

STATE OF VERMONT BOARD OF MEDICAL PRACTICE

In re: Sergio Horta Luna, M.D.)
a/k/a Sergio Horta-Samaniego)
a/k/a Sergio Horta Samaniego)
a/k/a Sergio Horta)

Docket No. MPC 75-0506

STIPULATION AND CONSENT ORDER

NOW COME Sergio H. Luna, M.D., and the State of Vermont, by and through Attorney General William H. Sorrell and undersigned counsel, Assistant Attorney General James S. Arisman, and agree and stipulate as follows:

1. Sergio H. Luna, M.D., Respondent, holds Vermont Medical License Number 042-0009729, issued by the Vermont Board of Medical Practice on August 5, 1998. Respondent, a board certified psychiatrist, practices in Saint Albans, Vermont where he is associated with Northwest Counseling & Support Services. Respondent also holds or has held medical licensure in Texas, New York, the District of Columbia, Maine, and Virginia.
2. Jurisdiction vests in the Vermont Board of Medical Practice (Board) by virtue of 26 V.S.A. §§ 1353, 1354-1366 & 1398.

I. Background.

3. The Vermont Board of Medical Practice opened this matter for investigation on or about May 22, 2006 following receipt of a complaint from a Saint Albans-area, school nurse regarding Respondent's care of and prescribing for a patient, who was then 8 years of age (hereinafter referred to as "Patient A"). The complaint to the Board expressed concern that Patient A was being "over medicated" and alleged that Respondent had not collaborated with others having knowledge of the child's medical circumstances.

4. The Board's investigation included a) review of relevant medical records and documentation; b) interviews the patient's mother, Respondent, and other physicians and individuals with knowledge of this matter; c) receipt of a written response from Respondent; and d) expert consultation. The Board's review identified several areas of concern regarding the care rendered by Respondent to Patient A.

5. Because of Respondent's continuing cooperation with the Board of Medical Practice and his recognition of these concerns, no Specification of Charges has been filed by the State in this matter. Respondent has agreed to take certain steps that the parties agree are appropriate to the care of pediatric psychiatric patients and that will permit this matter to be satisfactorily resolved. These steps are set forth herein, beginning on page 15.

II. Care and Treatment of Patient A.

A. Child's Initial Contact with Northwestern Counseling & Support Services.

6. Patient A first came to the attention of Northwestern Counseling & Support Services (NCSS) in Saint Albans on or about April 2003. He was then five years of age. An NCSS intake evaluation dated April 21, 2003 stated that the child's family had expressed concerns regarding his "excessive activity/hyper; not sleeping well; some defiant behavior."

7. The April 21, 2003 NCSS evaluation¹ described Patient A as "very social, polite, friendly" and characterized his affect as normal and his mood as "euthymic" (i.e., normal: neither elated nor depressed). The NCSS evaluation identified the following specific concerns: a) Patient A's "lack of age appropriate peer social ability & isolated play"; b) "possible domestic violence at home"; c) parental discipline methods; and d) Patient A's "high energy/defiant

attitudes at home." The evaluation entered an Axis I diagnosis of "Parent-Child Relational Problem".² The evaluation also referred to a family history of mental illness ("maternal").

9. An Individual Plan of Care prepared by NCSS in June 2, 2003 quoted one parent as describing Patient A as "easily distracted, can't sit still, has a hard time listening." The plan, however, also noted "family dynamics are still unstable [with] parents mental health issues." A developmental consultant described Patient A as "doing very well". His school reported no behavioral issues regarding Patient A.³

10. On November 10, 2004, the child's mother contacted NCSS and described Patient A as displaying "anger and hostility and rage" and threatening to run away from home. The mother stated that her child's behavior "sounds bipolar" and said of herself, "I have bipolar."

B. Respondent's November 2004 Psychiatric Evaluation of Patient A.

11. Respondent first saw Patient A in November 2004 at the request of the child's pediatrician⁴ and the child's mother. Respondent prepared a detailed psychiatric evaluation of Patient A, dated November 18, 2004, and noted that the child's behaviors including displays of anger and physical aggressiveness, throwing objects, rough treatment of animals, inattention, overreaction, self-harm, and problems related to sleep. Respondent indicated that his

1. Respondent was not involved in the preparation of this evaluation of Patient A.

2. A referring social services agency had expressed concerns regarding the "health/safety of household; discipline methods; possible domestic violence" within the child's family.

