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

In the Matter of the Accusation Against: **KYLE PATRICK SMITH, M.D.** **4620 Hollywood Blvd** **Los Angeles, CA 90027-5408** **Physician's and Surgeon's Certificate No. A 144448,** Respondent.	Case No. 800-2024-106655 OAH No. **ACCUSATION**

PARTIES

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

2. On or about August 12, 2016, the Board issued Physician's and Surgeon's Certificate Number A 144448 to Kyle Patrick Smith, 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 July 31, 2026, unless renewed.

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 2004 of the Code states:

The board shall have the responsibility for the following:

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

(b) The administration and hearing of disciplinary actions.

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

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

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

(f) Approving undergraduate and graduate medical education programs.

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

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

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

5. Section 2220 of the Code states:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold 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:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a 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.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the 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.

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

6. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

STATUTORY PROVISIONS

7. 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.

....

8. 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

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to 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, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DRUG DEFINITIONS

10. As used herein, the terms below will have the following meanings:

"Adderall," is a brand name for a combination medication which contains a mixture of amphetamine and amphetamine salts. It is a central nervous system (CNS) stimulant of the amphetamine class. When properly prescribed and indicated, it is used for attention-deficit hyperactivity disorder and narcolepsy. Adderall has a black box warning about its high potential for abuse and misuse, which can lead to the development of a substance use disorder, including addiction. Misuse and abuse of CNS stimulants, including Adderall, can result in overdose and death, and this risk is increased with higher doses or unapproved methods of administration, such as snorting or injection. Adderall is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug as defined in Code section 4022.

"Clonidine," is a medication used to treat high blood pressure, attention deficit hyperactivity disorder, drug withdrawal (alcohol, opioids, or smoking), menopausal flushing, diarrhea, spasticity and certain pain conditions. Clonidine lowers blood pressure by decreasing the levels of certain chemicals in the blood. This allows the blood vessels to relax and the heart to beat more slowly and easily, which lowers blood pressure. It is a dangerous drug as defined in Code section 4022.

"Desvenlafaxine," is a medication used to treat depression. It is sold under the brand names Pristiq and Khedexla. It is a type of antidepressant known as a serotonin and norepinephrine reuptake inhibitor (see SNRI below). It is a dangerous drug as defined in Code section 4022.

"Escitalopram," is a medication used to treat major depressive disorder or generalized anxiety disorder. It is a type of antidepressant known as a selective serotonin reuptake inhibitor (see SSRI below). Escitalopram is sold under the brand names Cipralex and Lexapro, among others. It is a dangerous drug as defined in Code section 4022.

"Lamotrigine," is an anticonvulsant medication used to treat seizures and bipolar disorder. It is sold under various brand names, including Lamictal XR, Lamictal ODT, and Lamictal Starter (Orange) Kit. It is dangerous drug as defined in Code section 4022.

"Propranolol," is a medication used to treat high blood pressure, chest pain (angina), and uneven heartbeat (atrial fibrillation). It can also treat tremors and proliferating infantile hemangioma. In addition, it can also be used to prevent migraine headaches. It belongs to a class of drugs known as beta blockers (which are medications that reduce your blood pressure and work by blocking the effects of the hormone epinephrine, also known as adrenaline; beta blockers cause the heart to beat more slowly and with less force, which lowers blood pressure). It is sold under the brand names Inderal LA, Hemangeol and InnoPran XL. It is a dangerous drug pursuant to Code section 4022.

"Sertraline," is an SSRI antidepressant medication used to treat depression, obsessive-compulsive disorder, panic disorder, posttraumatic stress disorder, social anxiety disorder and premenstrual dysphoric disorder. It is sold under the brand name Zoloft, among others. It is a dangerous drug pursuant to Code section 4022.

"SNRI" means selective serotonin and norepinephrine reuptake inhibitor, which is a class of medication used to treat depression. SNRIs are also sometimes used to treat other conditions, such as anxiety disorders and long-term (chronic) pain, especially nerve pain. SNRIs work by ultimately effecting changes in brain chemistry and communication in brain nerve cell circuitry known to regulate mood, to help relieve depression. SNRIs block the reabsorption (reuptake) of the neurotransmitters serotonin and norepinephrine in the brain.

