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8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 800-2023-100795

13 **SANJAY MASSON, M.D.**
7111 W. 151st Street #313
Overland Park, KS 66223-2231

A C C U S A T I O N

14 **Physician's and Surgeon's Certificate**
15 **No. A 90258,**

16 Respondent.

17 **PARTIES**

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

21 2. On or about February 25, 2005, the Medical Board issued Physician's and Surgeon's
22 Certificate Number A 90258 to Sanjay Masson, M.D. (Respondent). The Physician's and
23 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
24 herein and will expire on June 30, 2028, unless renewed.

25 **JURISDICTION**

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

1 4. Section 2004 of the Code states:

2 The board shall have the responsibility for the following:

3 (a) The enforcement of the disciplinary and criminal provisions of the Medical
4 Practice Act.

5 (b) The administration and hearing of disciplinary actions.

6 (c) Carrying out disciplinary actions appropriate to findings made by a panel or
an administrative law judge.

7 (d) Suspending, revoking, or otherwise limiting certificates after the conclusion
8 of disciplinary actions.

9 (e) Reviewing the quality of medical practice carried out by physician and
surgeon certificate holders under the jurisdiction of the board.

10 (f) Approving undergraduate and graduate medical education programs.

11 (g) Approving clinical clerkship and special programs and hospitals for the
12 programs in subdivision (f).

13 (h) Issuing licenses and certificates under the board's jurisdiction.

14 (i) Administering the board's continuing medical education program.

15 5. Section 2220 of the Code states:

16 Except as otherwise provided by law, the board may take action against all
17 persons guilty of violating this chapter. The board shall enforce and administer this
18 article as to physician and surgeon certificate holders, including those who hold
19 certificates that do not permit them to practice medicine, such as, but not limited to,
retired, inactive, or disabled status certificate holders, and the board shall have all the
powers granted in this chapter for these purposes including, but not limited to:

20 (a) Investigating complaints from the public, from other licensees, from health
21 care facilities, or from the board that a physician and surgeon may be guilty of
22 unprofessional conduct. The board shall investigate the circumstances underlying a
23 report received pursuant to Section 805 or 805.01 within 30 days to determine if an
interim suspension order or temporary restraining order should be issued. The board
shall otherwise provide timely disposition of the reports received pursuant to Section
805 and Section 805.01.

24 (b) Investigating the circumstances of practice of any physician and surgeon
25 where there have been any judgments, settlements, or arbitration awards requiring the
26 physician and surgeon or his or her professional liability insurer to pay an amount in
damages in excess of a cumulative total of thirty thousand dollars (\$30,000) with
respect to any claim that injury or damage was proximately caused by the physician's
and surgeon's error, negligence, or omission.

27 (c) Investigating the nature and causes of injuries from cases which shall be
28 reported of a high number of judgments, settlements, or arbitration awards against a
physician and surgeon.

6. Section 2227 of the Code states:

(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:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(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.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

7. Section 2228 of the Code states:

The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(d) Providing the option of alternative community service in cases other than violations relating to quality of care.

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STATUTORY PROVISIONS

8. Section 2234 of the Code states:

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:

(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.

(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.

...

COST RECOVERY

9. Section 125.3 of the Code states:

(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 licensee 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

1 reduce or eliminate the cost award, or remand to the administrative law judge if the
2 proposed decision fails to make a finding on costs requested pursuant to subdivision
(a).

3 (e) If an order for recovery of costs is made and timely payment is not made as
4 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.

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

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

9 (2) Notwithstanding paragraph (1), the board may, in its discretion,
10 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
11 costs.

12 (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
13 to be available upon appropriation by the Legislature.

14 (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.

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

17 DEFINITIONS

18 10. Seroquel is an antipsychotic medication used to treat mental health disorders such as
19 schizophrenia, bipolar disorder, and major depressive disorder. Seroquel carries an FDA warning
20 for increased risk of suicidal thoughts and behavior in children, adolescents and young adults.

21 11. Lexapro is a selective serotonin reuptake inhibitor (SSRI) used to treat depression and
22 generalized anxiety disorder.

23 12. Prozac is an SSRI used to treat depression. Prozac carries an FDA Black Box
24 warning for increased risk of suicidal thoughts and behaviors in children, adolescents and young
25 adults taking antidepressants.

