speak to her husband without she herself being present.

34. Respondent testified that in November 2007, for the first time, Dr. Vleugels suggested that she see an addictionologist—as a strategy in connection with the medical board investigation, i.e., to be proactive, to be able to go before the medical board and prove that she did not in fact have a substance dependency problem. Respondent did not like this idea.

35. Respondent testified that on only two occasions did she take more medication than prescribed or in a manner other than as prescribed: The Xanax incident of December 16, 2002, and an occasion when she took a Vicodin dose earlier—relative to her last dose—than was prescribed. She stated that when she took Neurontin under the care of Dr. Becerra, and her dosage was increased from 900 to 1200 mg, it caused her to become sleepy and groggy, but it did help to relieve her headaches. She disclosed these side effects to Dr. Becerra. Whenever

⁵⁷ Respondent’s first session with Dr. Vleugels was on January 12; her last with Dr. Endow was February 6, though she technically remained Dr. Endow’s patient until March 13.

⁵⁸ The February 26, 2007, incident about which Dr. Vleugels testified occurred during the Disneyland trip.

respondent was or appeared sedated, it was the result of having taken her medications in the prescribed manner. Since she was not practicing at the time, she did not think the side effects of her medication were a problem with regard to the practice of medicine.

Respondent testified that during 2006 and 2007, she drank alcohol on a social basis, i.e., less than one drink per day.

36. Respondent testified that she did not carefully read the opioid informed consent contract she signed at the San Diego Pain Management Center. In particular, she stated she did not read the requirement that she only obtain opiates from the PMC. Further, she believed the medication she received from Dr. Umansky for post-operative pain was unrelated to the headache medication she received from the PMC. She conceded that she did not advise Dr. Tiffany about the medication she received from Dr. Umansky, and vice versa.

37. Respondent testified that the filling of Dr. Umansky's Vicodin prescription on July 19 was a mistake: Her husband picked up the prescription, not knowing that she herself had already picked it up the preceding day. Respondent's testimony thus implies a claim that the pharmacy mistakenly filled the same prescription twice.

38. Respondent testified that she has taken no Benzodiazepines since March 2007, and has taken no opiates since December 2007. The CURES reports confirm her testimony. Today, respondent deals with the stressors in her life by exercise, various mind/body techniques such as biofeedback and deep breathing, and with the assistance of a psychologist. She deals with her migraine headaches by taking beta blockers, which she recently started, and by taking Fioricet and Frova as needed.

39. Respondent testified that she has never missed work because of a headache. Her headaches do not cause her "functional impairment." She added that when she was Director of Radiology at Promise, she had the majority of coverage, and was responsible for obtaining coverage when she was not available. However, other radiologists were also available, and, in addition, she always had one day off per week. Accordingly, respondent took issue with a statement by Dr. Vleugels that respondent was on call "24/7."

40. At times during her testimony, respondent was argumentative; she seemed to be advocating on behalf of herself, and to be providing more—or different—information than the question asked for.

Documents Submitted by Respondent

41. In her medical board pre-interview questionnaire signed on December 17, 2007, which respondent signed under penalty of perjury, declaring that the information provided was "true, complete and accurate," respondent was asked, inter alia, the following questions:

a. "To your knowledge, have you ever been the subject of an investigation? If yes, by whom and under what circumstances." In response, respondent checked the "Yes" box

and wrote, "Sexual harassment in the Navy."

According to Dr. Ricciardi's discharge summary in connection with respondent's December 11, 2002, inpatient hospitalization, respondent referred to "[a]llegations within the military of drug-seeking behavior, hit-and-run motor vehicle accident"

Respondent denied that she had ever been investigated by the Navy for a hit and run accident. She stated that Dr. Ricciardi's report inaccurately referred to such an investigation. However, a reference to hit and run charges against respondent also appears in NMCSD records of respondent's December 16, 2002 hospitalization. With regard to allegations that respondent and another colleague in the Navy had improperly written each other medication prescriptions, respondent testified that she considered these allegations to be within the scope of the sexual harassment issue, and she thus felt her general reference to sexual harassment provided sufficient detail.

b. "Have you ever had a chemical dependency, alcohol or substance abuse problem?" In response, respondent checked the "No" box.

Respondent testified that she did not consider the Xanax incident of December 16, 2002, to constitute a substance abuse problem. She explained that substance abuse implied (to her) a diagnosis or struggle. She thus considered her answer to this question to be truthful.

42. In a letter to the board dated September 30, 2008, respondent stated, inter alia, that "I have never had a single problem at work or any complaint against me in my personal or professional life."

Testimony of Mark Meoni

43. Respondent's husband Mark Meoni testified that during the late 2002 to early 2003 time period, near the time when the EEO report came out, respondent was taking medications for anxiety and headaches, was having great difficulty sleeping, and was drowsy on occasion. She was nevertheless able to take care of her family responsibilities, except at those times when she checked herself into the hospital. Meoni stated that he never saw respondent sedated or somnolent. He never observed her abusing any medication. In 2003, respondent went back to work in the civilian sector, she was able to put the Navy and the EEO investigation behind her, and she felt more confident and generally better.

Meoni testified that he did not like his wife taking Dilaudid, because it would "make her a little sleepy," and was potentially addictive. He asked her to find some other medication to take instead. At one point, Meoni took respondent's Dilaudid away from her—not because she was abusing it, but because it made her sleepy.

Meoni testified that when he spoke to Dr. Vleugels about respondent's medication, his main concern and the medication he specifically mentioned to Dr. Vleugels was Dilaudid. He did not express concern about respondent mixing alcohol and medication. If he used the phrase

“in denial,” he was using it with regard to Dilaudid.

Meoni testified that the family never planned to implement an “intervention” to help respondent stop using medications or alcohol through some form of rigorous treatment.

Meoni seemed to slant his testimony in favor of his wife. His testimony in explanation of various matters was not always convincing, and at times was rather vague. He seemed to downplay the extent of his concern about his wife’s condition at different times in the past. He seemed at times to try to steer away from subjects that he perhaps felt would be detrimental to his wife’s case.

Expert Witnesses

44. Timothy Botello, M.D., graduated from the UCLA Medical School in 1979, where the same year he also earned a Master’s Degree in Public Health. He completed an internship at Harbor General-UCLA Hospital in 1980, and a residency in psychiatry at the UCLA Neuropsychiatric Institute in 1983. He was Chief Resident from 1982 to 1983. He completed a forensic psychiatry fellowship at the USC Institute of Psychiatry in 1984. He has been licensed to practice medicine in California since 1981. He has been Board certified in Psychiatry since 1985, in Forensic Psychiatry since 1991, and in Addiction Psychiatry in 1997. He has been affiliated with the University of Southern California since 1983, first as a clinical instructor, and subsequently as an Assistant, Associate, and, for the past 10 years, a full Professor of Clinical Psychology. He has had experience teaching medical students, residents, and forensic psychiatry fellows. He provides training in general psychiatry matters, and in particular substance abuse and dependency problems. Among his many and varied administrative responsibilities, Dr. Botello has served at Los Angeles County USC Medical Center as a member of the Psychiatric Ethics Education Committee, as Chair of the Quality Assessment and Improvement Committee for the Department of Psychiatry, and as a member of the Physician Well-Being Committee.

45. In addition to conducting an interview of respondent on May 17, 2008, Dr. Botello reviewed numerous documents, including respondent’s CURES history, and the medical records of Dr. Endow, Dr. Vleugels, Dr. Umansky, Dr. Tiffany, Dr. Ricciardi and others.

