

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

In the Matter of the Accusation)
Against:)
)
)
STEWART W. LOVELACE, M.D.)
)
Physician's and Surgeon's)
Certificate No. C-30263)
)
Respondent)
_____)

Case No. 06-2005-169412

OAH No. L2008090100

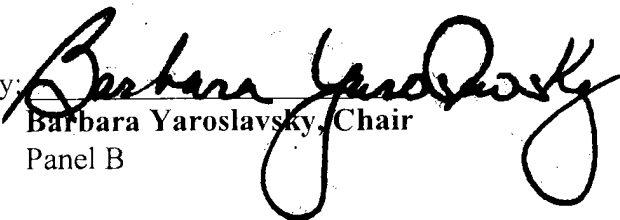
DECISION ON MOTION TO DISMISS

The attached Proposed Decision On Motion To Dismiss is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on **January 30, 2009.**

IT IS SO ORDERED **December 31, 2008.**

MEDICAL BOARD OF CALIFORNIA

By: 
Barbara Yaroslavsky, Chair
Panel B

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

In the Matter of the Accusation Against:

STEWART W. LOVELACE, M.D.

Physician and Surgeon's Certificate No. C30263,

Respondent.

Case No. 06-2005-169412

OAH No. L2008090100

PROPOSED DECISION
ON MOTION TO DISMISS

The Motion to Dismiss of Stewart W. Lovelace, M.D. (Respondent) came on regularly for hearing on November 21, 2008, in Los Angeles, California, before Administrative Law Judge Julie Cabos-Owen with the Office of Administrative Hearings. Respondent and moving party was represented by Robert S. McWhorter of Nossaman, L.L.P. Complainant and responding party was represented by Chris Leong, Deputy Attorney General.

Respondent/moving party sought dismissal of the Accusation on several grounds, including that it was filed after the three-year statute of limitations had run. The Administrative Law Judge, having read and considered the moving, opposition, and reply papers, and having heard argument by counsel, found that Respondent's Motion to Dismiss should be granted in part, and denied in part, on the following grounds:

Facts – Procedural Background and Pleadings

1. On September 12, 2006, Complainant filed an Accusation & Notification of Violation and Imposition of Civil Penalty (2006 Accusation) against Respondent. (Motion to Dismiss, Exhibit A.)

2. The 2006 Accusation arose from the Medical Board's November 2, 2005 request for Respondent to turn over the medical records of Patient S.S.¹ Despite the Board's issuance of a March 3, 2006 Citation to Respondent, followed by several letters advising compliance with the Citation, Respondent failed to produce the requested records, prompting the filing of the 2006 Accusation. (Motion to Dismiss, Exhibit A.)

¹ All patients' initials are used in lieu of their full names herein to protect their privacy.

3. Respondent finally turned over the requested records on December 22, 2006. (Motion to Dismiss, Exhibit H – Proposed Decision of H. Stuart Waxman, Administrative Law Judge, Factual Finding 16.)

4. The administrative hearing on the 2006 Accusation was held on January 20, 2007. ((Motion to Dismiss, Exhibit H – Proposed Decision of H. Stuart Waxman, Administrative Law Judge, p. 1, par. 1.)

5. On June 25, 2008, Complainant filed the current Accusation, alleging gross negligence in the care of patients S.S. (first cause for discipline), K.S. (second cause for discipline), and R.D. (third cause for discipline), as well as repeated negligent acts (fourth cause for discipline), unprofessional conduct/incompetence (fifth cause for discipline) and failure to maintain adequate/accurate medical records (sixth cause for discipline). The fourth, fifth and sixth causes for discipline are based on the allegations in the first, second and third causes for discipline. (Motion to Dismiss, Exhibit C - Accusation.)

6. The allegations in the first cause for discipline, pertaining to patient S.S., arose from treatment that began “on or about July 22, 2005.” (Motion to Dismiss, Exhibit C - Accusation, par. 8A, p. 3, line 25.)

7. Regarding patient S.S., the Accusation alleges:

G. Respondent was grossly negligent in the care and treatment of Patient S.S. as follows: Respondent failed to document a complete history and mental status examination. He failed to describe the problem as understood by the patient. He failed to document an objective assessment of the patient’s current issues, and a biopsychosocial formulation of her problems. He failed to document the patient’s psychiatric diagnosis in a DSM format. He failed to document the risks and benefits of his proposed treatment plan, or consider any alternate treatments for the patient. Respondent failed to document any efforts to achieve authorization of the patient’s medication through her HMO insurance or authorization of any alternate medication. He failed to document and respond to the patient’s telephone calls.