26 13. Zoloft is an SSRI used to treat various types of depression. Zoloft carries an FDA
27 warning for increased risk of suicidal thoughts and behaviors

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1 in pediatric and young adults taking antidepressants. FDA warnings and precautions also include
2 screening for bipolar disorder prior to starting Zoloft.

3 **FACTUAL ALLEGATIONS**

4 14. Aurora Vista Del Mar Hospital (AVDMH) is a healthcare organization located at 801
5 Seneca Street, Ventura, California 93001, that operates a federally funded program under 42
6 Code of Federal Regulations Part 2 that provides inpatient substance use disorder (SUD)
7 diagnosis, treatment, or referral.

8 15. From approximately April 2022 through August 2023, Respondent was a psychiatrist
9 at AVDMH.

10 16. The Board initiated an investigation into Respondent upon receipt of a complaint
11 from AVDMH on or about August 11, 2023, alleging that female adolescent patients had
12 complained of sexually inappropriate comments/conduct by Respondent.

13 17. In the course of its investigation, the Board investigator secured patient records from
14 AVDMH and interviewed Respondent on or about February 5, 2026.

15 **Patient 1**¹

16 18. Patient 1 was hospitalized at AVDMH on four separate occasions. The first
17 admission occurred from October 11, 2022, to October 19, 2022, the second from December 3,
18 2022, to December 8, 2022, the third from January 6, 2023, to January 11, 2023, and the fourth
19 from March 17, 2023, to April 12, 2023.

20 19. Patient 1's first admission, in October 2022, was for overdose of Lexapro.

21 20. Patient 1's second admission, from December 3, 2022, to December 8, 2022, was for
22 suicidal ideations with a plan to overdose after hearing about her father's substance abuse and/or
23 overdose. Patient 1 had just turned 14 years old.

24 21. According to a note of a psychiatric evaluation of Patient 1 on December 4, 2022,
25 Patient 1 had a history of substance abuse (the October 2022 admission) and cutting (with the last
26 time being a week ago), and a history of being sexually abused for over a year by a friend's father

27 ¹ To protect the privacy of the patients involved, the patients are referred to as Patient 1
28 through Patient 4, and their names are not included in this pleading. Respondent is aware of the
identity of the patients referred to herein.

1 who was subsequently jailed. Patient 1 was diagnosed with major depressive disorder by the
2 evaluating psychiatrist.

3 22. Patient 1 was seen by Respondent on December 5, 6, and 7, 2022. Respondent
4 ordered an increase in Seroquel dosage during this admission. On December 7, the note
5 described Patient 1 as presenting with swollen, red eyes. It was reported to Respondent that
6 Patient 1 had two crying episodes that day after finding out that her sexual perpetrator got
7 released on bail and had also been triggered during the group session by a peer sharing physical
8 abuse by a parent. The note states Patient 1 refused to talk further on these topics and remained
9 depressed, anxious, withdrawn and focused on her discharge. Patient 1 endorsed urges to cut.
10 She presented superficial, hyper, intrusive and unable to provide a safety plan. Respondent
11 recommended that Patient 1 continue medications and treatment, continue groups/therapy/milieu
12 activities, and continue discharge planning.

13 23. On or about December 7, 2022, Patient 1 submitted a complaint stating:

14 "Dr. M. He's always telling me how perfect my body is and that guys are
15 begging to take me out. I was talking to him about somebody I dated, and he
16 was talking abt [sic] me leaving and he said, 'how come he gets 2 years with
you, and I only get 1 day, am I not so special?'"

17 This complaint was forwarded to Human Resources on December 8, 2022.

18 24. On December 8, 2022, Respondent discharged Patient 1 from AVDMH. The
19 discharge summary states Patient 1 had a "meltdown" when she found out her perpetrator was
20 released from jail, but was not open to talking or elaborating on these issues. There is no
21 documentation that Respondent had a discussion with Patient 1's mother about keeping
22 Patient 1's and other family members' prescribed medications, as well as over-the-counter
23 medications, secured in a locked safety box and that Patient 1's parent should administer the
24 Seroquel.

25 25. On December 9, 2022, Respondent was interviewed by the Quality Improvement
26 Director at AVDMH regarding Patient 1's complaint from two days prior. Respondent denied all
27 allegations. Respondent was mandated to be retrained on sexual harassment.

