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

In the Matter of the Accusation Against: **CUYLER BURNS GOODWIN, D.O.** **711 Medford Center, Suite 347** **Medford, OR 97504-6772** **Osteopathic Physician's and Surgeon's Certificate No. 20A 13049** Respondent	Case No. 900-2019-000047 OAH No. 2021040515

DECISION

The attached Proposed Decision is hereby adopted by the Osteopathic Medical Board of California, Department of Consumer Affairs, as its Decision in the above-entitled matter.

This Decision shall become effective on 04/07/2022.

It is so ORDERED 03/08/2022.

CYRUS BUHARI, D.O., PRESIDENT
FOR THE OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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

In the Matter of the Second Amended Accusation Against:

CUYLER BURNS GOODWIN, D.O.,

Osteopathic Physician's and Surgeon's Certificate

No. 20A 13049

Respondent.

Agency Case No. 900-2019-000047

OAH No. 2021040515

PROPOSED DECISION

Administrative Law Judge Holly M. Baldwin, State of California, Office of Administrative Hearings, heard this matter on November 15 through 19, 2021, and January 19 and 21, 2022, by videoconference.

Supervising Deputy Attorneys General Jane Zack Simon and Mary Cain-Simon represented complainant Mark M. Ito, Executive Director of the Osteopathic Medical Board of California, Department of Consumer Affairs.

Marvin Firestone, M.D., Attorney at Law, represented respondent Cuyler Burns Goodwin, D.O., who was present at hearing.

The matter was submitted for decision on January 21, 2022.

FACTUAL FINDINGS

Introduction

1. On November 19, 2013, the Osteopathic Medical Board of California (Board) issued Osteopathic Physician's and Surgeon's Certificate No. 20A 13049 to respondent Cuyler Burns Goodwin, D.O. Respondent specializes in psychiatry. Respondent's certificate was in full force and effect at all times relevant to the charges, and is set to expire on October 31, 2022. There is no prior discipline against respondent's certificate.

2. Acting in his official capacity as Executive Director of the Board, complainant Mark M. Ito filed an accusation against respondent on November 30, 2020. Respondent requested a hearing. A first amended accusation was filed on October 29, 2021, and a second amended accusation was filed on November 30, 2021. Complainant alleges that respondent committed unprofessional conduct in respect to three patients while he was medical director and psychiatrist at Sequoia Mind Health.

(a) Patient A[1] is a young man with schizophrenia, whom respondent treated via house calls from June 2017 to January 2019. Respondent had a romantic and sexual relationship with Patient A's sister (Sister) while he was treating Patient A. Complainant alleges that this relationship violated ethical principles and professional boundaries because Sister was a significant third party in Patient A's life. Sister became pregnant during her relationship with respondent. Complainant alleges that respondent

[1] The patients are not identified by name, in order to protect their privacy.

prescribed misoprostol (a medication that can induce abortion) to Sister without conducting a medical examination or creating a medical record. Respondent admits the relationship with Sister; disputes whether Sister was a significant third party to Patient A; and denies prescribing the abortion medication. Complainant alleges that respondent's conduct with respect to Sister constitutes unprofessional conduct, gross negligence, repeated negligent acts, incompetence, a violation of ethical standards, and a failure to maintain adequate and accurate medical records.

(b) Patient B was treated by respondent starting in June 2017 for mental health issues including anxiety. Respondent hired Patient B to work as an employee in his office and treated her as a patient at the same time, including by administering ketamine (an anesthesia medication that is sometimes used to treat depression and anxiety). Complainant alleges that respondent violated ethical principles and professional boundaries by having a dual relationship (doctor-patient and employer-employee) with Patient B. Complainant also alleges that respondent asked inappropriate sexual questions of Patient B while she was under the influence of ketamine; and that on one occasion he offered her wine in his office after work, kissed her, unbuttoned her pants, and penetrated her vagina with his finger. Respondent admits having a dual relationship with Patient B, but denies the allegations of sexual misconduct. Complainant alleges that respondent's conduct with respect to Patient B constitutes unprofessional conduct, gross negligence, repeated negligent acts, sexual misconduct, sexual exploitation, and a violation of ethical standards.

