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

In the Matter of the Accusation Against: **GEOFFREY ANGELO DI BELLA, M.D.** **229 South State College Blvd.** **Anaheim, CA 92806** **Physician's and Surgeon's Certificate No. G 21681,** Respondent.	Case No. 800-2020-064569 **A C C U S A T I O N**

PARTIES

1. Reji Varghese (Complainant) brings this Accusation solely in his official capacity as the Deputy Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about November 9, 1971, the Medical Board issued Physician's and Surgeon's Certificate No. G 21681 to Geoffrey Angelo Di Bella, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2025, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states, in pertinent part:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
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> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
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> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
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> ...

5. Section 2234 of the Code, state, in pertinent part:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

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(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

...

6. Section 2266 of the Code states: 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.

COST RECOVERY

7. Business and Professions Code section 125.3 states that:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. G 21681 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he was grossly negligent in his care and treatment of Patient A,[1] as more particularly alleged hereinafter:

PATIENT A

9. On or about June 15, 2009,[2] Patient A, a then thirty-three-year-old female, presented to Respondent for the first time for psychiatric treatment with complaints that included depression, anxiety, stress, poor concentration, and poor sleep. Patient A had previously been diagnosed with bipolar disorder and prescribed Lamictal[3] and Ambien.[4]

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[1] To protect the privacy of the patients involved, the patients' names have not been included in this pleading. Respondent is aware of the identity of the patients referred to herein.

[2] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[3] Lamictal (brand name for Lamotrigine) is an anticonvulsant medication used to treat seizures and bipolar disorder. It is a dangerous drug pursuant to section 4022 of the Code.

[4] Ambien (brand name for zolpidem) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to section 4022 of the Code. It is a sedative used for the short-term treatment of insomnia.

10. Between in or around 2009, and in or around 2020, Respondent provided psychiatric treatment to Patient A for bipolar disorder, attention deficit disorder (ADD), and insomnia that included both controlled and non-controlled medications. Throughout that time, Respondent's handwritten notes in Patient A's chart are short, difficult to read, and rarely include significant information related to his neurobehavioral exam, assessment, interventions, or goals.

11. On or about July 27, 2017, Patient A presented to Respondent for a follow-up visit. At that time, Patient A reported she took Lamictal, Ambien, Vyvanse,[5] and dextroamphetamine.[6]

12. On or about December 17, 2018, Patient A presented to Respondent for a follow-up visit for the first time since on or about July 27, 2017. At that time, Patient A reported she took Lamictal, Ambien, and Vyvanse every day, and she took Adderall as needed.

13. Between in or around December 2017, and in or around February 2020, Respondent provided monthly prescriptions to Patient A for controlled medications that included, but was not limited to, Ambien, Vyvanse, and amphetamines. Throughout that time, Respondent only saw Patient A for approximately five (5) clinical visits.

14. Respondent committed gross negligence in his care and treatment of Patient A, which included, but was not limited to, providing monthly prescriptions for controlled substances between in or around July 2017, and in or around February 2020, and only documenting approximately six (6) clinical visits with the patient throughout that time period.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

15. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 21681 to disciplinary action under sections 2227 and 2234, as defined by section 2234,

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[5] Vyvanse (brand name for lisdexamfetamine) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to section 4022 of the Code. It is a stimulant medication used to treat attention-deficit hyperactivity disorder (ADHD) and binge-eating disorder.

[6] Dextroamphetamine (brand name Adderall) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to section 4022 of the Code. It is an amphetamine salts medication used to treat ADHD and narcolepsy.

subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B, and C, as more particularly alleged hereinafter:

PATIENT B

16. On or about November 20, 2013, Patient B, a then twenty-year-old female, presented to Respondent for the first time for psychiatric treatment with complaints of ADHD and anxiety. Patient B reported that she was not taking any medication at that time, but had previously been prescribed Lexapro,[7] Zoloft,[8] and Prozac.[9] On exam, Respondent found Patient B to be disorganized, hyperactive, and depressed. At the conclusion of the visit, Respondent diagnosed Patient B with severe anxiety disorder, panic disorder, and ADHD.

17. Between on or about November 20, 2013 and on or about July 29, 2019, Respondent provided psychiatric treatment to Patient B for anxiety disorder, panic disorder, and ADHD, that included prescriptions for both controlled and non-controlled medications. Throughout that time, Respondent's handwritten notes in Patient B's chart are short, difficult to read, and rarely include significant information related to his neurobehavioral exam, assessment, interventions, or goals.

18. On or about November 29, 2017, Patient B presented to Respondent for a follow-up. At that time, Patient B reported that she took Xanax[10] a few times each week. At the conclusion of that visit, Respondent prescribed Patient B clonazepam.[11] Patient B's chart did not include a documented reason for the clonazepam prescription on that date.

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[7] Lexapro (brand name for escitalopram) is a selective serotonin reuptake inhibitor (SSRI) medication used to treat depression and anxiety, and is a dangerous drug pursuant to section 4022 of the Code.

[8] Zoloft (brand name for sertraline) is a SSRI medication used to treat depression, obsessive-compulsive disorder, PTSD, anxiety, and panic disorder. It is a dangerous drug pursuant to section 4022 of the Code.

