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LAW OFFICE OF
DAVID J. DUCHROW
501 Santa Monica Boulevard, Suite 505
Santa Monica, California 90401-2443
Telephone (310) 395-5511
Facsimile (310) 395-6677

DAVID J. DUCHROW, C.S.B. No. 105617
JILL A. PIANO C.S.B. No. 193930

Attorneys for Petitioner Jay Singer, M.D.

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SUPERIOR COURT, STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

CENTRAL DISTRICT

Jay Singer, M.D., Petitioner, vs. Los Angeles County Civil Service Commission, etc., et al. Respondents	CASE NO: **BS 129788** Filed December 17, 2010 Assigned for all purposes to Dept. 86, Hon. Ann I. Jones **PETITIONER'S SUMMARY OF TESTIMONY AND EVIDENCE** Date: May 14, 2012 Time: 9:30 a.m. Dept: 86

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This Summary of Testimony and Evidence is a response to DMH Attorney Vincent McGowan's Summary for which Court granted request to submit a separate summary without prejudice to Petitioner to submit one of his own.

THE TESTIMONY AND EVIDENCE FOR CASE NO BS 129788 REVIEWED:

The Pattern of Testimony and Exhibits shows that as evidence was slowly and reluctantly produced during the case that showed the allegations were false, DMH shifted focus to allegations for which evidence was still withheld (CASS, Chart Pulling, Malingering) and created new and augmented dramatic allegations (disdain for opinions of others without citing any opinions, repeatedly citing variations of "flouting orders, disobedience, ongoing insubordination, lack of respect" etc for which there was no documentation whatsoever). In forensics such a dramatic presentation (a variant of the "poor me" presentation such as that of Patient 3 below) is a characteristic defensive posture to avoid scrutiny (of the lack of facts in DMH's case) described in the Textbook of Forensic Psychiatry by Albert Drukteinis, MD, JD (APL Ex R 14/AR925,2). Vague, ill defined and overdramatised symptoms are also associated with malingering per Kaplan and Saddock's Malingering Chapter 92 in Emergency Psychiatric Medicine (APL Ex R12, AR911), which DMH's case and Reply Brief is filled with (if you substitute allegations for symptoms).

The following abbreviations pertain to people and documents herein: AK, Alex Kopelowicz, MD, SFMHC Medical Director; CC, Chris Collins Asst. Mental Health Counselor; FA, Florencio Arceno, RN; LTJ, La Tina Jackson, LSCW; WT, Wendi Tovey, LCSW, Clinic Director; HO, Hearing Officer Jan Stiglitz; HO Decision, Hearing Officer's Decision; JS, Jay Singer, MD, Petitioner; LOT, Letter of Termination, RS, Roderick Shaner, MD, DMH Medical Director; VMc, Vincent McGowan, DMH Attny.

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1 Inconsistency of statements in any forensic setting is commonly known
2 to indicate lack of credibility. DMH witnesses delivered a multitude
3 of inconsistent testimony as shown below.

4 DMH fabricated, enhanced and focused on those allegations that
5 could not be countered with evidence as they also withheld evidence
6 whenever they could and for long as possible (some for over four
7 years) and by any means necessary - including motions to quash,
8 endless delays of the case and production of needed documents
9 stretching beyond four years after the fact, claiming documents were
10 not saved or archived, were shredded, could not be found, were
11 deleted, did not exist, were confidential, denying access to documents
12 and witnesses on false pretenses, including
13 VMc's claims that " I am giving you all I got, I gave you more than
14 you asked for, I did not cherry pick these records", as well as per
15 DMH Medical Director Dr. Shaner's orders not to contact anyone at DMH
16 etc. as described in the Summary of February 16, 2010 (AR 265-272) and
17 the record.

18 While DMH repeatedly tries to make a case that suspecting
19 malingering in a patient and using related standard forensic
20 terminology is clinically grossly insensitive to patients and while AK
21 and KS failed to notice even the most obvious formally recognized
22 signs of malingering (thereby concealing their part in the DMH drive
23 to get more patients on disability for which DMH was already
24 collecting $350 million annually per Dr. Shaner). Philip Resnick, MD
25 in Principles and Practice of Forensic Psychiatry (APL Ex 13/AR916,2/
26 ed. American Academy of Psychiatry & the Law) points out that
27 "Malingering should be suspected in the assessment of all cases.
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Otherwise, separate small clues of dissimulation that would lead to a more detailed investigation may be overlooked." Dr. Shaner testified (8/109/10-16) that treatment for an incorrect diagnosis could have serious adverse consequences, while Patients 1-4 were subjected to treatments by AK, KS and Dr. Sabounjian that were extensively documented as capable of causing cardiac arrest and ineffective and expensive as described below. But DMH failed to demonstrate in any manner whatsoever, that JS put a single patient in danger.