3. A developmental consultant described Patient A as "high/successful functioning".

4. In 2004, the pediatrician, Deanne Haag, M.D., referred the child to Respondent for psychiatric assessment. The child's mother had raised concerns with Dr. Haag regarding his behaviors at home. However, Dr. Haag called Respondent and reported to him that the child's school had not seen any problems with his functioning. Dr. Haag told Respondent that she was concerned that the mother might actually be describing her own problems rather, than her child's. Dr. Haag did not think that Patient A needed to be on medications at the time of the referral to Respondent. Following the referral, Respondent never communicated with Dr. Haag by telephone or in writing about assessment results or medications that he had prescribed for Patient A.

evaluation was based on the history provided by the child's mother and the child's own description of his symptoms.⁵

12. However, Respondent's written psychiatric evaluation also described the child more favorably as a) "very charming"; b) "cooperative and very interactive", albeit "fidgety"; c) "very polite and very eloquent", with "excellent" social skills; and d) at times happy, silly and joking. Respondent quoted Patient A as stating, "I just have problems" and "I have a lot of stress and sorrow" and "I have anger, I don't listen. I can't sleep because of the sounds in my head. I cannot concentrate on my reading."

13. Respondent in his written evaluation offered the following assessment:

[PatientA] is a 6-year old boy who presents symptoms very suggestive of bipolar disorder. He will be treated accordingly. The diagnosis however, is far from being certain, given the fact that children's behavior is dictated by environmental circumstances also. This needs to be explored in detail in subsequent visits. [Patient A's] primary care physician, Dr. Haag describes him as a very sensitive child who is very attuned with his mother's feelings, conflicts and problems, and consider the possibility that [Patient A] is mirroring his mother's behavior. This very important issue will be explored in subsequent interactions with both [Patient A] and his mother.

Respondent diagnosed Patient A with "bipolar disorder, NOS" and a differential diagnosis of "generalized anxiety disorder".

C. Respondent's Prescribing for Patient A.

14. On November 18, 2004, the same day as the child's evaluation, Respondent prescribed for Patient A "[Risperidone] 1 mg qhs for a few days. Increase to 1 mg BID if aggression persists. Klonopin 0.5 mg ½ or F qhs aiming his nightmares." He noted, "Potential side effects of Risperidone & Klonopin discussed [with patient's] mother."

5. Respondent's written evaluation of Patient A also reported that "mother is a patient at this agency [and] has been diagnosed with bipolar disorder, personality disorder, NOS and she has a history of polysubstance abuse and dependence." Respondent noted in a Psychopharmacology Review Note, dated November 18, 2004, "Although [patient] has a chart, no recent information [is] available. Mom doesn't know much about who sees or has seen her child."

15. On December 28, 2004, Respondent noted in a Psychopharmacology Review Note that the Risperidone prescribed for Patient A had caused sedation and drowsiness. Patient A's mother had decreased the child's dosage on her own initiative. The mother later increased the dosage because of the child's "hyperactivity".

16. On December 28, 2004, Respondent prescribed for Patient A: Concerta 18mg q am #30; Clonidine 0.1 mg qhs #30; Risperidone 1 mg BID #60.⁶ Respondent continued to prescribe psychotropic medications for Patient A throughout 2005 and 2006, adjusting dosages or changing medications over time.

D. The "Psychopharmacology Review Notes".

17. During its investigation, the Board of Medical Practice received copies of Psychopharmacology Review Notes prepared by Respondent for Patient A. These were dated November 18, 2004; December 28, 2004; January 25, 2005; February 28, 2005; April 4, 2005; May 11, 2005; June 22, 2005; August 5, 2005; September 19, 2005; December 15, 2005; February 15, 2006; March 29, 2006; May 10, 2006; June 21, 2006; and August 3, 2006.

18. The Board's review of the written Psychopharmacology Review Notes prepared by Respondent indicated the following:

- a. each note recorded a "Session Duration" of at least 30 minutes;
- b. the written content of the notes, as entered by Respondent, did **not** clearly state or otherwise indicate that Respondent had met with or spoken directly with Patient A regarding his functioning, reaction to medications, or emotional well being on the dates in question;
- c. the section within the notes identified as the "Objective (mental status status examination)" was generally sparse in content and lacking in detail;
- d. Respondent often described Patient A using the same terms, e.g., "charming", "insightful", "interactive"; "pleasant"; "playful"; "fidgety", without further explanation; the written content of the notes only occasionally appeared to quote remarks by Patient A.

6. Respondent's note for December 28, 2004 stated, "add[ing] Clonidine aiming evening agitation and Concerta aiming inattentiveness & lack of concentration at school."

