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

In the Matter of the Accusation Against: John Lee, M.D. Physician's and Surgeon's Certificate No. A 66604 Respondent.	Case No. 800-2019-058671

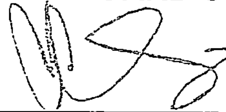
DECISION

The attached Decision 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 April 3, 2024.

IT IS SO ORDERED March 4, 2024.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

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

In the Matter of the Accusation Against:

JOHN LEE, M.D.,

(Previously Known as Dirk De Brito, M.D.)

Physician's and Surgeon's Certificate Number No. A 66604,

Respondent.

Case No. 800-2019-058671

OAH No. 2022090470

PROPOSED DECISION

Ji-Lan Zang, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter by videoconference from March 13 to March 17, September 11 to 14, October 6, and October 10 to 13, 2023.

Rebecca L. Smith, Deputy Attorney General, represented Reji Varghese, (complainant), Executive Director, Medical Board of California (Board), Department of Consumer Affairs.

Edward Idell, Attorney at Law, represented John Lee, M.D. (respondent), formerly known as Dirk DeBrito, M.D., who was present throughout the hearing.

At the hearing, the ALJ was provided with Exhibits 5, 13-14, 36-38, 47-54, 55, 58, 71-72, C, K, FFF, JJJ, and KKK, which contained confidential information. Redaction of the exhibits to obscure this information was not practicable and would not provide adequate privacy protection. To prevent the disclosure of confidential information to the public, the ALJ issued a Protective Order placing these exhibits under seal following their use in the preparation of the Proposed Decision.

At the end of the hearing, the ALJ held the record open until December 1, 2023, to allow the parties to submit closing briefs, and until December 15, 2023, to allow the parties to submit reply briefs. On November 11, 2023, the ALJ granted respondent's motion to extend the time for briefing, and the ALJ extended the deadlines for submission of closing and reply briefs to December 15, 2023, and December 29, 2023, respectively. All briefs were timely submitted. Complainant's closing and reply briefs were marked for identification as Exhibits 82 and 83, respectively, and respondent's closing and reply briefs were marked for identification as Exhibits OOO and PPP, respectively. The record was closed, and the matter was submitted for decision on December 29, 2023.

SUMMARY

Complainant seeks to revoke respondent's physician's and surgeon's certificate based on the following allegations: (1) respondent formed inappropriate dual relationships, i.e. significantly different relationships in addition to the doctor-patient relationship, with Patient 1 and Patient 2; (2) respondent did not indicate the presence

of these dual relationships in Patient 1 and Patient 2's medical records; (3) respondent made other significant omissions from Patient 1's medical records, including 14 medications he prescribed to her; (4) respondent prescribed medications to Patient 1 and Patient 2 without prior examination and/or medical indication; (5) respondent hired Patient 2 as an employee and inappropriately delegated to Patient 2 tasks, including completing a prescription for another patient, when Patient 2 lacked the medical training and experience to write a prescription; and (6) respondent failed to properly assess Patient 2 for substance use disorder, continued to prescribe medications to Patient 2, who had previously misused such medications, without monitoring and safeguards, failed to properly intervene in response to Patient 2's risk factors for substance use disorder, and placed Patient 2 at greater risk of harm by giving him access to a safe with cash, blank prescriptions, and pre-signed prescriptions.

Complainant established by clear and convincing evidence respondent committed multiple acts of gross negligence, repeated acts of negligence, prescription of medication without prior examination (only as to Patient 1), unprofessional conduct, and inadequate recordkeeping in his care and treatment of Patient 1 and Patient 2. Respondent's testimony at the hearing was less than candid, and he presented little evidence of rehabilitation. Considering the number and the gravity of the violations, respondent's prior disciplinary history, and the insufficiency of rehabilitation evidence, the only recourse for the protection of the public is the revocation of respondent's physician's and surgeon's certificate.

//

//

FACTUAL FINDINGS

Jurisdictional Matters

1. On October 2, 1998, the Board issued Physician's and Surgeon's Certificate Number A 66604 to respondent under his former name, Dirk De Brito, M.D. This license is scheduled to expire on October 31, 2024. On March 15, 2022, respondent changed his name with the Board to John Lee, M.D.

2. On July 13, 2022, complainant filed the Accusation in his official capacity. Respondent timely filed a Notice of Defense requesting a hearing. All jurisdictional requirements have been met.

Respondent's Background and Prior Board Discipline

3. Respondent graduated from Yale University with an undergraduate degree in biology in 1986. Respondent recalled his father's passing due to AIDS was a formative experience during his last year in college. Respondent saw his father's health providers at a loss about how to treat his father's disease, which inspired him to enter the medical field to help others.

4. From 1993 to 1997, respondent attended a joint degree program at the Columbia College of Physicians and Surgeons and the Columbia School of Public Health. After obtaining both his medical degree and his master's degree in public health, respondent completed residencies at LAC/USC Hospital in emergency medicine (1998 to 2001), UCLA Health, San Fernando Valley, in psychiatry (2005 to 2007), and the University of New Mexico in psychiatry (2009 to 2010).

//

5. From 2011 to 2017, respondent worked at both Methodist Hospital and Huntington Memorial Hospital (Huntington). From 2016 to 2017, respondent served as Huntington's Chair of Psychiatry. In 2017, Huntington terminated respondent from his position due to Board discipline against his license.

6. Specifically, on October 4, 2017, the Executive Director of the Board issued a full interim suspension order (ISO) prohibiting respondent from practicing medicine. The ISO was based on respondent's May 2, 2017 plea of nolo contendere to, and subsequent criminal conviction for, making criminal threat and assault, both misdemeanors. (Superior Court of California, County of Los Angeles, Case No. GA097514.) Respondent was sentenced to three years of summary probation with terms and conditions, including attending a 52-week anger management course for his criminal conviction. On October 24, 2017, after an ISO hearing before an ALJ, the ALJ dissolved the ISO.

7. On December 28, 2017, the Executive Director of the Board filed an Accusation (2017 Accusation) against respondent in case number No. 800-2015-018088. The 2017 Accusation alleged the following causes for discipline: (1) respondent's 2017 conviction for making criminal threat and assault, as described above; (2) mental impairment; and (3) gross negligence in the care and treatment of one patient. On November 8, 2018, respondent signed a Stipulated Settlement and Disciplinary Order (2018 Stipulation). Pursuant to this 2018 Stipulation, respondent agreed that "at a hearing, Complainant could establish a factual basis for the charges in the [2017] Accusation, and that [r]espondent hereby gives up his right to contest those charges." (Ex. 3, p. A58.) Respondent further stipulated staying the revocation of his license and placing his license on probation for three years (Board probation) with terms and conditions, including completion of an anger management program and

ethics course, undergoing psychotherapy treatment, and practicing for the first year of probation under a practice monitor.

8. On December 27, 2018, the Board adopted the 2018 Stipulation as its Decision and Order (2018 Decision), effective January 25, 2019. (Ex. 3 p. A55.)

9. Since 2017, respondent has had a private medical practice located in the City of Pasadena. Respondent specializes in the treatment of Attention-Deficit Hyperactivity Disorder (ADHD) because he was diagnosed with this disorder as a child.

Patient 1

10. Patient 1 is a 62-year-old female who was in a personal relationship with respondent from March 2014 to May 2019. At the hearing, Patient 1 described herself as respondent's "girlfriend" during that period, while respondent referred to Patient 1 as someone equivalent to a "domestic partner." Based on Patient 1's certified medical records respondent submitted to the Board, respondent saw Patient 1 at his office for six visits from October 5, 2016, to November 14, 2018 (in-office treatment period). However, Patient 1's pharmacy records show respondent prescribed medications to her, which were not documented in her certified medical records, from approximately May 2015 to April 2019, indicating that their physician-patient relationship spanned a longer period than the reported in-office treatment period. Respondent and Patient 1's personal and physician-patient relationship ended in May 2019, due to a domestic violence incident that occurred in the British Virgin Islands.

RESPONDENT'S PERSONAL RELATIONSHIP WITH PATIENT 1

11. Respondent's personal relationship with Patient 1 was complicated, featuring romantic/sexual, familial, and financial aspects. According to Patient 1, their

relationship was sexual. Patient 1 spent several nights a week, sometimes every night, with respondent, although this frequency decreased from December 2014 to March 2017, when she held a job in Northern California. During their relationship, Patient 1 and respondent took multiple vacations together. They traveled to San Francisco in 2015; to Laguna Beach, Tiburon, and the Virgin Islands in 2016; to England for the British Academy of Film and Television Awards in 2017; and to Greece, Seattle, and Rome in 2018. (Exs. 24 & 44.) Patient 1's sexual relationship continued with respondent until the domestic violence incident in May 2019.

12. Patient 1 was involved in respondent's family life. She picked up his children from school, attended back-to-school nights on his behalf, and corresponded with his children's teacher as a parental figure (ex. 32). When respondent required heart surgery in November 2018, Patient 1 arranged his flights (ex. 33) and supported him through his surgery. Respondent and Patient 1 also discussed marriage and went shopping for an engagement ring together.

13. In 2017 and 2018, during the Huntington and Board disciplinary proceedings, respondent shared with Patient 1 his professional problems. Respondent asked Patient 1 to review a letter he wrote to a doctor at Huntington complaining about the hospital's treatment of him. (Ex. 25.) Respondent also vented to Patient 1 about his frustrations with the allegations contained in the 2017 Accusation (ex. 28), and Patient 1 accompanied respondent to a hearing during the Board disciplinary process.

14. Furthermore, during their relationship, respondent and Patient 1 were involved in each other's finances. For example, on September 6, 2016, Patient 1 lent respondent $7,000 and wrote him a check in that amount. (Ex. 18.) In December 2016, respondent sought Patient 1's advice on how to respond to a bank representative

about his financials and credit report. (Ex. 22.) Patient 1 and respondent chartered yachts together for vacations in November 2016, May 2017, and May 2018. (Exs. 19, 26, 30.) In October 2018, respondent asked Patient 1 to sign a lease agreement on his behalf, and in November 2018, respondent copied Patient 1 on an email with his real estate broker regarding issues relating to the same property. (Exs. 31 & 34.) Patient 1 was also listed as a responsible party on respondent's utility bills in 2018. (Ex. FFF.)

RESPONDENT'S STATEMENTS RE HIS RELATIONSHIP WITH PATIENT 1

15. At the hearing, respondent characterized Patient 1 as his "domestic partner" and a "spousal equivalent." Respondent admitted Patient 1 lived with him at his house at times during their relationship between 2014 and 2019. However, according to respondent, Patient 1 was at times "in the friend zone" and would live in her own place. Moreover, respondent claimed that during Patient 1's in-office treatment period, he was in a "domestic partnership" with Patient 1, but was not in a sexual relationship with her. When asked if he was in a romantic relationship with Patient 1 during the same period, respondent sometimes avoided answering the question and sometimes denied having a romantic relationship with Patient 1. Respondent admitted to sharing his professional problems regarding Huntington and the Board with Patient 1, and he acknowledged "some" financial commingling with Patient 1 during their relationship.

16. Respondent's denial of a sexual and romantic relationship with Patient 1 during the in-office treatment period is not credible. First, respondent's denials are controverted by the documentary evidence. For example, during cross-examination, when asked why he took a trip with Patient 1 to Rome in June 2018 if he did not have a romantic relationship with her at the time, respondent claimed he took his children on the trip to Italy and paid Patient 1 to come along. This explanation is not plausible

because the photograph of respondent and Patient 1 in Rome shows them sitting in front of the Trevi Fountain with respondent wrapping one arm around Patient 1's shoulder and Patient 1 resting her hands on respondent's lap. (Ex. 24, p. A317.) Other photographs of respondent and Patient 1 vacationing in various locales from 2015 to 2018 depict either them holding hands or respondent with his arm wrapped around Patient 1's shoulder. (Ex. 24.) Moreover, during their relationship, respondent wrote emails to Patient 1 expressing his affection for her. In a November 11, 2016 email, respondent referred to Patient 1 as a "snorkling [*sic*] sweetie." (Ex. 21.) In a June 12, 2017 email, respondent wrote to Patient 1, "love you!!! [G]ive me some more!!!!!" (Ex. 27.) In an April 6, 2019 email, respondent denied dating another woman, indicated he purchased a ring for Patient 1, and wrote, "You know I DEFINITELY love you.........." (Ex. 35, p. A354.)

17. Second, respondent's statements about the nature of his relationship with Patient 1 were inconsistent. According to respondent's records, at a minimum, Patient 1's in-office treatment period with respondent spanned from October 5, 2016, through November 14, 2018. At the hearing during direct examination, respondent testified his sexual relationship with Patient 1 predated the in-office treatment period, i.e. no more sexual relationship after October 5, 2016. Under cross-examination, however, respondent admitted he had sex with Patient 1 every year between 2014 and 2018. Later during cross-examination, respondent changed his testimony again and claimed he did not have a sexual or romantic relationship with Patient 1 during the in-office treatment period. Notwithstanding these inconsistencies, respondent's admission at this hearing that he, at some point, had a sexual relationship with Patient 1 is at odds with his prior statements to the Board investigator at his interview (2021 Board interview) which took place on August 4, September 10, and October 11, 2021. During that 2021 Board interview, respondent denied having any sexual relationship

with Patient 1 and asserted repeatedly their relationship was entirely platonic. (Ex. 45, pp. A524, 552-553; 563-565; A611.) Additionally, while respondent characterized Patient 1 as a "domestic partner" at the hearing, he described her only as a "friend" at his Board interview. (*Id.* at pp. A524-A525; A563.) When asked if he was being honest at the hearing or at his Board interview, respondent insisted he was truthful on both occasions.

18. Third, at the hearing, respondent testified in a circuitous, evasive, and obstructive manner further eroding his credibility. For example, respondent did not answer a question asking whether he was legally married to Patient 1 because he purportedly did not understand the meaning of "legally married." He also did not answer a question regarding the location of his principal residence because he purportedly did not understand the meaning of "principal residence." Given his level of educational and professional achievement, respondent's professed lack of understanding of the meaning of these common terms is not plausible. Respondent also suffered many memory lapses during cross-examination. Respondent testified he could not recall how many marriage certificates he held; he could not recall whether he ever bought a ring for Patient 1; and he could not recall whether he had sex with Patient 1 between January 2019 and May 2019. Several times during cross-examination, rather than answering the questions complainant's counsel asked, respondent snapped back with inappropriate questions of his own. For example, at one point, respondent asked complainant's counsel if she understood the context of a medical notation. At another point, respondent, instead of responding to a question, asked complainant's counsel, "Is this a trick?"

19. By contrast, Patient 1's testimony that she maintained a sexual and romantic relationship with respondent from 2015 to 2019 was credible because it was

consistent with the documentary evidence and her prior statements to the Board investigator (Ex. 5, p. A103). Therefore, complainant established by clear and convincing evidence respondent had sexual, romantic, familial, and financial dual relationships with Patient 1 from 2015 to 2019, including during the in-office treatment period.