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1 26. In an interview with the Board on or about February 5, 2026 (the subject interview),
2 Respondent stated that he refused to see Patient 1 further after learning of the complaint.

3 27. Patient 1's third admission was on January 6, 2023, for suicidal thoughts.
4 Respondent signed the "Disposition" section of the Intake Assessment and the Physician
5 Certification for Patient 1 on January 6, 2023. Respondent also signed several medication orders
6 for Patient 1 on January 6, 2023. Patient 1's chart contains no evaluation notes authored by
7 Respondent during the January admission. During this admission, AVDMH was contacted by
8 Patient 1's social worker, who provided information that Patient 1 (along with several other
9 victims) had been sex trafficked from school within the last year, that the perpetrator had been
10 investigated and attempted to flee but was "taken to jail[,] and that Patient 1 had been working
11 with the police ever since.

12 **Patient 2**

13 28. Patient 2, a 13-year-old female, was admitted to AVDMH from April 8, 2023, to
14 April 18, 2023, after being stabilized in the Emergency Room following an overdose of 20 Prozac
15 40 mg tablets. Patient 2 was noted to have visual and auditory hallucinations. Patient 2 was
16 previously hospitalized at AVDMH in July 2022.

17 29. Respondent conducted a psychiatric evaluation of Patient 2 on April 9, 2023, with
18 diagnoses of major depressive disorder and post-traumatic stress disorder. Respondent
19 documented Patient 2's history of sexual abuse: at 8 years old by a landlord, and in February
20 2022 by her therapist. Respondent's plan included continuing Patient 2 on Prozac 20 mg, as well
21 as Neurontin 100 mg and Abilify 10 mg.

22 30. After the evaluation with Respondent on April 9, 2023, Patient 2 submitted a
23 complaint to AVDMH stating:

24 "Everything was fine until he looked down at my shirt, directly at my boobs.
25 After that, I got super uncomfortable. Not only that but he made me feel bad
 about everything that's happened to me."

26 Patient 2 requested a change in psychiatrist, failing which, a female attendant at her
27 examinations with Respondent.

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1 31. On April 10, 2023, a consultation request form sent by a nurse to Respondent stated,
2 "Pt [2] was very upset after speaking with [Respondent] & is requesting to be assigned to another
3 doctor. If Pt [2] cannot be switched to another doctor, she wants a female staff member with her
4 when she sees the doctor."

5 32. Patient 2 was evaluated by Respondent on April 10, 11, 12, 13, 14, and 17, 2023. A
6 female staff nurse is noted to have been present in the examinations from April 11, 2023,
7 onwards. Respondent's notes do not document any discussion of the reason for Patient 2 being
8 "very upset" and/or requesting to switch doctors or have a female chaperone present.

9 33. Patient 2's discharge had initially been planned for Saturday, April 15, 2023, but was
10 delayed by Patient 2's report of an episode over the weekend, with urges to cut. On April 18,
11 2023, Respondent discharged Patient 2 with medication orders that included Prozac 20 mg,
12 Prozac 10 mg, Neurontin 100 mg, and Abilify 10 mg.

13 34. There is no documentation in Patient 2's chart that Respondent had a discussion with
14 her mother about keeping Patient 2's and other family members' prescribed medications
15 (including Prozac), as well as over-the-counter medications, secured in a locked safety box and
16 that Patient 2's parent should administer the medication.

17 **Patient 3**

18 35. Patient 3, a 17-year-old female, was brought to AVDMH on a '5585 hold'² as a
19 danger to herself and was admitted from August 8, 2023, to August 17, 2023. Patient 3 had a
20 history of two prior psychiatric hospitalizations and depression for the past five years.

21 36. Respondent performed Patient 3's initial psychiatric evaluation on August 9, 2023.
22 During the evaluation, Patient 3 stated she had told her mother that she was planning to run away
23 and, because of her past history, her mother interpreted the statement as being suicidal.
24 Separately, Patient 3's mother reported that, while visiting her father the weekend before,
25 Patient 3 had snuck an adult male into her father's house for sex and had then been placed in a
26 temporary shelter because she did not want to return home to her mother; Patient 3 had then run

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28 ² California's Welfare and Institutions Code section 5585 authorizes the 72-hour
involuntary detention and psychiatric evaluation of minors experiencing mental health crises.