SAN FERNANDO MENTAL HEALTH CENTER MEDICAL DIRECTOR ALEX KOPELOWICZ, M.D. (AK) TESTIMONY AND RELATED EVIDENCE:

Dr. Kopelowicz testified twice under oath on direct (9/185/81-10) and (9//186/17-1/187/4 &9/152/15-25) that the statements he made in his only notes written about JS/ DMH Memo Exhibits 8 and 12 (as well as DMH Ex 13 written by Wendi Tovey, LCSW (WT)) were true. He testified again (10/64/10-25) on cross that he had reviewed the charts before making the allegations in DMH Ex 8 &12 and that the allegations were correct. AK testified again on cross (11/30/11) that he had reviewed the charts of the patients about whom he made allegations and that the allegations per DMH 8, 12, and 13 were true. He wrote DMH Ex 8/AR1775 on the 1/21/05 Friday before the 1/24/05 Monday meeting with Dr. Shaner that resulted in JS being evicted from the clinic on 1/27/05. AK testified (10/61/1-10/64/25) that he had no notes at all related to any of the numerous meetings with JS or related to any of the "ongoing" issues and problems with JS over the entire eight months JS was at SFMHC. AK said that DMH Ex 8 was based on his "recollections" and "a review of the related charts". AK had over

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1 three and a half years to review the charts to determine that the
2 statements in DMH Ex 8 & 12 (and the related statements in the LOT)
3 were false and misleading before he testified as shown below. JS's
4 12/23/05 FAX/DMH Ex 39 also urged him to do so.

5 AK established his credibility by stating he was Board Certified
6 in Psychiatry (9/24/20), a member of the Southern California
7 Psychiatric Association (12/6/21-23), recently promoted to Full
8 Professor of Psychiatry at UCLA (9/29/11-13), as well as promoted to
9 Chief of Psychiatry of the Olive View Medical Center Psychiatry
10 Department, Head of Consultation Services and Emergency Psychiatric
11 Services at Olive View Medical Center, Medical Director of San
12 Fernando Mental Health Center (9/23/5-9/25/21), and that his full CV
13 was 40 pages long, not just 12 pages like the CV in DMH Ex 27
14 (9/29/14-19). He further testified that he was responsible for patient
15 safety at SFMHC (9/108/21-25) but then proceeded to ignore all the
16 compromise of patient safety considerations that patients 1-4 were
17 subjected to by him and Dr. Karina Schulman and Dr. Sabounjian, the
18 psychiatrists he supervised.

19 In his testimony AK could not identify any of dozens of signs of
20 malingering and drug abuse in Patient 1, could not recall receiving
21 emails from JS related to the Antabuse Issue and problems with FA,
22 did not know what the AMA Code of Ethics said about honesty between
23 physicians, did not know when, where or with whom he had HIPAA
24 Training or any related HIPAA laws (just like WT, he only knew he was
25 HIPAA certified), could not cite a single element of DMH Dual
26 Diagnosis Policy, could most often not recall what was documented in
27 the charts of Patients 1-5 he alleged he had reviewed. AK claimed that
28 the signs of confusion and disorientation he documented on the EDD

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Disability Extension were documented in the Chart of Patient 3, but there were none. He could not recall what was discussed in team meetings about Patient 1 or what happened to her psych test after he claimed four years after the fact that it is a good idea to do psych testing. Could not recall seeing Patient 1 at all, while his 12/22/04 note showed he prescribed the very medications he testified should be changed due to side effects. He did not identify accuracy problems with urine drug testing. AK recalled things that never happened and made up new false statements ad lib on the witness stand as shown below and throughout Appellants Brief.

Patient 1: AK claimed (DMH Ex 8/AR1775,par 4) that JS "informed the SSI agency that Patient 1 was malingering resulting in the discontinuation of her SSI Benefits" and contributed to her 12/24/04 hospitalization. But Patient 1 was not on SSI but on SDI/EDD and lost her EDD benefits after the 10/6/04 EDD Independent Medical Evaluation per EDD Letter of Determination in the chart (AR158). Over three years later AK testified (9/133/1-5): "What I remember most about the situation, the aspect regarding the call to the SSI Office (AK still does not know that the issue was SDI, not SSI after repeatedly claiming he had reviewed the chart) is how clearly La Tina Jackson, LCSW (LTJ) remembered Dr. Singer telling her that he had done this." But LTJ testified (5/45/5-18) that JS "told her he intended to call EDD", changing her statement apparently after realizing the EDD Letter of Determination was in the chart. AK claimed (12/64/25-12/65/1) he did not know about the EDD IME Evaluation documented in the chart per EDD Letter of Determination (AR158).