END OF THE RELATIONSHIP

Patient 1's Testimony

20. On May 4, 2019, Patient 1 and respondent went on a sailing vacation in the British Virgin Islands. On May 16, 2019, Patient 1 and respondent had a physical confrontation while sailing on respondent's boat (2019 incident), which marked the end of their relationship. The facts surrounding this physical confrontation were disputed at the hearing.

21. Patient 1 testified she was standing on the boat in front of the steering console when respondent, who was seated behind the steering console in the captain's chair, directed her to let out the jib. Because Patient 1 was new to sailing, she could not remember which sail was the jib. Respondent became enraged and yelled at Patient 1. Patient 1 retorted something to the effect that she would never learn to sail under respondent. Patient 1 then turned around to face respondent, and respondent punched her in the mouth with a closed fist. Patient 1, in turn, slapped respondent with an open hand. Respondent, even more enraged, came around the steering console, pushed Patient 1 down a set of stairs to the bottom of the boat. Respondent subsequently followed Patient 1 down these stairs, pushed her shoulders back so she could not get up, and held her to the ground.

//

22. After the altercation with respondent, Patient 1 was in pain and wanted to get off the boat. Patient 1 asked respondent to take her to Tortola, an island, so she could disembark. However, respondent took her to Jost Van Dyke, a remote area. Patient 1 testified she was lying on the sofa and crying while respondent worked on his computer. When Patient 1 asked to get to shore, respondent became angry and called Patient 1 names, including "bitch," "fucking bitch," and "cunt." Patient 1 also testified respondent, at some point, took away her cell phone so she was unable to contact anyone. Patient 1, however, was able to get her cell phone back at a later time.

23. According to Patient 1, respondent became violent again after she repeatedly asked to go to Tortola. Respondent pushed Patient 1 against a kitchen counter, put her in a headlock, and poked her in the eye. Eventually, after this second incident of physical violence, respondent sailed toward Tortola. Once respondent docked at Tortola, Patient 1 went to the local police station. After taking her statement, the local police drove Patient 1 to New Peebles Hospital. A medical report dated May 17, 2019, indicates Patient 1's treating physician at New Peebles Hospital found multiple bruises on Patient 1's body, including a bruise on her left eye, with a small scrape and dried blood on her upper eyelid, and bruises on her back, hip, buttock, loin, and foot. The treating physician summarized his impression of Patient 1's injuries as follows: "[n]umerous contusions of varied age, consistent with multiple instances of blunt force trauma." (Ex. 14, p. A168.) The hospital staff also took photographs of these injuries, including images of Patient 1 with a cut on the inside of her lip and bruises on her chin, forearm, underarm, and back. (Ex. 9, p. A147.)

24. Patient 1 was discharged from New Peebles Hospital on the night of May 16, 2019. She stayed at a hotel and had no contact with respondent until May 19, 2019, when they both boarded a flight back to the United States. Patient 1 explained

she did not fly separately from respondent because she could not change her plane ticket without incurring a significant penalty. Patient 1 stayed away from respondent as much as possible during their flight home. Once they arrived at Burbank Airport, Patient 1 called for an Uber and went home by herself.

25. On May 20, 2019, Patient 1 filed a request for a civil restraining order against respondent. On July 3, 2019, after a hearing before a judge, Patient 1 obtained a one-year restraining order against respondent.

Respondent's Testimony

26. Respondent denied punching Patient 1 on his boat during the 2019 incident. According to respondent, Patient 1 was sullen and angry that day, and Patient 1 was drinking. While on the deck of the boat, respondent asked Patient 1 to set the jib. In response, Patient 1 said, "You'll never learn anything." She then moved in front of respondent, who was seated in the captain's chair, and unexpectedly punched him, knocking his sunglasses off. Respondent reported he did not hit Patient 1 back. Respondent testified it would not have been physically possible for him to have punched Patient 1, as Patient 1 claimed, while he was seated in the captain's chair and Patient 1 was standing in front of the steering console. According to respondent, his arm could not have reached where Patient 1 was standing because the length of his extended arm is approximately 24 inches, but the distance between the captain's chair and where Patient 1 was positioned in front of the steering console was approximately 54 inches.

27. Respondent denied calling Patient 1 a "cunt." He denied taking away Patient 1's cell phone. Respondent also denied restricting Patient 1's movements and maintained she was free to move about and leave the boat. Respondent reported they

sailed to Sandy Cay, an island near Jost Van Dyke, after the incident. Respondent stated there was a busy bar at the Sandy Cay beach and many boats docked in the area, and Patient 1 could have sought help there if she wanted to do so.

28. Respondent also denied pushing Patient 1 down the stairs of the boat. Respondent testified he had argued with Patient 1 because Patient 1 accused him of having a Mongolian girlfriend. He was stunned, but later, he heard a thud. Respondent reportedly put the boat on autopilot, went to the bathroom, and saw Patient 1 with a cut under her eye. Respondent further speculated Patient 1 got the bruises on her body from an earlier accident when Patient 1 fell out of a dingy and from Patient 1's cancer treatment medication which caused bruising.

29. Respondent testified he traveled with Patient 1 back to California. During a layover in Chicago, they had dinner together, and Patient 1 did not appear to be afraid of him at that time.

Expert Testimony on the 2019 Incident

30. At the hearing, Brian Lugo, M.D. testified on respondent's behalf as an expert witness only on the issue of whether Patient 1's injury pattern from the 2019 incident was consistent with a punch. Dr. Lugo obtained his Doctor of Medicine degree from New York University in 2002, and he completed his residency and fellowship at the University of California, Irvine. He specializes in trauma/surgical critical care and has been in private practice since 2014. Dr. Lugo reviewed Patient 1's medical records from the British Virgin Islands, the photographs of Patient 1's injuries taken at New Pebbles Hospital, the police report of the May 16, 2019 incident from the British Virgin Islands, and the transcript from the July 3, 2019 restraining order hearing to render his opinion.

31. Dr. Lugo opined Patient 1 was not punched during the 2019 incident but acquired her bruising pattern on her face "via an altogether separate mechanism." (Ex. E, p. B44.) Specifically, Dr. Lugo believes respondent, as a "220-pound active individual with elite martial arts and weightlifting experience," would leave signs of severe contusions, i.e., bruising, on Patient 1's face if he had punched her. He also opined such a punch would also have led to skin disruption and jawbone fracture. However, according to Dr. Lugo, photographs of Patient 1's face after the 2019 incident do not show such expected injuries, and the medical records from New Pebbles Hospital do not describe such injuries. Moreover, Patient 1's treating physicians at New Pebbles Hospital did not perform any computed tomography (CT) scans or magnetic resonance imaging (MRI) on Patient 1, thereby demonstrating Patient 1 did not suffer injuries to her face as severe as Dr. Lugo would have expected had respondent actually punched Patient 1.

Credibility Findings: Dr. Lugo

32. Dr. Lugo's expert opinion that Patient 1's facial injuries did not result from a punch is not credible. Although Dr. Lugo based his opinion on the assumptions that respondent weighed 220 pounds and had elite martial arts and weightlifting training, Dr. Lugo admitted he did not know respondent's weight and respondent's experience in martial arts or weightlifting at the time of the 2019 incident. Dr. Lugo also did not know whether respondent was left-hand or right-hand dominant and whether respondent struck Patient 1 with his left hand or right hand. Dr. Lugo admitted he did not calculate the distance, speed, or force of the strike in concluding respondent's punch should have caused severe bruising, skin disruption, and bone fracture to Patient 1's face. Dr. Lugo conceded that although he considered Patient 1's age, he did know, and therefore, did not consider, Patient 1'a height, weight,

athleticism, or predisposition to injury in reaching his conclusions. When asked whether he ever reconstructed the 2019 incident, Dr. Lugo replied he reconstructed the incident in his mind. Dr. Lugo also admitted he had no training in biomechanical or ergonomic engineering. Due to Dr. Lugo's lack of expertise in biomechanical engineering, failure to reconstruct the incident, and lack of consideration of significant factors potentially affecting the severity of Patient 1's facial injuries, his opinions were afforded no weight.

Credibility Findings: Respondent and Patient 1

33. Given Dr. Lugo's opinions are discredited, factual findings regarding the 2019 incident turn on the credibility of respondent and Patient 1. Respondent's testimony he could not have punched Patient 1 while seated behind the steering console in the captain's chair has some merit. Based on the photograph of the steering console submitted by Patient 1 (ex. 9, p. A149, photograph D), the distance between where respondent sat and where Patient 1 was positioned is significant.

34. However, even if respondent's contention he could not have reached Patient 1 with his arm fully extended is credited, respondent's testimony he did not call Patient 1 a "cunt," did not prevent her from getting off the boat, and did not push her down the stairs is not credible. First, respondent admitted in an audio recording taken by Patient 1 around the time of the May 16, 2019 incident that he in fact called Patient 1 a "cunt." (Ex. 10.)

35. Second, respondent's claim he did not prevent Patient 1 from getting off the boat is contradicted by a string of telephone texts submitted by respondent showing on May 16, 2019, Patient 1 wrote to him:

//

> I want to leave to go to Tortola so I can go home. You've taken me to a remote part of Jost Van Dyke and I am fearful of being here with you b [original text incomplete]
>
> PLEASE TAKE ME OUT OF HERE. I'm scared!!
>
> Why are You HOLDING ME AGAINST MY WILL HERE? I told you I want to go to Tortola. You keep saying you have to finish an email, but it's been 2 1/2 hours and you are calling about fixing your car and other things seemingly delaying the time.

(Ex. JJJ, p. B455, emphasis in the original.)

36. Third, respondent's testimony he did not push Patient 1 and Patient 1 got the cut under her eye after he heard a thud in the bathroom is contradicted by his prior testimony. Specifically, at the July 3, 2019 restraining order hearing, respondent testified that after Patient 1 punched him on the deck, he pushed her away, and Patient 1 then fell down the stairs as she was trying to get away from him. Respondent stated:

> . . . So she's [Patient 1] in front of me. I push her away. She's trying to get away down the stairs and does so and falls. I saw her take a hard fall. So it's just common sense-wise I can understand that she had fallen and could easily be injured.

(Ex. 17, p. A270.)

//

37. Furthermore, respondent's explanations about how Patient 1 got the bruises on her face and body were dubious. Respondent speculated Patient 1's bruising was from an accident on the dingy. However, Patient 1 testified she was not injured from the dingy accident; although she was bounced off the dingy after encountering a large wave, she got back into the dingy unharmed. Furthermore, respondent testified Patient 1 was taking cancer treatment medication causing her to bruise easily. At his 2021 Board interview, respondent also stated Patient 1 was taking "a tamoxifen-like med that caused extensive bruising." (Ex. 45, p. A604.) However, according to Dr. Nicolas Badre, M.D., complainant's expert witness, tamoxifen is a medication that "increases risks of clots (the opposite of blood thinning)." (Ex. 8, p. A144.)

38. By contrast, Patient 1's testimony about the verbal and physical abuse she suffered while on board respondent's boat in the British Virgin Islands was corroborated by contemporaneous photographs, audio recordings, and text messages, as described above. Moreover, Patient 1's reporting about the 2019 incident has been largely consistent over time. On the night of the incident, both the police report and the medical records from the British Virgin Islands document Patient 1 reported respondent physically assaulted her on the boat. (Exs. 13 & 15.) Three days after the incident, on May 19, 2019, Patient 1 emailed her friend describing in detail how respondent punched her, called her names including "cunt," pushed her down the stairs, poked her eye, and then held her captive on the boat for hours. (Ex. 12, p. A152.) Patient 1's testimony at the July 3, 2019 restraining order hearing and her testimony at the present hearing also recounted the same events. Additionally, Patient 1 testified at this hearing in a calm, even manner adding to her credibility.

//

39. Therefore, Patient 1's testimony is deemed credible, and complainant proved by clear and convincing evidence respondent called Patient 1 names, confined her to his boat against her will, and physically assaulted her, causing her injuries, on May 16, 2019.

RESPONDENT'S TREATMENT OF PATIENT 1

The In-Office Treatment Period

40. During Patient 1's in-office treatment period (i.e., from October 5, 2016, to November 14, 2018) Patient 1 had six visits with respondent. Those six visits occurred on October 5, and November 9, 2016; May 4, 2017; and May 17, October 29, and November 14, 2018. Respondent's medical records reflect that during each of these visits, respondent conducted Mental Status Exams (MSE) of Patient 1, describing Patient 1's appearance, orientation, speech, affect, and thought process. (Ex. 36, p. A359.) Respondent also diagnosed Patient 1 with "Bipolar II disorder." (*Ibid.*) However, respondent's medical records indicate respondent only prescribed medications, including oxcarbazepine, a psychotropic medication, to Patient 1, but he did not engage in any talk therapy. (*Id.* at p. A369.)

41. At the hearing, respondent denied providing "psychotherapy," which he defined as "talk therapy," to Patient 1. Although complainant submitted a billing statement, dated October 9, 2019, showing respondent billed Patient 1 for psychotherapy performed on November 14, 2018 (ex. 39, p. A399), respondent denied issuing this billing statement, asserting his billing company issued the statement. Patient 1 not only denied receiving any "psychotherapy" (Patient 1's word) from respondent but she also asserted none of the six visits documented in the medical records, including the November 14, 2018 visit, ever took place.

Authenticity of Patient 1's Medical Records

42. Given Patient 1's denial, the authenticity of respondent's medical records was questioned. According to Patient 1, although she frequented respondent's office to have lunch with him or to keep him company, she never saw respondent as a patient at his office. Patient 1 denied ever signing the Patient Rights form (ex. 36, p. A390) and the Assignment and Release form (*id.*, p. A391) respondent submitted as a part of Patient 1's medical records. A sample of Patient 1's actual signature (ex. 37, p. A393), which appears different from the signatures on those two forms, corroborates Patient 1's denial. Furthermore, a flight confirmation (ex. 20, pp. A297-298) showing Patient 1 was in Oakland on November 9, 2016, and bank statements (Ex. 23, pp. A310-311) showing Patient 1's transactions in a city in Northern California on May 4, 2017, demonstrate Patient 1 could not possibly have seen respondent on those days at his office in Pasadena, as reported in Patient 1's medical records. That all of Patient 1's medical records were electronically signed by respondent on July 3, 2020, almost two years after respondent purportedly last saw Patient 1 in his office, casts further doubt on the authenticity of Patient 1's medical records.