"SSRI" means selective serotonin reuptake inhibitor, which is a class of medication used to treat depression and anxiety. SSRIs block the reabsorption (reuptake) of the neurotransmitter serotonin in the brain. SSRIs can be associated with discontinuation syndrome. Withdrawal can be uncomfortable and distressing.

"Venlafaxine," is a medication used to treat major depressive disorder, anxiety and panic disorder. It is an antidepressant belonging to a group of drugs called SNRIs. Venlafaxine affects chemicals in the brain that may be unbalanced in people with depression. It is sold under various brand names, including Effexor XR®. It is a dangerous drug pursuant to Code section 4022.

"Vyvanse," brand name for lisdexamfetamine, is a central nervous system stimulant of the amphetamine class. It is used to treat attention-deficit hyperactivity disorder and binge eating disorder. Vyvanse has a black box warning which states, "Vyvanse has a high potential for abuse and misuse, which can lead to the development of a substance use disorder, including addiction. Misuse and abuse of CNS stimulants, including Vyvanse, can result in overdose and death." Vyvanse is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Code section 4022.

FACTUAL ALLEGATIONS

11. At all relevant times herein, Respondent practiced psychiatry in Los Angeles, California, treating adult patients on an outpatient basis, as an independent medical practitioner.

Patient 1[1]

12. On or about April 7, 2022, Patient 1, a 43-year-old male, who was employed as a television writer and producer, first presented to Respondent for care and treatment via videoconference. Patient 1's wife, Patient 2, participated in the visit. At that time, Patient 1 and Patient 2 resided together in Los Angeles, California. According to Respondent's "Intake

[1] The patients in this Accusation are identified by number (e.g., Patient 1) to address privacy concerns. The patients' identities are known to Respondent or will be disclosed to Respondent upon a duly issued request for discovery and in accordance with Government Code section 11507.6.

Encounter Note" for that visit, Patient 1's chief complaint was "anxiety and depression." Respondent documented that Patient 2 was concerned about Patient 1's anger. Respondent documented that Patient 1 believed that his strong emotions resulted from environmental stressors, including family issues, and wrote, "[Patient 1] says his mother has a personality disorder and his brother has autism which requires significant attention." Respondent further documented that Patient 2 reported that Patient 1 was "obsessively worried about family." The Intake Encounter Note for that visit also noted that Respondent diagnosed Patient 1 with anxiety, depression and Attention Deficit Hyperactivity Disorder (ADHD), which Patient 1 reported to Respondent that he had being diagnosed with as a child. Respondent did not obtain any target symptoms of ADHD or otherwise evaluate Patient 1 for ADHD before rendering the diagnosis. Respondent also did not document requesting or reviewing Patient 1's prior medical records. In Patient 1's family history, Respondent noted, "[b]rother has depression, autism, behavioral issues; takes cariprazine. Mother may have personality pathology per patient report." Respondent also documented his Mental Status Exam (MSE) of Patient 1 and prescribed Patient 1 escitalopram (Lexapro) for "mood and anxiety" and Adderall, as needed, for ADHD.

13. After that first patient encounter, Respondent had five (5) more virtual patient visits with Patient 1 before May 12, 2023, when Patient 1 presented to Respondent for care in person. During this time period, Respondent continued Patient 1's prescriptions and made dosage adjustments based on Patient 1's reporting of his symptoms and functioning to Respondent.

14. Respondent did not document conducting any follow up MSEs for Patient 1 after the initial exam on April 7, 2022.

15. During the course of Respondent's care and treatment of Patient 1, Respondent and Patient 1 communicated extensively over text messages regarding scheduling appointments, billing, prescription medication refills and management, and Patient 1's relationships with his family members and their respective mental health issues. The text messages exchanged between Respondent and Patient 1 comprise over half of Patient 1's medical record as maintained by Respondent.