1 away from the shelter twice. The adult male had reportedly admitted to having sex with Patient 3,
2 and her mother was planning to report him to the authorities. Patient 3 had previously been
3 sexually abused by an abuser who was now in prison.

4 37. According to Respondent's note on his August 9, 2023 psychiatric evaluation of
5 Patient 3, she had completed a mood questionnaire which screened positive for bipolar spectrum
6 disorder. Per Respondent, Patient 3's clinical history, family history, and recent manic behaviors
7 of being promiscuous while on the run, were consistent with Bipolar II disorder, and her mania
8 was likely fueled by her high dose Zoloft at 200mg/day. Respondent diagnosed Bipolar II
9 Disorder along with disruptive mood dysregulation disorder, cannabis abuse, and alcohol abuse.
10 Respondent discussed with Patient 3's mother his plan to decrease Zoloft to 50mg and start
11 Patient 3 on a titration of Seroquel with a 100 mg first dose.

12 38. Patient 3's chart contains two progress notes documenting separate assessments, both
13 reportedly performed by Respondent on August 10, 2023, at 18:00. The first note was signed by
14 Respondent on August 11, 2023 at 10:53, while the second note was signed by Respondent on
15 August 12, 2023 at 08:49.³

16 39. There are no documents in Patient 3's chart showing any lab studies, including tests
17 for pregnancy, were ordered, performed or reviewed.

18 40. On August 11, 2023, Patient 3 submitted a complaint to AVDMH, stating:

19 "Wednesday [August 9, 2023] when I met with Dr. Masoon[sic], he told me
20 that I shouldn't be single because I'm pretty and should settle down with a
21 guy that likes crazy girls like me. And on Thursday he said that my
22 superpower is being really good at sex because I'm bipolar and that all the
23 guys will want me because I'm good at sex and hyper sexual."

24 41. Patient 3 was interviewed by AVDMH staff on August 14, 2023, regarding her
25 complaint. During the interview, Patient 3 added that Respondent described her scars as looking
26 like hieroglyphics. She asked to be assigned to a different psychiatrist. Respondent did not treat
27 Patient 3 again after August 11, 2023.

28 ³ Respondent stated in his subject interview that the note dated August 10, 2023, and
signed on August 12, 2023, at 8:49 is for the evaluation performed on August 11, 2023, and was
incorrectly dated.

Patient 4

42. Patient 4, a 16-year-old female, was admitted to AVDMH from May 25, 2023, to June 2, 2023, after she had overdosed on her medication, Risperdal. Patient 4 relayed arguing with her mother about her phone and her girlfriend, leading to the overdose. Based on her initial psychiatric evaluation, Patient 4 was diagnosed with Disruptive Mood Dysregulation Disorder, Major Depressive Disorder, Anxiety Disorder, unspecified, and Cannabis Use Disorder. With her mother's consent, Patient 4 was started on Prozac and Seroquel.

43. Respondent first examined Patient 4 on May 30, 2023, and performed psychiatric evaluations of Patient 4 on May 31, 2023, and June 1, 2023, before discharging her on June 2, 2023. On May 30, 2023, Respondent described Patient 4 as having "ongoing depressed mood, apathy, mood swings, irritability, and thoughts of suicide." Respondent noted Patient 4 was tolerating the medications with no side effects but with poor efficacy, and Seroquel was increased to 150 mg. Respondent's treatment recommendations included ongoing hospitalization due to depressed mood and suicidal ideations, continuing groups/therapy/milieu activities, and discharge planning.

44. On May 31, 2023, Respondent's notes documented Patient 4 reporting that she felt unloved by her family, that she came out to her mother a year ago and had grown distant from her since, and that her mother was against her worshipping the dead spirit god who communicated with Patient 4 in the past, in sixth grade. Respondent's treatment recommendations included ongoing hospitalization due to depressed mood and suicidal ideations, and continued groups/therapy/milieu activities. He noted the increase in Seroquel to 150 mg, and to increase Prozac 20 mg titrating to steady state.

45. On May 31, 2023, Patient 4 submitted a complaint to AVDMH, stating:

"Dr. Masson was making me explain my story n he was blaming it on my sexuality n i didn't know what to do so i just sat there in silence n he said what if I actually was straight n not gay."