43. Respondent, however, insisted Patient 1's medical records are accurate and authentic. He denied forging Patient 1's signature on the Patient Rights form and the Assignment and Release form. Respondent claimed he "re-signed" (his word) Patient 1's charts to explain why the date of his electronic signature did not match the dates of Patient 1's visits. However, respondent did not explain why he needed to re-sign Patient 1's charts. To corroborate his assertion he saw Patient 1 in his office for medical visits, respondent also presented the testimony of another patient, C.A. At the hearing, C.A. testified that between 2016 and 2019, he saw Patient 1 on three to five

different occasions at respondent's office and on at least one occasion, Patient 1 told C.A. that she was at respondent's office for a medical appointment.

44. Regardless of these contentions, the authenticity of Patient 1's medical records need not be resolved in this proceeding. Even assuming Patient 1's medical records are authentic, respondent's documentation of Patient 1's care and treatment contain significant omissions.

No Documentation of Prescriptions Outside the In-Office Treatment Period

45. From May 25, 2015, to August 5, 2020, Patient 1's pharmacy records reflect that before Patient 1 purportedly began her in-office treatment with respondent on October 5, 2016, respondent prescribed for Patient 1 the following medications:

- One prescription of levofloxacin, an antibiotic, on May 25, 2015;
- One prescription of ciprofloxacin, an antibiotic, on May 27, 2015;
- One prescription of Divalproex, a mood stabilizer, on June 18, 2015;
- Three prescriptions of cephalexin, an antibiotic, on September 20, 2015, November 5, 2015, and January 23, 2016;
- One prescription of ciprofloxacin, an antibiotic, on May 29, 2016;
- Two prescriptions of sulfamethoxazole/trimethoprim, an antibiotic, on June 3, 2016, and July 15, 2016; and

//

- One prescription of amoxicillin/clavulanate, an antibiotic, on July 25, 2016.

(Ex. 41, pp. A403, 405, 411.)

46. Patient 1's pharmacy records also reflect on April 23, 2019, after Patient 1's purported last in-office visit with respondent on November 14, 2018, respondent prescribed Patient 1 acyclovir, an antiviral medication. (Ex. 41, p. A411.)

47. Respondent's medical records for Patient 1 do not include any of the prescriptions respondent ordered before October 5, 2016, the time of Patient 1's first visit, in Patient 1's medication list. Respondent's medical records for Patient 1 also do not contain any progress notes reflecting a physical examination of Patient 1, any medical indication (i.e., diagnosis or rationale) for the prescriptions, or any discussions of risks and benefits of the medication respondent prescribed Patient 1.

48. At the hearing, when asked whether he had medical records to support his prescription of these 11 medications, respondent contended the prescriptions themselves constitute medical records. When asked whether he provided the prescriptions to the Board, respondent asserted he failed to do so due to an "oversight." Respondent also claimed he reviewed the records of Dr. Jeff Denham, Patient 1's primary care physician before prescribing the medications, but respondent could not provide any documentation of his coordination of care with Dr. Denham. Furthermore, during cross-examination, respondent initially admitted he did not perform a physical examination of Patient 1 before prescribing the 11 medications to her. Later, however, respondent changed his testimony and claimed he performed "elements of a physical examination" of Patient 1 "many times throughout [their] five-year relationship."

49. Respondent's testimony regarding these 11 prescriptions was not credible, as it was inconsistent and unsupported by the medical records. Therefore, complainant established by clear and convincing evidence respondent issued these 11 prescriptions outside of Patient 1's in-office treatment period without documentation and without physical examination or medical indication.

No Documentation of Prescriptions During the In-Office Treatment Period

50. Respondent also prescribed three medications to Patient 1 during the in-office treatment period without including them on Patient 1's medication list and without including any related progress notes or noting any medical indication for the prescriptions. Specifically, Patient 1's pharmacy records reflect respondent prescribed cephalexin to Patient 1 on November 19 and December 28, 2016, and he prescribed vitamin D2 to her on April 25, 2017. (Ex. 42, p. A429.)

51. At the hearing, respondent claimed he wrote these prescriptions for Patient 1 after speaking to her primary care physician, Dr. Denham, who purportedly confirmed respondent should prescribe the medications for Patient 1.

52. However, respondent's explanation is not credited, as the medical records do not indicate any such discussion occurred. Complainant proved by clear and convincing evidence respondent ordered two prescriptions of cephalexin and one prescription of vitamin D2 for Patient 1 during Patient 1's in-office treatment period without documentation, prior examination, or medical indication.

//

//

No Documentation of Dual Relationships

53. Respondent did not indicate in Patient 1's medical records he had dual relationships with Patient 1. Respondent contended, however, he documented his relationship with Patient 1 in the medical records by noting at every visit he recommended Patient 1 to follow up with her primary psychiatrist. (Ex. 36, p. A364, A370, A374, A378, A382, A388.) Respondent also indicated several times in the medical records that he was acting solely as a "limited consultant." (*Id.* at pp. A360, A364, A368, A374, A378, A388.)

54. Respondent's assertions are not supported by the documentary evidence and therefore are not credited. Even though he may have documented his role in Patient 1's care was limited in scope, respondent did not indicate Patient 1 was his domestic partner or spousal equivalent in Patient 1's medical records. Nor did respondent indicate anywhere in Patient 1's records he had been sexually, romantic, financially, and otherwise involved in personal relationships with Patient 1 since 2014. Respondent also fails to note in the medical records he informed Patient 1 about, or that she consented to, the dual relationships. Therefore, complainant proved by clear and convincing evidence respondent did not document in the medical records the nature, scope, and length of his dual relationship with Patient 1.

No Documentation of Patient 1's Primary Psychiatrist

55. Respondent's medical records for Patient 1 do not identify Patient 1's her primary psychiatrist or note any effort by respondent to coordinate Patient 1's care with that psychiatrist. At the hearing, respondent contended when treating Patient 1 he did not consider himself Patient 1's psychiatrist but instead her "ER doctor." According to respondent, a psychiatrist diagnoses mental health disorders. However,

in Patient 1's case, he did not evaluate her for bipolar disorder because it was previously diagnosed by Patient 1's primary psychiatrist. Respondent further asserted he was not Patient 1's psychiatrist because he did not discuss with her issues about her job, love life, or family relationships. Respondent claimed he discussed Patient 1's case with her primary psychiatrist, who was designated to perform long-term treatment of Patient 1's mental health issues. Respondent reported he also coordinated Patient 1's care with her primary psychiatrist and prescribed oxcarbazepine to her at her primary psychiatrist's request.

56. Respondent's assertions are not credited because they are not supported by the medical records. Furthermore, during cross-examination, when asked to locate in the medical records where he documented the identity of Patient 1's primary psychiatrist or coordination of Patient 1's care with such psychiatrist, respondent was unable to do so. Respondent also was unable to locate in the medical records where he documented Patient 1's primary psychiatrist's request to prescribe oxcarbazepine. Therefore, complainant proved by clear and convincing evidence respondent failed to document Patient 1's primary psychiatrist's identity and any coordination of care with that psychiatrist.

EXPERT OPINION ON RESPONDENT'S TREATMENT OF PATIENT 1

57. Nicolas Badre, M.D. testified at the hearing as complainant's expert witness about respondent's treatment of Patient 1 and also submitted an undated expert report (Expert Report #1). Dr. Badre obtained his Doctor of Medicine degree from the University of Kentucky in 2011, and he served his psychiatry residency at the University of California, San Diego (UCSD) from 2011 to 2015. After 2015, Dr. Badre worked as a psychiatrist at San Diego County Jails and San Diego County Psychiatric

Hospital. Since 2017, he has been in private practice and serving on the teaching faculty at UCSD.

58. Respondent did not present any expert witnesses regarding respondent's treatment of Patient 1.

Dual Relationships

59. According to Dr. Badre, the standard of care requires psychiatrists to carefully attend to the separation of their work as clinicians from personal relationships with patients and strive to eliminate compromising dual relationships. Dr. Badre explained patients are in a vulnerable position with respect to their doctors, as they entrust their lives to doctors and often discuss intimate aspects of their lives such as their work, family, and romantic relationships. The inherent inequality in the doctor-patient relationship places patients at risk for exploitation and impinges on patients' ability to provide informed consent. Dual relationships can be financial, romantic, or sexual. Dr. Badre emphasized engaging in a sexual relationship with a patient is especially destructive to the doctor-patient relationship because it undermines patients' trust in their doctor and interferes with their recovery. However, having a business relationship with a patient, as well as having a non-sexual social relationship, can also negatively affect the therapeutic relationship.

60. Dr. Badre noted rules guiding professional behavior are context sensitive, and it is important to distinguish between boundary violations and boundary crossings. Boundary violations are harmful transgressions, likely to cause future harm, or exploitative of the patient. Boundary crossings are deviations from customary behavior that do not harm the patient and that on occasion can facilitate the therapeutic process. For example, acknowledging a patient in a grocery store is a type

of permissible boundary crossing. Dr. Badre wrote in his Expert Report #1, "Psychiatrists must evaluate each situation and ensure that the conduct is not misconstrued and in the best interest of patients." (Ex. 8, p. A137.)

61. Applying these principles to Patient 1's case, Dr. Badre opined respondent had inappropriate dual relationships with Patient 1 that caused patient harm. According to Dr. Badre, respondent and Patient 1's doctor-patient relationship extended beyond Patient 1's in-office treatment period because respondent prescribed medications to Patient 1 both before and after this period. Dr. Badre reasoned that prescribing a medication involves assessment, diagnosis, and treatment. Therefore, the doctor-patient relationship between respondent and Patient 1 was first established in 2015, when respondent first prescribed medication to Patient 1, and ended in 2019, when respondent last prescribed medication. During this period, respondent maintained many relationships with Patient 1 in addition to the doctor-patient relationship. Respondent had a sexual relationship with Patient 1, as they engaged in sex throughout their relationship. Respondent had a financial relationship with Patient 1, as Patient 1 lent money to, and chartered yachts with, respondent. Respondent had a romantic relationship with Patient 1, as they traveled to different locales as a couple. Respondent had another personal relationship with Patient 1, insofar as he confided in her about his termination from Huntington and his discipline by the Board. Respondent also had a violent dual relationship with Patient 1, as he called her names and physically assaulted her. Dr. Badre concluded the nature, scope, and length of the dual relationships between respondent and Patient 1 represent clear boundary violations and an extreme departure from the standard of care.

62. Although Dr. Badre assumed Patient 1's allegations to be true in rendering his opinions, he also considered respondent's claims that some of these

dual relationships were platonic rather than romantic or sexual. Dr. Badre wrote in his Expert Report #1:

> While [respondent's] version of events may represent a less severe departure from the standard of care; those dual relationships, even if platonic and without violence, were still grossly inappropriate and still an extreme departure from the standard of care.
>
> The standard of care requires psychiatrists to evaluate each situation and ensure that their conduct is not misconstrued and in the best interest of patients. Even if his intent was platonic and without violence, [respondent] failed to appropriately evaluate and re-evaluate the nature of their relationship and whether it was in the best interest of [Patient 1].

(Ex. 8, p. A140.)

Documentation Issues

63. Dr. Badre further opined the standard of care is for psychiatrists to keep accurate records of their care of patients. Accurate documentation includes notations about the occurrence of boundary violations altering the nature of the doctor-patient relationship and the presence of dual relationships potentially affecting patient care. Psychiatrists must describe the dual relationships and define and establish appropriate boundaries for those relationships to minimize risks to the patient. Psychiatrists must also document providing and obtaining appropriate consent from their patients about dual relationships. According to Dr. Badre, the medical records must contain

explanations and assessments of any boundary violations. In Dr. Badre's opinion, respondent's omission in the medical records of his multiple dual relationships with Patient 1 is an extreme departure from the standard of care.

64. Proper documentation also includes the accurate notation of a patient's symptoms and medication lists, the physician's evaluations, and an explanation of diagnoses and treatment plans. Dr. Badre opined any falsification by respondent of Patient 1's medical records and billing would represent extreme departures from the standard of care. Alternatively, even assuming the accuracy of Patient 1's medical records, the records contain significant omissions., including the 11 prescriptions respondent issued to Patient 1 before and after the in-office treatment period, the three prescriptions respondent issued to Patient 1 during the in-office treatment period (cephalexin on November 19 and December 28, 2016, and vitamin D2 on April 25, 2017), the identity of Patient 1's primary psychiatrist, and the coordination of care between respondent and Patient 1's primary psychiatrist. According to Dr. Badre, such omissions also represent an extreme departure from the standard of care.

Credibility Findings

65. Dr. Badre's opinions are reasonable, unrefuted, and thus, afforded substantial weight. Consequently, complainant proved by clear and convincing evidence respondent committed extreme departures from the standard of care by (1) engaging in multiple dual relationships with Patient 1 over an extended period; (2) failing to document his dual relationships with Patient 1 in the medical records; and (3) failing to document prescriptions he issued to Patient 1, Patient 1's primary psychiatrist's identity, and the coordination of care with that psychiatrist.

//

Patient 2

66. Patient 2 is a 23-year-old male who was respondent's patient for 17 months from March 15, 2018, to August 20, 2019. Respondent saw Patient 2 for 11 visits of medication management and talk therapy, based on a diagnosis of ADHD and "other psychoactive substance abuse." (Ex. 58, p. A835.) At respondent's initial evaluation of Patient 2 on March 15, 2018, Patient 2 reported he had been treated for ADHD since age 12 or 13 and had a history of drug and alcohol abuse, including past participation in a detoxification program. (*Id.*, p. A821 & A831.)

DUAL RELATIONSHIP WITH PATIENT 2

Patient 2's Statement and Testimony

67. According to a July 25, 2019 statement written by Patient 2 (ex. 59) and his testimony at the hearing, respondent hired Patient 2 as an office manager from approximately June 14, 2019, to July 25, 2019, while Patient 2 was still under respondent's treatment. During this period, respondent gave Patient 2 keys to his house and car so Patient 2 could run personal and work-related errands for him. Patient 2 performed house and gardening work for respondent during this period as well. Around July 25, 2019, while respondent was on his sailing vacation in the Caribbean, respondent gave Patient 2 access to a safe in his office. The contents of the safe included cash, blank checks, and multiple prescription pads, some of which were pre-signed by respondent. Furthermore, at respondent's direction, Patient 2 forged respondent's signature on a check to another doctor, J.C. (ex. 64), on a July 22, 2019 letter to the Board (ex. 65), and on a prescription for a patient, H.M. (ex 70). Additionally, during Patient 2's employment, respondent called Patient 2 derogatory names, including "moron."

68. Patient 2's testimony at the hearing was scattered and difficult to follow. However, Patient 2's hearing testimony was largely consistent with his July 25, 2019 statement. Patient 2's testimony at the hearing was also filled with anguish. Patient 2 felt respondent treated him as a "pawn," as though he was "disposable."

69. It should be noted that Paragraph 71 of the Accusation alleges:

> 71. Patient 2 moved to a sober living facility in June 2021. He stated that he felt his relationship with [r]espondent was a form of emotional abuse and that the stress from his interactions with [r]espondent contributed to his substance relapse.