There was no evidence presented that noticing signs of malingering had any effect whatsoever on the diagnostic workup in

progress on Patient 1 nor that it was related to treatment in any way (as the patient was noncompliant with treatment for two and a half months prior to her 12/24/04 Olive View Hospitalization (DMH Ex 42 (AR1611,1614)).

For Patient 1, AK also claimed that ((9/126/19-25) and again (9/126/22)) the fact that JS lowered the medication during the time that Patient 1 was "still experiencing psychotic symptoms most likely contributed to her eventual decompensation and hospitalization at Olive View Hospital", but the hospital chart shows (AR1611&1614) that she did not take her medication for two and a half months before her 12/24/04 Hospitalization (noncompliance is associated with malingering (APL Ex 11 /AR911#2)). In his memo DMH Ex 8 (AR1775, par3), he did not qualify the same assertion with a "most likely". He then testified on cross (12/27/11-20) that he did not know why Patient 1 had to go to the hospital but "it is possible that it had to do with her not receiving the right treatment for her psychotic illness.

AK claimed the chart diagnosis for Patient 1 was Schizoaffective Disorder (DMH Ex 12/AR1790, par 2), when the chart shows it was Major Depression with Psychotic Features (APL Ex AR723). He claimed on direct (9/128/5-16) that "everyone in the treatment team except JS felt the Patient 1 had a Schizophrenic Spectrum Disorder Diagnosis", but then on cross could not recall what diagnoses were discussed in team meetings (10/19/9-25) and said that without seeing the patient he could not determine the diagnosis. AK dismissed drug abuse (the most common cause of psychotic symptoms per Saddock & Saddock's Synopsis of Psychiatry/APL Ex R2 (AR832) on direct (9/141/19-25) but then testified on cross (11/12/1-3) that Patient 1 was confused and disorganized at times and had earlier testified (10/52/12-10/53/8)

with respect to Patient 3 that cocaine, methamphetamine, alcohol, and ecstasy can cause confusion. A medical evaluation found no medical cause for her symptoms other than vasculitis of the brain per MRI consistent with cocaine/meth abuse (APL Ex R15/AR936-937).

Drug abuse is associated with malingering per false attribution of symptoms and denial of the symptom cause as being drug related per (APL Ex 13/AR417, 1) but Drs. Kopelowicz and Schulman, as well as trainee social worker Ms. Jackson did not consider nor properly evaluate the Patient 1 for this diagnostic possibility that was further confirmed by the MRI Report (AR1574-1575) (which MRI Report LTJ never procured for the chart despite JS instructions (APL Ex G3(AR647-648) to do so). This failure to treat her drug abuse further increased her risk of cardiac arrest and stroke (APL Ex R2/AR830 & E. Braunwald's Heart Disease/R5(AR895-897)) from the already increased and totally ignored risk of Patient 1 being prescribed effexor and seroquel at high doses by Karina Shulman despite the DMH Drugdex Information (APL Ex R7/AR900) warning that this combination should not be used due to the increased risk of cardiac arrest. As KS testified (7/100/11-15), the patient did not improve with this treatment in the next four years, received no vocational or drug rehabilitation treatment and did not return to work per KS, while the chart showed continued signs of drug abuse that went untreated (14/30/20-24). Notably, Presley Reed's Medical Disability Advisor (14/15/24-14/16/1) used by EDD to judge disability duration gives 56 days as the maximum period of disability for her chart diagnosis. Patient 1's alleged disability has lasted 24 times the usual maximal duration with no end in sight. Without documented vocational or drug rehabilitation, that is the expected outcome.

AK claimed (9/128/24-9/129/11) there were no signs of malingering in the chart of Patient 1, like Karina Schulman, MD (KS) and LTJ, despite the over two dozen accepted signs cited in Appellant's Brief pp18-27. But if they had admitted there were such signs they would have inculpated themselves and Patient 1 in disability fraud violations of CA Unemployment Insurance Code 2121 and 42 US Code 1383, (a) 1-(3), as well as putting Patient 1 at risk of cardiac arrest from the combination of seroquel and effexor KS prescribed that was not warranted and that only added to the risk of death from substance abuse. The record shows there were no independent psychological testing experts, radiologists for the MRI report, forensic experts in malingering, or rehabilitation expert witnesses that testified for DMH about anything. Rehabilitation of Patient 1 was not even mentioned by any DMH witness.

Vincent McGowan managed to elicit over 100 pages of testimony of opinions related to the malingering issue of Patient 1 (while ignoring the plethora of evidence of malingering as described in Appellant's Brief pp18-27. 34 of these pages of testimony were from LTJ, a trainee social worker at the time) including extensive direct and cross examination of the vaguest of hearsay testimony about Dr. Ascani who concluded after a 15 minute examination that Patient 1 was "psychotic" but came up with no diagnosis and did not rule out drug abuse as required for any DSM IV-TR Diagnosis (APL Ex R3, pp883-880). She did not do the psychological testing requested of her and that AK testified was a good idea to do (12/64/21-12/65/2) but AK did not know what happened to the MMPI JS requested.