(c) Patient C came under respondent's care in May 2017 for mental health issues including depression and anxiety. Respondent hired Patient C to work as an employee in his office and treated her as a patient at the same time, including by administering ketamine. Complainant alleges that respondent violated ethical

principles and professional boundaries by having a dual relationship with Patient C. Complainant also alleges that while Patient C was under the influence of ketamine, respondent asked her inappropriate sexual questions, asked her to show him her breasts, and sexually assaulted and raped her. Complainant alleges that respondent conducted a visual assessment of Patient C's breasts without a preferred-gender observer, in the absence of any urgent medical necessity, and without contemporaneous documentation. Respondent admits having a dual relationship with Patient C and admits visually assessing her breasts without contemporaneous documentation, but denies the allegations of sexual misconduct. Complainant alleges that respondent's conduct with respect to Patient C constitutes unprofessional conduct, gross negligence, repeated negligent acts, sexual misconduct, sexual exploitation, a violation of ethical standards, and a failure to maintain adequate and accurate medical records.

Respondent's Education and Professional Experience

3. Respondent received a bachelor's degree in biology from Sonoma State University in 2007. Respondent graduated from Touro University in 2012 with a master of public health degree and a doctor of osteopathic medicine degree.

4. Respondent completed a psychiatry internship and residency at the University of California, San Francisco (UCSF), completing his residency in June 2016. Respondent is board-certified in psychiatry.

5. In July 2016, the day after completing his residency, respondent opened his own practice in Santa Rosa, Sequoia Mind Health, where he worked as both a psychiatrist and the medical director. Respondent's family members worked with him at Sequoia Mind Health. His mother, Cynthia Melody, was the office manager, and his

wife, Heather Goodwin,[2] worked as a registered nurse at the practice. Respondent's sister, Erica Goodwin, also worked at the front desk for a period of time.

6. In addition to his private practice, respondent also worked as an emergency services psychiatrist for Sonoma County Behavioral Health until 2020, and at John George Psychiatric Pavilion in San Leandro until 2018. Respondent also worked as a psychiatrist at Mendocino County Jail from 2018 to 2021 and at Lake County Jail from 2020 to 2021.

7. Respondent closed Sequoia Mind Health in October 2019. Since November 2019, respondent has worked as a psychiatrist for Redwood Quality Management Company in Ukiah.

8. Respondent was a member of the American Medical Association (AMA) from 2008 to 2019, and a member of the American Psychiatric Association (APA) from 2009 to 2016.

Applicable Ethical Standards

9. The APA publishes The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (Principles with Annotations). As the Foreword to the 2013 edition explains:

> All physicians should practice in accordance with the medical code of ethics set forth in the *Principles of Medical Ethics* of the American Medical Association. . . . However, these general guidelines have sometimes been difficult to

[2] For clarity, Heather Goodwin is subsequently referred to as "Heather."

interpret for psychiatry, so further annotations to the basic principles are offered in this document. While psychiatrists have the same goals as all physicians, there are special ethical problems in psychiatric practice that differ in coloring and degree from ethical problems in other branches of medical practice, even though the basic principles are the same.

The following sections of the Principles with Annotations are pertinent to this matter. (Text in italics is from the AMA's Principles of Medical Ethics, and plain text following each italicized section is the APA's annotation.)

Section 1: A physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights.

1. A psychiatrist shall not gratify his or her own needs by exploiting the patient. The psychiatrist shall be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor–patient relationship, and thus upon the well-being of the patient. These requirements become particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist.

. . .

Section 2: A physician shall uphold the standards of professionalism, be honest in all professional interactions

and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities.