(Ex. 1, p. A26.)

70. Patient 2 apparently made this statement as a part of his interview with the Board Investigator on January 25, 2022, which was included in a 2022 Supplemental Investigation Report on Patient 2. (Ex. 57, p. A803.) However, at the hearing, complainant only submitted an Investigation Report on Patient 2 from 2021 (ex. 55), and the 2022 Supplemental Report was not submitted. Patient 2 did not testify about moving to a sober living facility or a relapse in 2021 at the hearing, although he stated he struggled with substance use before, during, and after his treatment with respondent. Therefore, the allegations in Paragraph 71 of Accusation were not established by the record.

//

//

//

Patient 2's Parents' Testimony

71. Both Patient 2's mother (Mother) and father (Father) testified at the hearing in a clear, calm, and forthright manner and corroborated Patient 2's version of the events.

72. Father testified that around July 25, 2019, Patient 2 called him from respondent's office. Patient 2 told him he had access to respondent's office safe which contained pre-signed prescriptions and cash. Father advised Patient 2 to take photographs of what he saw and then to "get out." Patient 2, heeding his father's advice, took videos of himself opening respondent's safe with a numerical code, counting the cash left inside the safe, and flipping through a prescription pad in which the first few prescriptions were pre-signed. (Exs. 66, 67.) Patient 2 also took a photograph of the check he signed on respondent's behalf to J.C. (ex. 64), the prescription for patient H.M. (ex. 70), and the July 22, 2019 letter to the Medical Board (ex. 65). Father further testified that after learning of these incidents, he called respondent on two occasions to discuss his concerns about these events. These interactions with respondent made Father more concerned because respondent appeared to be "bullying, dangerous, and unprofessional." Father did not wish anyone else to be subjected to respondent's behavior. Therefore, he made a complaint to the Board.

73. Mother testified she accompanied Patient 2 on three visits with respondent in the summer of 2018. At all three meetings, respondent used swear language, including the word "fuck" in every sentence, and in one conversation, respondent called Patient 2 a "fucking moron." Mother thought these meetings were "extremely alarming."

Respondent's Testimony

74. At the hearing, respondent testified he hired Patient 2 as an assistant because respondent believed "it would be helpful" to Patient 2. However, respondent claimed the period of Patient 2's employment was only five days. Respondent denied giving Patient 2 keys to his house and his car. He also denied having Patient 2 perform house and gardening work for him. Respondent asserted the keys to his house and car were left with another "female assistant." He also denied giving access to the office safe to Patient 2 while he was on vacation. Respondent asserted this "female assistant" gave Patient 2 access without his permission. Respondent denied directing Patient 2 to sign the prescription for patient H.M. Respondent claimed he had signed the prescription and left the prescription at his office for H.M. to pick up, but when H.M. failed to do so, H.M.'s prescription was left in the safe. Respondent initially denied asking Patient 2 to sign his July 22, 2019 letter to the Medical Board, but later respondent asserted he "allowed" Patient 2 to sign the letter. Respondent also initially admitted Patient 2 signed the check to J.C., but he later retracted his statement and claimed Patient 2 did not sign the check to J.C., but did sign a check that was made out to Patient 2 himself.

Credibility Findings

75. Respondent's credibility was undermined not only by his inconsistent testimony explained above but also by his prior inconsistent statements. For example, respondent's assertion the "female assistant" gave Patient 2 access to the safe contradicted his earlier statements to the Board Investigator at the 2021 Board Interview during which respondent admitted he "need[ed] [Patient 2] to give a prescription to [patient H.M.], and so [he] let [Patient 2] ha—have access to the safe so that [Patient 2 would] get the prescription." (Ex. 46, p. A726.) During the 2021 Board

Interview, respondent also conceded with regards to the July 22, 2019 Medical Board letter, he directed Patient 2 to "find a signature and xerox it on there." (*Id.* at p. A747.)

76. Furthermore, text messages exchanged between respondent and Patient 2 when respondent was sailing in the Caribbean cast further doubt on respondent's denials at hearing he did not give Patient 2 keys to his house or car and did not have Patient 2 perform housework for him. In those texts, Patient 2 indicated he was at respondent's house, watering his plants for him, and had warmed up his car. (Ex. CC, p. B305.) Later, when Patient 2 expressed discomfort in doing some of the tasks assigned by respondent, respondent demanded Patient 2 to "[r]eturn the car and all keys immediately." (*Id.*, at p. B310.) Respondent also wrote:

> Let me know when the items will be returned. Leave all prescriptions and checks including any you touched in the safe, unless you send [J. C.'s] which you were asked to do. Return car and leave Car [*sic*] and office keys. Please do this ASAP, since it is in your interest.

(*Id.*, at p. B311.)

77. Because respondent's statements were inconsistent over time and contradicted by the documentary evidence, respondent's version of the events relating Patient 2's employment is not credited. On the other hand, Patient 2's statements were corroborated by videos, photographs, text messages, and his parents' testimony. Therefore, Patient 2's statements were given significant weight, and complainant established by clear and convincing evidence respondent hired Patient 2 as an employee for approximately one and a half months in 2019. During that time, respondent gave Patient 2: (1) keys to his house and car to do personal and

housework for him; (2) access to his office safe containing cash, blank checks, blank prescription pads, and pre-signed prescriptions; and (3) directions to forge respondent's signature on patient H.M.'s prescription, the July 22, 2019 letter to the Board, and a check for J.C. Respondent also called Patient 2 derogatory names, including "moron."

No Documentation of Dual Relationship

78. While respondent employed Patient 2 from June 14, 2019, to July 25, 2019, respondent saw Patient 2 as a patient, including at an in-office visit on July 12, 2019. After Patient 2's employment ended with respondent, respondent continued to see Patient 2 at two more in-office visits on August 6, 2019, and Augst 30, 2019. However, respondent did not document in Patient 2's medical records his dual relationship with Patient 2, any education of Patient 2 regarding the dual relationship, and Patient 2's consent to the dual relationship.

79. At the hearing, respondent testified he explained to Patient 2 their employee-employer relationship was separate from their psychiatrist-patient relationship. Respondent reported he gave Patient 2 time to consider their relationship before hiring him. Respondent asserted he did not chart these discussions with Patient 2 because, in respondent's words, "it was not about the medical relationship." However, respondent averred he would now document dual relationships in his medical records.

80. Respondent believes Patient 2 understood the separate nature of their employee-employer and psychiatrist-patient relationships and Patient 2 had the competence to consent to such relationships. Respondent contended Patient 2's continuation of therapy on August 6, 2019, and August 30, 2019, after respondent had

terminated him as an employee, demonstrates Patient 2 understood the separation of their dual relationships. According to respondent, Patient 2's demeanor at those visits was confident, comfortable, and apologetic. Respondent further claimed Patient 2's statement during the August 6, 2019 visit that "[he] appreciated all the treatment [respondent has] been giving him" constitutes documentation of their employee-employer relationship.

81. However, respondent's testimony that he educated Patient 2 about, and Patient 2 had consented to, their dual relationship is not credible, as it is uncorroborated by either Patient 2 or the medical records in this case. Respondent's testimony that he documented his employer-employee relationship with Patient 2 is also not credible, as it is not supported by the medical records.

EXPERT OPINION ON RESPONDENT'S DUAL RELATIONSHIP WITH PATIENT 2

82. Dr. Badre testified at the hearing and also submitted an undated expert report (Expert Report #2), about respondent's dual relationship with Patient 2. Respondent presented no expert witness testimony on this issue.

The Dual Relationship

83. Dr. Badre opined the standard of care requires psychiatrists to be responsible for rendering medical care in their patients' best interest while respecting the patients' goals and autonomy. According to Dr. Badre, the physician-patient relationship is the cornerstone of psychiatric practice. Because patients lack medical expertise and can struggle with symptoms that affect decision-making, the inherent inequality in the doctor-patient relationship can lead to exploitation.

//

84. In Patient 2's case, Dr. Badre found many instances of dual relationship between respondent and Patient 2. There was an employment dual relationship, where Patient 2 worked for respondent as an office manager and was given access to the office safe. There was a personal dual relationship, where respondent gave Patient 2 the keys to his car and house so Patient 2 could perform house and garden work for respondent. There was what Dr. Badre termed an "illegal dual relationship" where respondent directed Patient 2 to forge signatures on a patient prescription, a check, and a letter to the Board. There was also what Dr. Badre termed a "demeaning dual relationship" where respondent called Patient 2 a "moron." Dr. Badre noted that given Patient 2's substance abuse diagnosis, it was "extremely dangerous" for respondent to give Patient 2 access to the office safe, which contained pre-signed blank prescriptions. Dr. Badre concluded the nature, scope, and length of respondent's dual relationships with Patient 2 represented clear boundary violations and constitute an extreme departure from the standard of care.

No Documentation of Dual Relationship

85. Dr. Badre explained the standard of care is for psychiatrists to keep accurate records of any boundary violations and the existence of any dual relationships. Psychiatrists should also define and establish appropriate boundaries for any dual relationships, as well as document providing and obtaining appropriate consent from their patients about dual relationships. Dr. Badre concluded respondent's failure to document his dual relationships with Patient 2, his education of Patient 2 about this subject, and Patient 2's consent to the dual relationships constitute extreme departures from the standard of care.

//

Inappropriate Delegation of Tasks

86. Dr. Badre explained the standard of care is for psychiatrists to make referrals or to delegate care only to persons who are competent to deliver the necessary treatment and intervention. In this case, respondent tasked Patient 2 with forging respondent's signature on a company check to a physician. Respondent also tasked Patient 2 with forging his signature on a prescription for patient H.M. Patient 2, however, does not have the medical training and experience required to complete prescriptions. In addition, patients such as H.M. suffered the risk of having prescriptions written by someone who lacks the knowledge, experience, or medical training to write such prescriptions. Thus, Dr. Badre concluded respondent's delegation of these tasks to Patient 2 as part of his employment represents an extreme departure from the standard of care.

Credibility Findings

87. Dr. Badre's opinions are reasonable, unrefuted, and thus, afforded substantial weight. Consequently, complainant proved by clear and convincing evidence respondent committed extreme departures from the standard of care by (1) engaging in dual relationships with Patient 2; (2) failing to document his dual relationships with Patient 2 in the medical records; and (3) inappropriately delegating tasks to Patient 2 during his employment.

RESPONDENT'S TREATMENT OF PATIENT 2'S SUBSTANCE USE ISSUES

Indications of Substance Use Issues in the Medical Records

88. At the time of his initial visit with respondent on March 15, 2018, Patient 2 stated he had been treated for ADHD since the age of 12 or 13. (Ex. 58, p. A821.)

Patient 2 reported a history of substance use, including past use of ecstasy, methamphetamine (one time), and alcohol, and past participation in a detoxification program. (*Id.* at pp. A831-833.) Patient 2 also reported using cocaine, although his reporting was inconsistent. At one point, the medical records for the March 15, 2018 visit note Patient 2 stated, "I did coke 3 times" (*id.* at p. A832), but at another point, Patient 2 also "denie[d] cocaine" (*id.* at p. A833). Patient 2, however, stated he was completely sober, "except for pot." (*Id.* at p. A832.) Respondent also wrote in the medical records Patient 2 "admits sometimes used extra doses adderall, commits to NOT doing this in future." (*Ibid*, emphasis in original.) Respondent diagnosed Patient 2 with ADHD and "other psychoactive substance abuse, uncomplicated." (*Id.* at p. A835.)

89. At the next visit on April 12, 2018, respondent noted Patient 2's "appearance [was] highly unusual." (Ex. 58, p. A838.) In a different section of the progress note for the same visit, respondent wrote, "Substances: sober Substance Use Details: denies ETOH [alcohol], denies coke denies benzo's--admits tempted due to anxiety." (*Id.* at p. A837.)

90. At the next visit on May 8, 2018, respondent again documented Patient 2's appearance was "highly unusual." He also noted Patient 2 "feels more anxiety, trying to not use benzos off street........" (Ex. 58, p. A840.) Regarding his mood, Patient 2 reported to respondent: "My mood gets anxious and it really slows me down, I have to chill out several times a day and its tiring [sic] and hard not to smoke a lot of pot[.]" (*Id.* at p. A841.)

91. At the next visit on June 4, 2018, Patient 2 reported to respondent he "feels sudden moods, both down or up." (Ex. 58, p. A843.)

//

92. During Patient 2's next three visits with respondent on July 12, 2018, August 9, 2018, and September 6, 2018, respondent again documented Patient 2's appearance was "highly unusual." (Ex. 28, p. A845-A850.) Additionally, at the September 6, 2018 visit, respondent also described Patient 2 as scattered.

93. During Patient 2's next visit on October 8, 2018, respondent described Patient 2 as intense, slightly irritable, and having a "highly unusual" appearance. (Ex. 58, p. A855.) Regarding Patient 2's substance use, respondent wrote, "Substances: sober Substance Use Details: still has benzodiazepines, used pot twice, discussed not to use, no others-cocaine/etc[.]" (*Ibid.*)

94. During Patient 2's next visit on November 5, 2018, respondent described Patient 2 as "slightly irritable" and noted that Patient 2 "admit[ted] [to using] pot once this time." (Ex. 58, p. A859.)

95. Patient 2 had visits with respondent on January 29, 2019, and March 18, 2019, neither of which were remarkable.

96. At the next visit on May 21, 2019, respondent documented Patient 2's substance use as "admits pot, denies cocaine, admits 'social' ETOH [alcohol]-- patient admits he wishes to be sober, states he will bring parent possibly next session in order to have assistance with his sobriety." (Ex. 58, p. A873.)

97. At the next visit on June 19, 2019, Patient 2 brought his mother to his session. Respondent documented the interaction as follows: "[P]atient brings parent talks about substance abuse, parent wants to encourage sobriety. Patient admits increased alcohol above reported at times, more marijuana use. Continues to try not to use........" (Ex. 58, p. A876.)

98. On July 12, 2019, respondent documented Patient 2's substance use as "admtus [*sic*] abused xanax admits pot smokes pot often, less now." (Ex. 58, p. A881.)

99. Respondent saw Patient 2 for two more visits on August 6, 2019, and August 30, 2019, when Patient 2 terminated his treatment with respondent. Neither visit was remarkable concerning respondent's treatment of Patient 2's substance use issues.

100. At the hearing, respondent explained his many references to Patient 2 having a "highly unusual" appearance are due to Patient 2's nose ring or wearing of T-shirts with profanity. However, respondent admitted the repeated references could also be attributable to "a glitch in the system," i.e., the use of a template and respondent's failure to change the template language for each visit.