(Motion to Dismiss, Exhibit C - Accusation, par. 8G, p. 5, lines 15-24.)

8. The allegations in the second cause for discipline, pertaining to patient K.S., were as follows:

A. Patient K.S. was forty years old when he initially saw respondent in 1990. . . . Respondent did not document in the record a complete history and a thorough mental status examination. He did not describe the problem as understood by the patient. There was no documentation of an objective assessment of the patient’s current issues

and a bio psycho social formulation of his problems in a treatment plan. Respondent diagnosed the patient with Post Traumatic Syndrome Disorder (PTSD). There was no documentation of the patient's psychiatric diagnosis in a DSM format.

B. Patient K.S. saw respondent from 1990 until about February 2007.

C. On follow-up appointments, respondent did not document the patient's subjective symptoms, assess the patient's current level of functioning and mental status, and did not formulate and document a reasonable plan of action. There was no documentation of telephonic communications with the patient. On several occasions when Patient K.S. experienced severe symptoms, he attempted to contact respondent who did not return his telephone calls.

D. In about February 2007, respondent advised Patient K.S. to taper off his Depakote medication, and said he would place him on a different medication. Patient K.S. began to experience severe psychiatric symptoms. In March 2007, he was admitted to Redlands Community Hospital with severe chest pains. The patient and his wife left telephone messages for respondent which were not returned. When the patient no longer had any medication left, he attempted to contact respondent, who could not be reached. In June 2007, the patient sent a certified letter to respondent stating he was in desperate need of medication, treatment, and follow-up care. Respondent did not retrieve the certified mail letter.

E. Respondent was grossly negligent in the care and treatment of Patient K.S. as follows: Respondent failed to document a complete history and mental status examination. He failed to describe the problem as understood by the patient. He failed to document an objective assessment of the patient's current issues, and a bio-psycho-social formulation of his problems. He failed to document the patient's psychiatric diagnosis in a DSM format. He failed to document telephonic communications with the patient. He failed to treat a seriously ill patient with extreme symptoms in a multi-disciplinary setting.

(Motion to Dismiss, Exhibit C - Accusation, par. 9, pp. 6-7.)

///
///
///
///

9. The allegations in the third cause for discipline, pertaining to patient R.D., were as follows:

A. On or about April 19, 2000, Patient R.D., a thirty-two-year-old male, was seen initially with complaints of depression, post-traumatic stress disorder, and bipolar issues. Respondent did not document in the record a complete history, including the patient's family history of mood disorders, and a thorough mental status examination. There was no documentation of an objective assessment and consideration of bio-psycho-social factors. There is no documentation of a treatment plan. There was no documentation of the patient's psychiatric diagnosis in a DSM format. Respondent prescribed the antidepressant Zoloft for the patient.

B. Over the following months, respondent continued to treat Patient R.D. with Zoloft. The patient experienced violent dreams, rapid thoughts, surges of energy, and aggressive behavior. Respondent adjusted the dosage of Zoloft several times, and also prescribed the anti-anxiety medication BuSpar.

C. From about May 2002 through December 2002, the patient experienced erratic highs and lows, depression, numbness and constant buzzing in his head. His concentration and focus deteriorated, and his sensitivity to noise become more problematic. In May 2002, and for the next several months, Respondent prescribed the drug Sonata, which is used for the short-term treatment of insomnia.

D. The patient's condition continued to deteriorate over the months, his symptoms became more severe, and in September 2003, he reached a crisis point. . . . Respondent did not properly address the patient's symptoms. He did not recognize the patient was experiencing bipolar switching induced by Zoloft. Respondent continued to prescribe sleeping pills, alternate SSRIs (selective serotonin reuptake inhibitors) such as Zoloft and Lexapro, and benzodiazepines to the patient who was exhibiting manic symptoms. . . .

[¶] . . . [¶]

F. Respondent was grossly negligent in the care and treatment of Patient R.D. as follows: Respondent failed to document a complete history, including the patient's family history of mood disorders, and a complete mental status examination. There was no documentation of an objective assessment and consideration of bio-psycho-social factors. There is no documentation of a treatment plan. There was no documentation of the patient's psychiatric diagnosis in a DSM format.