16. On or about each of the following dates, Respondent and Patient 1 had the following

text message exchanges on their cellular phones:

a. June 30, 2022:

i. Patient 1: "Would you be willing to take on my wife [Patient 2] as a client?"

ii. Respondent: "Of course! I would be happy to."[2],

b. August 7, 2023:

i. Patient 1: "would it be alright if I forwarded you the assessment / denial letter my brother [Patient 3] received re: ADHD? Just so you can see if it makes him a candidate."

ii. Respondent: "Ok sure."

c. August 22, 2023:

i. Respondent: "Can your brother do 9/19 at 1:30pm or 9/21 at 4pm? I can't see your Mom until October due to administrative reasons that are too boring to explain (even though I don't take Medicare, I can't see Medicare patients until after 10/1)."

d. August 28, 2023:

i Respondent: "Ok reserved. What's [Patient 3's] DOB, phone number, and email? I will send him admin documents. Am I billing you for this?"

ii. Patient 1: " – is it easier if you bill me? Does it affect his medical records, etc?"

iii. Respondent: "Who pays does not matter but I bet it will be easier to bill you."

iv. Patient 1: "No problem."

e. August 30, 2023:

i. Respondent: "Hi [Patient 1], I sent a deposit request for [Patient 3's] appointment. Have your mother [Patient 4] contact me about scheduling for October. I have good availability now but they go fast!"

f. September 28, 2023:

i. Patient 1: "I'm sorry for [Patient 3's] actions and attitude. It's a problem we're

[2] On or about July 19, 2022, Respondent began caring for Patient 2 and continued to treat Patient 2 thereafter, including by prescribing medication to her, until December 2023.

constantly battling,"

ii. Respondent: "Thanks, [Patient 1]. Sounds like a mix of autism and me sending out two different times. All in a day's work."

iii. Patient 1: "Would you like me to be in the session?"

iv. Respondent: "Yes it may be helpful for you to be here and/or on standby. I don't know if [Patient 3] wants you in the session, but it would be helpful to have you here in case I need to ask you a quick question from the waiting room."

g. September 29, 2023:

i. Patient 1: "Thank you again for yesterday. Very hopeful for [Patient 3] and he really liked you."

h. October 19, 2023:

i. Respondent: "Hey looking for extra info: [Patient 4] said she got testing a few years ago bc there was concern for her memory. What did you see back then?"

ii Patient 1: "[t]he specialist said that she was one of the smartest people she'd ever tested and that her intelligence and memory was off the charts."

iii. Respondent: "So why did [Patient 4] get testing?"

iv. Patient 1: "We started to wonder if all of her reckless behavior was due to mental decline resulting from her age, and if it was, we'd take appropriate steps to know what we were dealing with…"

v. Respondent: "What kind of reckless behavior?"

vi. [Patient 1 then proceeded to describe several examples of Patient 4's dysfunctional behavior, including irresponsible spending, allowing her home to fall into disrepair and other unreasoned or impulsive behavior.] Patient 1 concluded his response by stating, "But to be honest, after a lot of reflection and realization – it's always been like this. It's just gotten exponentially worse, and it's harder for her to hide now that there's nobody she can shift the blame to. Hard to get a full picture as a kid." Patient 1 then described how her behavior negatively impacts his work, finances and marriage, stating, "it was so bad that it led to the beginning of me seeing

you and getting on medication."

vii. Respondent: "This is helpful. Thank you. Follow-ups: When did your father first get ill? When did he move to assisted living and when did he pass?"

viii. Patient 1 [responded with an explanation of his father's demise due to mental decline and his perception of Patient 4's reaction].

i. October 21, 2023:

i. Respondent: "Gonna spitball some thoughts. You'll notice that I'm not revealing any private health information here – just soliciting family observations."

ii. Respondent[3]: "Your description of her reckless behavior reads like classic ADHD. But also, it must have been devastating to her to lose her husband; then move to LA where she has no life. Irrespective of personality issues, I wonder if she developed worsening anxiety and mood disorders over the last 5-10 years that contributed to worsening everything else (ADHD, theoretical personality disorder)."

iii. Patient 1[4]: "We are also now in control of her money. . . . [Patient 2] overheard [Patient 4] tell [Patient 3] when we were butting heads: 'What do I tell you [Patient 3]? Just ignore [Patient 1], don't' react, and eventually [Patient 1] will forget about it.' That was also eye opening, as it explained [Patient 4's] actions and not-fulfilled promises that have been going on for 10+ years."

j. October 23, 2023:

i. Respondent: "Ok thank you for this info. What exactly do you mean that you are in charge of [Patient 4's] money? Is there a power of attorney? Other sort of legal arrangement?"

ii. Patient 1: "She was spending an average of 8k per month when she moved back to LA. My financial advisors suggested we manage her money. She agreed to have them manage it and set a budget."

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[3] Instead of soliciting any observations from Patient 1, Respondent launched into a discussion of his assessment of Patient 4.