E. The May 31, 2006 Prescription for Depakote Written by Respondent.

19. On May 31, 2006, Respondent wrote a prescription for Depakote⁷ for Patient A.

The prescription, as written, stated:

Depakote ER 250 mg is added to medications aiming at anger, aggression and self-injurious behavior—start at 250 mg am x 7 days, then 250 mg am & bedtime

The Board of Medical Practice obtained a copy of this prescription, bearing Respondent's signature. The Board reviewed a copy of a Psychopharmacology Review Note⁸, also appearing to be in Respondent's handwriting, and appearing to address the Depakote prescribing:

[Patient A] reacted as if drunk [from] ↑ dose of Klonopin. His BP reportedly went down. Dr. Larrow stopped am dose and [patient] went back to baseline. Mom is still concerned about anger & aggression towards siblings, hitting himself in the head, leaving bruises. Recomm: add Depakote ER 250 mg T q am x 7 days, then T bid #60 T refill

20. A Medical Board investigator interviewed Respondent on June 1, 2006 regarding his care and prescribing for Patient A. Respondent told the investigator that he had never prescribed for Patient A if the child was not present at his office. Respondent added, however, that his prescribing for Patient A included when the child's mother had come into the office for her appointment and the child was with her in the waiting area.

7. Depakote ER (divalproex sodium extended-release) is indicated for the treatment of acute manic or mixed episodes associated with bipolar disorder, with or without psychotic features. Depakote ER bears a prominent "Boxed Warning" stating:

LIVER FUNCTION TESTS SHOULD BE PERFORMED PRIOR TO THERAPY AND AT FREQUENT INTERVALS THEREAFTER, ESPECIALLY DURING THE FIRST SIX MONTHS. * * * CASES OF LIFE-THREATENING PANCREATITIS HAVE BEEN REPORTED IN BOTH CHILDREN AND ADULTS RECEIVING [DEPAKOTE]. * * * PATIENTS AND GUARDIANS SHOULD BE WARNED THAT ABDOMINAL PAIN, NAUSEA, VOMITING, AND/OR ANOREXIA CAN BE SYMPTOMS OF PANCREATITIS THAT REQUIRE PROMPT MEDICAL EVALUATION.

See Physicians' Desk Reference at 434 (61st ed. 2007).

8. The Note was unsigned, and the date section of the Note included a handwritten entry that had been blacked out. The Session Duration section included a handwritten entry that had been blacked out. However, the Note also bore a handwritten entry of "5/31/06" inserted its upper left margin. The Note included no initials or clear indication of who had made these changes to the record.

21. On June 5, 2006, the Medical Board investigator again spoke with Respondent and asked him specifically about the May 31, 2006 Depakote prescription he had written for Patient A. See Paragraph 19, above. At this time, Respondent admitted that Patient A had not been present on May 31, 2006, either in his office or in the waiting room, when he had written the Depakote prescription for the child.

22. With regard to the May 31, 2006 prescribing, the record appears to indicate to the Board that Respondent based his decision to write a prescription for psychotropic medication for Patient A very substantially on the mother's representations regarding her son's mood and behavior, including purported anger, aggression, and self-injurious behavior. It appears that Respondent did so, without examining, questioning, or speaking with the child at the time to confirm the accuracy and currency of the mother's reporting. Nor is there any record of any consultation by Respondent with any other individual who might have had pertinent, current knowledge of Patient A's moods, needs, and behaviors.

III. Collaboration.

A. Attempts by School Nurse to Communicate with Respondent.

23. After Respondent evaluated Patient A in November 2004, the school nurse at the child's elementary school attempted to contact Respondent by telephone regarding the child and concerns regarding the child's medical care. The school nurse reported that she left telephone messages for Respondent on January 11, 2005 and January 18, 2005 asking that Respondent call her regarding Patient A. The school nurse later provided to the Board a copy of a letter dated April 13, 2005 that she had written to Respondent and that specifically referred to these two telephone calls and to the nurse's concerns regarding Patient A's medical care. The school nurse stated that Respondent never returned either telephone call.

24. Respondent denied to a Board investigator ever receiving these telephone calls.

B. The April 13, 2005 Letter from the School Nurse.

25. The April 13, 2005 letter from the school nurse to Respondent, stated, "I am concerned as a medical professional that efforts to collaborate between school, home, pediatrician and your organization [NCSS] have been unsuccessful." In contrast, the letter emphasized that the school nurse had been able to work closely with both the pediatrician for Patient A and with the patient's mother concerning the child's medical care and needs.

26. The April 13, 2005 letter from the school nurse added, "I have learned that as a result of an evaluation with you last fall, [Patient A] was diagnosed with Bipolar Disorder and ADHD. Records supplied to me . . . indicate that [Patient A] has been prescribed [Risperidone], Clonidine and Concerta." The school nurse expressed concern regarding this prescribing, stating, "It is important to know that [Patient A's] behaviors at school have neither warranted such a serious diagnosis nor justify the group of drugs prescribed to him." The letter to Respondent continued, "To my knowledge, no contact was made with our school at any time [while Patient A] was being evaluated. Nor was any information shared following his diagnosis with the school concerning [his] diagnosis, medications, or potential side affects." The school nurse observed, "I am unaware of any [past] situation where a diagnosis of this magnitude and medications with such potential serious side affects are given without input from school personnel." The letter to Respondent urged greater collaboration in the care of Patient A.