101. Regarding Patient 2's substance use, respondent testified he told Patient 2 not to use marijuana. Respondent explained that because Patient 2 has ADHD, using marijuana undermines executive functioning and worsens ADHD. Respondent stated he used motivational interviewing, a counseling technique, to intervene with Patient 2's marijuana use. Respondent also advised Patient 2 to seek out therapy, but Patient 2 refused to do so. Respondent stated he asked Patient 2 at the initial March 15, 2018 evaluation about past experiences with taking extra doses of Adderall to assess Patient 2's honesty. Respondent believed Patient 2 was honest and forthright in his reporting of substance use. Respondent's testimony about Patient 2's benzodiazepine use was inconsistent. At one point, respondent conceded Patient 2 reported one use of benzodiazepine. However, at another point of the hearing, respondent asserted Patient 2 was asked about his benzodiazepine use throughout his treatment period, but he never reported any use.

102. On cross-examination, when questioned about whether he believed Patient 2 to be sober during his treatment period, respondent's answers varied. Respondent asserted that Patient 2 was sober except for marijuana and social alcohol. When asked if sobriety means abstinence from all substances, respondent disagreed and claimed sobriety can consist of marijuana use. When asked about his October 8, 2018 entry that Patient 2 "still has benzodiazepines" (ex. 58, p. A855), respondent stated he considered Patient 2 sober "by his context" even though he still had benzodiazepines. When asked about his November 5, 2018 entry that Patient 2 "admit[ted] [to using] pot once this time," respondent claimed Patient 2 was "California sober" and further claimed "California sober" is a medical term. When asked about his June 19, 2019 entry that "[p]atient admits increased alcohol above reported at times, more marijuana use. Continues to try not to use" (ex. 58, p. A876), respondent refused to agree Patient 2 was no longer sober.

103. Respondent also asserted Patient 2 met none of the criteria for substance use disorder under the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). For example, Patient 2 went to work and texted when he could not make it to work, demonstrating he met his social obligations. Additionally, respondent claimed occasional use of marijuana does not meet DSM-5 criteria for substance use disorder because marijuana is not addictive. Respondent further claimed using an extra dose of Adderall occasionally does not meet any of the DSM-5 criteria for substance use disorder and does not constitute addiction. According to respondent, on the DSM-5 rating scale for severity of substance use disorder, 0 to 2 is mild, and Patient 2 scored 0. However, the medical records contain no notations to support respondent's assertion he assessed and analyzed Patient 2's substance use issues under the DSM-5 criteria.

Respondent's Documentation of Patient 2's Substance Use

104. Throughout Patient 2's treatment period, respondent did not specify the patient's particular drug of abuse although he diagnosed Patient 2 with "other psychoactive substance abuse, uncomplicated." Moreover, respondent did not note this diagnosis in Patient 2's medical records for Patient 2's visits on July 12, 2018, August 9, 2018, September 6, 2018, August 6, 2019, and August 30, 2019.

105. At the hearing, respondent did not explain these discrepancies in the medical records. Respondent, however, asserted Patient 2 had the "highest level of healthy relationship" with respect to substance use because he was sober.

Controlled Substances Utilization Review and Evaluation System (CURES) Reports

106. During Patient 2's treatment period with respondent, respondent documented obtaining one CURES report for Patient 2 on February 21, 2019. (Ex. 58, p. A827.)

107. At the hearing, respondent stated his assistant ran the CURES reports at the initial visit and every few months subsequently. Respondent averred he is aware of the requirement to check CURES, but he believed he was not required to chart any review of CURES.

Respondent's Interventions

108. For each of Patient 2's visits, respondent either used motivational interview, made referrals to therapy, or made suggestions to focus on sobriety to encourage Patient 2's substance abstinence. Respondent did not obtain any urine drug screens from Patient 2 and did not enter into a substance treatment agreement, which

sets forth the responsibilities of the physician and the patient concerning prescriptions of controlled substances and the conditions for termination of treatment (ex. 81, p. A1149) with Patient 2.

109. At the hearing, respondent contended he did not obtain a urine drug screen from Patient 2 because it can take a long time for an outpatient doctor to obtain the results of any urine drug screen. Respondent also asserted a urine drug screen for Patient 2 was unnecessary because Patient 2's "clinical history was clear." Respondent further contended urine drug screens have limited value because they are easy to cheat and tend to be inaccurate.

110. Respondent asserted the Policies and Procedures Form (ex. 58, p.A822), which every patient is required to sign regarding compliance with appointments and medications, was his treatment agreement with Patient 2. However, respondent also claimed Patient 2 did not require a treatment agreement because Patient 2 would not read the agreement. Respondent also stated it would be dangerous for him to terminate Patient 2's treatment if Patient 2 did not comply with rules about substance use because Patient 2 would not be able to get a new doctor quickly and he may resort to street drugs.

Respondent's Prescription of Adderall

111. At Patient 2's initial evaluation on March 15, 2018, respondent prescribed to Patient 2 Adderall (30 mg) extended release in the morning and Adderall (15 mg) at noon. Respondent noted in the progress notes, "**Past Psychiatric Medications:** Adderall since 2015 [¶] used effectively, hard to be consistent........." (Ex. 58, p. A832, emphasis in original.) There is no evidence respondent checked CURES to confirm Patient 2's report of prior medication use. There is also no evidence respondent

attempted to titrate the Adderall, or to start Patient 2 at a lower dose and then adjust the dosage depending on Patient 2's reaction to the medication. Although respondent decreased Patient 2's 45 mg per day dosage for a brief period, respondent maintained Patient 2 at the 45 mg dosage throughout most of Patient 2's treatment period.

112. At the hearing, respondent testified he prescribed 45 mg of Adderall to Patient 2 at the initial March 15, 2018 evaluation because Patient 2 reported that dosage to be effective. Respondent asserted he confirmed Patient 2's report because Patient 2 had brought his old bottle of Adderall with him to the visit. Respondent stated he did not check CURES on March 15, 2018, because CURES became mandatory in October 2018, and he was not required to check it at that time. However, this statement contradicts respondent's other assertion at the hearing that his "female assistant" checked CURES for him at Patient 2's initial evaluation. (See Factual Finding 107.) He also testified the 45 mg of Adderall was not excessive, as the recommended maximum daily dose of Adderall is 60 mg. Respondent asserted Patient 2 made no report of taking extra doses of Adderall during his treatment period. Respondent testified Patient 2 never asked for any refills or early doses of Adderall, which indicated Patient 2 was not abusing Adderall.

Dr. Badre's Opinions on Respondent's Treatment of Patient 2's Substance Use Issues

113. Dr. Badre rendered his opinions on respondent's treatment of Patient 2's substance use issues based solely on reviewing the records in this case, including Patient 2's medical records. He did not personally evaluate Patient 2.

114. At the hearing and in his Expert Report #2, Dr. Badre opined the standard of care is for a physician not to prescribe dangerous or addicting medicines without a

medical indication. For patients with substance use disorders, physicians are required to carefully monitor any potential for abuse, prescribe controlled substances with care, and appropriately monitor any side effects. In Patient 2's case, Dr. Badre believes respondent's assessment and monitoring of Patient 2 for substance use disorder departed from the standard of care.

115. According to Dr. Badre, although respondent diagnosed Patient 2 with "other psychoactive substance abuse," respondent did not specify the substance Patient 2 was misusing. Patient 2 disclosed to respondent that he was using "pot" or marijuana on March 15, May 8, October 8, and November 6, 2018, and again on May 21, and July 12, 2019. Patient 2 also disclosed to respondent on May 8, 2018, he was "trying to not use benzos off street"; on October 8, 2018, he "still has benzodiazepines"; and on July 12, 2019, he "admtus [*sic*] abused xanax." (Ex. 58, p. A840, 855, 881.) To Dr. Badre, these are indications Patient 2 was at least using marijuana and benzodiazepines. However, respondent did not perform any assessments to determine whether Patient 2 used marijuana and benzodiazepines to such an extent to constitute misuse or abuse. Thus, it is difficult to discern the extent of Patient 2's substance use disorder.

116. Additionally, Dr. Badre opined respondent should have performed a substance use assessment for other substances given Patient 2's history of drug use. For example, because Patient 2 reported past use of cocaine, respondent should have performed an assessment even though Patient 2 did not indicate any current active use of cocaine. In Dr. Badre's opinion, Patient 2's reports of struggling with sobriety on April 12, 2018, May 8, 2018, and May 12, 2019, are further indications of a need for substance use assessment.

//

117. Dr. Badre also found respondent's failure to identify the type of Patient 2's substance use disorder was a part of a larger documentation problem. According to Dr. Badre, overall, Patient 2's substance use disorder was poorly documented in the medical records, as respondent failed to include "other psychoactive substance abuse," as a diagnosis on July 12, 2018, August 9, 2018, September 6, 2018, August 6, 2019, and August 30, 2019, even though there was no indication Patient 2 was in remission.

118. Under these circumstances, Dr. Badre opined respondent's prescription of Adderall required significant monitoring and safeguards, which were not present in Patient 2's case. Dr. Badre noted Adderall is a stimulant with the potential for abuse. Patient 2 reported having previously taken cocaine, which is in the same class of stimulants as Adderall, and Patient 2 also reported having taken extra doses of Adderall beyond what he was prescribed at his initial visit on March 15, 2018. This history placed Patient 2 at greater risk for abuse of the medication.

119. However, at his initial March 15, 2018 visit and for much of the remainder of Patient 2's treatment period, respondent prescribed Patient 2 45 mg of Adderall per day. Citing reference guides recommending maximum doses ranging between 40 mg to 60 mg per day (ex. 57, p. A813), Dr. Badre opined 45 mg of Adderall per day is a high dosage. Yet, respondent's choice of dosage was based only on Patient 2's report of prior use of Adderall at the same dosage. There was also no evidence respondent checked CURES to confirm Patient 2's report of prior use at the initial March 15, 2018 visit. Dr. Badre noted in his report Patient 2's consolidated CURES reports (ex. 72) for the period of January 1, 2018, to January 1, 2021, show Patient 2 was not prescribed any controlled substances before March 15, 2018. (Ex. 57, p. A808.) Therefore, for at least three months before his initial March 15, 2018 visit with respondent, Patient 2 was not prescribed Adderall. Dr. Badre also noted respondent made no attempts to

titrate, or to start the Patient 2 on a lower dose of the medication and adjust the Adderall depending on Patient 2's response. Thus, Dr. Badre does not believe respondent provided adequate justification for prescribing a high dosage of Adderall to Patient 2.

120. Dr. Badre explained studies show children with ADHD who take Adderall may have decreased risk of developing substance use disorder as adults. However, these studies do not apply to Patient 2's case as an adult, especially considering his history of past substance use and indications in the medical records of his current substance use. Dr. Badre cited multiple references in the medical records of Patient 2's highly unusual appearance, reports of mood swings and irritability, reports of struggles with sobriety, reports of past and current substance use, and admission of substance use higher than previously reported as risk factors for continuing and worsening substance use disorder. Under these circumstances, Dr. Badre opined that Adderall should not be prescribed to Patient 2 without significant safeguards, monitoring, or interventions, which include drug assessment on each visit, periodic checks of CURES reports, urine drug screening, treatment agreements, and clear boundaries with no dual relationships.

121. Dr. Badre clarified urine drug screening is not necessary for every patient. However, in Patient 2's case, Patient 2's reports he used various drugs previously, Patient 2's admissions of then using marijuana and benzodiazepines, and Patient 2's parents' report that Patient 2 struggled with sobriety are factors requiring urine drug screen in this case. Dr. Badre also explained a treatment agreement between the physician and the patient is important in Patient 2's case because of reports of both past and current substance use. A treatment agreement should contain (1) a discussion of controlled substances, (2) monitoring of controlled substances using urine drug

screens and CURES reports, and (3) consequences of continued use of controlled substances, such as termination of any controlled substance prescription. Nevertheless, in Patient 2's case, none of these safeguards or interventions were used.

122. Furthermore, Dr. Badre noted Patient 2's substance use disorder placed Patient 2 at even greater risk of having any dual relationships go wrong. Despite treating him for ongoing misuse of controlled substances, respondent placed Patient 2 in a position where he was asked to forge signatures and where he had access to cash, blank checks, and blank and pre-signed prescriptions.

123. Dr. Badre concluded:

> Overall, [respondent] failed to recognize signs of continued substance use disorder, continued to prescribe medications which were previously misused by the patient, failed to properly intervene in response to those risk factors, and placed the patient in precarious employment with access to prescriptions despite inadequate training and continued illicit drug use. [Respondent's] treatment of [Patient 2's] substance use disorder represents an extreme departure from the standard of care.

(Ex. 57, p. A813.)

Dr. Robert Vinh Ashley's Opinions on Respondent's Treatment of Patient 2's Substance Use Issues

124. Robert Vinh Ashely, M.D. testified as respondent's expert at the hearing about respondent's treatment of Patient 2's substance use and also submitted an

expert report, dated February 12, 2023, about his findings. Dr. Ashley obtained his Doctor of Medicine degree from UCSD in 2000, and he served his psychiatry residency at UCLA from 2000 to 2004. He was a research fellow at the Veteran Affairs Medical Center from 2004 to 2006. Since 2006, Dr. Ashley has been in private practice, and he also serves as a voluntary Associate Clinical Professor of Psychiatry at UCLA. Dr Ashley rendered his opinions based solely on reviewing the records in this case, including Patient 2's medical records. He did not personally evaluate Patient 2.

125. Dr. Ashley disagreed with Dr. Badre and opined respondent provided a proper and precise diagnosis of Patient 2's substance use disorder. Dr. Ashley wrote in his expert report:

> It should be noted that the diagnosis that [respondent] recorded is F19.10 which, in the ICD-10 diagnostic classification system, is the code for "Mental and behavioral disorders due to use of other psychoactive substances and multiple drug use; uncomplicated." Confusingly, it appears that his EMR may have abbreviated the diagnosis, leaving off the final phrase "and multiple drug use. " [Respondent] clearly diagnosed the patient had substance use issues pertaining to multiple drug use. This is the proper diagnosis in cases of mental problems arising from use of multiple drugs, which in earlier coding systems was referred to as Polysubstance dependence.

(Ex. C, p. B19.)

//

126. Dr. Ashley further opined respondent's documentation of Patient 2 met the standard of care. He found respondent documented in detail during each of Patient 2's visits what substances the patient was using, including marijuana, benzodiazepines, and alcohol. Even though respondent omitted substance use disorder as a diagnosis in Patient 2's diagnosis for five visits on July 12, 2018, August 9, 2018, September 6, 2018, August 6, 2019, and August 30, 2019, respondent addressed Patient 2's substance use and substance use disorder in the body of the progress note. For example, on July 12, 2018, respondent noted Patient 2 denied using benzodiazepines, pot, and other substances; respondent also recommended therapy and used motivational interviewing for substance abstinence. On August 9, 2018, respondent noted again Patient 2 denied using benzodiazepines, pot, and other substances; respondent also recommended therapy and made suggestions to Patient 2 to focus on sobriety.