46. Based on his review of the records, and his interview with respondent, Dr. Botello reached certain opinions. It is his view that respondent has a documented history and DSM-IV-TR diagnosis of abuse of benzodiazepines and narcotic pain medications (opiates). Respondent’s abuse of these medications has been compounded at times by her consumption of alcohol. Her abusive behavior has led to a number of episodes of oversedation and altered mental status. Her abusive behavior is comorbid with other mental disorders, specifically major depression, general anxiety disorder, and by chronic migraine headaches. Her abusive behavior is further complicated by her use of medications to address these other mental and physical conditions. It is Dr. Botello’s opinion that respondent has used prescription medication and/or alcohol in such a manner as to be dangerous to herself.

Dr. Botello based the foregoing opinions on a number of matters contained in her medical records, including: Evidence of impairment (e.g., slurred speech, sedation) reflected in medical records of certain providers, such as Drs. Endow and Vleugels; respondent's use of benzodiazepines and narcotics obtained from more than one source (e.g., Hydrocodone from both Dr. Umansky and Dr. Tiffany in mid 2007); her failure to advise each provider of her use of medications prescribed by other providers (and in particular her failure to abide by her pain management contract with the San Diego Pain Management Center); the concerns expressed by respondent's husband to Dr. Vleugels; the incident of May 24, 2007 (including the diagnoses reflected in the relevant records); respondent's desire to try Fentanyl "pops," a strong narcotic; her filling of Hydrocodone prescriptions on two days "back to back" (i.e., July 18 and 19, 2007); the hospitalizations of December 2002 and January 2003; and respondent's drinking of alcohol while taking medications, contrary to Dr. Vleugels' advice.

Dr. Botello also formed the opinion that respondent is impaired with regard to her ability to practice medicine safely. This opinion was based on a number of factors considered collectively: Her depression and anxiety disorders, the medications she has taken to treat them (benzodiazepines), her migraine headaches, the medications she has taken to treat them (opiates), the abuse of these various medications, which has led to several instances of sedation and altered mental state, and her family history of alcohol abuse.⁵⁹ Notably, Dr. Botello's opinion was not explicitly based on respondent's conduct or statements or on any observations he made during his interview of respondent: instead, it was based on historical information.

Dr. Botello also expressed the opinion that respondent has engaged in unprofessional conduct by failing to adhere to the pain management contract, which led to episodes of oversedation. He opined that if respondent misrepresented her alcohol consumption to a physician, or used alcohol contrary to the directive of a physician, these matters would also constitute unprofessional conduct, because of her complicated family and medical history and because it was necessary that her treating physician have accurate knowledge about what drugs and alcohol she was ingesting.

47. David J. Sheffner, M.D., received his medical degree in 1968 from the UCLA Medical School. He completed his internship in internal medicine at L.A. County General Hospital in 1969, and his residency in psychiatry at the UCLA Medical School Department of Psychiatry in 1972. He completed a fellowship in legal psychiatry at the same institution in 1973. Dr. Sheffner is board certified in psychiatry and forensic psychiatry. He has been in full-time private practice since 1974. He previously served as an assistant clinical professor of psychiatry at UC Irvine. He was a past Chairman, Legal Psychiatry Committee, Southern California Psychiatry Society. He is a member of the Ethics Committee, Orange County Psychiatry Society and of the Ethics Committee, American Academy of Psychiatry and the Law. He has served as a consultant for the medical board on about four to six cases per year for the past 30 years.

⁵⁹ With regard to the matters that took place in late 2002 to early 2003, Dr. Botello testified that his opinions were unaffected by the fact that respondent was not practicing at the time.

48. Dr. Sheffner reviewed Dr. Botello's report. He also reviewed certain medical records.⁶⁰ He met with respondent twice, for a total of seven hours. He asked respondent, as a "homework" assignment, to write down her response to each of 46 points raised in Dr. Botello's report, which he then went over with her. Dr. Sheffner expressed concern that Dr. Botello's report did not include respondent's version of the events.

Dr. Sheffner testified that he felt it was important to interview respondent's husband, and that he did so. He also met with Dr. Tiffany, and spoke with Dr. Becerra and another of respondent's physicians, Dr. Rudolph, by phone. Dr. Sheffner did not contact Dr. Vleugels, explaining that since respondent was suing her, he assumed she would not want to meet with him. He did not contact Dr. Hicks, because he had not seen his records and would not want to talk to him until he had had an opportunity to review them. He did not contact Dr. Ricciardi, because the events were so remote in time and there was so little data that he had doubts as to what information Dr. Ricciardi would be able to add to what was in his records. He did not contact Dr. Endow because he felt he understood her records (her records spoke for themselves), and he did not find any reference in her records to drug abuse.

Dr. Sheffner testified that he reviewed certain reference letters submitted by colleagues of respondent. These letters were significant to him, because, in Dr. Sheffner's view, the truest test of one's ability to function is to examine the area of functioning that is of concern.

Dr. Sheffner testified that he conducted two psychological tests on respondent, an MMPI II⁶¹ and a personality assessment inventory (PAI). He considered the MMPI results to be significant (a "data point"), but not the PAI. With regard to the MMPI, respondent received a low score on the McAndrews Alcohol Subscale, indicating that she did not have the personality characteristics and MMPI findings that correlate with substance or alcohol abuse. Respondent also had low scores on MMPI scales correlating to persons who are manipulative. The PAI results suggested respondent may not have answered in a completely forthright manner, i.e., that respondent tended to present herself in a favorable light, and appeared reluctant to admit to any minor fault, thus minimizing areas where her functioning might be less than optimum.

49. Dr. Sheffner testified that he did not believe respondent was mentally ill. He elaborated that he saw no data supporting a present diagnosis of benzodiazepine or other substance abuse. He explained that the December 16, 2002 Xanax episode was too remote in time to establish such a diagnosis. The December 2002 and January 2003 incidents of sedation also did not support a substance abuse diagnosis, again because of their remoteness in time, and also because of the brief time period involved, as well as the fact that Xanax and Neurontin/Topomax in combination may produce sedation even when taken as prescribed.

⁶⁰ Dr. Sheffner did not directly, explicitly, or precisely identify the records that he reviewed.

⁶¹ MMPI refers to the Minnesota Multiphasic Personality Inventory.

Dr. Sheffner described certain indicia of substance abuse, which he apparently did not believe respondent exhibited, or exhibited sufficiently to support a diagnosis: A pattern of chronic abuse, doctor shopping, behavior manifestations of abuse (e.g., talking too much or inappropriately, impulse control, drowsiness, belligerence). Dr. Sheffner stated that if respondent was a drug abuser, she would not have volunteered to Dr. Vleugels that she drank, or that she drank while taking medication, or that she took medications other than those prescribed by Dr. Vleugels. Respondent's signing of reciprocal releases for the medical records of Dr. Endow and Dr. Vleugels was also inconsistent with physician shopping.

Dr. Sheffner testified concerning the CURES report. He observed that in 2005, respondent filled no Norco prescriptions between June and November, and that the Vicodin prescriptions of Dr. Umansky filled in November were within normal limits. Respondent did not thereafter fill any Norco prescription until January 3, 2006. To Dr. Sheffner, this history did not look like that of a drug-seeking or doctor-shopping individual. In Dr. Sheffner's opinion, Dr. Berry's prescription in 2007 of 16 Vicodin for ear pain was an isolated instance of securing the same medication from two physicians (the other being Dr. Tiffany). With regard to Dr. Umansky's several Vicodin prescriptions in July and August 2007, Dr. Sheffner assessed them in the broader context of all Vicodin and Norco prescribed to respondent during the period from May to August 2007. During that period, prescriptions totaling an equivalent of 330 Norco tablets were filled by respondent. Assuming she consumed all of those 330 Norco equivalent tablets, that worked out to about 3.7 Norco tablets per day, which is within normal limits.