C. Respondent's Reply to the School Nurse.

27. Respondent replied by letter to the school nurse on May 9, 2005. His letter did not invite further communication from the school nurse regarding Patient A's diagnosis,

medications, or behaviors at school.⁹ Nor did Respondent request additional details or in any way address the possibility of future collaboration regarding Patient A or request further information.¹⁰ There is no record of any other communication from Respondent to the school nurse regarding Patient A.

IV. Incidents Related to Prescribing.

28. Respondent continued his prescribing for Patient A during the remainder of 2005 and into 2006.

A. The May 11, 2006 Incident at School.

29. On May 11, 2006, while at school, Patient A complained to the school nurse about feeling dizzy. Patient A told the nurse that he had taken Concerta, Risperidone, and "a new medicine" that morning.¹¹ Shortly after this, the nurse was notified by a classroom teacher that Patient A was unable to stand in class, was unsteady, and seemed unable to focus. The school nurse verified that Patient A seemed unwell. He required support while walking from the classroom.

30. The school nurse spoke with the mother of Patient A and learned from her that Respondent had increased the dosages of some of the child's medications the day before. The

9. In discussing the concerns of the school nurse, Respondent commented to a Board investigator, "Who was she to tell me how to do my job?"

10. Respondent's letter to the school nurse referred to "a very efficient communication loop" that he said included NCSS "School Based Clinicians placed in the local schools." When Respondent was interviewed on June 1, 2006 by a Board investigator, he stated that he did not know the name of the "School Based Clinician" for Patient A and did not know whether the a clinician actually had been assigned to the child.

11. The day before, on May 10, 2006, Respondent had doubled Patient A's daily dose of Klonopin and increased the child's daily dose of Risperidone. On May 10, 2006, Respondent's prescribing for Patient A consisted of: "[Risperidone] 1 mg. BID aiming at aggression #60"; Klonopin 0.5 BID aiming at anxiety #60"; "Clonidine 0.2 mg qhs #30"; and "Concerta 36 mg q AM#30 [and] 18 mg q 3 PM #30". The child's pediatrician later recalled that after talking with the mother, it was clear that she did not know what she was to dispense to her son and what each prescription was for.

child's mother came to the school and to pick him up. The school nurse contacted a Saint Albans-area pediatrician who was caring for Patient A, and who also had concerns regarding Patient A's condition and the prescribing for him by Respondent.

B. The Pediatrician's Observations.

31. The pediatrician, Daniel Larrow, M.D., saw Patient A on both May 11th and 12th, 2007. The patient's mother accompanied her child to these office visits. The pediatrician found the mother to be slow and shaky in answering questions and confused as to the child's medications and when they were to be taken. The pediatrician found Patient A to be unable to walk, stumbling, and acting intoxicated, exhilarated, and confused. The pediatrician advised the mother to discontinue the Patient A's morning dose of Risperidone, which appeared to be the cause of the child's adverse symptoms.

32. On May 11th, the pediatrician contacted NCSS and left a message for the nurse in Respondent's office who was already familiar with Patient A's circumstances. On May 12, 2006, the pediatrician spoke directly with the NCSS nurse in Respondent's office regarding Patient A's adverse reaction to medication prescribed by Respondent.

33. The pediatrician, Dr. Larrow, later told a Medical Board investigator that he had two concerns regarding the prescribing for Patient A. First, given the mother's own significant mental health problems, was she then capable of properly managing and dispensing the child's multiple medications? Second, the pediatrician was concerned that Respondent's prescribing for the child seemed to be largely based on the mother's reporting of symptoms, without input from other sources such as other family members, friends, school, and other medical providers.

34. Dr. Larrow stated that in treating Patient A, he personally had **not** seen problems that required medication. The pediatrician expressed concern regarding escalating dosages and

prescribing for Patient A. He also stated that staff at the child's school had not reported seeing the symptoms described by the mother. The pediatrician opined that the symptoms being reported by the mother actually might reflect the mother's own difficulty coping with a stressful household and family situation.

35. The pediatrician told the Board investigator that he had never been contacted directly by Respondent regarding Patient A.

C. The September 9, 2006 Incident.

36. On September 1, 2006, again while at school, Patient A experienced an episode of shaking, drooling, difficulty talking, biting his cheeks, and back pain. The child's mother was contacted. She picked up Patient A at school and drove him to see his pediatrician, Dr. Larrow. At the office of the pediatrician, Patient A was biting his fingers and cheeks and drooling.