127. Dr. Ashley contended there was no indication in the medical records Patient 2 was misusing any substances during his treatment period with respondent. Although respondent documented Patient 2 as having used marijuana during the treatment period, Dr. Ashley testified Patient 2's "occasional recreational use of pot" does not constitute substance use disorder. Dr. Ashley also noted respondent documented Patient 2 to have used Xanax, a benzodiazepine, once during his 17-month treatment period. In Dr. Ashley's opinion, this one-time use also does not constitute substance use disorder. Specifically, Dr. Ashley asserted Patient 2's use of substances met none of the DSM-5 criteria such as escalating use, seeking-out behavior, having withdrawal, and failure at work, home, or school. Thus, Dr. Ashley concluded respondent's prescription of Adderall to Patient 2 was within the standard of care. Dr. Ashley also stated it was within the standard of care for respondent to prescribe Adderall even if Patient 2 had a benzodiazepine substance use disorder,

because having a substance use disorder is not a contraindication for prescribing Adderall. According to Dr. Ashley, patients with untreated ADHD have higher rates of substance use, and treating the ADHD is what prevents these patients from using other substances.

128. Moreover, Dr. Ashley disputed Dr. Badre's contention that respondent's prescribed dosage of Adderall was high. Dr. Ashley explained the Food and Drug Administration (FDA) recommends starting new patients at a dosage of 20 mg a day. While respondent's dosage of 45 mg is 25 mg higher than that recommendation, Adderall doses are highly individualized, and there is no hard cap on the Adderall dosage. According to Dr. Ashley, it is within the standard of care to start a new patient on a prior, known dose of Adderall. A patient's report of prior use and a bottle of the prior medication is sufficient to establish the baseline for an Adderall prescription. Dr. Ashley also disagreed respondent was at risk of Adderall addiction. He contended respondent's notation on March 15, 2018, that Patient 2 "admits sometimes used extra doses adderall [*sic*]" is not a sign of possible Adderall abuse. (Ex. 58, p. A832.) During his testimony, Dr. Ashley asserted for most patients, "taking an extra dose of Adderall is usually a misunderstanding." Dr. Ashley stated 80 to 90 percent of patients take an extra dose of Adderall, but it does not signify those patients are at heightened risk of substance use disorder.

129. With respect to respondent's alleged failure to check CURES, Dr. Ashley conceded the standard of care is to check CURES before prescribing any controlled substances. However, during his testimony at hearing, Dr. Ashley asserted CURES "does not provide much information" and it is not the standard of care for a physician to chart any reviews of CURES reports. Nevertheless, in his expert report, Dr. Ashley agreed with Dr. Badre that respondent was required to check CURES more often than

the single instance when he did so during Patient 2's 17-month treatment period. Dr. Ashely wrote: "I found no record of [respondent] performing a CURES report prior to February 21, 2019, as would be required. This appears to have been a failing on the part of [respondent]." (Ex. C, p. B24.)

130. Dr. Ashley, however, disputed Dr. Badre's opinion regarding the utility of urine drug screening. Dr. Ashley contended urine drug screening results are hard to interpret because there are so many false positive tests. Urine drug screening can erode the therapeutic relationship, and this cost outweighs any benefit. Dr. Ashley testified it is not the standard of care to conduct urine drug screening in an outpatient setting.

131. Dr. Ashley further claimed respondent had a treatment agreement with Patient 2. According to Dr. Ashley, the Policies and Procedures Form (ex. 58, p. A822), signed by respondent and Patient 2 on March 15, 2018, is the treatment agreement. He cites to language in the Policies and Procedures Form as similar to those in substance abuse treatment agreements. Specifically, that language in the Policies and Procedures Form includes: item 1, "I agree to pursue health and will make every effort to engage in activities that promote my well-being;" item 5, "I agree that an appointment is necessary to assess my condition and for medications to be refilled:" and item 6, " I agree to take my medications only as prescribed and to keep the medications in a safe and secure place and understand and accept that lost medications may not be refilled until the next appointment." (*Ibid.*) Dr. Ashley also questioned the efficacy of treatment agreements, opining that they do more harm than good. According to Dr. Ashley, terminating an ADHD patient due to violations of the treatment agreement would lead to "catastrophic" results because patients with untreated ADHD have higher rate of mortality.

132. Dr. Ashley opined respondent recognized potential substance use issues in Patient 2 and intervened appropriately. Dr. Ashley noted in his expert report respondent recommended psychotherapy, motivational interviewing, and other strategies, including lifestyle changes and enlisting family and social networks for sobriety support. (Ex. C, p. B27-28.) Dr. Ashley explained motivational interviewing involves using specific techniques to help the patient reach a point of committing to change and then planning that change. (*Id.* at p. B28.) It is an evidence-based approach for behavior change and recognized as standard of care for assisting people with substance use disorders. (*Ibid.*) In Dr. Ashley's opinion, respondent intervened properly to assist the Patient 2 with his substance use issues. (*Ibid.*)

133. Dr. Ashely did not offer any opinions on the impact of respondent's dual relationships on Patient 2's substance use disorder.

Credibility Findings

134. Both Drs. Badre and Ashely are well qualified experts in their field. However, the opinions of Dr. Badre are credited over those of Dr. Ashley for the following reasons.

135. First, Dr. Badre's opinion that respondent did not perform a thorough assessment of Patient 2's substance use disorder is better supported by the medical records. Although Patient 2 revealed to respondent that he was actively using marijuana, benzodiazepine, and alcohol, there is no indication that respondent assessed the quantity and the manner in which Patient 2 was using these substances. For example, on July 12, 2019, respondent documented Patient 2's substance use as "admtus [*sic*] abused xanax admits pot smokes pot often, less now." (Ex. 58, p. A881.) However, respondent did not document whether Patient 2 was taking Xanax pursuant

to a prescription from a physician or getting the benzodiazepine off the street, as Patient 2 seemed to have suggested he had done earlier on May 8, 2018, when he told respondent that he was "trying not to use benzos off street." (Ex. 58, p. A840.) Similarly, there is no assessment as to what "smokes pot often" means (*id.*, at p. A881), whether that indicates Patient 2 is taking marijuana often in a recreational manner or if he is using marijuana in such a quantity and manner that it can be considered abuse. Notably, while the medical records reflect respondent used an 18-item scale to assess the severity of Patient 2's ADHD (*id.*, at p. A825-826), the medical records do not indicate whether respondent used any instrument to assess Patient 2's substance use, despite respondent's diagnosis of Patient 2 for "other psychoactive substance abuse, uncomplicated" (ex. 58, p. A835).

136. Second, given respondent's failure to assess the extent of Patient 2's substance use, it is questionable how Dr. Ashley concluded Patient 2's marijuana use was recreational, Patient 2's benzodiazepine use did not constitute substance abuse, or Patient 2's disclosure of having taken extra doses of Adderall was the result of a misunderstanding. It is even more questionable how Dr. Ashley, who based his opinions solely on respondent's medical records, concluded Patient 2's substance use met none of the DSM-5 criteria when the medical records do not indicate respondent ever assessed Patient 2 for issues such as escalating use, seeking-out behavior, having withdrawal, and failure at work, home, or school, in accordance with the DSM-5 criteria. Instead, the medical records suggest respondent used the ICD-10 diagnostic classification system, not the DSM-5. Respondent's diagnosis of Patient 2 for "other psychoactive substance abuse, uncomplicated" (ex. 58, p. A835) is a diagnosis for "[m]ental and behavioral disorders due to use of other psychoactive substances and multiple drug use" under the ICD-10 diagnostic classification system, as Dr. Ashley explained in his expert's report. (Ex. C, p. B19). Thus, while the evidence establishes

Patient 2 had a mental and behavioral disorder due to drug use under the ICD-10 classification system, there is insufficient evidence to establish whether Patient 1 had a substance use disorder under the DSM-5 because respondent did not use the DSM-5 criteria. Thus, Dr. Badre's opinion, that it is difficult to discern the extent of Patient 2's substance use disorder due to respondent's failure to conduct a proper assessment, including a failure to diagnose Patient 2's disorder by drug type, is consistent with the evidence in this case and afforded significant weight.

137. Third, Dr. Ashley's opinion on the appropriate dosage of Adderall for respondent does not directly refute Dr. Badre's opinions on this issue. Dr. Ashley opined 45 mg of Adderall was not excessive because Adderall prescriptions are highly individualized and there is no hard cap on the maximum Adderall dosage. However, Dr. Badre's opinion was that respondent's prescription of 45 mg of Adderall required additional safeguards beyond merely relying on Patient 2's report of prior use at this dosage because Patient 2 admitted he had previously taken extra doses of Adderall and used cocaine, another stimulant. The issue was not whether dosage at 45 mg was acceptable but whether respondent failed to have proper safeguards, such as confirming Patient 2's report of prior use of 45 mg of Adderall through CURES, additional periodic checks of CURES reports, urine drug screening, treatment agreements, and clear boundaries with no dual relationship, to prevent abuse and ensure Patient 2's safety.

138. Fourth, Dr. Ashley's credibility was damaged because some of his assertions at hearing were contradicted by the resource he cited to in his expert report. Dr. Ashley contended in his expert report and at hearing the Policies and Procedures Form (ex. 58, p. A822) contains the same language and therefore should be treated as a substance use treatment agreement. He cites as support for this

proposition a sample treatment agreement from the National Institute on Drug Abuse (NIDA). (Ex. C, p. B20.) However, a comparison of the NIDA sample treatment agreement (ex. 81, p. A1152) and the Policies and Procedures Form (ex. 58, p. A822) demonstrates significant differences. While the Policies and Procedures Form states generally the patient will take medications only as prescribed by the physician, the NIDA sample treatment form requires the patient and the physician to specify the type of medication and the type of condition for which the medication is intended to treat. (Ex. 81, p. A1152.) The NIDA sample treatment agreement also requires the patient to list goals for taking the medication; to acknowledge certain advisements from the physician, such as a family history of drug or alcohol problems results in a higher chance of addiction; and to agree to certain conditions, such as giving a blood or urine sample on request. (*Ibid.*) The NIDA sample treatment agreement also sets forth responsibilities for both the patient and the doctor for terminating the agreement. (*Ibid.*) None of these provisions are present in the Policies and Procedures Form. Thus, Dr. Ashley's citation to the NIDA sample treatment agreement does not support his opinion that the Policies and Procedures Form is equivalent to a substance use treatment agreement.

139. Fifth, Dr. Ashley did not refute Dr. Badre's opinion that respondent's dual relationship with Patient 2 placed Patient 2t in even greater risk of harm because respondent gave Patient 2 access to cash, blank checks, and blank prescriptions despite his substance use issues.

140. Therefore, complainant proved by clear and convincing evidence respondent committed an extreme departure from the standard of care in his treatment of Patient 2's substance use disorder. Specifically, respondent failed to recognize signs of continued substance use disorder, continued to prescribe

medications previously misused by the patient without monitoring and safeguards, failed to properly intervene in response to Patient 2's risk factors, and placed Patient 2 at greater risk of harm by employing him and giving him access to blank prescriptions.

Evidence of Rehabilitation

141. At the hearing, respondent testified he has a good understanding of dual relationships after earning his master's degree in public health. According to respondent, dual relationships can occur if certain factors, such as patient consent and duration of the relationship, are considered. Respondent asserted he considered these factors when forming his dual relationship with Patient 2. Respondent reported Patient 2 had the ability to consent because he showed stability by working in a sushi restaurant and maintaining a relationship with a girlfriend. Respondent also believes his dual relationship with Patient 2 was limited because Patient 2 was working only while respondent was away on vacation. Furthermore, respondent explained the difference between a boundary violation, which is harmful to the patient, and a boundary crossing, which is nonexploitative and can be therapeutic. Respondent claimed Patient 2's case is an example of a nonexploitative, therapeutic boundary crossing because Patient 2 understood their employer-employee relationship was separate from their doctor-patient relationship.

142. Respondent asserted he applied the same principles regarding dual relationships to Patient 1's case. Respondent emphasized his "long-standing spousal relationship" with Patient 1 predated their "limited-duration" doctor-patient relationship. Respondent also claimed Patient 1 understood their "long-standing spousal relationship" would continue while their "limited-duration prescription medication" relationship was maintained for "logistical reasons." Respondent believes

the prohibition against dual relationships for doctors does not apply when the patient is a spouse.

143. Respondent submitted evidence showing his May 2, 2017 criminal conviction for making criminal threat was dismissed pursuant to Penal Code section 1203.4 on June 24, 2020. (Ex. DD.)

144. Respondent completed his Board probation on January 25, 2019. (Ex. GG.) As a part of his Board probation, respondent completed a 40-hour anger management course. (Ex. JJ.) Respondent reported he benefitted from the anger management course by learning exercises such as breathing techniques to help him calm down. Respondent also completed a medical ethics course on August 4 and 5, 2017, as a part of his Board probation. (Ex. II.) Respondent testified he learned from this course that "many things can be fraught with boundary issues" and "the importance of being only the psychiatrist." Respondent noted his practice also improved after his Board probation due to periodic reviews by a practice monitor, but respondent also emphasized his practice monitor reviewed Patient 2's charts and found no issues.

145. Additionally, respondent submitted continuing medical education (CME) certificates from 2022, showing that he was compliant with CME requirement. (Ex. HH.) Respondent also completed a medial record keeping course in 2023. (Ex. LLL.)

146. Moreover, respondent submitted a PACE Fitness for Duty report (PACE Report) dated January 31, 2023. (Ex. F-1.) According to the PACE Report, respondent participated in a Fitness for Duty test on October 19, 25, and 30, 2022, and he was found to be fit for duty. (*Id.*, p. B423.) Although the PACE Report noted respondent met the criteria for ADHD and narcissistic and histrionic traits, it did not find the ADHD

or other traits at that time impaired respondent's ability to practice medicine. (*Ibid.*) The PACE Report specified: "During his interview with [the evaluating psychiatrist] and his interactions with [PACE] faculty and staff, [respondent] displayed these [narcissistic] behaviors with limited insight, which does give us some pause for concern." (*Ibid.*) The PACE program recommended respondent continue with weekly or biweekly psychotherapy, continue with his ADHD treatment, and engage in mindfulness training. (*Ibid.*) Regarding the recommendation for continued psychotherapy, the PACE Report stated:

> . . . Although he has been in treatment previously, the presence of his narcissistic and histrionic traits suggest that more work may help him professionally and personally. [Respondent] should undergo psychotherapy for a minimum of six months as described above. However, [respondent] may benefit from indefinite psychotherapy to assist him with some of his challenges (e.g., emotion regulation, impulsivity) that are multicausal, and for which pharmacological treatment has only limited impact. Additionally, we recommend his therapist receive a copy of our report.