Dr. Sheffner conceded that respondent departed from the PMC opioid agreement. However, in order to determine whether violating the contract is a manifestation of drug abuse, one must examine the entirety of the data. Dr. Sheffner added that violating the contract did not constitute unprofessional conduct in his view, unless (as he did not believe to be the case) it was a manifestation of substance abuse—absent that, it was not related to respondent's practice of medicine. In Dr. Sheffner's view, unprofessional conduct requires some reasonable notice to the licensee that the behavior in question is unacceptable—he does not believe such reasonable notice exists as to the violation of an opioid agreement.

Dr. Sheffner testified to the absence of evidence that respondent presently has general anxiety disorder accompanied by such severe symptoms as would render her impaired. Similarly, he testified that respondent's depression is not now sufficiently severe to be impairing. He added that respondent's MMPI score was within normal limits for depression.

50. Sheffner testified that respondent was impaired due to substance abuse (a Xanax overdose) on December 16, 2002, and that such impairment amounted to unprofessional conduct.

51. Sheffner testified in an especially careful, detailed, thoughtful, articulate, and precise manner.

Medical Character Witnesses

52. Steve Rindsberg, M.D., has been the Chairman of the Department of Radiology at Sharp Rees-Stealy Medical Group since 2002. He has worked with respondent several times a month. He considers her to be "very skilled at what she does," and "an excellent general radiologist." He is "extremely comfortable" with the procedures she performs for Sharp. Her interaction with staff is "great." Staff is very fond of her. Patients are "very comfortable with her." Other radiologists are always very happy when they know respondent is going to be present. Dr. Rindsberg does not believe respondent's migraine headaches affect her ability to work. In the past five years, he has never had occasion to question her medical judgment, has never seen her impaired, and has never suspected her to abuse medication. He has read the accusation in almost its entirety; he was "shocked and surprised" to read the allegations, as he has never seen any of that sort of behavior on respondent's part.

Dr. Rindsberg testified that respondent began working at Sharp in approximately February 2004, on a locum tenens basis,⁶² starting at several days per month. Her employment gradually increased in frequency. For about a year until January 2009, respondent worked regularly on Mondays and Fridays. Once the accusation was filed, he had to curtail her schedule, based on a directive from the Medical Director. The credentialing committee never changed her status. She continues to work at Sharp on occasion, when the department is short-staffed.

53. George Scher, M.D., has been a staff radiologist at Sharp since 1983. He was the director of radiology for 20 years, until 2002, when he went to part-time status and was succeeded as chair by Dr. Rindsberg.

Dr. Scher testified that he has known respondent for about five years, i.e., since she came to Sharp. She has worked at the same facility where he works. He has observed her perform certain procedures and has reviewed some of the x-rays that she has read. He considers her an "excellent radiologist," who does an "excellent job" in relating with staff, peers, patients, and families. He has never noticed her migraine headaches cause any problems in terms of her work, has never questioned her medical judgment, has never seen her impaired, and has never suspected her of substance abuse. He has briefly read the accusation and has observed no behavior such as that alleged therein.

54. Michael McKenna, M.D., is an anesthesiologist who has practiced off and on at Promise Hospital since 1992. He testified that he has known respondent for five to six years, and worked with her about five times per week, when she reviewed x-rays for patients for whom Dr. McKenna performed central line placements, difficult intubations and other "intensivist" procedures. He has observed nothing "untoward" or unusual with regard to respondent's interaction with patients and others, has never had a reason to question her medical judgment, has never seen her impaired, and has never suspected her to abuse alcohol or medications.

⁶² Locum tenens refers to the practice whereby a physician fills in for another physician when the latter is not available on a given day.

55. Robert Haynes, M.D., a Sharp radiologist, has known respondent since 2005. He used to work with her about three times per week, though more recently he has worked with her between once per week and once per month.⁶³ The last time he worked with her was about three months before the hearing. Both Dr. Hayes and respondent work at Sharp on a part-time basis.

Dr. Haynes testified that respondent has “superlative” technical skills as a radiologist. He has also observed her interaction with patients, families, and staff. She is conscientious, pleasant and courteous. He has never seen her in a bad mood.

Dr. Haynes testified that he became aware of respondent’s migraine headaches in late 2008 or early 2009, when she mentioned to him in passing one day that she had a headache. He has never seen her impaired, has never questioned her medical judgment, and has never suspected that she was overmedicated.

56. Judith Choonoo has worked at Promise Hospital as an ultrasound stenographer since 2000, first as a contractor and then, since December 2007, as a full-time employee.

Choonoo testified that she met respondent at Promise in November 2003, and worked with her three to four times per week until respondent left Promise in August 2008. Choonoo considers respondent an excellent radiologist. Her interaction with staff and patients is very professional, compassionate, well-mannered, friendly and respectful. Choonoo has never questioned respondent’s medical judgment or suspected her of being impaired. Choonoo was not aware that respondent had migraine headaches.

Ultimate Findings

57. Respondent used prescription medication in such a manner as to be dangerous to herself, in violation of Business and Professions Code section 2239, subdivision (a), by virtue of her ingestion of Xanax on December 16, 2002, in a quantity substantially in excess of that permitted in her prescription.

The evidence bearing on respondent’s abuse of prescription medication is of three basic types: (i) Specific episodes of sedation, altered mental state and other, similar behavioral indicia of impairment and medication abuse; (ii) respondent’s prescription history, including her receipt of certain medications from more than one source and her failure to disclose this fact to each provider; and (iii) the perceptions and opinions expressed by respondent’s treating providers and the parties’ retained expert witnesses.

Specific behavioral episodes. The majority of the incidents in question occurred in late 2002 or early 2003, as reported by Dr. Hicks, CIOG’s Kathleen Flanigan, and in the records of respondent’s four inpatient hospitalizations. While the reported matters suggested possible

⁶³ Dr. Haynes explained that “working with” respondent meant that they were at work on the same day, in their own work stations, across the hall from one another, and that throughout the course of the day they discussed cases and showed each other images that they are reviewing.

impairment due to improper use of medication, the evidence reflected that sedation and related conditions could also have been the result of respondent's use of her medications (e.g., Neurotin, Topamax, Xanax) in accordance with her prescriptions. Further, as to the inpatient hospitalizations, on none of the four occasions did respondent's discharge diagnosis include drug abuse or dependency. More recently (in 2007), Dr. Endow noted one occasion when respondent had slurred speech and seemed unsteady on her feet, which she attributed to respondent's Lorazepam use. Dr. Endow conceded that at least slurred speech could be a side effect of proper Lorazepam use. Finally, with regard to respondent's May 24, 2007, hospitalization, and because of the substantial—and possibly severe—pain respondent experienced in connection therewith, it cannot be inferred that any altered mental state she manifested at that time resulted from improper use of medication.

Of greater concern are the statements attributed to respondent's husband Mark Meoni (and possibly other family members) by Dr. Hicks and Dr. Vleugels about respondent's medication-related impairment at home. Not only did two different psychiatrists, with no relationship to one another, report the same basic concerns on Meoni's part, but these reports were over four years apart. Meoni's testimony in denial of most of these matters came across to some extent as an attempt to explain away or even retract statements he had made earlier and is not credible. While Dr. Hicks's demeanor raised concerns about his credibility, that of Dr. Vleugels did not—and, in addition, her contemporaneous chart notes describing Meoni's comments supported her credibility. Further, and regardless of Meoni's denials, it is undisputed that he initiated contact with Dr. Vleugels because of his concern about his wife's use of at least one strong opioid medication, and that at one point he physically took that one medication away from respondent so that she could not use it. On the other hand, Meoni is not a physician, and regardless of any subjective belief on his part about his wife's condition, his perception or understanding as to any impairment he may have thought he detected, not to mention the reason(s) for such impairment (e.g., proper use vs. abuse of medication), must be taken with a certain degree of circumspection.