[4] Patient 1 told Respondent about the details of his problems with Patient 4 and money and her house.

17. On or about November 20, 2023, Patient 1 had his final visit with Respondent. Respondent documented that Patient 1 reported "compulsive futzing around all night; used to be very regimented before strike; all messed up last three weeks" and Respondent started him on clonidine 0.1 mg/ER 0.1 mg for insomnia in ADHD.

18. On or about December 5, 2023, at 6:19 AM, Respondent texted Patient 1: "I have two outstanding Venmo charges for you for last month. Please remit these ASAP. I have a waiting list 8 weeks long of patients who are dying to pay me on time."

19. Later that day at 12:50 PM, Patient 1 texted Respondent back: "That last sentence is wildly unprofessional. It's not okay." Patient 1 then proceeded to explain that he had now made the requested payments.

20. That evening Respondent called Patient 1, but Patient 1 did not answer Respondent's telephone call.

21. On or about September 16, 2024, Respondent was interviewed by Board investigators regarding his care and treatment of Patient 1 and Patient 2 ("Board Interview"). During the Board Interview, Respondent stated that he intended his text requesting payment from Patient 1 to "come across [as a joke]...[b]ecause we had a fun – we had a friendly relationship... Like he didn't seem like a – out of the ordinary text if you have a friendly relationship with somebody." Also, Patient 1 was a "rich" man. Respondent further stated that he called Patient 1 that evening to try to ameliorate the situation and left a "sing songy" voice message in which he said, "[H]ey[,] [Patient 1,] I – I know there was thingy over the text, I just wanted to call and smooth things over blah, blah, blah."

22. A week later, on or about December 13, 2023, Respondent and Patient 1 engaged in the following text message exchange:

a. Respondent: "I called you to discuss your text and I have not heard back from you. We need to move your appointment to this week so was can speak about it. Can you meet at 6pm today?"

b. Patient 1[5]: "Is there an issue that can't be resolved via text?"

c. Respondent: "I am concerned that our last medication change may be causing side effects that you are not aware of. I have known you for almost three years and you have seemed different than the person I have known previously. It is my responsibility to follow-up on this when I am prescribing mood-altering medications."

d. Patient 1: "This feels like gaslighting. You're invalidating my reaction to your initial text."

23. After that text exchange on or about December 13, 2023, Respondent attempted to call Patient 1 again. Patient 1 did not answer any calls from Respondent. Thereafter, Respondent and Patient 1 engaged in the following text message exchange:

a. Patient 1: "I'm safe. I'm fine. I can't talk right now. Thanks for understanding."

b. Respondent: "I am your doctor and I am expressing concern for your health. You require a medical examination. You should also know that I am not able to prescribe stimulants to patients who are unable to follow my medical advice."

c. Patient 1: "I had a session with my psychologist just now and he assessed me. I am fine. Please respect my boundaries and I will reach out to you if I need any further assistance."

24. During the Board Interview, Respondent explained that he thought Patient 1's reaction to his December 5, 2023, text (calling it "wildly unprofessional" and then refusing to take Respondent's calls) was unusual. Respondent stated that Patient 1's reaction seemed "extremely irritable and angry and combative," when he was typically "polite." Respondent thought Patient 1 "might be hiding something" and "might be manic. [Patient 1] might be abusing his Adderall[,] and [Respondent] thought [Patient 1] might be abusing steroids." Respondent described Patient 1's physique as "jacked," which he stated he did not realize until he met him in person. "[Patient 1] was so big, I thought maybe he was using steroids."

[5] Patient 1's response to Respondent was that he did not see why his appointment needed to be advanced due to a billing issue that had already been resolved.

25. In a final text message to Patient 1, Respondent stated, "I will not contact you again. I do need to clarify that inability to agree on a treatment plan is grounds for ending our doctor-patient relationship. It was a pleasure to get to know you and I send you my sincere best wishes."

26. During the Board Interview, Respondent stated that after he terminated his treatment of Patient 1 on or about December 13, 2023, Respondent also cancelled his prescriptions to Patient 1 for Adderall and Lexapro because he was concerned that Patient 1 was abusing Adderall and also manic. Respondent did not explain to Patient 1 at that time that he was also cancelling all of his prescription medications effective immediately.