For Patient 2, AK claimed Antabuse was "a good choice" (11/23/16-17) and "state of the art" (11/66/9-16) for her alcohol cravings as

part of Dual Diagnosis Treatment; despite the fact that Antabuse has been associated with cardiac arrest, stroke, liver failure and has not been shown to be effective in treating alcohol abuse since its release in 1948 (AHFS Drug Information/APL Ex R4, (AR887)). Social Worker trainee LTJ felt so strongly that Patient 2 should be on this dangerous and ineffective drug that she wrote a memo DMH Ex 9/AR1778 to WT &AK. AK claimed that JS did not know anything about Antabuse (9/71/16-18), while AK ignored the fact that drugs were her substance of choice, not alcohol, (11/50/15-11/51/4) and no evidence or testimony indicated antabuse is used for drug abuse. JS had sent AK an email (APL Ex H/AR649-650), which AK could not recall receiving (11/45/1-24) outlining the hazards of Antabuse. AK was not able to identify any of these lethal hazards or major risk factors of Antabuse under cross examination (11/34/24-11/35/1). That is until JS showed him the email outlining some of these hazards (11/47/6-19).

The HO announced that he did not expect AK to know such "intimate details of treatment" such as risk factors for cardiac arrest and liver failure for the antabuse AK recommended (11/71/13-25) while stating that DMH had "the right to protect the public from harm" (HO Report/AR75). While AK was posing as an "expert witness", he did not appear to know answers to questions one would expect a medical student to know. (11/72/20-11/73/11)

AK also did not know KS had not prescribed Antabuse for Patient 2, when she took over Pt 2's care (11/58/21-11/59/21) and had never talked to her about it nor any other psychiatrist at SFMHC. He claimed that JS interaction with Patient 2 on 1/12/05 adversely affected Patient 2's "recovery trajectory" (DMD Ex8 /AR1776, par2) but the 1/19/05 chart note (AR775) by Social Worker Pat Tryon showed she had

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markedly improved after JS instructions on 1/12/05 to increase activity. It appears that once again AK had not read the chart or considered what it said. The patient had a drinking relapse some months after KS took over her care (14/62/18-23)and disappeared from the clinic with no trace and with no signs of being rehabilitated from her drinking or for a return to work.

For Patient 3, AK provided no testimony nor made any allegations whatsoever about ICD-9 Codes, whose job it was to fill them in, or that this was a standard of care issue. Nor did anyone else. There was no evidence presented that it was related to treatment in any way. While the HO expected JS to know the ICD 9 Code per his Finding 23, while overlooking all the related diagnostic and treatment issues, AK testified (10/39/2-7) he did not know the code for Patient 3, which was made even harder by not knowing if her symptoms were due to bipolar disorder or substance abuse as AK admitted was the case. The patient not coming in to be evaluated by JS on 11/10/04 made any currently accurate code determination impossible.

AK did not prescribe Antabuse for Patient 3(AR653-655) and gave no reason per chart or testimony for not doing so, even though she had reported she still has the desire to drink on the 10/19/04 visit (AR1178) just before AK took over her care on 11/10/04. AK repeatedly testified about the importance of treating substance abuse and claimed he had spoken to JS three times about it per his memo/DMH Ex 12 /AR 1791, par2
& (11/44/4-16) but could not recall what was discussed during any of these meetings with JS. AK did not even mention the DMH Dual Diagnosis Policy 202.19./ LOT p4 that JS was accused of not following in the LOT and recalled not a single point of the Dr. Shaner's DMH 9 Point

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Module for Dual Diagnosis Treatment, even with prompting (11/57/10-11/58/7). He entirely failed to treat Patient 3 for substance abuse as the record shows (AR653-655) despite documented continued cocaine and alcohol use in the chart per 2/28/05 Annual Assessment Update (AR656) and also ignored JS 10/19/04 referral to AA Meetings and for drug counseling (AR1178).

AK claimed JS had only prescribed an antidepressant in therapeutic doses for Patient 3 (DMH Ex 8, par3/AR1776) indicating that the dose of lithium JS prescribed for Patient 3 (AR660) was not "therapeutic", but AK then prescribed a lower dose for the patient when he took over her care (AR660). When this was pointed out to AK, he claimed the lithium formulation he prescribed was "entirely different" (10/72/16-10/73/6), but the chart showed it was identical (Eskalith per AR660). Again it appears he had not read the chart or considered the facts in his written allegations nor his testimony.