Respondent failed to document telephone communications with the patient. He failed to recognize and properly treat the patient's developing manic symptoms, including bipolar switching, which resulted from his prescribing Zoloft. Respondent failed to properly diagnose the patient's psychiatric issues, and continued to prescribe sleeping pills, alternate SSRIs, and benzodiazepines to a patient who exhibited manic symptoms.

(Motion to Dismiss, Exhibit C - Accusation, par. 10, pp. 7-9.)

Discussion and Conclusions

10. The Board may dismiss a case prior to hearing, pursuant to granting of a motion to dismiss based on undisputed facts, if the parties are afforded notice and opportunity to be heard. (*Duarte v. New Motor Vehicle Board* (2002) 104 Cal.App.4th 626, 637.) Such notice and opportunity to be heard were afforded in the case at hand.

First Cause For Discipline – Patient S.S.

11. Regarding the allegations of Respondent's treatment of patient S.S., contrary to the moving party's assertions, this case does not involve the doctrine of *res judicata* or improper splitting of actions. The 2006 Accusation alleged only Respondent's failure to turn over the records of patient S.S., and did not allege any gross negligence in S.S.'s treatment. Moreover, since S.S.'s records were not produced prior to the filing of the 2006 Accusation, the allegations of gross negligence had not been fully investigated, and therefore could not have been pleaded in 2006. While the records were turned over prior to the hearing on the 2006 Accusation, only one month lapsed from the time the records were produced until the hearing. Consequently, there was little time for the Board to complete its investigation and file any amendment to the 2006 Accusation. Furthermore, Complainant was not required to delay filing the 2006 Accusation until its investigation of patient S.S.'s treatment was completed. In this case, Complainant was compelled to file the 2006 Accusation because its request for records, citation and subsequent correspondence were ineffective in obtaining the records. The filing of the 2006 Accusation proved effective since the records were finally produced thereafter. Given the foregoing, Respondent's request to dismiss the first cause for discipline based on *res judicata* or improper splitting of actions is denied.

Second Cause For Discipline – Patient K.S.

12. Business and Professions Code section 2230.5, subdivision (a) provides, in pertinent part:

[A]ny accusation filed against a licensee pursuant to Section 11503 of the Government Code shall be filed within three years after the board, or a division thereof, discovers the act or omission alleged as the ground for disciplinary action, or within seven years after the act or

omission alleged as the ground for disciplinary action occurs, whichever occurs first.

13. In the case at hand, the current Accusation was filed on June 25, 2008. Therefore, discipline based on any acts prior to June 25, 2001, is barred by Business and Professions Code section 2230.5, subdivision (a).

14(a). The Accusation alleges that Respondent's treatment of patient K.S. began in 1990 and continued through 2007. Paragraph 9A of the Accusation describes K.S.'s initial visit in 1990. Additionally, several of the allegations of gross negligence in paragraph 9E pertain to that initial visit. Consequently, all of paragraph 9A and the following allegations in paragraph 9E describe acts outside the statute of limitations:

Respondent failed to document a complete history and mental status examination. He failed to describe the problem as understood by the patient. He failed to document an objective assessment of the patient's current issues, and a bio-psycho-social formulation of his problems. He failed to document the patient's psychiatric diagnosis in a DSM format.

14(b). Consequently, all of paragraph 9A and the above-stated allegations in paragraph 9E of the Accusation are barred by Business and Professions Code section 2230.5, subdivision (a), and should be dismissed.

15(a). The allegations contained in paragraphs 9B and 9C are vague as to the time the alleged acts occurred. Additionally, the following allegations of gross negligence in paragraph 9E are vague as to the time the alleged acts occurred:

He failed to document telephonic communications with the patient. He failed to treat a seriously ill patient with extreme symptoms in a multi-disciplinary setting.

15(b). Because they are vague as to time, these allegations fail to give Respondent proper notice to allow him to prepare a defense, which could include a statute of limitations defense. Consequently, these allegations must be amended and pleaded with more specificity as to time.

16. Respondent also moved to dismiss the second cause for discipline based on a failure to plead gross negligence. Such a determination is one of fact which requires the submission of evidence, including expert testimony, and cannot be made pursuant to the instant motion. Consequently, Respondent's motion to dismiss the second cause for discipline on this ground is denied.

///
///

Third Cause For Discipline – Patient R.D.