27. Respondent prepared a "Free Text Note" in Patient 1's medical record, dated December 13, 2023, documenting that he was "terminating [Patient 1's] care at [Patient 1's] request and also due to inability to agree on the treatment plan. He is not at danger from withdrawal from any of his meds... I know his wife and that she will contact me if there's an extreme emergency. I don't have license to contact her now under privacy rules."

28. Respondent did not make any notes in Patient 1's medical record between November 20, 2023, and December 13, 2023.

29. Respondent did not document any concern that Patient 1 might be suffering from mania or abusing Adderall and/or steroids in Patient 1's medical record. Respondent also did not document any suspicion that Patient 1 used steroids or any discussion with Patient 1 about his use of steroids.

30. According to the Controlled Substance Utilization Review and Evaluation System (CURES) report for Patient 1, November 25, 2023 was the last date on which Patient 1 filled a prescription written by Respondent for a controlled substance, specifically Adderall.

Patient 2

31. On or about July 19, 2022, Patient 2, a 33-year-old female, who was working in the pharmaceuticals industry and attending graduate school on a part-time basis, first presented to Respondent for care and treatment, via videoconference. At that time, she was married to Patient 1 and they had no children. Respondent documented that Patient 2 disclosed during the initial Intake Encounter Note that a month prior she had attempted suicide by overdosing on her

prescription drugs, namely, sertraline. At the time, Patient 1 took her to the Emergency Room, where they spent 36 hours[6]. Respondent documented in the Intake Encounter Note that Patient 2's chief complaint was, "overwhelmed." According to Respondent's note, Patient 2 reported that her primary care physician had diagnosed her with major depressive disorder and prescribed Zoloft to her. Respondent documented that Patient 2 had frequently experienced suicide ideation (SI) and that she had a brother who died by suicide. Respondent also documented the results of an MSE[7] in the Intake Encounter Note, and diagnosed Patient 2 with major depressive disorder and generalized anxiety disorder. Respondent also prescribed Patient 2 Zoloft and alprazolam at that visit and Respondent further documented "Zoloft 37.5mg daily since 11/2021; started at 50mg daily but got SI... sometimes feels normal, although obviously had SA as well." Respondent's plan included, "Titrate [Zoloft] 50mg daily< -37.5mg; Then to [Zoloft] 100 mg daily as tolerated." Respondent further documented that Patient 2 should, "[r]eturn in four weeks."

32. Patient 2's next patient encounter with Respondent was on or about August 23, 2022, via videoconference. Respondent documented in a "Free Text Note" that she reported that her primary care physician had switched her from Zoloft to Effexor, due to side effects. Patient 2 complained to Respondent about the side effects she suffered from Effexor and Respondent switched her medication to desvenlafaxine.

33. On or about January 17, 2023, Respondent evaluated Patient 2 for ADHD, at her request, via videoconference. Following that evaluation, Respondent diagnosed Patient 2 with ADHD and prescribed Adderall to her.

34. On or about May 11, 2023, Patient 2 had an in-office visit with Respondent. This was the only time they met in person during the course of her care and treatment with Respondent. At that visit, Respondent prescribed Patient 2 Vyvanse to treat her ADHD.

35. During the course of Respondent's care and treatment of Patient 2, Respondent and

[6] Respondent's medical records for Patient 2 fail to document that Respondent requested or reviewed her medical records from her other providers or the Emergency Room or otherwise communicated with her other treaters at any point during the time that he treated her.

[7] Respondent did not document conducting any follow up MSEs for Patient 2 after the initial exam on or about July 19, 2022.

Patient 2 communicated extensively over text messages regarding scheduling appointments, billing, prescription medication refills and management, and Patient 2's mental health issues.

36. On or about August 22, 2023, Respondent texted Patient 2, "I work with a lot of people with BPD [Borderline Personality Disorder][,] and I never got that vibe from you." Respondent did not reference or further elaborate on any "vibe" or clinical impression that he may have formed with respect to Patient 2 and borderline personality disorder in her medical record.

37. On or about August 31, 2023, Respondent documented in a "Free Note Text" the results of an evaluation for borderline personality disorder that he had performed on Patient 2, at her request. With respect to borderline personality disorder, Respondent documented "r/o [rule out] BPD" in her treatment plan. At that visit, Respondent stopped prescribing Vyvanse to Patient 2 due to side effects she experienced and started her on a prescription for Lamictal for mood stabilization.