1. The requirement that the physician conduct himself/herself with propriety in his or her profession and in all the actions of his or her life is especially important in the case of the psychiatrist because the patient tends to model his or her behavior after that of his or her psychiatrist by identification. Further, the necessary intensity of the treatment relationship may tend to activate sexual and other needs and fantasies on the part of both patient and psychiatrist, while weakening the objectivity necessary for control. Additionally, the inherent inequality in the doctor-patient relationship may lead to exploitation of the patient. Sexual activity with a current or former patient is unethical.

. . .

Section 8: A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

. . .

2. When the psychiatrist's outside relationships conflict with the clinical needs of the patient, the psychiatrist must always consider the impact of such relationships and strive

to resolve conflicts in a manner that the psychiatrist believes is likely to be beneficial to the patient.

3. When significant relationships exist that may conflict with patients' clinical needs, it is especially important to inform the patient or decision maker about these relationships and potential conflicts with clinical needs.

10. The AMA also publishes medical ethics opinions to inform the ethical practice of medicine. AMA Code of Medical Ethics Opinion 9.1.2 (AMA Opinion) addresses "Romantic or Sexual Relationships with Key Third Parties." The AMA Opinion notes that patients are often accompanied by third parties who play an integral role in the patient-physician relationship, and that third parties may be deeply involved in the clinical encounter and in medical decision making. The AMA Opinion states that sexual or romantic interactions between physicians and such third parties "may detract from the goals of the patient-physician relationship, exploit the vulnerability of the third party, compromise the physician's ability to make objective judgments about the patient's health care, and ultimately be detrimental to the patient's well-being." The AMA Opinion concludes: "Physicians should avoid sexual or romantic relations with any individual whose decisions directly affect the health and welfare of the patient."

The AMA Opinion also lists factors that a physician should consider before initiating a relationship with a key third party: (1) the nature of the patient's medical problem and the likely effect on patient care; (2) the length of the professional relationship; (3) the degree of the third party's emotional dependence on the physician; (4) the importance of the clinical encounter to the third party and patient; and (5) whether the patient-physician relationship can be terminated in keeping with ethics guidance and what implications doing so would have for the patient.

11. The APA also publishes Opinions of the Ethics Committee regarding the Principles with Annotations, presented as responses to questions about the principles. In the 2017 edition's section on "boundary and dual relationship issues," Opinion A.1.d provides:

> **Question:** Is it ethical for me to have a romantic relationship with a key third party associated with my patient, such as the parent of a child or adolescent patient?
>
> **Answer:** No. Key third parties include, but are not limited to, spouses or partners, parents, guardians, surrogates, and the like. (See AMA Council on Ethical and Judicial Affairs Report, Annual 1998, and Opinion 8.14, AMA Council Opinions, 2000–2001.) Treatment of minors is typically rendered in the context of the family; a parent plays an integral role in the treatment process. Romantic relationships with parents, other family members, or key third parties may jeopardize the treatment of the child or adolescent. By entering into a dual relationship, the psychiatrist would face the incompatible task of trying to meet the medical needs of the patient simultaneous with the romantic needs of the key third party. Such involvement with a key third party raises concerns about the psychiatrist gratifying his or her own needs by exploiting the patient; there is also a risk of breaching confidentiality. The priority of the patient's needs is compromised or rendered

impossible by a romantic or sexual relationship with the patient's primary caretaker or other key third party. (2000)

Opinion A.2.f provides:

> **Question:** May a psychiatrist hire a current or former patient?
>
> **Answer:** It is not ethical to switch a doctor-patient relationship to an employer-employee one. For an ex-patient, the issue is the exploitation of the former doctor-patient relationship, and, in most cases, such an arrangement would be unethical. (1990)

Expert Witnesses

12. Alex Sahba, M.D., testified as an expert on behalf of complainant, and wrote two reports dated September 2, 2020 (one report regarding Patient A, and another report regarding Patient B and Patient C). Dr. Sahba is a forensic psychiatrist. He graduated from medical school at Ross University School of Medicine, and completed a psychiatry residency at Louisiana State University Health Sciences Center and a fellowship in forensic psychiatry at the University of California, Los Angeles. Dr. Sahba has been a licensed physician in California since 2001. He is board-certified in psychiatry and forensic psychiatry. Dr. Sahba has practiced at Metropolitan State Hospital since 2006, treating psychiatric inpatients, primarily for schizophrenia. He also maintained a private practice in outpatient psychiatry until 2014. He has performed evaluations as a qualified medical examiner and agreed medical examiner since 2012, and has served as an expert reviewer for the Medical Board of California since 2006.