A staff member met and discussed the complaint with Patient 4 on June 1, 2023, and agreed to speak with a nurse about changing psychiatrists but also recommended that Patient 4 advocate for herself.

1 46. On June 1, 2023, Patient 4 was noted with ongoing sadness and was withdrawn.
2 Respondent recommended that Patient 4 attend outpatient group and family therapy. There are no
3 further notes in Patient 4's chart relating to her statement about the dead spirit god.

4 47. Respondent discharged Patient 4 on June 2, 2023. The discharge summary was
5 written and signed by Respondent on August 17, 2023 at 20:38 hours. After the May 31, 2023,
6 note, there was no documentation in Respondent's progress notes or discharge summary
7 regarding the dead spirit. Patient 4's diagnosis of Major Depressive Disorder, that was listed on
8 each of Respondent's prior evaluations of Patient 4, was not listed in his discharge summary.

9 48. There are no documents in Patient 4's chart showing any lab studies, including tests
10 for pregnancy, were ordered, performed, or reviewed.

11 49. There is no documentation that Respondent had a discussion with Patient 4's mother
12 about keeping Patient 4's and other family members' prescribed medications (including the
13 Prozac and Seroquel), as well as over-the-counter medications, secured in a locked safety box.

14 **FIRST CAUSE FOR DISCIPLINE**

15 **(Gross Negligence)**

16 50. Respondent Sanjay Masson, M.D. is subject to disciplinary action under Code section
17 2234, subdivision (b), in that Respondent committed acts of gross negligence in his care and
18 treatment of Patient 1, Patient 2, Patient 3, and Patient 4. The circumstances are as follows:

19 51. The facts and allegations set forth in paragraphs 14 through 49 are incorporated
20 herein by reference as though fully set forth.

21 **Patient 1 – Sexual Comments to an Adolescent Patient**

22 52. It is below the standard of care, unethical, and unprofessional to make sexual
23 comments to a patient who is under a physician's care.

24 53. Inappropriate sexual comments about an adolescent female patient's body by a
25 treating psychiatrist can be frightening and retraumatizing.

26 54. Patient 1 was the victim of sexual abuse and, at the time of being under Respondent's
27 care, a patient in an inpatient psychiatric unit.

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1 55. Respondent committed gross negligence when he, as her treating psychiatrist, told
2 Patient 1 “how perfect [her] body is and that guys are begging to take [her] out” and “how come
3 ... I only get 1 day” and/or similar comments while Patient 1 was under his care.

4 **Patient 1 – Premature Discharge**

5 56. For a patient who is admitted for psychiatric symptoms, including suicidal ideations,
6 the standard of care requires that the patient not be discharged while the patient is emotionally
7 distressed.

8 57. Respondent’s notes on December 7, 2022, state that Patient 1 had found out that her
9 sexual perpetrator had been released from jail and had had multiple crying episodes (described as
10 a “meltdown” in the discharge summary), refused to talk, and remained depressed, anxious,
11 withdrawn, and endorsed urges to cut. The following day, on December 8, 2022, Respondent
12 discharged Patient 1.

13 58. Respondent committed gross negligence when he discharged an emotionally
14 distressed psychiatric patient, who presented an elevated suicide risk, without providing time for
15 emotional support and/or monitoring her response to that support prior to discharging the patient.

16 **Patient 1 – Failure to Discuss Safety Plans Prior to Discharge**

17 59. It is the standard of care for the prescribing psychiatrist to discuss with the parent of
18 an adolescent patient a safety plan about how to secure medications and safely administer
19 medications to the adolescent upon discharge.

20 60. There is no documentation that Respondent held a deliberate discussion with
21 Patient 1’s parent about keeping the antipsychotic medication, Seroquel, and other family
22 members’ prescribed medications, as well as over-the-counter medications, secured in a locked
23 safety box after discharge, with the parent administering the Seroquel to Patient 1. This was
24 particularly relevant for Patient 1’s safety since she had previously overdosed on medications that
25 were kept in the medicine cabinet.

26 61. Respondent was grossly negligent when he discharged Patient 1, who had a known
27 history of overdose and suicidal attempts on prescription medications, with prescription

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1 antipsychotic medications without discussing maintaining these and other medications in a secure
2 locked box and/or having the antipsychotic medication Seroquel administered by the parent.