[9] Prozac (brand name for fluoxetine) is a SSRI medication used to treat depression, obsessive-compulsive disorder, bulimia, and panic disorder. It is a dangerous drug pursuant to section 4022 of the Code.

[10] Xanax (brand name for alprazolam) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to section 4022 of the Code. It is a benzodiazepine medication used to treat anxiety and panic disorder.

[11] Clonazepam (brand name Klonopin) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to section 4022 of the Code. It is an anti-anxiety medication in the benzodiazepine family.

19. Between in or around January 2018, and in or around July 2019, Respondent prescribed Patient B Xanax and clonazepam. Throughout that time, Patient B's chart did not include a documented reason for simultaneously prescribing the patient two benzodiazepines.

PATIENT C

20. On or about September 5, 2012, Patient C, a then forty-four-year-old female, presented to Respondent for the first time for psychiatric treatment with complaints that included depression, anxiety, fatigue, migraine, and suicidal thoughts. Patient C had a complex psychiatric history that included a prior hospitalization and outpatient treatment for an eating disorder and depression. At that initial visit, Patient C signed a release for her records from her treating psychologist and neurologist.

21. Between on or about September 5, 2012, and on or about October 6, 2020, Respondent provided psychiatric treatment to Patient C for bipolar disorder, depression, anxiety, and ADD, that included prescriptions for both controlled and non-controlled medications. Throughout that time, Respondent's handwritten notes in Patient C's chart are short, difficult to read, and rarely include significant information related to his neurobehavioral exam, assessment, interventions, or goals.

22. Between in or around 2012, and in or around 2020, Respondent was aware that Patient C received care and treatment from various specialists including a psychologist, neurologist, and pain management physician. Throughout that time, Patient C's chart contained no records from these specialists, and Respondent did not discuss and/or document any discussions with these specialists regarding their coordination of Patient C's care.

23. On or about January 31, 2020, Patient C presented to Respondent for a follow-up visit with complaints of severe symptoms related to her depression, sleep disturbance, low energy, and migraines. Patient C reported that she took a variety of medications that included Topamax,[12]

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[12] Topamax (brand name for topiramate) is an anticonvulsant and nerve pain medication that can be used to prevent migraines, and a dangerous drug pursuant to section 4022 of the Code.

Latuda,[13] Lamictal, Ritalin,[14] Klonopin, Lunesta,[15] and Ambien. At the conclusion of that visit, Respondent prescribed Patient C 15 tabs of Percocet.[16] Patient C's chart did not include a documented reason for the Percocet prescription at that time.

24. Between on or about January 31, 2020, and on or about June 5, 2020, Respondent wrote Patient C four prescriptions for 15 tabs of Percocet. Throughout that time, Patient C's chart did not include a documented reason for prescribing Patient C an opioid medication.

25. Respondent committed negligence in his care and treatment of Patients A, B, and C, which included, but was not limited to, the following:

A. Paragraphs 8 through 24, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Maintaining sparse and incomplete treatment records for Patient B that, among other things, fail to include a documented reason for simultaneously prescribing Patient B two benzodiazepines;

C. Prescribing opioid pain medication to Patient C without a documented reason; and

D. Maintaining sparse and incomplete treatment records for Patient C that, among other things, fail to include discussions with specialists regarding their coordination of Patient C's care.

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[13] Latuda (brand name for lurasidone) is an antipsychotic medication used to treat schizophrenia, and a dangerous drug pursuant to section 4022 of the Code.

[14] Ritalin (brand name for methylphenidate) is a stimulant medication used to treat ADHD and narcolepsy, and a dangerous drug pursuant to section 4022 of the Code.

[15] Lunesta (brand name for eszopiclone) is a sedative medication used to treat insomnia, and a dangerous drug pursuant to section 4022 of the Code.

[16] Percocet (brand name for oxycodone and acetaminophen) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to section 4022 of the Code. It is an opioid medication used to treat pain.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

26. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 21681 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patients A, B, and C, as more particularly alleged in paragraphs 8 through 25(D), above, which are hereby incorporated by reference and realleged as if fully set forth herein.

DISCIPLINARY CONSIDERATIONS

27. To determine the degree of discipline, if any, to be imposed on Respondent Geoffrey Angelo Di Bella, M.D., Complainant alleges that on or about May 5, 1989, in a prior disciplinary action entitled, *In the Matter of the Accusation Against Geoffrey Di Bella, M.D.*, before the Division of Medical Quality, Board of Medical Quality Assurance, in Case No. D-3591, Respondent's license was suspended for sixty (60) days and placed on probation for a period of ten (10) years subject to various terms and conditions of probation. Respondent's probation was terminated on or about July 11, 1996, and that Decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 21681, issued to Respondent, Geoffrey Angelo Di Bella, M.D.;

2. Revoking, suspending, or denying approval of Respondent, Geoffrey Angelo Di Bella, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent, Geoffrey Angelo Di Bella, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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4. Taking such other and further action as deemed necessary and proper.

DATED: JAN 11 2023

REJI VARGHESE
Deputy Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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