13. Sarah J. Polfliet, M.D., testified as an expert on behalf of respondent, and wrote a report dated July 13, 2021, regarding Patient A. Dr. Polfliet is a forensic psychiatrist. She graduated from medical school at University of Virginia School of Medicine, and completed a psychiatry residency and fellowship in forensic psychiatry, both at UCSF. Dr. Polfliet has been a licensed physician in California since 2003. She is board-certified in psychiatry. Dr. Polfliet is a staff psychiatrist at Napa State Hospital, and previously worked as a psychiatrist for inpatients at St. Francis Medical Hospital. She also has a private practice in adult psychotherapy and psychopharmacology. Dr. Polfliet has performed evaluations as a qualified medical examiner since 2006. She has not previously been retained as a medical expert in a disciplinary matter.

14. Robert M. McCarron, D.O., testified as an expert on behalf of respondent, and wrote a report dated October 9, 2021, regarding Patient A, Patient B, and Patient C. Dr. McCarron graduated from Midwestern University – Chicago College of Osteopathic Medicine, and completed a residency in internal medicine and psychiatry at Rush University. Dr. McCarron has been licensed by the Board since 2003. He is board-certified in internal medicine, psychiatry, and psychosomatic medicine. Dr. McCarron was a professor of internal medicine and psychiatry at the University of California, Davis from 2003 to 2017. He has been a professor and vice chair of the psychiatry and human behavior department at the University of California, Irvine since 2017. He has not previously been retained as a medical expert in a disciplinary matter.

Ketamine Treatment

15. Ketamine is a controlled substance commonly used as an anesthesia medication, and approved by the Food and Drug Administration for that purpose. In recent years, ketamine has also been used by psychiatrists in smaller, sub-anesthetic doses as an off-label treatment for symptoms of depression and anxiety in people who

have not responded well to other treatments. Ketamine is a dissociative anesthetic with some hallucinogenic effects.

16. At Sequoia Mind Health, ketamine was administered either by intramuscular injection or intravenous (IV) infusion. Respondent stated that he was the person administering injections or hitting the start button on the IV pump.

17. Respondent's informed consent forms for ketamine treatments note a variety of potential effects on mood, cognition, and perception, as well as a reduced sense of balance and coordination. Respondent stated at hearing that ketamine can cause elevated blood pressure, so that a patient's blood pressure is checked in connection with the ketamine treatment. Respondent also stated that ketamine can cause hallucinations, illusions, or delusions.

18. Respondent's expert Dr. McCarron noted that common side effects of ketamine treatment can include changes in blood pressure, mood, and perception of reality (derealization and depersonalization). Complainant's expert Dr. Sahba agreed that ketamine has the potential to alter cognition.

Patient A's Sister

19. Respondent treated Patient A for schizophrenia or a similar psychotic disorder from June 11, 2017, to January 15, 2019. Patient A was 24 years old when respondent began treating him.

20. In early 2017, Patient A lived with his mother in Santa Rosa. His parents were divorced, but his father was involved in Patient A's life, as was a large extended family in the area. Sister is 15 years older than her brother; she testified credibly that she felt like a second mother to him and they were very close. As Patient A's mental

health worsened, he and his mother moved to a house in Sebastopol, nearer to Sister's home. Sister saw Patient A daily at his home or hers, and he was close to Sister's husband and children. Patient A has never lived on his own or had an independent job, cannot drive, and depends on his family for all his needs. Patient A's mother provided his daily care, having stopped working in order to do so.