Prescription history. Particular concern is raised by respondent's receipt of benzodiazepines from both Dr. Endow and Dr. Vleugels, and her receipt of opioids from both the PMC and Dr. Umansky/Dr. Berry, in both cases without respondent disclosing to each practitioner her receipt of medications from the other(s). With regard to opioids, further concern is raised by respondent's direct violation of her PMC opioid consent agreement. However, none of these matters directly prove medication abuse—they merely constitute circumstantial evidence that would provide some support for such a finding. In fact, only one specific, significant incident of actual drug abuse is reflected in the record: respondent's ingestion of multiple Xanax pills on December 16, 2002.⁶⁴ Further, as to the benzodiazepine prescriptions, respondent freely

⁶⁴ Respondent's admitted taking of two Vicodin tablets without waiting the proper time interval between the two was an isolated and insignificant occurrence. Her utilization of two Fentanyl "pops" at a time when her prescription called for only one causes greater concern, but that concern is substantially reduced by two additional factors: (i) Respondent's voluntary disclosure of this fact to Dr. Tiffany; and (ii) Dr. Tiffany's subsequent modification of respondent's prescription, which reflected his judgment that two pops at a time was in fact an

disclosed to Dr. Vleugels at the outset that she had been seeing Dr. Endow, and she subsequently executed reciprocal releases for both providers. And, with one exception, respondent did not fill any benzodiazepine prescription from Dr. Endow after she filled her first such prescription from Dr. Vleugels.⁶⁵ As to the opioid prescriptions, the duplication resulted from discrete incidents of unrelated medical treatment for which pain medication was prescribed. The medication prescribed by Dr. Berry (16 Vicodin tablets) was not of great significance. The medication prescribed by Dr. Umansky was certainly substantial, but Dr. Sheffner's un rebutted testimony was that, assuming respondent ingested all Norco and Vicodin respondent received from any source between May and August 2007, the average amount ingested per day would have been within normal limits. Finally, respondent has not filled any benzodiazepine or opiate prescriptions since March and December 2007 respectively.

Respondent's receipt of benzodiazepine and opioid medications from multiple sources without disclosing these facts to the providers in question cannot be condoned or justified. However, the issue at this point is whether or to what extent these matters imply abuse of medication. As to this question, the evidence is decidedly mixed, i.e., some of the evidence suggests drugs abuse, but other evidence does not. The record as a whole is inconclusive.

Treating providers and expert witnesses. With regard to treating physicians and others, the evidence again is mixed. Dr. Hicks reached the conclusion, only after four-and-a-half years of treatment, that respondent had a diagnosis of polysubstance abuse. Dr. Ricciardi at about the same time noted "substance abuse" as an "impression." His chart note provided little guidance as to how he came to that conclusion—but from the content of the note it may be inferred that he relied heavily on statements made by others, including family members and the diagnosis of Dr. Hicks. In contrast, Dr. Becerra, Dr. Endow, Dr. Tiffany, Dr. Umansky, and Dr. Vleugels did not diagnose respondent with any kind of substance abuse, and in most instances never even suspected such a condition.⁶⁶

Dr. Botello and Dr. Sheffner were both highly-qualified experts, who testified in a professional, objective, and otherwise generally credible manner. Each emphasized or focused on somewhat distinct aspects of the evidence bearing on whether respondent had abused medication. Overall, Dr. Sheffner's testimony seemed slightly more persuasive—in particular with regard to his analysis of the CURES report and the inferences that could or could not reasonably be drawn from respondent's prescription history. Even Dr. Sheffner conceded, however, that respondent had abused medication on one occasion, i.e., when she overdosed on Xanax on December 16, 2002.

appropriate dose. The related issue of respondent's use of alcohol and medications together despite Dr. Vleugels' cautions to the contrary is considered below in Finding 59.

⁶⁵ Respondent did not fill her first benzodiazepine prescription from Dr. Vleugels until February 24, 2007; she received one such prescription from Dr. Endow two days later, which respondent explained to be the result of the VA continuing to send prescriptions to her automatically.

⁶⁶ Dr. Vleugels' one-time reference to "benzo abuse" (without the question mark) reflected no more than a temporary concern, which Dr. Vleugels soon abandoned.

Conclusion. While the evidence as a whole raised considerable and troubling concerns about the existence and extent of respondent's medication abuse at various times, substantial evidence weighed in the other direction. Further, the force of the evidence that supported a finding of abuse was in many cases attenuated by reasonable inferences of non-abuse that could also be drawn. Accordingly, based on the entirety of the record, it was not established by clear and convincing evidence that respondent violated section 2239, subdivision (a), except with regard to the December 16, 2002 incident.

58. Respondent's ability to practice medicine is not impaired because of a mental illness or a physical illness affecting competency pursuant to Business and Professions Code section 822.

This Finding is based in part of the matters set forth above in Finding 57, and in particular the finding that respondent used prescription medication in a manner dangerous to herself on only one occasion, which occurred over six years ago. Though Dr. Hicks testified that a substance abuse diagnosis can follow or remain with an individual even during periods of non-use, he did not attempt to assess the likelihood of that happening in respondent's case. Further, a potential inclination to substance abuse must be distinguished from actual relapse.

Of course, a finding under section 822 need not be based on substance abuse, but may be based on a proper use of prescription medication, either alone or in combination with other matters. It is clear from the record that respondent went through an extremely difficult and painful period of great personal struggle in December 2002 and, to a lesser extent, the several months thereafter. She was hospitalized on a psychiatric basis four times in less than a month, overdosed on medication at one point, suffered from severe depression, and to one extent or another considered taking her own life. It may well be that respondent's ability to practice medicine was impaired within the meaning of section 822 at that time. At issue here, however, is not whether respondent was impaired in 2002, but whether she is impaired at present, six years later, after a great deal of medical and psychological treatment, and living under very different circumstances than those with which she had then to cope. Notably in this regard, Dr. Botello's opinion that respondent is presently impaired due to mental illness was not based on any observations he made during his examination of her, and he did not seek or receive any input from other persons as to respondent's present circumstances or condition. Instead, his opinion appeared to be based solely on matters of a historical nature, i.e., his review of the medical records. Dr. Sheffner's contrary opinion took into account respondent's present condition, as well as the opinions of other persons who know her, in particular her professional colleagues. Indeed, the opinions of respondent's numerous colleagues who testified at the hearing provided significant evidence that respondent is not presently impaired with regard to the practice of medicine. Finally, even Dr. Vleugels, who filed the board complaint against respondent, did not reach the conclusion that respondent was impaired. Instead, she could only state that respondent's alcohol and prescription drug use "may impair her ability to work." Accordingly, based on the entirety of the record, and even though respondent still suffers in a substantial way from depression, anxiety, and migraine headaches, it was not established by clear and convincing

evidence that these or any other mental or physical conditions presently impair respondent's ability to practice medicine.

59. Respondent engaged in unprofessional conduct in violation of section 2234, subdivision (a).

This finding is derivative in nature, based solely on the finding of a violation of section 2239, subdivision (a), as set forth above.

Dr. Botello in essence testified that respondent also engaged in unprofessional conduct on an independent basis by: (i) Violating the opioid consent agreement with PMC; (ii) using alcohol and benzodiazepines against the directive of Dr. Vleugels; and (iii) misrepresenting to Dr. Endow that she was not using alcohol.⁶⁷ Dr. Sheffner opined to the contrary that respondent did not engage in professional conduct on the basis of any of these three matters.

With regard to the first point, neither Dr. Botello nor Dr. Sheffner provided an entirely persuasive rationale for their opinions. However, Dr. Sheffner's point that unprofessional conduct requires reasonable notice to the licensee that the behavior in question is unacceptable seems well taken, at least as applied here, where it was not established that respondent's non-adherence to the consent agreement was a manifestation of drug abuse.