37. The pediatrician referred the child to Fletcher Allen Health Care (FAHC) for further evaluation. The mother reported that the child had difficulty breathing while driving to the hospital. At FAHC, the child presented with body tremors and had difficulty speaking. He also was arching his neck and back and gazing upward. His mother reported that the child had been experiencing tremors for some time. Patient A was admitted to FAHC through the Emergency Department.

38. At FAHC, the mother reported that her child had been diagnosed with bipolar disorder. She identified his medications as Depakote, Risperidone (1 mg and 2 mg), Clonidine, Clonazepam, and Concerta.

39. A FAHC psychiatric consultation note stated, "Since last year he has started on psychoactive meds [with] several additions & fewer deletions." The consultation described Patient A as suffering a "likely acute dystonic reaction observed in the ED possibly related to

stopping Klonopin abruptly while on 3 mg of Risperodal." The consultant added, "Parents [of Patient A] have started some past guidance but likely need more guidance. Doses of meds can likely be reduced [with] more home support." The consultation recommended reducing the dosage levels of the Depakote, Risperidone, Clonazepam, and Concerta from those ordered by Respondent for Patient A.

40. On hospital day three, Patient A was discharged with the following note:

Over the last several months he has had escalating doses of his psychiatric medications. * * * He was evaluated by Pediatric Neurology who felt this was a dystonic reaction and he was treated with Benadryl which resolved dystonia. Child psychiatry was consulted and felt that the [patient's] medications should be decreased to reflect proper pediatric dosing and that the [patient] should be evaluated and followed by a child psychiatrist.

41. Subsequently, both Patient A and his mother began to receive psychiatric services from another NCSS physician. Bipolar disorder has been ruled out as a diagnosis for Patient A, whose mood state is characterized as "good" and who is reported to be doing well generally. Patient A is no longer being prescribed Risperidone or Klonopin.

V. The Board's Assessment of Care Rendered.

42. Following review, the Board of Medical Practice regards the care rendered by Respondent to Patient A as raising serious concerns.

a. It is unclear from the child's medical records whether he was actually seen and given substantive medical attention during each visit for which there is an office note, i.e., "Psychopharmacology Review Notes". The content of many of the notes reviewed by the Board was sparse and lacking detail.

It is the position of the Board that a child receiving multiple psychotropic medications should be seen, observed, and spoken with regularly by the prescribing physician. The child's medical records should clearly indicate that such direct interaction has taken place and report the salient results with sufficient detail to identify the basis for treatment and prescribing decisions.

b. Respondent's almost exclusive reliance on the child's mother as a reporter, limited the range of information available to Respondent regarding the child's moods, behavior, and response to medications.

The mother's own significant mental health problems should have signaled the need for Respondent to verify her observations regarding her child's behaviors and to seek information from additional sources having knowledge of the child. The impact of the home environment, including possible family instability and dysfunction should have been actively explored in evaluating the child and continuously considered in treating and prescribing for the child. The medical record should clearly reflect such consideration and sources of relevant information.

c. Respondent's diagnosis of bipolar disorder for the child was not well been supported in the record by detail regarding the intensity and frequency of mood symptoms, as well as detail regarding changes in sleep, cognition, and motor activity.

More active, ongoing exploration of differential diagnoses, e.g., generalized anxiety disorder, attention deficit hyperactivity disorder, conduct disorder, post-traumatic stress disorder, and developmental disorders should have been given consideration in light of the child's particular home and family circumstances. The record should identify in detail and describe the symptoms considered in establishing a diagnosis and ruling out other diagnoses.

d. The child's medical record reflected minimal attention by Respondent to his patient's safety and vulnerability. Prescribing multiple medications, as well as adjustments of medications and dosages over time necessarily required the parent to be able to reliably comply with dispensing instructions, monitor effects, and consult with practitioners regarding questions or concerns.

Respondent's care of Patient A should have demonstrated continuing attention to fluctuations in the mother's mental health and functioning, given her central role in caring for the child, including overseeing his medications. Continuing attention also should have been directed to: (i) possible domestic abuse affecting or directed to the child in the home setting; and (ii) the ability of the parents to provide parental control, supervision, and protection of their child. The medical record also should have reflected clear, ongoing attention to the possibility of self-harm or to abnormal perceptions experienced by the child.

e. Respondent's manner of prescribing of psychotropic medications for his patient did not demonstrate and allow for careful monitoring of response and effects on the child.