AK claimed he had to see Patient 3 on 11/10/04 because JS was absent from the clinic that day (10/22/14-20) after she was crying about her EDD Disability Extension (AR1768) and complaining about "exacerbation" of unidentified and undocumented symptoms to Florencio Arceno, RN (FA) and sending angry faxes and making angry phone calls to AK (DMH Ex 12/AR1790, par 4), but JS 11/10/04 chart note (AR654) shows JS was present in the clinic that day. AK claimed Patient 3 had an increase in symptomatology over time before she disappeared from the clinic (9/160/10-12), but his own chart notes did not document any symptoms whatsoever for this patient (AR653-655). He testified that JS should have stuck to the same bipolar diagnosis he had given her (while all JS chart diagnoses were Bipolar NOS per DMH Ex 30/AR1178-1184), but then testified that he did not know if her symptoms were

1 due to bipolar disorder or the substance abuse (10/55/16-17)
2 documented in the chart. AK testified he was not aware of her
3 substance abuse (10/52/12-15), until JS pointed it out in the chart in
4 front of him, indicating again AK had never read the chart. He totally
5 failed to document drug abuse in his chart notes (AR653-655).

6 AK also testified that he believed Patient 3 lost her apartment
7 as a result of the delay of her Disability Certification (9/160/6),
8 but her memo addressed to him DMH Ex 14/AR1790states that she "almost"
9 lost her apartment. The patient disappeared from the clinic without a
10 trace and with no attempt at drug or vocational rehabilitation
11 whatsoever or return to work one month after AK helped her get
12 permanent SSI disability worth $400,000 over her lifetime with no
13 documented symptoms whatsoever (13/31/12-21), with a maximum
14 disability duration for her diagnosis of two months per EDD disability
15 duration criteria (13/94/1-4), and after quitting her job because it
16 did not make her happy (13/29/22-25).

17 Notably, when AK took over the care of Patient 3 on 11/10/04, he
18 wrote in her 11/12/04 EDD Disability Extension (AR661) under penalty
19 of perjury that she was "disoriented and confused". He was to describe
20 her current condition as per standard EDD Certification Form (AR667).
21 The same day AK pronounced her "disoriented and confused", Patient 3
22 sent him a fax (AR662) telling him to disregard the JS evaluation and
23 make sure that he writes on the disability form that she is disabled.
24 AK could identify no documentation of disorientation or confusion
25 anywhere or anytime in her chart. AK testified that "he imagined"
26 (10/40/5-20) this disorientation and confusion was documented
27 elsewhere in the chart but it was not. AK also ignored the risk of
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1 cardiac arrest from use of cocaine and alcohol further increased by
2 the lithium he prescribed for Patient 3. (JS13/95/19-25).
3 For Patient 4, AK claimed (DMH Ex 8/AR 1176, par 3) JS did not
4 prescribe any antispychotic medication , but all 9/9 chart notes
5 showed JS did (DMH Ex31/AR1189-1201: dated 11/18, 11/23, 12/1, 12/8,
6 12/14, 12/23, 1/11, 1/20/05, 1/25). He then claimed that it was
7 important to prescribe full antipsychotic doses for his diagnosis of
8 Psychotic Depression. AK also claimed that another clinic psychiatrist
9 Dr.Sabounjian (DMH Ex 12 /AR1791, par3) had to prescribe an
10 antipsychotic medication after Patient 4 decompensated in a group
11 therapy session because JS had not prescribed any, but there was no
12 documentation for such an incident in the chart other than by Dr.
13 Sabounjian who documented there had been "apparent" agitation (DMH Ex
14 31, 1/12/05 note/AR784) per report and stated that he prescribed a
15 second antipsychotic "to calm the team" and not the patient
16 (13/34/19-22). The second antipsychotic increased the risk for
17 cardiac arrest for this patient (APL Ex R2, p 498/AR832 & APL Ex
18 R6/AR889) "in order to calm the team". This was another potentially
19 fatal but unwarranted intervention deemed appropriate by AK. The
20 patient, after Dr. Sabounjian took over his care and treated him with
21 a full dose of antipsychotic as AK had recommended (while APL Ex R9,
22 AR905-907 showed no advantage of treating psychotic depression with
23 any antipsychotic) that created an increased risk of cardiac arrest
24 (APL Ex R6/AR832) was subsequently transferred to an inpatient unit, a
25 sign of deterioration, not improvement (13/36/1-8).
26 For Patient 5 , AK claimed per (LOT, p 5/AR) and (DMH Ex
27 12/AR1790 par 3) that this patient developed myoclonus due to an
28 antipsychotic JS prescribed for the patient, but all 7/7 chart notes