With regard to the second point, Dr. Vleugels' statements, which can best be characterized as general "cautions" to respondent about the use of alcohol, did not constitute the clear proscriptions against alcohol use that complainant contended they were. This understanding of the evidence is supported by the undisputed fact that respondent more than once freely disclosed her consumption of alcohol to Dr. Vleugels. The latter's records do not reflect that she ever responded to such disclosures by forcefully warning respondent against such use of alcohol. Finally, Dr. Sheffner's observations with regard to respondent's violation of the opiate consent agreement apply even more to respondent's failure to adhere to Dr. Vleugels' informal caution regarding alcohol and medication.

With regard to the third point, the evidence did not establish that respondent misrepresented her alcohol use to Dr. Endow. For the reasons noted earlier, Dr. Endow's chart notes are of little probative value in this regard. Further, the record as a whole clearly establishes respondent's habitual willingness to disclose her consumption of alcohol.

Accordingly, based on the entirety of the record, it was not established by clear and convincing evidence that respondent engaged in unprofessional conduct in any of these three independent respects. Otherwise stated, it has not been established that respondent in this regard engaged in conduct which is unbecoming to a member of in good standing of the medical profession, and which demonstrates unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

⁶⁷ Dr. Botello did not in all instances explicitly state respondent acted unprofessionally, but he at least opined that such conduct, if it occurred, would constitute unprofessional conduct.

CONCLUSIONS OF LAW

Burden and Standard of Proof

1. “The purpose of an administrative proceeding concerning the revocation or suspension of a license is not to punish the individual; the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners.” (*Ettinger v. Board of Medical Quality Assurance* (1982) 139 Cal.App.3d 853, 856.)

2. Absent a statute to the contrary, the burden of proof in disciplinary administrative proceedings rests upon the party making the charges. (*Parker v. City of Fountain Valley* (1981) 127 Cal.App.3d 99, 113; Evid. Code, § 115.) The burden of proof in this proceeding is thus on complainant.

3. The standard of proof in administrative disciplinary proceedings brought against professional licensees to establish unprofessional conduct is “clear and convincing proof to a reasonable certainty.” (*James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1105.)

The “clear and convincing” standard of proof applies to the issue of whether physician’s ability to practice medicine competently is impaired due to mental or physical illness under Business and Professions Code section 822. (*Medical Board of California v. Superior Court (Liskey)* (2003) 111 Cal.App.4th 163, 170-171.)

4. “The key element of clear and convincing evidence is that it must establish a high probability of the existence of the disputed fact, greater than proof by a preponderance of the evidence.” (*People v. Mabini* (2001) 92 Cal.App.4th 654, 662.) This standard is less stringent than proof beyond a reasonable doubt. (*Ettinger v. Board of Medical Quality Assurance, supra*, 135 Cal.App.3d at 856.)

Motion in Limine to Exclude Expert Testimony

5. On May 7, 2009, complainant filed a motion in limine seeking “to exclude the expert testimony of each of respondent’s six expert witnesses, on the grounds that respondent has violated the mandatory expert witness disclosure requirements of [Business and Professions Code] section 2334.” The motion was based primarily on the following arguments: (i) Contrary to the requirements of section 2334, respondent’s expert witness disclosure did not occur at least 30 calendar days before the commencement of the hearing; and (ii) the mandatory penalty for the failure to comply on a timely basis with the requirements of section 2334 is the automatic exclusion of the offending party’s expert testimony. Complainant also contended that: (iii) Respondent’s expert disclosures failed to comply with the requirements of section 2334 in other respects than timeliness (e.g., the description of the expected testimony of respondent’s experts); and (iv) respondent’s various failures to comply with the requirements of section 2334 were highly prejudicial to complainant’s ability to prepare for the hearing.

6. Respondent has violated the requirements of section 2334 in two respects. First, respondent failed to provide its expert witness disclosure within 30 calendar days prior to the commencement of the hearing. On March 5, 2009, OAH granted respondent's motion to continue the hearing, and set the hearing to commence on May 14, 2009. Based on that hearing date, and pursuant to section 2334, subdivision (a), expert witness disclosure was to be made no later than April 14, 2009. Respondent did not, however, make her formal disclosure until April 30, 2009.⁶⁸ For purposes of the motion in limine, respondent's disclosure is deemed to have been 16 days late.⁶⁹ It is thus concluded that respondent's disclosure was untimely.

Second, respondent failed, as to two of its experts, to provide "a brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis." Complainant argued essentially that the descriptions provided in respondent's disclosure were not adequate to meaningfully inform complainant of the actual substance of the expected testimony of respondent's experts, including the experts' actual opinions and the bases therefor. Complainant's argument is rejected with regard to William Umansky and Luis Becerra. The description of the expected testimony of these individuals as set forth in respondent's disclosure did not constitute the kind of testimony that is typically considered "expert testimony," i.e., as described, it did not consist of formal expert opinions, but instead involved the physician's course of care of respondent.⁷⁰ As such, such testimony is properly characterized as percipient witness testimony, not expert testimony per se.⁷¹ On the other hand, the description of the expected testimony of Frank Tiffany and David Sheffner clearly involved, at least in part, the rendering of genuine expert opinions. The description of their testimony adequately set forth the general substance of the testimony, including opinion testimony,⁷² but did not set forth any "basis" for such opinion testimony, and thus fails to comply

⁶⁸ The analysis that follows focuses on respondent's formal expert witness disclosure of April 30, 2009. On April 16, 2009, respondent served a Final Witness and Exhibit List. This list may be viewed as constituting respondent's initial expert witness disclosure. Under either view, based on the reasoning set forth below, violations of section 2334 would be found, though the violations would differ to a certain extent. For example, respondent did not disclose the fee to be charged by all of her experts until April 30.

⁶⁹ On April 16, 2009, Presiding Administrative Law Judge Alan R. Alvord issued a prehearing conference order, in which the parties were ordered to exchange the information required by section 2334 by April 30, 2009. Complainant objected to that portion of the order and contended in her in limine motion that OAH lacked the authority to grant additional time within which to make a section 2334 disclosure after the 30-day deadline had already passed. For the purposes of ruling on the in limine motion, it is assumed *arguendo* that the disclosure was to be made on April 14, 2009, notwithstanding the prehearing conference order.

⁷⁰ Indeed, the testimony of these two physicians, as described above, was limited to issues directly relating to the course of care, and did not constitute expert opinion testimony.

⁷¹ In the absence of any statutory, regulatory or judicial guidance as to the meaning of "expert testimony," recourse is taken to the somewhat analogous use of expert testimony in civil cases pursuant to Code of Civil Procedure section 2034.

⁷² Complainant's contention that the disclosures provide insufficient detail to permit

with section 2334.⁷³

7. In light of the conclusion that respondent has violated section 2334, the remedy for respondent's violations must now be addressed. The Administrative Law Judge denied the motion in limine and rejected exclusion of the expert testimony on the grounds that section 2334 affords both OAH and the administrative law judge a measure of discretion with regard to the remedy for non-compliance to be applied in a given case, depending on the totality of the circumstances.

8. The administrative law judge determined that exclusion of respondent's expert witness testimony would not further the apparent legislative purpose of the statute, but would instead undermine the interests of justice, and based this conclusion on the following considerations.

First, with regard to the timeliness of disclosure, even though formal disclosure did not occur until April 30, the identity of respondent's six experts, and at least a short description of the subject matter of their expected testimony, was provided on April 16, 2009, i.e., just two days after the April 14 deadline.

Second, in the absence of clear guidance as to what level of detail satisfies the "brief narrative statement" requirement of section 2334, great caution and restraint is appropriate before excluding expert testimony based on a finding that a proffered description did not constitute an adequate "brief narrative statement."

Third—and closely related to the preceding point—complainant did not place respondent on notice prior to filing the motion in limine of the alleged inadequacy of respondent's disclosure.