Respondent could have started medications at lower dosages, could have begun the patient's medications one at a time, and could have assessed the effects of medications over a longer period of time. Without such an approach, interpretation of effect (positive or negative) of any single medication would have been difficult. For example, the child's problems with sedation/fatigue and insomnia should have received consideration as effects related to medications prescribed for him. Given the medications prescribed,

Respondent's care of Patient A should have included ongoing monitoring of weight and consideration of possible metabolic problems. Depakote was prescribed by Respondent, but the medical records do not reflect patient warnings as to possible adverse effects (such as somnolence or tremulousness) or include mention of any need for laboratory monitoring.

f. In caring for this child, Respondent failed to collaborate with other medical practitioners and individuals who had knowledge of and experience with the child. Respondent neither actively sought information regarding his patient from others nor provided information to other practitioners regarding the child's medical condition, needs, or medications. Respondent's care of this patient demonstrated either indifference to the value of collaboration within the medical field or a passivity of approach that was unhelpful in assessing a child whose home and family circumstances were both difficult and complex.

Psychiatric assessment of a child differs from that of an adult in that a key focus of evaluation is developmental, requiring consideration of the child's functioning relative to the age and circumstances. Symptoms observed in the home should be assessed in concert with observations from others and in settings outside the home, such as at school. Given his patient's circumstances, the symptoms and behaviors described by his mother, and the multiplicity of medications prescribed, Respondent should have demonstrated greater efforts to communicate with other medical professionals caring for the child to obtain their observations and insights regarding the child and to provide them with information regarding the child's diagnoses, functioning, and medications.

E. Respondent's Position.

43. Respondent agrees with many of the Board's general observations and concerns as set forth above. Respondent also wishes to emphasize his view that as a general matter, the practice of clinical psychiatry in Vermont is burdened by the high level of need, with too few practitioners to provide the services that are needed. As a result, the availability and adequacy of patient care suffers. Community based mental health clinics and practitioners are particularly burdened by the level of need. Neither patients nor practitioners are satisfied or well-served by this situation.

44. Respondent emphasizes here his full commitment to his patients and care of their needs. Respondent has agreed to the terms and conditions within this agreement to assure his continuing cooperation with the Vermont Board of Medical Practice and to providing his patients with care that is responsive and consistent with their needs.

VI. Terms and Conditions.

A. Preliminary.

45. Respondent assures here his continued cooperation with the Vermont Board of Medical Practice and its public responsibilities. Respondent enters no admission here. Respondent disagrees with some of the facts and analysis, as set forth above, in Paragraphs 1 through 42. However, for the purpose of expeditiously resolving the matter now before the Board, Respondent agrees not to contest such exceptions and agrees that the Vermont Board of Medical Practice may adopt and enter Paragraphs 1 through 42, above, as a factual basis for this agreement.

46. Respondent agrees and admits that had the State of Vermont filed a formal specification of charges in this matter and satisfied its evidentiary burden at hearing, the Board could enter a finding adverse to him, pursuant to 26 V.S.A. § 1354 and/or § 1398, in light of Paragraphs 1 through 42, above. Respondent further agrees that the Board of Medical Practice may adopt and enter as its findings and/or conclusions this paragraph and those set forth above as the basis for the actions agreed to herein by the parties.

47. The parties to this Stipulation and Consent Order agree that appropriate resolution of this matter shall consist of the following:

A. Respondent's Vermont license to practice medicine shall be designated as "conditioned", and Respondent shall comply fully and in good faith with each of the terms and conditions of licensure, set forth below, until such time as he has been relieved of all conditions herein by express written order of the Vermont Board of Medical Practice. Although this agreement is with the Vermont Board of Medical Practice, nothing in this agreement shall prevent Respondent from practicing medicine in states other than Vermont so long as he maintains full compliance with the terms herein.

B. Substantial or repeated failure by Respondent to comply with any of the terms and conditions herein may constitute unprofessional conduct and may result in such other disciplinary action as the Board may deem appropriate under the circumstances.

C. This agreement shall remain in force for at least 36 months, from the date of Board approval. The terms and conditions herein shall continue in force until Respondent is relieved of these, in writing, by the Board, in its sole discretion.

B. Record Keeping.

48. Respondent agrees as a condition of licensure that all patient medical records prepared by him or at his direction shall clearly indicate: (a) whether the patient was seen in person and directly cared for by Respondent during the visit or session; (b) the date of service and the actual beginning and ending times of each visit or session with the patient; and (c) the nature of the care and treatment provided; (d) prescriptions ordered or renewed; and (e) statement of subjective and objective findings, in sufficient detail to indicate a clear basis for treatment and prescribing decisions.

49. The medical record for each patient visit or session shall include quotation or verbatim content from the patient with regard to complaints, mood and affect, and medication response and effect. Sufficient detail shall be included in such entries to be understood as illustrative of subjective and objective findings set forth within the record.