38. Patient 2's next and final visit with Respondent was on or about October 26, 2023. Respondent added propranolol (for performance anxiety) to Patient 2's medication regimen. Respondent documented that Patient 2 had reported getting tremulous and sweaty before social events.

39. On or about January 2, 2024, Respondent texted Patient 2: "I see that we do not have another appointment scheduled. I understand that you may wish to transfer care to another provider, so I just wanted to verify." Patient 2 responded, "Correct, I will be transferring care soon."

40. On or about January 2, 2024, Respondent documented in a "Free Text Note" in Patient 2's medical record, "Contacted patient to determine care status since she did not book a followup after our appointment in October. She indicated she wished to terminate care. A check of the controlled substances database shows she has been getting Adderall from another psychiatrist (Dr. W[8]) since December 2023."

[8] Patient 2's other psychiatrist's name is redacted to protect her privacy. The provider's full name is documented in Respondent's medical records for Patient 2 and, therefore, known to Respondent.

Standard of Care

41. The standard of care requires that psychiatrists exercise caution when treating multiple members of the same family due to potential conflict of interest and confidentiality issues. These issues include, but are not limited to: difficulty remembering which family member provided which piece of information; potentially not being able to use clinically relevant information provided by one family member with another family member; and deepening dysfunctional dynamics within a family system. Unless faced with a compelling reason, such as a paucity of available psychiatrists, a psychiatrist should not take on multiple members of the same family.

42. The standard of care requires psychiatrists to be reasonably professional in all their communications with their patients. The doctor-patient relationship formed in the context of psychiatry is highly personal and sometimes intensely emotional. The standard of care requires a psychiatrist to be vigilant about the impact that his or her conduct has upon the boundaries of the doctor-patient relationship and the well-being of the patient.

43. The standard of care requires a psychiatrist to evaluate perceived significant changes in a patient's behavior and to document the results in the patient's medical record. If a psychiatrist suspects a patient of experiencing mania or abusing substances, the suspicion and the basis for the suspicion should be documented in the patient's record.

44. The standard of care requires that when terminating a relationship with a patient, a psychiatrist provide an end date and either a plan for continued medication supply and/or referrals to other providers with instructions regarding how to obtain medical records, as applicable.

45. The standard of care requires a psychiatrist to assess for symptoms of ADHD prior to diagnosing a patient with the disorder and prior to prescribing controlled substances to treat ADHD. At a minimum, a provider should document that a patient endorses many of the symptoms listed in the diagnostic criteria for ADHD in the Diagnostic and Statistics Manual of Mental Disorders V prior to diagnosing and treating a patient for ADHD.

46. The standard of care requires a psychiatrist to document a mental status examination (MSE) in all in-take and follow up notes. The MSE is an essential part of the evaluation in both

initial and subsequent encounters because it can aid in the diagnosis of a patient and comparing the MSE to previous ones will help a clinician to determine if a patient's symptoms are improving or worsening.

47. The standard of care requires a psychiatrist to closely follow a patient with a recent suicide attempt.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

48. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient 1, Patient 2, Patient 3, and Patient 4. The circumstances are as follows:

49. The facts and allegations set forth in paragraphs 11 through 47 above, are incorporated by reference and realleged as if fully set forth herein.

50. Respondent committed gross negligence when he treated four members of the same family (Patient 1, Patient 2 (wife), Patient 3 (brother) and Patient 4 (mother)) at the same time without adequate justification. Patient 1 disclosed at his very first visit with Respondent that his relationship with his mother (Patient 4) was highly conflictual and caused tension in his marriage with Patient 2. Respondent should not have then proceeded to take on each of Patient 3 and Patient 4 as patients, while also treating Patient 1 and Patient 2. During the course of treatment and in text messages found in Patient 1's medical record, Respondent sought out private information about Patient 4 from Patient 1, and divulged private information about Patient 4 to Patient 1. When Patient 1 asked Respondent if he could treat Patient 3 and Patient 4 as well, Respondent should have declined and, instead, provided Patient 1 with referrals to other psychiatrists for his brother and mother. There was no compelling reason for Respondent to take on Patient 1's mother and brother as patients, as they had access to other providers. Respondent referred to Patient 1 as a "rich" man and Patient 1 and Patient 2 resided in Los Angeles, California.