17(a). The Accusation alleges that Respondent's treatment of patient R.D. began in 2000 and continued through 2003. Paragraph 10A of the Accusation describes R.D.'s initial visit in 2000. Additionally, several of the allegations of gross negligence in paragraph 10F pertain to that initial visit. Consequently, all of paragraph 10A and the following allegations in paragraph 10F describe acts outside the statute of limitations:

Respondent failed to document a complete history, including the patient's family history of mood disorders, and a complete mental status examination. There was no documentation of an objective assessment and consideration of bio-psycho-social factors. There is no documentation of a treatment plan. There was no documentation of the patient's psychiatric diagnosis in a DSM format.

17(b). Therefore, all of paragraph 10A and the above-stated allegations in paragraph 10F of the Accusation are barred by Business and Professions Code section 2230.5, subdivision (a), and should be dismissed.

18. The allegation contained in paragraph 10F regarding Respondent's failure "to document telephone communications with the patient" is vague as to the time the alleged act(s) occurred. Therefore, this allegation fails to give Respondent proper notice to allow him to prepare a defense, which could include a statute of limitations defense. Consequently, this allegation must be amended and pleaded with more specificity as to time.

19. The remaining allegations in paragraph 10 of the Accusation regarding Respondent's failure "to recognize and properly treat the patient's developing manic symptoms" and failure "to properly diagnose the patient's psychiatric issues" are within the statute of limitations. Consequently, Respondent's motion to dismiss regarding these allegations is denied.

20. Respondent also moved to dismiss the third cause for discipline based on a failure to plead gross negligence. Such a determination is one of fact which requires the submission of evidence, including expert testimony, and cannot be made pursuant to the instant motion. Consequently, Respondent's motion to dismiss the third cause for discipline on this ground is denied.

Fourth, Fifth and Sixth Causes For Discipline.

21. Respondent also moved to dismiss the fourth, fifth and sixth causes for discipline, which alleged repeated negligent acts, unprofessional conduct/incompetence and failure to maintain adequate/accurate medical records, respectively. Since these causes for discipline were based on the allegations in the first, second and third causes for discipline,

the analyses in paragraphs 11, 12, 13, 14, 15, 17, 18 and 19, above, apply to the fourth, fifth and sixth causes for discipline.


WHEREFORE, THE FOLLOWING ORDERS are hereby made:

Respondent's Motion to Dismiss is **GRANTED in part and DENIED in part** as follows:

1. The motion to dismiss the first cause for discipline is denied.
- 2(a). The motion to dismiss the second cause for discipline is granted in part, and denied in part.
 - 2(b). All of the allegations in paragraph 9A, and the allegations in paragraph 9E, as set forth in Finding 14(a) above, are hereby stricken from the Accusation and dismissed.
 - 2(c). The allegations in paragraphs 9B and 9C and the last two sentences of paragraph 9E of the Accusation (see Finding 15(a), above) shall be amended and pleaded with more specificity as to time. If Complainant fails to do so by the hearing of this matter, Respondent may make a motion to strike these allegations or a motion to restrict any evidence regarding these allegations.
 - 2(d). Respondent's motion to dismiss the second cause for discipline based on a failure to plead gross negligence is denied.
- 3(a). The motion to dismiss the third cause for discipline is granted in part, and denied in part.
 - 3(b). All of the allegations of paragraph 10A and the allegations in paragraph 10F, as set forth in Finding 17(a) above are hereby stricken from the Accusation and dismissed.
 - 3(c). The allegation contained in paragraph 10F of the Accusation regarding Respondent's failure "to document telephone communications with the patient" shall be amended and pleaded with more specificity as to time. If Complainant fails to do so by the hearing of this matter, Respondent may make a motion to strike these allegations or a motion to restrict any evidence regarding these allegations.
 - 3(d). Respondent's motion to dismiss regarding the remaining allegations in paragraph 10 of the Accusation (i.e. the allegations of Respondent's failure "to recognize and properly treat the patient's developing manic symptoms" and failure "to properly diagnose the patient's psychiatric issues") is denied.
 - 3(e). Respondent's motion to dismiss the third cause for discipline based on a failure to plead gross negligence is denied.

4. Respondent's motion to dismiss the fourth, fifth and sixth causes for discipline is granted in part and denied in part. Since these causes for discipline were based on the allegations in the first, second and third causes for discipline, the orders above (numbers 1 through 3) apply to the fourth, fifth and sixth causes for discipline.

DATED: December 2, 2008



JULIE CABOS-OWEN
Administrative Law Judge
Office of Administrative Hearings