21. By June 2017, Patient A was suffering from auditory hallucinations, delusions, paranoia, suicidal ideation, agoraphobia, and severe panic attacks. He had not previously received mental health treatment. Patient A could not leave his home to visit a doctor. Sister researched psychiatrists who would make home visits, and located respondent, who was retained by Patient A's family.

22. Respondent began treating Patient A on June 11, 2017, by providing medication management and psychotherapy at Patient A's home. He later also provided art therapy. At each visit, respondent would meet with Patient A's mother and Sister before and after the treatment session with Patient A. Sister was the primary point of contact between the family and respondent, arranging for appointments and communicating with respondent about Patient A's care by text message and telephone between visits. Patient A did not have health insurance. Sister provided cash payments to respondent at each visit.

23. Patient A responded well to psychiatric treatment and bonded with respondent. Sister and the rest of the family were deeply grateful to respondent, feeling that respondent had saved Patient A's life.

24. Patient A had a hard time dealing with changes in his life. His father was planning to get remarried. Sister talked with respondent about her fears that this

change would adversely affect Patient A, and that their father's future wife would make it difficult for their father to see Patient A.

25. On January 12, 2018, respondent wrote a letter, stating:

> [Patient A] is receiving treatment from me for a psychiatric condition. Though he has demonstrated remarkable improvement, he is currently in a tenuous state. In my medical opinion, I recommend he not be introduced to situations that could be potentially destabilizing for him. These situations might include being around individuals who are known to trigger his anxiety. In addition, I strongly recommend that routines—including spending time with loved ones—not be altered.

26. In June 2018, Sister began seeing respondent outside of Patient A's treatment sessions. She went to respondent's office to pick up supplements for her brother. Sister and respondent went for a walk and talked, and discussed their respective troubled marriages. Sister and respondent began texting each other about personal matters, and developed a friendship and then a romantic relationship. Respondent and Sister began meeting regularly apart from Patient A's treatment visits. In early September 2018, their relationship became sexual.

27. Respondent and Sister kept their affair a secret while respondent continued treating Patient A. Respondent and Sister planned to divorce their spouses and marry each other.

28. In November 2018, Sister discovered she was pregnant. She begged respondent to provide her with abortion medication because she did not want to see

another doctor. Respondent provided a prescription for misoprostol for Sister. She received the medication from a pharmacy and took it. Respondent's denial that he prescribed the medication was not credible, as set forth in Finding 44. Respondent did not create any medical record for Sister or document any medical examination.

29. In late December 2018, the affair and abortion were discovered by Sister's husband and her family, throwing the entire family into turmoil. The family pressured Sister to break off her relationship with respondent. In January 2019, members of Patient A's family came to respondent's office and made a scene in the reception area, demanding that respondent end his relationship with Sister. Several days later, Patient A's mother, father, and uncle came to respondent's office, again demanded that he end his relationship with Sister, and terminated his treatment of Patient A. The family threatened to file a complaint with the Board and to make negative statements about respondent to the public. Respondent agreed not to communicate with Sister, in exchange for the family not filing a Board complaint and not making negative statements about him.[3] On January 23, 2019, respondent's attorney sent the family a letter noting the agreement and threatening them with civil and criminal liability for extortion, libel, and slander.

30. Despite the discovery of their affair, respondent and Sister did not immediately end their relationship. Sister created a new email account using an alias. Respondent and Sister continued to communicate by email, discussing that they

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[3] Business and Professions Code section 2220.7 provides that a physician and surgeon shall not prohibit another person from making a Board complaint as part of an agreement to settle a civil dispute; such a provision is void as against public policy.

needed to keep their ongoing communications a secret while they continued with their plan to separate from and divorce their spouses.

31. On February 6, 2019, Patient A's father filed a complaint with the Board. Patient A's mother also sent a complaint letter to the Board on February 12, 2019.