(per DMH Ex 32/AR1205-1214) show that JS never prescribed any antipsychotic medication for this patient. AK claimed Patient 5 had to go to the ER (DMH Ex 8/ AR 1775 & again DMH Ex 12, AR1790, par3) due to this myoclonus related to the medication JS prescribed but there was no documentation in the chart related to this ER visit whatsoever and no evaluation of this myoclonus was ever done, even after KS took over his care and prescribed the identical medications in the same doses. AK claimed that FA showed him the ER doctors report, but that report disappeared along with FA (10/149/20-10/150/15) who never got to testify about what happened to that alleged ER Doctor's Report. AK also claimed the patient's medications should have been adjusted due to the myoclonic twitches, but when AK saw the patient, he prescribed the identical medications at the identical doses with the identical myoclonic symptoms (AR1207) and did not even bother addressing those symptoms in his 11/12/04 note that JS had documented in the note above that of AK.

For Patient 8 (Pt 14 per DMH Ex 35), he claimed per (DMH Ex 8, AR1176, par3) that JS did not prescribe an antidepressant, but per DMH Ex 35/AR 1298-1301), but 7/7 notes showed JS did.

AK's allegations about JS's diagnosis and treatment in DMH Ex 8, 12, 13 and the LOT were all patently false. It showed that AK neither read the chart nor considered the related facts when he made those allegations. His allegations, testimony and the evidence demonstrate that when AK (15/133/6-14) told JS at the clinic that "he does not have time to read the charts" when he sees patients, he was totally sincere. AK's faulty judgments are further demonstrated by there being no evidence whatsoever in the record that Patients 1-5 improved in function in any manner whatsoever under the subsequent extended care

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of AK, KS, and Dr.Sabounjian - all under the supervision of AK. In Patients 1-4 AK ignored the risk of cardiac arrest from medications prescribed for patients 1,2, 4 and the antabuse AK recommended for Patient 2 as described above. Such disregard for fatal risks of medications adds to the 100,000 annual US deaths from medication side effects. (13/82/23-24).

AK's entire direct testimony contained not one word about the risks of drugs known to cause cardiac arrest, liver failure, and other serious side effects despite the plethora of available evidence; nor one word about rehabilitation of any patient; nor any need for objective evaluations such as psych testing, simple cognitive testing, or rehabilitation evaluations. His testimony was all pure opinion and shows that opinion based practice is harmful, not beneficial to patients, as well as bypassing evidence based practice Policy 101.1 that AK blatantly ignored.

In spited of the above, RS (8/122/17-20) lauds AK's reputation as a first-rate clinician, and AK (9/39/25) calls KS a very good psychiatrist. It illustrates once more the results of the Survey of Administration by Staff that gave Administration a grade of F for the integrity of the DMH discipline, promotion and recruitment process.

AK's testimony per Vol 9, 10, 11 and 12 dramatically changed from his allegations per DMH 8, 12, 13 and the LOT - as he must have realized those allegations could be shown to be false with the charts in evidence. More of his selective amnesia, false memories, and false and ever changing allegations are evident in the Appellants Brief pp 63-73 and other sections of the Appellant' Brief related to the allegations and the Transcripts Vol 9, 10, 11, 12.

When AK's false statements and unethical conduct constituting egregious AMA Code of Ethics Violations was pointed out to him by JS per DMH Ex 39, he responded with the "poor me" crocodile tear technique claiming that he felt threatened. On direct exam he testified (9//191/2-4) that JS urging him to be careful not to violate the AMA Code of Ethics and the Law: "I also felt towards the end of the document that there was some kind of implicit threat that he was planning on doing something you know malicious." But when asked on cross exam what that might be (12/29/13-31), he said, "I wasn't exactly sure what you meant, but the tone was threatening to my...my sense." The statement brought up no other concerns in his mind. AK testified (10/9/3-6) that he doesn't "remember what the AMA Code of Ethics says regarding honesty between physicians" three years after receiving DMH Ex 39/AR1506. Dramatic Presentation are forensically associated with malingering and avoidance of scrutiny in forensic assessments per Textbook of Forensic Psychiatry (APL Ex R14, p925). An unending plethora of distraction and evidence avoiding maneuvers by DMH follows the same pattern throughout the over five years of this case as outlined in Feb 16, 2010 summary AR265-272, the Appellant's Post Hearing Brief and the record.

AK's claims for the Chart Pulling/Review Allegation varied from his claim per Performance Evaluation (DMH Ex 3, AR1760, par 3) that "JS adamantly refused to review the charts" to "JS explained he often did not get the charts" on direct (9/52/11-9/53/3) to "JS did not always get the charts" (12/34/17-23) on cross, which does not match AK's claim that he got the charts (9/53/14-18) for JS. While WT claimed (6/37/10-12) she did not know that JS ever checked out the charts (after testifying JS refused to check out the charts), she

(5/92/20-25) "was not sure if she ever spoke to JS about this specifically." AK (10/136/7-19) could give no specific related example or or consequence related to this chart checkout issue. Neither WT nor AK ever mentioned any of the related DMH Policies 103.1 and 101.1 that JS was found violating by the HO.