51. Respondent's acts and/or omissions as set forth in this First Cause for Discipline, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute

gross negligence pursuant to section 2234, subdivision (b), of the Code. As such, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

52. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient 1 and Patient 2, as more particularly alleged hereinafter. The circumstances are as follows:

53. The facts and allegations set forth in the First Cause for Discipline above, are incorporated by reference and realleged as if fully set forth herein.

Patient 1

54. Respondent was negligent in his care and treatment of Patient 1 when he texted him on or about December 5, 2013, "I have two outstanding Venmo charges for you for last month. Please remit these ASAP. I have a waiting list 8 weeks long of patients who are dying to pay me on time." In the context of the psychiatrist-patient relationship, billing is a serious topic that should not be joked about over a communication method, in which tone is generally not discernable, such as texting. Further, comparing a patient to other hypothetical patients (particularly, in a negative manner) is inappropriate in a relationship as potentially emotional as that between a psychiatrist and a patient, as it could leave the patient feeling deficient as compared to others.

55. Respondent was negligent in his care and treatment of Patient 1 when he failed to document any concern about possible mania, abuse of Adderall, or abuse of steroids in Patient 1's medical record, and lacked an adequate basis for such concerns. Patient 1's texts to Respondent are not suspicious for mania. They are not repetitive, lengthy, disinhibited, and/or disorganized. To the contrary, Patient 1's reaction to Respondent's text on December 5, 2023 regarding billing was clear and reasonable. Respondent made no note in Patient 1's medical record at any time documenting any behavior suspicious for stimulant abuse, including requests for early refills of Adderall. Respondent made no notes at all in Patient 1's medical record between November 20,

2023 and December 13, 2023.

56. Respondent was negligent in his care and treatment of Patient 1 when he discontinued all of Patient 1's prescription medications (Adderall and Lexapro) without adequately notifying Patient 1 that he would be discontinuing all of his prescriptions effectively immediately. When he terminated care, Respondent did not provide Patient 1 with any end date to his medication supply or plan regarding his medications going forward. Respondent also failed to offer Patient 1 any referrals to alternate providers or instructions regarding how to obtain his medical records from Respondent, even though Respondent was purportedly concerned about an abrupt change in Patient 1's behavior.

57. Respondent was negligent in his care and treatment of Patient 1 when he failed to adequately evaluate Patient 1 for ADHD prior to diagnosis and to prescribing Adderall, a stimulant.

58. Respondent was negligent in his care and treatment of Patient 1 when he failed to document an MSE in any of Patient 1's progress notes following the initial intake examination.

Patient 2

59. Respondent was negligent in his care and treatment of Patient 2 when he waited four weeks to see her again following her initial intake visit at which she disclosed a recent suicide attempt, continued suicidal ideation, and a brother who had committed suicide. Patient 2 was also titrating up on a medication, Zoloft, which can contribute to suicidal thoughts. Respondent should have followed her progress more closely given her high risk status.

60. Respondent was negligent in his care and treatment of Patient 2 when, after the initial intake examination, he failed to document performing an MSE in any of Patient 2's subsequent progress notes and/or otherwise document any continued assessment of Patient 2's suicidality after the initial intake encounter. Basic information about suicidality is conventionally listed in the MSE. Documenting regular MSEs of Patient 2 was particularly important given 1) her suicidality; 2) that she was ultimately assessed for Borderline Personality Disorder and 3) that Respondent did not document anywhere else in Patient 2's medical record any continued assessment of her suicidality after the initial intake encounter.

61. Respondent's acts and/or omissions as set forth in the First and Second Causes for Discipline, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts pursuant to section 2234, subdivision (c), of the Code. As such, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

62. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records in connection with his care and treatment of Patient 1 and Patient 2. The circumstances are as follows:

63. The allegations of the First and Second Causes for Discipline are incorporated by reference as if fully set forth herein.

64. Respondent's acts and/or omissions as set forth in the First and Second Causes for Discipline, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute the failure to maintain adequate and accurate records pursuant to section 2266 of the Code. As such, cause for discipline exists.

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 Number A 144448, issued to Respondent Kyle Patrick Smith, M.D.;

2. Revoking, suspending or denying approval of Respondent Kyle Patrick Smith, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Kyle Patrick Smith, 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: JUN 12 2025

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

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