(*Ibid.*)

147. Respondent believes the PACE recommendations were important in helping him to improve. He reported he has implemented all three recommendations. Specifically, respondent submitted an October 2, 2020 letter from his therapist, Daniel Linscott, PsyD., who wrote that respondent has been in therapy since September 2018. Notably, this letter is from three years ago, and respondent did not submit a more

recent letter from Dr. Linscott. Respondent currently sees a psychiatrist for his ADHD, and he is compliant with his ADHD medication. Respondent has also engaged in mindfulness training, and he has learned techniques to live in the moment and to be present.

148. Respondent averred he is a different physician than who he was six years ago, before he was put on Board probation. Respondent reported that although probation "killed his practice," it forced him to make positive changes such that he is a safer physician today. Respondent wants to continue to practice psychiatry because he believes he can help his patients. Respondent stated he is good at his job, and his career is "the best thing [he has] ever done." Through his role as a physician, respondent wants to give kindness and decency to his patients, just like the doctors who treated his father did during the AIDS epidemic.

Character Evidence

149. David Leonardson (Leonardson), respondent's patient since 2017, testified at the hearing as a character witness. Leonardson sees respondent for monthly sessions for the treatment of ADHD. He has made progress with his condition under respondent's care. Leonardson believes respondent is a good listener and makes him comfortable during their sessions. Leonardson reported respondent prescribes Adderall to him, but respondent thoroughly discusses the risks and benefits of all his medications with him. According to Leonardson, respondent has a good understanding of how to treat ADHD, and he would like to continue to be under respondent's treatment. Leonardson also submitted a letter, dated February 17, 2023, in support of respondent. (Ex. WW.) However, during cross-examination, Leonardson admitted he does not know about the allegations contained in the Accusation, and he was unaware of Accusation when he wrote his February 17, 2023 letter.

150. Monica Vaccino (Vaccino), who has been respondent's patient for eight years, testified at the hearing as a character witness. Vaccino stated she was suspicious of psychiatry when she first started her treatment with respondent. However, respondent empathized with her and made her feel comfortable. Vaccino reported respondent's style is straight forward with no "sugar coating." Vaccino described respondent as a dedicated practitioner who saw her every month, even through the COVID-19 lockdown. Vaccino also submitted a letter dated February 15, 2023, in support of respondent. (Ex. YY.) Although during direct examination, Vaccino asserted she knew the allegations against respondent, she admitted during cross-examination she did not review the Accusation. Vaccino based her knowledge of the allegations against respondent on what respondent and his counsel told her. According to Vaccino, these allegations involve "a patient [who] was picking up phone" and "a domestic partner for whom [respondent] prescribed medication and there was a dispute."

151. Sara Beth Trussell (Trussell), who has been respondent's patient for 10 years, testified at the hearing as a character witness. Trussell has suffered from ADHD since she was in elementary school. She reported respondent has great bedside manner, which she described as "straightforward" and "firm," but also "tender." Trussell believes respondent is invested in his patients and wants to see his patients succeed and improve. She recounted during the COVID-19 lockdown there was a shortage of medications, but respondent called the pharmacy to make sure she would not run out of her medication. Trussell testified she has invested 10 years of her life with respondent, and she does not know what she would do if she were to lose him as a doctor. Trussell also submitted a letter, dated February 10, 2023, in support of respondent. (Ex. PP.) During cross-examination, Trussell described her understanding of the allegations against respondent as involving "an issue with a former domestic

partner, she alleged he punched her" and "a former patient who was answering phone, [and] his father got involved." Trussell admitted she did not read the Accusation, but based her knowledge of the allegations on what respondent told her.

152. Respondent submitted additional character reference letters from patients who uniformly describe him as a caring, skilled psychiatrist. (Exs. SS-CCC.)

Cost Recovery

153. Complainant certified the expert reviewer costs incurred in this matter totaled $8,000. (Exhibit 78.) However, a Board representative, not Dr. Badre, certified the Costs Certification for the Board's expert reviewer services. (*Ibid.*) Dr. Badre's time and billing records were not attached to the Costs Certification. (*Ibid.*) In addition, complainant requests reimbursement of the actual costs of prosecuting this matter by the Department of Justice (DOJ) totaling $40,348.75. (Ex. 79, p. A1134). The DOJ costs consist of the following: 172.5 hours of attorney time billed at $220 per hour and 10.75 hours of paralegal time billed at $205 per hour. (*Id.* at pp. A1146-A1147.) Total costs claimed are $48,348.75.

154. Respondent did not present any evidence regarding his ability to pay these costs.

LEGAL CONCLUSIONS

Standard and Burden of Proof

1. Complainant has the burden of proof in an administrative action seeking to suspend or revoke a professional license, and the standard is clear and convincing

proof to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

2. Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

Governing Law and Legislative Intent

3. The Medical Practice Act governs the rights and responsibilities of the holder of a physician's and surgeon's certificate. (Bus. & Prof. Code, §§ 2000 et seq.) (All further references are to the Business and Professions Code, unless otherwise designated.) The state's obligation and power to regulate the professional conduct of its health practitioners is well settled. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 577.) Protection of the public is the highest priority for the Board in exercising its disciplinary authority and is paramount over other interests in conflict with that objective. (§ 2001.1.)

First and Second Causes for Discipline

4. The Accusation alleges, as the first and second causes for discipline, that respondent violated sections 729, for engaging in sexual exploitation of Patient 1, and 726, for engaging in sexual misconduct with Patient 1.

5. Under section 729, subdivision (a), any physician who engages in an act of sexual intercourse, sodomy, oral copulation, or sexual contact with a patient is guilty of sexual exploitation. However, subdivision (e) of the statute provides an exception, stating: "This section does not apply to sexual contact between a physician and

surgeon and his or her spouse or person in an equivalent domestic relationship when that physician and surgeon provides medical treatment, other than psychotherapeutic treatment, to his or her spouse or person in an equivalent domestic relationship."

6. Section 726, subdivision (a), provides that any act of sexual abuse, misconduct, or relations with a patient, constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under the Healing Arts. However, subdivision (b) of the statute provides an exception, stating: "This section shall not apply to consensual sexual contact between a licensee and his or her spouse or person in an equivalent domestic relationship when that licensee provides medical treatment, other than psychotherapeutic treatment, to his or her spouse or person in an equivalent domestic relationship." (*Id.*, subd. (b).) Thus, section 726, subdivision (b), and section 729, subdivision (e), provides essentially the same exception for physicians who provide medical services to their domestic partners, unless the medical services include psychotherapeutic treatment.

7. Complainant contends Dr. Badre's opinions on the standard of care for physicians who have sexual relationships with patients and Dr. Badre's definition of psychotherapy should guide the interpretation of sections 726 and 729. (Ex. 82, p. A1156.) This argument is not persuasive. Dr. Badre opined on the standard of care, which is relevant to whether respondent was grossly negligent under section 2234. Sections 726 and 729 do not involve negligence and therefore do not require expert opinion on the standard of care. Interpreting sections 726 and 729 only involve statutory construction. Under these circumstances, Dr. Badre's opinion testimony is, in fact, inadmissible and irrelevant to adjudging questions of law. (*Adams v. City of Fremont* (1998) 68 Cal.App.4th 243, 266.)

//

8. Sections 726, subdivision (b), and 729, subdivision (e), exempt those physicians providing medical treatment to their spouses or spouse equivalents from charges of sexual exploitation or abuse unless the physicians provide psychotherapeutic treatment. Here, respondent concedes he and Patient 1 were in a spouse-equivalent domestic relationship predating the beginning of their physician-patient relationship. (Factual Finding 15.) Although Patient 1 referred to herself as respondent's girlfriend, her extensive involvement in respondent's life demonstrates she was acting in the capacity of a spouse. For example, Patient 1 went on romantic trips with respondent, helped him arrange his vacation, lent him money, help him lease his property, picked up his children from school, and dealt with his children's teachers on his behalf. (Factual Finding 10-14.) Thus, respondent's provision of medical treatment to Patient 1 falls under the exceptions of sections 726, subdivision (b), and 729, subdivision (e), unless he provided "psychotherapeutic treatment" to Patient 1.

9. Sections 726 and 729 strictly prohibit the provision of "psychotherapeutic treatment," regardless of whether the physician and the patient are in a spouse or spouse-equivalent relationship. Although neither statue defines the term "psychotherapeutic treatment," the term "psychotherapy" is defined in at least two other statutes governing licensees in the Healing Arts. Specifically, for psychologists, "psychotherapy" means "the use of psychological methods in a professional relationship to assist a person or persons to acquire greater human effectiveness or to modify feelings, conditions, attitudes, and behaviors that are emotionally, intellectually, or socially ineffectual or maladaptive." (§ 2903, subd. (c).) Additionally, for licensees in behavioral sciences, "psychotherapy" means "the use of psychosocial methods within a professional relationship, to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, and to modify internal and external conditions which affect

individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes. (§ 4996.9.)

10. Using these two statutory definitions as guidance, there is little evidence respondent provided psychotherapy or psychotherapeutic treatment to Patient 1. Both respondent and Patient 1 denied any psychotherapy occurred. (Factual Finding 41.) Moreover, assuming Patient 1's medical records to be authentic, the medical records indicate respondent performed only medication management. (Factual Finding 40.) Although respondent diagnosed Patient 1 with bipolar disorder, conducted MSE's, and prescribed psychotropic medications to Patient 1, respondent was using only medication to modify Patient 1's emotions or behaviors. (*Ibid.*) There was no indication respondent used any psychological or psychosocial methods, i.e., talking therapy such as cognitive behavioral therapy, to address Patient 1's emotional and behavioral issues. (*Ibid.*) The only evidence that respondent's treatment of Patient 1 included psychotherapy is a billing statement showing Patient 1 was billed for a psychotherapy session on November 14, 2018. (Factual Finding 41.) However, respondent denied issuing the billing statement, and Patient 1 denied having any medical treatment on November 14, 2018. (*Ibid.*) Consequently, complainant did not prove by clear or convincing evidence respondent provided "psychotherapeutic treatment" within the meaning of sections 726 and 729 to Patient 1.

11. Because respondent's treatment of Patient 1 falls into the exceptions provided under section 726, subdivision (b), and 729, subdivision (e), cause does not exist to discipline respondent's certificate under these two statutes for sexual exploitation and sexual misconduct.

//

Third Cause for Discipline

12. The Accusation alleges respondent's certificate is subject to discipline under section 2234, subdivision (b), because he was grossly negligent in his care and treatment of Patient 1 and Patient 2.

13. The Medical Practice Act does not define "negligence." Generally, negligence is conduct that falls below the standard established by law for the protection of others against unreasonable risk of harm. (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997; Restatement (Second) of Torts § 282 (1965).) It is well settled that the standard of care for physicians is the "reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of the medical profession under similar circumstances." (*Avivi v. Centro Medico Urgente Medical Center* (2008) 159 Cal.App.4th 463, 470; *Brown v. Colm* (1974) 11 Cal.3d 639, 643.) Importantly, a medical professional is held to the standard of care in their own "school" or specialty. Specialists are held to that standard of learning and skill normally possessed by such specialists in the same or similar locality under the same or similar circumstances. (*Quintal v. Laurel Grove Hospital* (1964) 62 Cal.2d 154, 159.) Gross negligence includes "the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Van Meter v. Bent Const. Co.* (1956) 46 Cal.2d 588, 594.)

14. Complainant proved by clear and convincing evidence respondent committed extreme departures from the standard of care in his care and treatment of Patient 1. Respondent's multiple dual relationships with Patient 1, including sexual, romantic, financial, and violent dual relationships, over an extended period of time represent boundary violations and an extreme departure from the standard of care. (Factual Findings 10-25, 57-62, 65.) Assuming respondent forged Patient 1's medical

records, such forgery constitutes an extreme departure from the standard of care. (Factual Findings 42-43, 65.) Assuming Patient 1's medical records are authentic, respondent omitted the following items from the medical records: the existence of his dual relationships with Patient 1, 14 prescriptions he issued to Patient 1, the identity of Patient 1's primary psychiatrist, and the coordination of care between respondent and Patient 1's primary psychiatrist. (Factual Findings 45-56, 64-65.) These omissions constitute extreme departures from the standard of care. (Factual Findings 63-65.)

15. Complainant proved by clear and convincing evidence respondent committed extreme departures from the standard of care in his care and treatment of Patient 2. Respondent's multiple dual relationships with Patient 2, including employment, personal, and demeaning dual relationships, represent boundary violations and an extreme departure from the standard of care. (Factual Findings 67-84.) Respondent also committed extreme departures from the standard of care by failing to document the presence of his dual relationships with Patient 2, and his education of, and Patient 2's consent to, the dual relationships in the medical records. (Factual Findings 78-81, 85.) Respondent also inappropriately delegated tasks, including directing Patient 2 to forge respondent's signature on a prescription, during the course of Patient 2's employment, constituting another extreme departure from the standard of care. (Factual Findings 67-77, 86.) Moreover, respondent committed an extreme departure from the standard of care in his treatment of Patient 2's substance use disorder by failing to recognize signs of Patient 2's continued substance use disorder, continuing to prescribe medications which were previously misused by Patient 2 without monitoring and safeguards, failing to properly intervene in response to Patient 2's risk factors, and placing Patient 2 at greater risk of harm by employing him and giving him access to blank prescriptions. (Factual Findings 88-140.)

16. Cause therefore exists to discipline respondent's certificate for violation of section 2234, subdivision (b), based on his gross negligence in his care and treatment of Patient 1 and Patient 2.

Fourth Cause for Discipline

17. The Accusation alleges respondent's certificate is subject to discipline under section 2234, subdivision (c), because he engaged in repeated acts of negligence in his care and treatment of Patient 1 and Patient 2. Based on the analysis in Legal Conclusions 14 and 15 above, cause exists to discipline respondent's certificate for violation of section 2234, subdivision (c), based on his repeated acts of negligence in his care and treatment of Patient 1 and Patient 2.

Fifth Cause for Discipline

18. The Accusation alleges respondent's certificate is subject to discipline under section 2242, subdivision (a), because he committed unprofessional conduct when he prescribed dangerous drugs to Patient 1 and Patient 2 without an appropriate prior examination and/or medical indication. Section 2242, subdivision (a), refers to section 4022 in defining dangerous drugs. Section 4022, in turn, provides dangerous drugs include any drugs that can be lawfully dispensed only by prescription. (§ 4022, subds. (a) & (c).)

19. Complainant proved by clear and convincing evidence respondent prescribed to Patient 1 the following medications without prior examination and/or medical indication: (1) 10 medications from May 25, 2015, to August 5, 2020, (2) three medications from November 19, 2016, to April 25, 2017, and (3) one medication on April 23, 2019. (Factual Findings 45-52.) Respondent prescribed these medications to Patient 1 without any corresponding progress notes, without listing them in Patient 1's

medication list, and without any medical indication. (*Ibid.*) All these medications required prescriptions and are therefore dangerous drugs within the meaning of sections 4022 and 2242.