50. Third persons who are present during a visit or session shall be identified in the record. Statements and observations from third parties or informants regarding the patient, symptoms, and functioning shall be clearly attributed to such individuals, by name.

C. Pediatric Patients.

51. Respondent agrees that pediatric patients for whom medication has been prescribed shall be seen in person by Respondent at least monthly for face-to-face contact, care and treatment, and medication management. Record keeping for each such visit or session shall conform to the requirements set forth above in Paragraphs 48-50.

52. Each pediatric patient visit or session shall include consideration of patient safety, including risk of self harm or harm to others, possible risk or abuse within the child's home or family, and adverse effects from medications. Such areas of concern shall be explored as warranted and findings explicitly recorded in the note for the visit or session.

53. Respondent shall make reasonable efforts to communicate with and meet both parents of pediatric patients (or other significant relations having knowledge of and contact with the child).

D. Collaboration.

54. Respondent agrees that in caring for pediatric patients he shall actively communicate and collaborate with other physicians, nurses/school nurses, teachers, social workers, and others having knowledge of and contact with the child. Respondent shall in every case contact and speak with the child's primary care physician to obtain information regarding the child's medical needs, medications, and home and family circumstances.

55. Respondent shall respond promptly to written, telephonic, or electronic communications from other physicians, nurses/school nurses, teachers, social workers, and others having knowledge of and contact with the child. If Respondent does not respond personally, he shall ensure that responsible staff promptly respond and prepare a

written record of information, questions, and concerns that are the subject of the communication. Respondent shall promptly review such written records to determine whether personal communication by him or further action is required.

56. Respondent shall ensure that copies of written psychiatric evaluations are promptly sent to the child's primary care physician, as well as other physicians, nurses/school nurses, teachers, and social workers directly involved in the child's care or development.

57. Whenever there is a significant change in medication or dosage, Respondent shall ensure that copies of the written pharmacological note are sent to the child's primary care physician, as well as other physicians, nurses/school nurses, teachers, and social workers directly involved in the child's care or development.

58. The parents, guardian, or other caretaker for pediatric patients shall be provided a clear written statement, in "plain English" listing each of the child's prescribed medications and dosages, times/frequency of administration, purpose, and notice of possible adverse side effects. Such statement shall be promptly updated whenever necessary.

E. Peer Supervision.

59. Respondent agrees that he shall meet at least monthly in consultation with a supervising peer physician, who shall be a licensed, board certified pediatric psychiatrist.¹² Each such meeting for supervision and consultation shall focus on Respondent's evaluation,

12. Should supervision by a board certified pediatric psychiatrist prove to be impracticable, Respondent shall so advise the Board, identifying in writing the efforts made by him to obtain such supervision and the results. Upon proper demonstration of such unsuccessful efforts, Respondent alternatively may propose the name of a board certified psychiatrist to act as his supervising peer physician. The manner of consideration shall be as described above in Paragraph 61. The supervising peer physician proposed by Respondent shall be subject to actual approval or disapproval by the Board, in its sole discretion, at any time.

care, and prescribing for pediatric patients. Such meetings and supervision shall be required only if Respondent's patient population includes one or more pediatric patients. Each meeting for supervision and consultation shall include review and consideration of at least five charts for pediatric patients who are receiving care from Respondent. If Respondent's patient population includes five or fewer pediatric patients, the care and treatment of each such pediatric patient shall be reviewed during the supervisory meeting.

60. The duration of meetings for such consultation shall be no less than one hour in length. Respondent shall maintain a written record of the date of each such meeting and its actual duration.

61. Respondent shall promptly inform the Vermont Board of Medical Practice in writing of all sites where he shall practice and the name of the practitioner proposed to act as his supervising peer physician. Respondent shall provide the Vermont Board with a resume or c.v. for the physician proposed for this purpose and shall describe in writing how such supervision and consultation will be carried out. The proposed supervising peer physician shall review and concur with this plan prior to its submission to the Board. The supervising peer physician proposed by Respondent and the proposed plan of supervision shall be subject to actual approval or disapproval by the Board in its sole discretion, at any time.

62. Respondent agrees that he shall provide a complete copy of this Stipulation and Consent Order to (a) his proposed supervising peer physician; (b) to any prospective employer, practice site administrator, or privileging entity; and (c) to any State medical board or other licensing authority in any location or jurisdiction where he may seek to practice or where he may make application, so long as this agreement remains in effect.