The CASS Issue was presented in a similarly inconsistent manner and without any related documentation produced that AK (10/83/12-10/84/24 - but AK said he did not know when CASS use was supposed to begin) and WT (6/38/18-22) testified existed. While WT testified (6/139/5-10) she "did not know how to save an email" and "didn't know a computer saves emails automatically", DMH did produce WT emails (DMH Ex 5, 6, 44) when they wished to. The LOT allegation (DMH Ex 2/AR1737) claimed AK meet with JS two times over the CASS issues, while AK then claimed (9/48/17-22) on direct that he ordered JS to use CASS five or six times. On cross exam AK testified (10/82/14-16) that he reminded JS to use the CASS system or transition towards using the CASS system (versus claiming the CASS system already being in place, and he "could not recall the exact date" for related meetings with JS (10/81/20-21)). He gave no indications that he ordered JS to use CASS or when this transition period was or when the CASS system actually was in place. He could not recall (10/82/21-10/83/24) at all what JS said during the third meeting or what was said at all in the fourth, fifth or sixth meetings but recalled that WT "sent out an email "encouraging" the psychiatrists to use the CASS System", using "encourage" vs. "ordered", as previously alleged by AK and WT in direct.

With regard to the HIPAA violation allegations by JS, AK testified (9/56/23-25) on direct that he told JS to stop storing PHI

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on his personal computer after WT informed him it was inappropriate (the H Drive is a server, not a personal computer) and that (9/57/9-11) this was around August or September of 2004, making it seem like an ongoing problem. But WT's related email (APL Ex D/AR635-636) indicates that WT was still not sure even on 1/13/05 what the related policy was and that AK "was supposed to speak to him" , not that AK had, and "others are doing it.."

AK's illegible handwriting (as shown per AR 653-655) and (10/120/23-10/121/3) and AK's awareness that people die due to medication errors due to bad handwriting, showed another gap between DMH practice and policy and his claim that he was responsible for the safety of patients at SFMHC.

2006 Staff Survey of Administration: AK testified (10/103/2-3 & 10/104/12-19) that he was "not familiar with such a survey" and implied that it did not exist, while 883 employees had participated in the 2006 Staff Survey of Administration APL Ex S1/AR941-942. AK's testimony and related evidence illustrates the huge gap between alleged practice and actual practice at DMH which is further illustrated by the 2006 Survey of Administration by Staff F Grade Results that DMH tried so hard to conceal with motions to quash etc. as outlined in 10/16/10 JS Summary (AR267-268).

Missing Chart Note Allegation: AK (9/54/11-20) and WT(5/92/20-22) testified about JS notes missing from charts but the final tally (see Appellant's Brief p74) showed there were only 2/260 notes missing out of original 25 alleged missing per LOT and the two missing notes could have been printed from the H Drive by request. By contrast, 70/80 Units of Service Logs disappeared or could not be produced by DMH, as

well as Patient 1 EDD IME Exam Report, Patient 5 alleged ER Visit Doctor Report, and all CASS emails.

DMH MEDICAL DIRECTOR RODERICK SHANER, M.D. (RS) TESTIMONY AND EVIDENCE:

DMH Medical Director Roderick Shaner, M.D. testified he did not check charts to see if AK allegations are true (8/50/14-15) and did not discuss the allegations with JS (8/66/4-10). He was not a percipient witness (8/59/4-8). RS testified based on opinions he had not confirmed and made the final conclusions on the witness stand even before AK made his false, contradictory and changing allegations and testimony under oath and again demonstrated DMH's consistent attempts to avoid the facts. It is not clear which statements of AK RS agreed with - the initial statements per DMH 8 and 12 and those quoted in the LOT and shown to be false as outlined above or the subsequent altered, contradictory, and false allegations AK made on the witness stand as outlined above. It appears RS knows that the answers AK will give on the witness stand will support his conclusions, without even knowing what the questions are.

RS approved AK's judgments related to Patients 1 to 4 that are associated with multiple causes and risks of cardiac arrest, liver failure and other major sequelae and lauded AK's credentials and abilities (8/122/1-20). Furthermore, RS implies Patients 1 and 3 were harmed by not getting disability money in a timely manner, but forgets his own brother UCLA Professor Andrew Shaner's study (APL Ex 10/AR 908) shows that disability income worsens the condition of drug abusing patients (as well as increasing their risk of sudden death from drugs and medication) and increases their rate of

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hospitalization. Notably neither Patient 1 nor 3 improved in function in any documented manner whatsoever and not even token attempts were made by AK to rehabilitate them to return to work or in treating their substance abuse.