20. Complainant did not prove by clear and convincing evidence respondent prescribed to Patient 2 Adderall without prior examination and/or medical indication. There is no dispute respondent properly examined and diagnosed Patient 2 with ADHD or respondent prescribed Adderall for the treatment of Patient 2's ADHD. The dispute in this case is whether respondent's prescription of 45 mg of Adderall to Patient 2, without safeguards, monitoring, and confirmation of prior use, is within the standard of care, an issue which is addressed in Legal Conclusion 15 above.

21. Cause therefore exists to discipline respondent's certificate for violation of section 2242, subdivision (a), based on his unprofessional conduct for prescribing dangerous drugs to Patient 1 without an appropriate prior examination and/or medical indication. However, cause does not exist to discipline respondent's certificate for violation of section 2242, subdivision (a), relating to Patient 2.

Sixth Cause for Discipline

22. The Accusation alleges respondent's certificate is subject to discipline under section 725, because he excessively prescribed dangerous drugs to Patient 2.

23. Section 725, subdivision (a), provides that "repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs . . . as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon........"

//

24. Complainant did not prove by clear and convincing evidence respondent committed repeated acts of clearly excessive prescribing of Adderall to Patient 2. Because section 725 references the standard of the community of licensee, expert testimony is required to establish respondent's prescription of Adderall to Patient 2 constitutes repeated acts of clearly excessive prescribing of drugs. In this case, while Dr. Ashley opined Adderall dosage is individualized without a hard limit on the maximum dosage, Dr. Badre opined the maximum daily dose of Adderall can range between 40 mg and 60 mg. (Factual Findings 119, 128.) Thus, no expert opinion was presented that respondent's prescription of 45 mg of Adderall was "clearly excessive" by the standard of respondent's community of psychiatrists. Dr. Badre's opinion is not that the 45 mg dosage is in itself excessive, but that respondent did not provide adequate justification and safeguards for the prescription of this high dosage under Patient 2's specific circumstances of current and past drug use. (Factual Finding 119.)

25. Cause therefore does not exist to discipline respondent's certificate for violation of section 725.

Seventh Cause for Discipline

26. The Accusation alleges respondent's certificate is subject to discipline under section 2241, because he prescribed controlled substances to Patient 2. Under the version of section 2241 which was in effect at the time the Accusation was filed in 2022, a physician was prohibited from prescribing controlled substances to an "addict," except under limited circumstances. (Section 2241 has since been amended by replacing the word "addict" with "a person with substance use disorder.") Subdivision (d) of that statute defined "addict" as "a person whose actions are characterized by craving in combination with one or more of the following: [¶] (A) [i]mpaired control over drug use[;] [¶] (B) [c]ompulsive use[;] (C) [¶] [c]ontinued use

despite harm." (This definition remains unchanged in the current version of section 2241, even though the word "addict" is now replaced with "a person with substance use disorder.") Adderall is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d)(1).

27. Complainant did not prove by clear and convincing evidence respondent's prescription of Adderall to Patient 2 constitutes prescribing controlled substances to an addict within the meaning of section 2241. Although respondent diagnosed Patient 2 with a mental and behavioral disorder due to drug use under the ICD-10 classification system, complainant did not proved Patient 2 had substance use disorder under the DSM-5 classification system because no such assessment using the DSM-5 criteria took place. (Factual Finding 136.) While Patient 2's continued substance use as documented in the medical records warranted a thorough assessment by respondent, the evidence did not clearly and convincingly establish Patient 2's actions were characterized by craving in combination with impaired control over drug use, compulsive drug use, or continued drug use despite harm, such that Patient 2 was an "addict" within the meaning of the 2022 version of section 2241.

Eighth Cause for Discipline

28. The Accusation alleges respondent's certificate is subject to discipline under sections 2234 and 2228.1, because he committed unprofessional conduct.

29. The Board is required to take action against any licensee who is charged with unprofessional conduct. (Bus. & Prof. Code, § 2234.) Unprofessional conduct includes violation of any provision of the Medical Practice Act, gross negligence, and repeated negligent acts. (*Id.,* subd. (a), (b), & (c).)

//

30. Cause therefore exists to discipline respondent's certificate for violation of section 2234, subdivision (c), based on respondent's unprofessional conduct for his violations of the Medical Practice Act, gross negligence, and repeated negligent acts. (Legal Conclusions 12-21.)

31. Section 2228.1 requires licensees to disclose the licensee's probation status, sexual misconduct, drug or alcohol abuse, criminal conviction, or inappropriate prescribing following an administrative hearing or a settlement. This statute is inapplicable to this case.

Ninth Cause for Discipline

32. The Accusation alleges respondent's certificate is subject to discipline under sections 2227 and 2266, because he failed to maintain adequate and accurate medical records for Patient 1 and Patient 2.

33. Section 2227 relates to the mode of discipline against licensees after a finding of guilt. It is not a cause for discipline and therefore inapplicable.

34. However, under section 2266, the failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct. Accurate and adequate records promote a physician's skillful treatment of a patient, contain the essence of what the physician was told and what the physician observed, and trace the physician's medical decision-making process. Accurate and adequate records permit a review of the progression of an illness or disease, and document what treatment proved successful and what did not. A physician's memory does not constitute an adequate medical record. A patient may be seen by other physicians. Patients move, change health care plans, and seek second opinions. Poor charting practices may support claims of unprofessional

conduct and provide patients, attorneys, expert witnesses, and others with a basis for asserting negligence when none exists. Accurate charting both protects a physician from false claims and promotes skillful patient treatment.

35. Complainant established by clear and convincing evidence respondent's medical recordkeeping was inadequate for Patients 1 and Patient 2. In Patient 1's case, the authenticity of the medical records is questionable, given Patient 1's denials and evidence showing some visits could not have occurred. (Factual Findings 42-43.) Alternatively, even assuming Patient 1's medical records are accurate, respondent omitted from these records his multiple dual relationships with Patient 1, multiple prescriptions he issued to Patient 1, the identity of Patient 1's primary psychiatrist, and the coordination of care between respondent and Patient 1's primary psychiatrist. (Factual Findings 45-56.) In Patient 2's case, respondent omitted the presence of his dual relationships with Patient 2, and his education of, and Patient 2's consent to, the dual relationships in the medical records. (Factual Finding 78.) Even though respondent diagnosed Patient 2 with a disorder due to drug use, he did not specify the patient's particular drug of abuse. (Factual Finding 104.) Moreover, respondent did not include "other psychoactive substance abuse," one of Patient 2's diagnoses on multiple visits, even though there was no indication that Patient 2 was in remission. (*Ibid.*)

36. Cause therefore exists to discipline respondent's certificate for violation of section 2266, based on respondent's failure to maintain adequate and accurate medical records for Patient 1 and Patient 2.

//

//

Disposition

37. Under the Board's Disciplinary Guidelines (Guidelines), the recommended range of penalty for gross negligence, repeated acts of negligence, prescribing medication without prior examination, unprofessional conduct, or inadequate medical record is a minimum of five years of probation and maximum of revocation. (Ex. 78, p. A1110, 1112.)

38. Based on the evidence and the Guidelines, the appropriate penalty here is revocation. First, respondent's offenses are multiple and serious. Complainant established respondent committed gross negligence, repeated acts of negligence, prescribing without examination, unprofessional conduct, and inadequate recordkeeping involving numerous separate violations in his care and treatment of Patient 1 and Patient 2. While he served as Patient 1's physician, respondent maintained a personal relationship with her for five years, the end of which was marked by violence. Respondent either forged Patient 1's medical records, or omitted significant information from her medical records rising to the level of gross negligence. Respondent hired Patient 2 as an employee and tasked him with forging respondent's signature on documents including a patient prescription. Respondent also gave Patient 2, whom respondent had diagnosed with a disorder due to drug use, access to a safe with cash and pre-signed prescriptions. Patient 2 also reported to respondent his struggles with substance use and several attempts to achieve sobriety. Respondent, however, did not properly assess and intervene in Patient 2's substance use issues.

39. Second, respondent's misconduct caused potential and actual harm to Patient 1 and Patient 2. In Patient 1's case, she suffered physical injuries, including a cut on her lip and bruises on her eye, arm, chin, and back as a result of the 2019

incident. In Patient 2's case, he suffered emotional harm, as his anguish, at having been treated like a "pawn," was laid bare during his testimony at the hearing. Respondent, as a psychiatrist treating patients with serious mental health conditions, wielded significant power over his patients. Given this power differential, respondent's failure to set and maintain professional boundaries could, and did cause, his patients to be susceptible to confusion and potential exploitation. Additionally, the potential harm in Patient 2's case was also grave, as he could have used the cash and the pre-signed prescriptions in the safe to obtain illicit drugs. As Dr. Badre pointed out, there was also potential harm to patient H.M. When respondent inappropriately tasked Patient 2 with forging respondent's signature on a prescription, H.M. suffered the risk of having a prescription written by someone who lacks the knowledge, experience, or medical training to write the prescription.

40. Third, respondent expressed little remorse for his actions. He admitted little wrongdoing and shifted blamed onto others for his own actions. For example, respondent repeated blamed his "female assistant" for giving Patient 2 access to the safe in his office. Even assuming this "female assistant" did, in fact, give Patient 2 access to the safe, respondent, as the business owner and the medical licensee, is responsible is responsible for the acts of his employees done in the course of his business in the operation of his medical license. (*Arenstein v. California State Bd. of Pharmacy* (1968) 265 Cal.App.2d 179, 192.) Furthermore, in his treatment of Patient 2's substance use issues, respondent preposterously defined Patient 2's continued use of benzodiazepines and marijuana as "California sober" to eschew any responsibility for his failure to recognize the numerous indications scattered throughout Patient 2's medical records that the patient was struggling with substance use. Moreover, although respondent completed a medical ethics and professionalism course in 2017 and purportedly learned about boundary issues in those classes, he continued with his

dual relationships with Patient 1 until 2019 and hired Patient 2 as an employee in 2018. Even at the hearing, respondent was unrepentant about his dual relationships with Patient 1 and Patient 2, insisting they understood and consented to the dual relationships, when the medical records lack any documentation to support this claim. Respondent also insisted his dual relationships were not harmful but therapeutic for Patient 1 and Patient 2, when the evidence demonstrates to the contrary, as discussed above. Respondent's lack of remorse about his dual relationships with Patient 1 and Patient 2 demonstrates his boundary violations were more than mere lapses in judgment. It demonstrates respondent's failure to recognize the inherent power differential between himself and his patients, when acknowledgement of this power differential forms the core of a physician's ethical awareness to effectively address patients' needs.

41. Fourth, respondent offered little evidence of rehabilitation. Some of respondent's rehabilitation evidence, such as his completion of anger management and ethics and professionalism classes, were requirements he completed as a part of his Board probation. Such evidence carries little weight because respondent was expected to behave in exemplary fashion while on Board probation. (See *In re Gossage* (2000) 23 Cal.4th 1080, 1099.) Respondent submitted character references and offered testimony from his patient who hold him in high regard. However, none of the character witnesses or the authors of the character letters evinced an understanding of the magnitude of respondent's wrongdoing. Thus, the character evidence carried less weight. Most significantly, the PACE Report suggested respondent continue psychotherapy on a weekly or biweekly basis for a minimum of six months, and possibly indefinitely, due to the presence of histrionic and narcissistic traits. Although respondent submitted a letter from his psychologist Dr. Linscott, the letter is dated

2020. There is no evidence confirming respondent has followed through with the recommendations in the PACE Report or he is currently in therapy.

42. Fifth, respondent exhibited a troubling level of dishonesty. Several factors, such as respondent's signing of Patient 1's medical records more than two years after the fact, Patient 1's credible testimony she never had an in-office visit with respondent, and Patient 1's receipts showing she was not in town for at least two of the in-person visits that purportedly took place in respondent's office, indicate respondent forged Patient 1's medical records. Respondent was also less than candid in his interview with the Board investigator and in his testimony at hearing. As examples of these instances of dishonesty, respondent repeatedly denied having a sexual and romantic relationship with Patient 1 to the Board investigator, he admitted Patient 1 was his domestic partner at this hearing. Respondent denied calling Patient 1 a "cunt" around the time of the May 16, 2019 incident, but Patient 1's audio recording refutes this denial. Respondent denied giving Patient 2 keys to his house and car and tasking him with house and garden work, but his own texts to Patient 2 contradict this assertion. Respondent denied giving Patient 2 the code to the office safe at the hearing, but he admitted he did so during his interview with the Board investigator.

43. Finally, in aggravation, the Board previously disciplined respondent in 2019, and respondent's license was placed on Board probation for three years.

44. In light of the multiple serious violations established in this case, respondent's propensity for dishonesty, and the insufficiency of the rehabilitation evidence, respondent cannot be relied upon to comply with reasonable terms or conditions that would be imposed if he were allowed to operate under a probationary license. As a result, protection of the public health, safety, and welfare requires the revocation of respondent's physician's and surgeon's certificate.

Costs

45. As set forth in Factual Finding 153, the Board seeks costs of $8,000 in expert reviewer costs. However, the Costs Certification fails to provide sufficient information to support a finding of the reasonableness of such costs. California Code of Regulations, title 1, section 1042 requires a certification for costs sought for the services of a regular agency employee to describe the general tasks performed, the time spent on each task, and the method of calculating the cost. For costs sought for non-agency employees, the certification must be executed by the person providing the service, or the agency may attach copies of the time and billing records submitted by the service provider. (Cal. Code. Regs., tit. 1, § 1042, subd. (b).) In this case, the non-agency expert reviewer, Dr. Badre, did not certify the Costs Certification and Dr. Badre's time and billing records were not submitted as part of the Costs Certification. (Factual Finding 153.) Accordingly, complainant's request for reimbursement of $8,000 is disallowed for failure to comply with California Code of Regulations, title 1, section 1042.

46. However, after consideration of the factors set forth under *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45, including the scope of the matter and the lack of evidence of respondent's ability to pay, complainant's cost of $40,348.75 for legal services is reasonable. (Factual Findings 153-154.) Therefore, pursuant to section 125.3, respondent shall be ordered to pay $40,348.75 in costs to the Board as a condition of reinstatement.

//

//

//

ORDER

1. Certificate Number A 66604 issued to respondent John Lee, M.D. is revoked pursuant to determination of Issues/Causes for Discipline 3, 4, 5, 8, and 9, separately and for all of them.

2. Respondent John Lee, M.D. shall pay $40,348.75 in costs to the Medical Board of California as a condition of reinstatement.

DATE: 01/29/2024

Ji-Lan Zang

JI-LAN ZANG

Administrative Law Judge

Office of Administrative Hearings