3 **Patient 2 – Sexually Inappropriate Behavior Toward a Patient**

4 62. It is unethical, unprofessional, and below the standard of care for a physician to look
5 at a female patient's breasts when not performing a medical physical examination.

6 63. Patient 2, a victim of sexual abuse and, at the time, a patient in an inpatient
7 psychiatric unit, complained that Respondent had looked at her breasts while evaluating her.
8 There is no documentation in Patient 2's chart that Respondent discussed with Patient 2 her
9 complaint about him or why she was upset and had requested a chaperone.

10 64. Respondent was grossly negligent when Respondent looked at Patient 2's breasts
11 and/or failed to address Patient 2's complaints against him after finding out that Patient 2 was
12 upset and had requested another physician or a female chaperone.

13 **Patient 3 – Sexual Comments to an Adolescent Patient**

14 65. It is unethical, unprofessional, and below the standard of care for a physician to make
15 sexual comments to a patient who is under his care.

16 66. Patient 3 was the victim of sexual abuse and had just engaged in sneaking a young
17 man into her father's house to have sex with him against her father's permission, and her mother
18 was filing charges against the young man. In this context, Patient 3 was admitted to the inpatient
19 unit for suicidality. Respondent's comments to Patient 3 caused her to file a complaint during a
20 time when she was already emotionally distressed and upset. Patient 3 did not experience
21 Respondent's comments as therapeutic intervention. Instead, the statements were contraindicated
22 and disruptive to her care, created barriers to the doctor-patient relationship, and destroyed trust.
23 Patient 3 was likely retraumatized by Respondent's comments, placing her at a higher risk of
24 suicidality, mistrust of future doctors, and rehospitalization.

25 67. Respondent committed gross negligence when he made sexual comments to Patient 3
26 who was under his care.

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1 **Patient 4 – Sexual Comments to an Adolescent Patient**

2 68. It is unethical, unprofessional, and below the standard of care for a physician to make
3 sexual comments to a patient under his care, blaming the patient's sexual orientation for causing
4 her mental illness.

5 69. Scientific evidence does not support the conclusion that an adolescent's mental health
6 illness is due to their sexual orientation. Communicating to a patient that their sexual orientation
7 is causing their mental health symptomatology, is incorrect and hurtful.

8 70. Patient 4 did not experience Respondent's sexual comment as an empathetic
9 therapeutic intervention, and the statement likely was traumatizing to Patient 4.

10 71. Respondent was grossly negligent when he made sexually inappropriate comments to
11 Patient 4.

12 **Patient 4 – Failure to Address Concerns Raised by Parent**

13 72. When a parent raises a concern regarding their hospitalized adolescent child to the
14 attention of the physician, it is the standard of care to address it clinically and communicate to the
15 parent how it is being addressed.

16 73. Patient 4's mother's concern over the patient worshipping a dead spirit god was not
17 addressed by Respondent diagnostically, pharmacologically, or therapeutically, with Patient 4 or
18 with Patient 4's mother. That Patient 4's talking to a dead spirit was not documented by
19 Respondent as being addressed with Patient 4 or her mother, indicates that it was not of clinical
20 concern to Respondent.

21 74. Respondent's failure to address Patient 4's statement relating to worshipping a dead
22 spirit god constitutes gross negligence in his care and treatment of Patient 4.

23 **Patient 4 – Failure to Discuss Safety Plans at Discharge**

24 75. It is the standard of care for the prescribing psychiatrist to discuss with the parent of
25 an adolescent patient a safety plan about how to secure medications and safely administer
26 medications to the adolescent upon discharge.

27 76. There is no documentation that Respondent held a deliberate discussion with
28 Patient 4's parent about keeping the psychotropic medications, Seroquel and Prozac, and any

1 other prescribed medications secured in a locked safety box after discharge, and having the parent
2 administer the Seroquel and Prozac to Patient 4. This was particularly relevant for Patient 4's
3 safety since she had previously overdosed on psychotropic medications.

4 77. Respondent was grossly negligent when he discharged Patient 4, who had a known
5 history of overdose and suicidal attempts on prescription medications, with prescription
6 psychotropic medications without discussing maintaining these and other medications in a secure
7 locked box and having the psychotropic medications administered by Patient 4's parent.