Fourth, complainant did not establish prejudice by virtue of either the untimeliness or the inadequacy of respondent's disclosures.

Fifth, no evidence was presented that respondent's failure fully to comply with section 2334 was in bad faith, i.e., constituted a conscious attempt to "hide the ball" or otherwise circumvent proper disclosure.

complainant to prepare to meet the testimony of respondent's experts at the hearing was unpersuasive given the absence at that time of any guidance—both for respondent and for the administrative law judge—as to how "brief" the required narrative statement may be. It is not appropriate to retrospectively construe that adjective in an unduly narrow fashion that would in effect constitute a trap for the unwary.

⁷³ Since respondent's other two experts, Christine Baser and Steven Rudolph, did not testify at the hearing, it is not necessary to address the adequacy of respondent's disclosures of their testimony.

Sixth, the administrative law judge presumed that the ultimate decision maker in this case, the Medical Board of California, would desire to have all relevant evidence available for its consideration, so that it can make the most well-informed and appropriate decision possible in this very important matter

9. In her written argument and during oral argument, complainant asked the board to reverse the decision denying the motion in limine, exclude expert testimony as a result of that reversal, and, in the decision itself, designate its decision as a precedent decision. The board denies these requests for the following reasons.

First, as required by law, the board has read all of the expert testimony in question as part of its review of the record and therefore does not believe it is appropriate, fair or equitable at this stage of the proceedings to attempt to “unring the bell.”

Second, there is a process set out in regulation (Title 16 CCR section 1364.40) for designating precedent decisions and complainant’s request is inconsistent with that process. Complainant may certainly renew her request in the manner prescribed in that regulation.

The board does agree with both the administrative law judge and with complainant about the critical need for guidance in interpreting Business and Professions Code Section 2334, in order to carry out the purpose for which that section was enacted, and intends to convey its interpretation of that section in this decision.

10. Business and Professions Code section 2334 provides as follows:

“(a) Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless the following information is exchanged in written form with counsel for the other party, as ordered by the Office of Administrative Hearings:

“(1) A curriculum vitae setting forth the qualifications of the expert.

“(2) A brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis.

“(3) A representation that the expert has agreed to testify at the hearing.

“(4) A statement of the expert's hourly and daily fee for providing testimony and for consulting with the party who retained his or her services.

“(b) The exchange of the information described in subdivision (a) shall be completed at least 30 calendar days prior to the commencement date of the hearing.

“(c) The Office of Administrative Hearings may adopt regulations governing the required exchange of the information described in this section.”
(Stats. 2005, c. 674 (S.B. 231), § 14.)

11. The board finds that Section 2334 governs the entire subject of expert witness disclosures in Medical Board cases, including the penalty to be imposed for failure to comply with the disclosure requirements by the statutory production deadline and therefore Section 2334 prevails over any other provision of law, including provisions of the Administrative Procedure Act (APA). Evidence of this is found in the first sentence of section 2334, subdivision (a), which begins with the phrase: “Notwithstanding any other provision of law . . .” This phrase is indicative of the Legislature’s intent to have the provisions of section 2334 control notwithstanding the existence of other laws that might otherwise govern the subject. (See *People v. DeLaCruz* (1993) 20 Cal.App.4th 955, 963 [phrase “has been read as an express legislative intent to have the specific statute control despite the existence of other law which might otherwise govern.”].)

12. A review of the legislative history of section 2334 confirms both the problem section 2334 was specifically enacted to address, as well as the legislative intent to place a mandatory obligation on the parties to make the required disclosures by the statutory deadline in order to promote, rather than defeat, its underlying public policy. In her Initial Report to the Legislature, the Medical Board’s Enforcement Monitor⁷⁴ described the problems that result from defense counsel’s failure to disclose the opinions of their experts as follows:

“As described above, MBC requires its experts to reduce their expert opinions to writing – and those expert opinions are immediately discoverable by the defense. However, defense counsel frequently instruct their experts not to reduce their opinions to writing so the HQE DAG has no idea of the substance of defense counsel’s expert opinion until that expert takes the stand at the evidentiary hearing.

“This practice results in the unfair ‘sandbagging’ of the DAG at the hearing, and stifles the possibility of prehearing settlement. Although true bilateral discovery is not a feature of administrative hearings under the Administrative Procedure Act, the general discovery principle of eliminating undue litigation surprise is a public policy with important application here. The expert medical opinions in these MBC administrative hearings go to the heart of the Board’s case and are partly or entirely dispositive of the result. Litigation surprise regarding this

⁷⁴ Business and Professions Code section 2220.1 provided for the appointment of a “Medical Board Enforcement Program Monitor” to monitor and evaluate “the disciplinary system and procedures of the board, making as his or her highest priority the reform and reengineering of the board’s enforcement program and operations and the improvement of the overall efficiency of the board’s disciplinary system.” (Added by Stats. 2002, c. 1085, (Sen. Bill No. 1950), § 18; repealed by Stats. 2004, c. 909 (Sen. Bili No. 136), § 3, operative Jan. 1, 2006.)

central element of the administrative action disserves all parties to the process and the public interest as a whole.”

(Initial Report, Medical Board of California Enforcement Program Monitor, prepared by Julianne D’Angelo Fellmeth and Thomas A. Papageorge, dated November 1, 2004, at pp. 160-161.)

In the wake of the Enforcement Monitor’s Initial Report, Senate Bill 231, as amended, included a new statute specifically designed to address this problem. That statute, as originally introduced, provided that:

“2334. Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless a detailed written report by the expert witness, including findings and conclusions of the expert witness, is exchanged by the parties in advance of the hearing. The Office of Administrative Hearings shall adopt regulations in consultation with the Medical Board of California governing the required exchange of expert testimony in these proceedings.” (Sen. Bill No. 231 (2005-2006 Reg. Sess.) § 11, as amended in Assembly on June 13, 2005.)

Thus, as original introduced, the Legislature only required that the disclosure be made “in advance of the hearing.” As the bill moved through the legislative process, the Legislature amended section 2334, never losing sight of its objective to compel the timely production of information regarding expert witnesses. For example, the Legislature eliminated the requirement that “a detailed written report” be produced and, instead, required only that the expert testimony be “reduced to writing by the expert witness, including findings and conclusions of the expert witness, . . .” Thus, as later amended in the Assembly, section 2334 then provided:

“2334. Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless ~~a detailed written report~~ *it is reduced to writing* by the expert witness, including findings and conclusions of the expert witness, is exchanged by the parties in advance of the hearing. The Office of Administrative Hearings shall adopt regulations in consultation with the Medical Board of California governing the required exchange of expert testimony in these proceedings.” (Sen. Bill No. 231 (2005-2006 Reg. Sess.) § 11, as amended in Assembly on July 11, 2005.)

Then, on August 30, 2005, the Legislature abandoned the requirement that the disclosure simply be made “in advance of the hearing” and, instead, established a specific statutory deadline for the production. In this regard, section 2334, as amended, stated:

“2334. (a) Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be

permitted by any party unless it is reduced to writing by the expert witness, including findings and conclusions of the expert witness, and it is exchanged by the parties in advance of the hearing. The Office of Administrative Hearings shall adopt regulations in consultation with the Medical Board of California governing the required exchange of expert testimony in these proceedings. the following information is exchanged in written form with counsel for the other party, as ordered by the Office of Administrative Hearings:

(1) A curriculum vitae setting forth the qualifications of the expert.

(2) A brief narrative statement of the general substance of the testimony the expert is expected to give, including any opinion testimony and its basis.

(3) A representation that the expert has agreed to testify at the hearing.

(4) A statement of the expert's hourly and daily fee for providing testimony and for consulting with the party how retained his or her services.

(b) The exchange of the information described in subdivision (a) shall be completed at least 30 calendar days prior to the commencement date of the hearing.