63. The supervising peer physician referred to above shall provide written quarterly reports to the Vermont Board of Medical Practice indicating that the required meetings for supervision and consultation have taken place at least monthly. Such reports shall address the substance and results of consultation, Respondent's practice activities, his care of pediatric patients, and shall verify that the required oral review and discussion of individual charts has taken place. Such written reports to the Vermont Board of Medical Practice by the supervising peer physician normally shall be made by letter. Respondent shall be responsible making reasonable efforts to ensure that such reports are prepared and promptly provided to the Board. Respondent is aware and agrees that the Board may communicate with the supervising peer physician as needed to obtain additional information or to verify written reporting.¹³

VII. Other Matters.

64. No specification of charges has been filed by the State in this matter. Respondent has not previously been the subject of disciplinary action by the Board.

65. Respondent acknowledges that he is knowingly and voluntarily agreeing to this Stipulation and Consent Order. He acknowledges that he has had advice of counsel regarding the matter before the Board and has had advice of counsel in reviewing this Stipulation and Consent Order. He agrees and understands that by executing this document he is waiving any right to be served with formal charges, to challenge the jurisdiction and continuing jurisdiction of the Board in this matter, to be presented with the evidence against him, to cross-examine adverse witnesses, and to offer evidence of his own to contest the State's charges.

13. For any quarterly period during which Respondent has not been actively practicing pediatric psychiatry or otherwise treating pediatric patients for psychiatric conditions, he shall provide written quarterly notice of that status to the Board of Medical Practice in lieu of the reporting required by Paragraph 63, above.

66. Respondent agrees that he personally has read and carefully considered all terms and conditions herein and agrees to accept and be bound by these while licensed to practice medicine in the State of Vermont or elsewhere and to be bound by these until such time in the future as he may be expressly relieved of these conditions, in writing, by the Vermont Board of Medical Practice. The Board, in its sole discretion, may consider a petition from Respondent for relief from or modification of these conditions, no sooner than 24 months after the effective date of this Stipulation and Consent Order.

67. Respondent's Vermont license to practice medicine shall include the designation "Conditioned" until such time as **all** terms and conditions upon his medical license have been removed by order of the Board.

68. The parties agree that this Stipulation and Consent Order shall be a public document, shall be made part of Respondent's licensing file, and shall be reported to other licensing authorities and/or entities including, but not limited to, the National Practitioner Data Bank and the Federation of State Medical Boards.

69. During the period that Respondent's license is conditioned he shall comply fully with all the requirements set forth herein and agrees to be bound by all terms and conditions of this Stipulation and Consent Order. Respondent agrees that the Board of Medical Practice shall retain jurisdiction to enforce all terms and conditions of this Stipulation and Consent Order during its lifetime, whether he practices in the State of Vermont or elsewhere. Respondent expressly agrees that any failure by him to comply with the terms of this Stipulation and Consent Order, including but not limited to its supervision and reporting requirements, whether he practices in the State of Vermont or elsewhere, may constitute unprofessional

conduct under 26 V.S.A. §1354(a)(25) and may subject Respondent to such further disciplinary action as the Board may deem appropriate.

70. This Stipulation and Consent Order is subject to review and acceptance by the Vermont Board of Medical Practice and shall not become effective until presented to and approved by the Board. If the Board rejects any part of this Stipulation and Consent Order, the entire agreement shall be considered void. In exchange for the Board's consideration of this proposed agreement, Respondent agrees that he shall not assert a claim of prejudice with regard to subsequent proceedings, should the Board of Medical Practice withhold its approval for any reason. However, the parties agree, that should the terms and conditions of this Stipulation and Consent Order be deemed acceptable, the Vermont Board of Medical Practice may enter an order conditioning Respondent's license to practice medicine as set forth above, subject to each of the terms and conditions as set forth herein.

Dated at Montpelier, Vermont, this 26th day of September 2007.

STATE OF VERMONT

WILLIAM H. SORRELL
ATTORNEY GENERAL

by:

James S. Arisman
JAMES S. ARISMAN
Assistant Attorney General

Dated at ST ALBANS Vermont, this 25th day of SEPTEMBER 2007.

Sergio H. Luna, M.D.
SERGIO H. LUNA, M.D.
Respondent

Dated at Burlington Vermont, this 26th day of September 2007.

Robert R. McKearn
ROBERT R. McKEARN, ESQ.
Counsel for Respondent

Office of the
Attorney General
100 State Street
Montpelier, VT
05609

FOREGOING, AS TO SERGIO H. LUNA, M.D.
APPROVED AND ORDERED
VERMONT BOARD OF MEDICAL PRACTICE

Richard Greenewald M.D.

Margaret Fink Martin

William H. Stovel M.D.

Patricia A. Long M.D.

W. Allen

Sally R. Dwyer M.D.

Sergio H. Luna M.D.

DATED: October 3, 2007

ENTERED AND EFFECTIVE: October 3, 2007

JSA/STIP/REV VII: SERGIO H. LUNA, M.D. 08/07; Not Approved by BMP Until Executed and Entered Above