8 **SECOND CAUSE FOR DISCIPLINE**

9 **(Repeated Negligent Acts)**

10 78. Respondent Sanjay Masson, M.D. is further subject to disciplinary action under Code
11 sections 2234, subdivision (c), and 2266, in that Respondent committed repeated negligent acts in
12 his care and treatment of Patient 1, Patient 2, Patient 3, and Patient 4. The circumstances are as
13 follows:

14 79. The facts and allegations set forth in paragraphs 14 through 49 and in the First Cause
15 for Discipline are incorporated herein by reference as if fully set forth.

16 80. Each of the alleged acts of gross negligence set forth in the First Cause for Discipline
17 is also a negligent act.

18 81. The following acts and/or omissions in Respondent's care and treatment of Patient 1,
19 Patient 2, Patient 3, and Patient 4 further constitute negligent acts.

20 **Patient 1 – Signing Orders Without Seeing Patient**

21 82. The standard of care in an inpatient hospital setting requires the physician to see and
22 assess the patient, document the information in the patient's chart, and write orders for the
23 patient's care, including medication prescriptions and levels of risk monitoring, among others.

24 83. During Patient 1's third admission, from January 6, 2023, to January 11, 2023 (third
25 admission), Patient 1 was assigned to a different psychiatrist and Respondent did not see
26 Patient 1. However, Respondent signed electronic orders regarding Patient 1 despite not having
27 seen her for evaluation and not being her treating psychiatrist.

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1 84. Respondent committed negligence when he signed orders for Patient 1 without
2 having seen or assessed the patient during the third admission.

3 **Patient 2 – Failure to Discuss Safety Plans at Discharge in Prescribing Prozac After**
4 **Overdose on Prozac**

5 85. It is the standard of care for the prescribing psychiatrist to discuss with the parent of
6 an adolescent patient a safety plan about how to secure medications, including medications on
7 which the patient had previously overdosed, and safely administer medications to the adolescent
8 upon discharge.

9 86. For Patient 2, who had been admitted after overdosing on 20 Prozac tablets, there is
10 no documentation that Respondent had a deliberate discussion with Patient 2's parent about
11 keeping the Prozac and other prescribed medications secured in a locked safety box and having
12 the parent administer the medication to Patient 2 after discharge. This was particularly relevant
13 for Patient 2's safety since she had previously overdosed on Prozac.

14 87. Respondent committed negligence/repeated negligent acts when he discharged
15 Patient 2, who has a known history of overdose and suicidal attempts on Prozac, with a
16 prescription for Prozac without discussing maintaining these and other medications in a secure
17 locked box and/or having the medications administered by the parent.

18 **Patient 3 – Diagnostic and Treatment Concerns**

19 88. The standard of care provides that a patient cannot be diagnosed with Disruptive
20 Mood Dysregulation Disorder (DMDD) and Bipolar Disorder at the same time.

21 89. Both DMDD and Bipolar Disorder diagnoses require careful consideration, due to the
22 necessary criteria and exclusionary criteria of each. Since the two disorders also require very
23 different treatment, a misdiagnosis can, and often does, lead to mismanagement and exposure to
24 multiple unnecessary medication trials.

25 90. Patient 3 was already on antidepressant Zoloft 200 mg, which is known to cause
26 hypomanic and manic symptoms in patients with Bipolar Disorder. Because Respondent
27 diagnosed Patient 3 with both DMDD and Bipolar Disorder, he significantly reduced the dosage
28 of an antidepressant which may have been effectively treating her other symptoms, and

1 introduced an antipsychotic, Seroquel, which may not have been necessary but for the incorrect
2 diagnosis of Bipolar Disorder.

3 91. Respondent committed negligence/repeated negligent acts when Respondent
4 diagnosed Patient 3 with Disruptive Mood Dysregulation Disorder and Bipolar Disorder at the
5 same time.

6 **Patient 3 – Failure to Perform Pregnancy Test and Routine Labs**

7 92. It is the standard of care to perform a pregnancy test on sexually active female
8 patients. It is also the standard of care to perform baseline lab work, including a complete blood
9 count, thyroid function test, and complete metabolic panel with hemoglobin A1c, on patients
10 when prescribing new medication.