(c) The Office of Administrative Hearings may adopt regulations governing the required exchange of the information described in this section."

(Sen. Bill No. 231 (2005-2006 Reg. Sess.) § 12, as amended in Assembly on August 30, 2005.)

This would remain the statutory production deadline throughout the remainder of the legislative process (see Sen. Bill No. 235 (2005-2006 Reg. Sess.) § 11, as amended on September 2, 2005) and ultimate approval by the Governor on October 7, 2005 (see Bus. & Prof. Code, § 2334). Thus, subsequent amendments to Senate Bill 231 confirm the Legislature's explicit rejection of the requirement that the expert witness disclosures be made simply "in advance of the hearing" and, instead, its intention that such disclosures shall be made "at least 30 calendar days prior to the commencement date of the hearing." (Cf. *Cooper v. Swoap* (1974) 11 Cal.3d 856, 864-865 [Legislature's direct consideration and explicit rejection of proposal to reduce grants of AFDC recipients sharing housing with an adult aid recipient an "unambiguous indicant of legislative intent"]; see also *Martin v. Szeto* (2004) 32 Cal.4th 445, 450 [subsequent amendments to bill cited as clarifying legislative intent].)

Permitting OAH to order the required expert witness disclosures to be made *less than* 30 calendar days prior to commencement of the hearing was included in an earlier version of Senate Bill 231 that was explicitly rejected by the Legislature and, thus, to permit it now would be entirely inconsistent with legislative intent. (Cf. *Cooper v. Swoap* (1974) 11 Cal.3d 856, 864-865 [Legislature's direct consideration and explicit rejection of proposal to reduce grants of AFDC recipients sharing housing with an adult aid recipient an "unambiguous indicant of legislative intent"].)

13. The board finds that the obligation of both parties to make the required exchange of expert witness information by the statutory deadline set by the Legislature in section 2334 (b), is mandatory, not merely directory. (Business and Professions Code Sections 8, 19) This is also consistent with case law:

"... 'Time limits are usually deemed to be directory unless the Legislature clearly expresses a contrary intent.' (*Id.* at p. 1145.) For example, if the statute attaches consequences or penalties to the failure to observe time limits, the statute is construed as mandatory. (*County of Sacramento v. Insurance Co. of the West* (1983) 139 Cal.App.3d 561, 565-566; see also *Edwards v. Steele, supra*, 25 Cal.3d at p.410.)" (*Matus v. Board of Administration* (2009) 177 Cal.App.4th 597, 608-609.)

14. In the proposed decision, the administrative law judge construed section 2334 as affording both OAH and the administrative law judge a measure of discretion with regard to the remedy for non-compliance to be applied in a given case, depending on the totality of the circumstances.

(a) The board finds, using well-settled rules of statutory construction, that an interpretation granting discretion as to whether to impose the statutory remedy of exclusion is inconsistent with the legislative intent underlying the statute, would defeat (rather than promote) the statute's general purpose and would lead to absurd consequences.

"In construing a statute, our fundamental task is to ascertain the Legislature's intent so as to effectuate the purpose of the statute. (*Day v. City of Fontana* (2001) 25 Cal.4th 268, 272.) We begin with the language of the statute, giving the words their usual and ordinary meaning. (*Ibid.*) The language must be construed 'in the context of the statute as a whole and the overall statutory scheme, and we give 'significance to every word, phrase, sentence, and part of an act in pursuance of the legislative purpose.'" (*People v. Canty* (2004) 32 Cal.4th 1266, 1276.) In other words, "we do not construe statutes in isolation, but rather read every statute 'with reference to the entire scheme of law of which it is part so that the whole may be harmonized and retain effectiveness.' [Citation.]" (*In re Marriage of Harris* (2004) 34 Cal.4th 210, 222.) If the statutory terms are ambiguous, we may examine extrinsic sources, including the ostensible objects to be achieved and the legislative history. (*Day, supra*, 25 Cal.4th at p. 272.) In such circumstances, we choose the construction that comports most closely with the Legislature's apparent intent, endeavoring to promote rather than defeat the statute's general purpose, and avoiding a construction that would lead to absurd consequences. (*Ibid.*)" (*Smith v. Superior Court* (2006) 39 Cal.4th 77, 83.)

Section 2334, subdivision (a), states that:

"(a) Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert

testimony shall be permitted by any party unless the following information is exchanged in written form with counsel for the other party, *as ordered by the Office of Administrative Hearings: . . .*" (Italics added.)

The board finds that section 2334 is a self-executing statute in the sense that it applies in all Medical Board cases, regardless of whether OAH orders the parties to comply with its provisions or not.⁷⁵ In this regard, section 2334 is similar to a statute of limitations (see, e.g., Bus. & Prof. Code, § 2230.5) which applies whether or not the parties are ordered to comply with its provisions.

To interpret the phrase "as ordered by the Office of Administrative Hearings" as requiring an OAH order before the statute could apply in Medical Board cases would violate the general rules of statutory construction cited above. It would also lead to the absurd consequence of section 2334 applying in those Medical Board cases where OAH has issued an order requiring compliance with its provisions but not to those cases where OAH has not issued such an order.

Here, the phrase "as ordered by the Office of Administrative Hearings" is more appropriately read as referring to an order from OAH prohibiting expert testimony offered by a party whenever it has been determined that the party has failed to comply with the expert witness disclosure requirements of section 2334 by the statutory deadline. Without such an order from OAH, the statutory penalty fixed by the Legislature for violation of section 2334 could never be imposed. This reading is also consistent with other prescribed duties and responsibilities of administrative law judges under the APA, including those provisions requiring an administrative law judge to issue orders and decisions. (See, e.g., Gov. Code, §§ 11511.5, subd. (e) ["The administrative law judge shall issue a prehearing conference order incorporating the matters determined at the prehearing conference."]; and 11517 ["If a contested case is originally heard by an administrative law judge alone, he or she shall prepare . . . a proposed decision in a form that may be adopted by the agency as the final decision in the case."]) The Legislature was presumed to be aware of existing law (here, the authority of an administrative law judge to issue orders) when it required an order from OAH to impose the statutorily required penalty for failure to comply with the requirements of section 2334. (*People v. Cruz* (1996) 13 Cal.4th 764, 775)

(b) "The most basic principle of statutory construction is that courts must give effect to statutes according to the ordinary import of the language used in framing them." (*People v. Herman* (2002) 97 Cal.App.4th 1369, 1380-1381, internal quotes and citation omitted.) "If there is no ambiguity in the language of the statute, then the Legislature is presumed to have meant what it said, and the plain meaning of the language governs." (*Id.*, at p. 1381, internal quotes and citations omitted.) Here, there is no ambiguity regarding the penalty to be imposed for a violation of section 2334. The Legislature has made a policy choice to fix that penalty as exclusion of the expert testimony.

⁷⁵ While OAH has reportedly begun the practice of routinely issuing orders requiring the parties to comply with the provisions of section 2334, issuance of such orders are not required since section 2334 is otherwise applicable in Medical Board cases, regardless of whether OAH orders the parties to comply or not. Such orders do, however, serve a useful purpose by helping to ensure that section 2334 does not become a trap for the unwary.

The board finds that OAH lacks the authority to refuse to impose the legislatively mandated penalty of exclusion where a party has failed to comply with the requirements of section 2334. Whenever it has been determined that a party in a Medical Board case has violated the expert witness disclosure requirements of section 2334, either by failing to disclose the information specified in section 2334, subdivision (b), and/or failing to make the required disclosures by the statutory deadline contained in section 2334(c), section 2334(a) requires that an order be issued prohibiting that party from presenting the proffered expert testimony in the case.⁷⁶

The board notes that the conclusion expressed above applies equally to both complainant and respondent. Based upon its review of the record (Exh. 29 in particular), the board urges both parties in future cases to be diligent in fully complying with Section 2334 in order to fulfill the purposes of the statute.