Not only did Dr. Shaner disregard the evidence in the charts and the entire testimony of AK and JS, he made sure that JS did not have access to witnesses and evidence per his letters APL Ex Q1(AR801-803) and Q6(AR812-813) forbidding JS access to witnesses and evidence related to his case. He thereby also committed egregious and multiple violations of the AMA Code of Ethics he is to follow as Southern California Psychiatric Association member and thereby also violated DMH Policy 605.1 - 4.5.2 and DMH Ethics Policy 2.3.1/DMH Ex 20(AR1902).

As medical director over DMH's 100,000 patients this total disregard for the well documented fatal consequences (APL Ex 4, 5, 6, 7 and 15/128/6-11) of medications that psychiatrists at DMH prescribe under his direction and that AK recommends has undoubtedly had many fatal consequences and contributed significantly to the 100,000 annual US medication side effect related deaths (13/82/23-24).

Despite RS telling JS "we have been finding dead bodies in the street" (13/34/1-18) related to well known and documented antipsychotic side effects of sudden death from cardiac arrest, his supervisees AK, KS and Dr. Sabounjian have continued to disregard these risks, and while DMH Medical Director Shaner has issued not one directive related to these fatal risks but lauds the credentials and expertise of AK who exposed patients to these risks. That is again consistent with the Grade of F the administration that Dr. Shaner was Medical Director of received for overall performance

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and the efficacy and integrity of the promotion, recruitment and discipline process in the April 28 2006 Survey of Administration by Staff that was taken just when DMH Administration was investigating allegations against JS. DMH failed to focus on DMH Patient Safety.

KARINA SCHULMAN, MD (KS) TESTIMONY:

As Patient 1's current psychiatrist, KS testified (7/77/19-23) that she never saw any evidence that Patient 1 was malingering, while admitting (7/76/23-7/77/3) she had never seen a single patient that was feigning illness. She had no explanation for the catalogue of signs of malingering and drug abuse in the chart, and while stating (7/91/19-23) malingering is difficult to determine, she did not attempt to get psych testing nor drug testing, nor did she talk (7/7/98/16-7/99/9) to AK, Dr. Dasher, or Olive View Social Workers Ellen Smith and Margaret Kazarian about Patient 1. She also claimed (7/78/2-5) that Patient 1 "always tried to hide her symptoms" and failed to notice that Patient 1's chart is full of symptoms from six different diagnostic categories including mood, anxiety, psychotic, cognitive and even multiple medical disorders, starting from the first day she was seen at the clinic on 8/17/04 as per Patient 1 Chart and JS Testimony (14/8-14/29). KS believed (7/78/15-18) that JS documented somewhere in the chart that Patient 1 was malingering, when there is no documentation in the chart. She testified (7/103/10-12 that she did not have to talk to JS because she "could read your (JS) notes". When she claimed (7/92/7-8) that she does not recall Patient 1 wanted to get EDD benefits, she overlooked the evidence that said otherwise. The hospital chart documents Patient 1 discussed

finances at the hospital (DMH Ex 42/AR1648) further documented by LTJ (APL Ex J1/AR708 per 1/4/05 note) that Patient 1 "continued to request signature of the State Disability Claim" while in Olive View Hospital. Patient 1 returned to the clinic only after LTJ told her she could reapply for EDD (APL Ex J1/AR704). KS even signed a letter (15/128/13-22) by LTJ that indicated Patient 1 could not make car payments because she was mentally ill (per Patient 1's own statement). KS also claimed (7/99/22-24) that the MRI of Patient 1 "found nothing organic", while the report indicated vasculitis of the brain, consistent with cocaine or methamphetamine abuse as discussed above. She claimed she did not miss anything about this patient in terms of diagnosis or treatment, while subjecting her to four years of full doses of seroquel and effexor associated with cardiac arrest, while ignoring dozens of signs of malingering and drug abuse in the chart, a positive MRI report, and her failure to even attempt rehabilitation or evaluation thereof in this patient "because (7/100/11-13) she has a chronic mental illness."

KS could not recall (7/79/9-12) the year that JS left the clinic, nor did she recall treating Patient 2 at all. The only relevant thing she recalled about Patient 5 (7/114/11-13) was that he stopped complaining about myoclonic twitches. See also AK Testimony Section.

WENDI TOVEY, LCSW (WT), SFMHC CLINIC DIRECTOR TESTIMONY:

See above and Appellant's Brief pp 103-105 and Sections related to CASS, HIPAA, Chart Pulling and Missing Charts Sections.

Dated this May 1, 2012

Respectfully submitted
LAW OFFICE OF DAVID J. DUCHROW

By: ______________________
David J. Duchrow, Attorney for Petitioner