11 93. There is no record in Patient 3's chart that a pregnancy test or routine lab work had
12 been ordered, performed or reviewed by Respondent prior to prescribing psychotropic
13 medications to Patient 3.

14 94. Respondent committed negligence/repeated negligent acts when he failed to order,
15 perform or review a pregnancy test or routine lab work while Patient 3 was admitted at AVDMH
16 and before Respondent prescribed Patient 3 new medications, such as the antipsychotic
17 medication Seroquel.

18 **Patient 4 – Delayed Discharge Summary**

19 95. It is the standard of care to complete and sign discharge summaries timely.

20 96. Respondent discharged Patient 4 on June 2, 2023, but the discharge summary was not
21 signed until August 17, 2023.

22 97. Respondent committed negligence/repeated negligent acts when he failed to complete
23 and sign Patient 4's discharge summary for more than 60 days after discharging the patient.

24 **Patient 4 – Failure to Perform Pregnancy Test and Routine Labs**

25 98. It is the standard of care to perform a pregnancy test on sexually active female
26 patients. It is also the standard of care to perform baseline lab work, including a complete blood
27 count, thyroid function test, and complete metabolic panel with hemoglobin A1c, on patients
28 when prescribing new medication.

99. There is no record in Patient 4's chart that a pregnancy test or routine lab work had been ordered, performed or reviewed by Respondent prior to prescribing or continuing to prescribe psychotropic medications to Patient 4.

100. Respondent committed negligence/repeated negligent acts when he failed to order, perform or review a pregnancy test or routine lab work when he was providing care and treatment to Patient 4 during her hospital admission and when Respondent prescribed and/or continued prescription medications such as the antipsychotic medication Seroquel.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

101. Respondent Sanjay Masson, M.D. is further subject to disciplinary action under Code section 2266, in that Respondent failed to maintain adequate and accurate records in his care and treatment of Patient 4, as more particularly described hereunder.

102. The facts and allegations set forth in paragraphs 42 through 49, and in paragraphs 95 through 97 of the Second Cause for Discipline, above, are incorporated herein by reference as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Sexually Inappropriate Comments and/or Behavior to Patients)

103. Respondent Sanjay Masson, M.D. is further subject to disciplinary action under Code section 2234, subdivision (e), in that Respondent committed unprofessional conduct when he made sexually inappropriate comments and/or exhibited sexually inappropriate behavior to Patient 1, Patient 2, Patient 3, and/or Patient 4. The circumstances are as follows:

104. The facts and allegations set forth in paragraphs 14 through 49, and in paragraphs 52 through 55 and 62 through 71 in the First Cause for Discipline, are incorporated herein by reference as if fully set forth.

DISCIPLINARY CONSIDERATIONS

105. To determine the degree of discipline, if any, to be imposed on Respondent Sanjay Masson, M.D., Complainant alleges that on or about January 12, 2023, in a prior criminal proceeding titled *The People of the State of California v. Sanjay Masson* in Ventura County

1 Superior Court, Case Number 2020021659, Respondent was convicted of violating Penal Code
2 section 550(b)(1) – insurance fraud, a misdemeanor, and was placed on probation. The record of
3 the criminal proceeding is incorporated by reference as if fully set forth herein.

4 106. On May 24, 2024, in Medical Board of California Case Number 800-2023-096411,
5 Respondent was issued a Public Letter of Reprimand and was required to complete a
6 Professionalism Program (Ethics Course) for the criminal conviction in violation of Penal Code
7 section 550(b)(1) – insurance fraud. That action is now final and is incorporated by reference as
8 if fully set forth herein.

9 **PRAYER**

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

- 12 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 90258,
13 issued to Respondent Sanjay Masson, M.D.;
- 14 2. Revoking, suspending or denying approval of Respondent Sanjay Masson, M.D.'s
15 authority to supervise physician assistants and advanced practice nurses;
- 16 3. Ordering Respondent Sanjay Masson, M.D., to pay the Board the costs of the
17 investigation and enforcement of this case, and if placed on probation, the costs of probation
18 monitoring; and.
- 19 4. Taking such other and further action as deemed necessary and proper.

20
21 DATED: 09/16/2026

Reji Varghese

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

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