What constitutes compliance with Section 2334(a)(2)? Merely listing topics or subjects that the expert witness will testify about, without disclosing the general substance of the expert's anticipated testimony, the actual expert opinions he/she will testify to, and the basis for each of those opinions, is plainly insufficient and would clearly violate the statutory requirements of section 2334. A "brief narrative statement" of the "general substance" of the expert's testimony means a short narrative statement that provides the main features of the testimony—the essential nature of the testimony to be proffered. The statement must include any opinion to be presented and the basis for that opinion. By way of example as to what is not acceptable, taken from the record in this matter: A party merely states (see Exh. 29) that an expert will testify "whether Respondent can practice medicine safely, and whether the circumstances surrounding Respondent's use of medication constituted general unprofessional conduct as alleged." This narrative does not state what expert opinion will actually be proffered (i.e. that respondent can practice medicine safely and that respondent's use of medication is not general unprofessional conduct). Nor does it describe whatsoever the basis for that opinion. This is simply insufficient.

Statutory Authority

15. Business and Professions Code section 2227 provides in part:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the

⁷⁶ Administrative disciplinary proceedings that are commenced by the issuance of an interim order of suspension (ISO) under Government Code section 11529 constitute an exception to the otherwise applicable provisions of section 2334. In ISO cases, the filing of the accusation and subsequent hearing are necessarily expedited (Gov. Code, § 11529, subd. (f)) and, as a result, the hearing may be scheduled such that is impossible for the parties to comply with the expert witness disclosure requirements of section 2334 by the statutory deadline set by section 2334, subdivision (c). Compliance with section 2334 is excused when it is impossible to comply. (See e.g., *McKenzie v. City of Thousand Oaks* (1973) 36 Cal.App.3d 426, 430 [compliance with procedural statute may be excused when it is "impracticable, impossible or futile" to comply].)

Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the division, may, in accordance with the provisions of this chapter: (1) Have his or her license revoked upon order of the division. (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the division. (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the division. (4) Be publicly reprimanded by the division. (5) Have any other action taken in relation to discipline as part of an order of probation, as the division or an administrative law judge may deem proper.”

16. Business and Professions Code section 822 provides:

“If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

- (a) Revoking the licentiate's certificate or license.
- (b) Suspending the licentiate's right to practice.
- (c) Placing the licentiate on probation.
- (d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

The licensing agency shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated.”

17. Business and Professions Code section 2239 provides in pertinent part:

“(a) The use or prescribing for or administering to himself or herself, of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of such unprofessional conduct.”

18. Business and Professions Code section 2234 provides in part:

“The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. . . .”

Final Conclusions

19. To summarize the foregoing authority in the context of this proceeding, disciplinary action may be taken against respondent only if complainant has established by clear and convincing evidence that: (i) Respondent's ability to practice medicine is impaired because of a mental illness or a physical illness affecting competency; (ii) respondent used prescription medication and/or alcohol in such a manner as to be dangerous to herself or others, or to the extent that her ability to practice medicine was impaired; or (iii) respondent engaged in unprofessional conduct by virtue of either of the above.⁷⁷

20. By reason of Factual Findings 1 through 59 and Legal Conclusions 1 through 19, and based on the applicable burden of proof, it is concluded that:

a. Respondent's ability to practice medicine is not impaired because of a mental illness or a physical illness affecting competency, pursuant to section 822. In reaching this conclusion, section 822 is construed to involve a present impairment on the part of a physician, i.e., that a physician may have been impaired at some time in the past is insufficient to meet the requirements of section 822. This understanding of section 822 is based both on its language ("If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired") and on the non-disciplinary nature of section 822. No judicial authority has been found that addresses this issue, however.

b. Respondent used prescription medication in such a manner as to be dangerous to herself, in violation of section 2239, subdivision (a). In reaching the conclusion that respondent violated section 2239, subdivision (a) based only on her ingestion of Xanax on December 16, 2002, in a quantity substantially in excess of that permitted in her prescription, section 2239, subdivision (a) is understood to require some sort of improper use of medication, such as using more medication than prescribed, using medication as prescribed but under circumstances where the individual improperly obtained multiple prescriptions for the purpose of abusing the medication, or improperly combining the use of medication with other activities (such as driving a vehicle). By way of contrast, a physician's mere use of medication as prescribed, without more, is not understood to be a violation of section 2239, as such an interpretation of the provision is not required by its language and would seem to raise due process issues. No judicial authority has been found that addresses this issue, however.

c. Respondent, by virtue of Conclusion 20(b), engaged in unprofessional conduct, in violation of section 2234, subdivision (a).

21. By reason of Factual Findings 1 through 59, and Legal Conclusions 1 through 20, the board is authorized to take disciplinary action against respondent. Whether and what kind of disciplinary action should be taken is to be considered in the context of the board's highest

⁷⁷ The Accusation does not allege any conduct to violate section 2234 that is independent of complainant's allegations under sections 822 and 2239, subdivision (a).

priority, the protection of the public. (Bus. & Prof. Code, § 2001.1.) To the extent not inconsistent with this priority, “disciplinary actions shall be calculated to aid in the rehabilitation of licensees.” The Guidelines also state:

“The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility and demonstrated willingness to undertake Board- ordered rehabilitation, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.”

(Medical Board of California Model Disciplinary Orders and Disciplinary Guidelines, p. 6.)

22. Respondent contends that even if any of the three causes are sustained in this matter, the imposition of probation would constitute unnecessary and unjustified punishment. Respondent’s argument has a certain force, in that the only conduct found to be grounds for discipline is respondent’s ingestion of Xanax on December 16, 2002, over six years ago. The board is greatly concerned about Respondent’s repeated failure to fully appreciate and/or admit the extent of her problems. Respondent’s state of denial is clearly manifested throughout the record. For example, Dr. Endow believed that respondent tended to “minimize her symptoms.” Dr. Vleugels believed that respondent minimized concerns about her receipt of benzodiazepines from two different sources. Indeed, respondent’s explanations for her failure reciprocally to advise Dr. Endow and Dr. Vleugels, and Dr. Umansky and Dr. Tiffany, of the medications she was receiving from the other, seemed casual and to reflect a lack of appreciation as to the importance—which, as a physician she of all people should recognize—of advising her health care providers of all medication she receives from every source. The same may be said for her failure to abide by the opioid contract—her explanation that she did not read the contract again reflects a casual attitude on respondent’s part, a lack of appreciation for the seriousness of over medicating and the potential dangers of these highly potent medications. Further, her answers to the two questions on the medical board pre-interview questionnaire can hardly be considered “true, complete and accurate,” notwithstanding respondent’s forced and dubious attempt to explain why she answered the way she did. Remarkably, in her letter to the board dated September 30, 2008, respondent stated, inter alia, that “I have never had a single problem at work or any complaint against me in my personal or professional life.” Dr. Sheffner’s testimony that the PAI results suggested a lack of forthrightness on respondent’s part and a tendency to minimize areas of less-than-optimum functioning only confirms these other observations. Even respondent’s own husband stated that respondent was “in denial.”⁷⁸

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⁷⁸ Though Mark Meoni denied that he had concerns about any medication other than Dilaudid, he never denied that he made this statement.

However, given the age (2002) of the one incident found to be grounds for discipline and the lack of subsequent similar incidents, the board concludes that a public reprimand is the appropriate penalty under the facts of this case.

Accordingly, there issues the following:

ORDER

Certificate No. A 55229, issued to respondent Jill Siren Meoni, is hereby publicly reprimanded.

This decision shall become effective at 5 p.m. on June 7, 2010.

IT IS SO ORDERED this 6th day of May, 2010.


HEDY CHANG, Chairperson
Panel B, Medical Board of
California