32. On February 28, 2019, Sister sent a letter to the Board. The letter stated that Sister had a romantic relationship with respondent, her family did not approve, her family's complaint to the Board about respondent was retaliation, her relationship with respondent was not unethical, and respondent provided the highest level of care to Patient A. Among other things, the letter stated that "our relationship was not inappropriate from a medical-legal perspective—I have never been a patient of Dr. Goodwin's, I do not live with my brother and I am not the primary caregiver or decision-maker for my brother." The letter urged the Board not to take action against respondent's medical license. At hearing, Sister testified credibly that this letter was written by respondent and given to her to sign, which she did. Sister agreed with the statements in the letter at the time she signed it.

33. The complaint by Patient A's family was investigated for the Board by the Department of Consumer Affairs Division of Investigation, Health Quality Investigation Unit. An investigator interviewed Patient A's family members, Sister, and respondent.

34. On July 11, 2019, Sister was interviewed by the investigator. Sister confirmed that she was in a romantic and sexual relationship with respondent while he was treating her brother. Sister stated that when she became pregnant, she begged respondent to help her by providing abortion medication, he tried to persuade her to see another provider but she resisted, and respondent then helped her obtain the medication through a pharmacy.

During her Board interview, Sister stated that respondent provided excellent care to Patient A, and that her relationship with respondent did not affect her brother's care. Sister stated that she still loved respondent, but their relationship had ended. Sister told the investigator that she was not Patient A's primary caregiver. Sister also stated that the cash payments she gave to respondent were from money saved by her mother before the mother stopped working to care for Patient A.

35. At hearing, Sister testified credibly that at the time of her July 2019 interview she was still in love with respondent, and she minimized her involvement with Patient A's care because she was trying to keep respondent from losing his medical license. At hearing, Sister explained that the money for Patient A's treatment came from her and her husband, and that respondent knew this because she told him. (Board interviews with Patient A's father and Sister's husband corroborated the information that Sister's husband was wealthy and that Sister paid for the treatment.) Sister also stated at hearing that she and her husband paid for the house Patient A and his mother lived in.

36. Since July 2019, Sister's feelings about her relationship with respondent have changed. With the passage of time, she has come to realize that their relationship was inappropriate and that it "spiraled into a catastrophe" harming many lives. This experience has changed how Sister views psychiatrists, who deal with fragile people and can be "agents of destruction" if they act outside professional boundaries. Sister continues to believe, however, that respondent's treatment helped Patient A.

37. After Sister's affair with respondent was discovered, her relationships with her brother and her family were damaged. Sister has since divorced her husband and now lives in a different state. Sister has reconnected with Patient A, but their relationship is not the close one it once was.

38. When Patient A's family terminated respondent's treatment of him, Patient A did not understand why, and he was hurt and upset. Sister reported that Patient A was "devastated" by the abrupt termination of respondent as his doctor, but that he is now doing well under the care of a new psychiatrist.

RESPONDENT'S STATEMENTS AND TESTIMONY REGARDING SISTER

39. Respondent was interviewed by an investigator on July 31, 2019. He refused to answer questions about his relationship with Sister, contending that to do so was an invasion of his privacy. Respondent refused to discuss the allegation that he prescribed abortion medication to Sister, stating he would not provide information about medical services rendered without a signed release of information, and refusing to say whether Sister was his patient.

40. Respondent was interviewed again on December 5, 2019. He refused to answer questions about the allegations that he prescribed abortion medication to Sister, exercising his privilege under the Fifth Amendment.

41. At hearing, respondent stated that he regrets his relationship with Sister. However, respondent does not believe that he violated ethical boundaries by engaging in such a relationship. Respondent stated he was not aware of the term "key third party" at that time, but that he did not identify Sister as a significant third party in Patient A's life, and did not feel her decisions and presence directly affected Patient A's health and welfare. Respondent testified that it was his understanding that the mother was Patient A's primary caregiver, and that Sister's role was to assist her. He received payments from Sister for Patient A's treatment, but denied knowing the source of those funds.

42. Respondent admitted that when he entered into a romantic relationship with Sister, he did not give any thought to how it would affect Patient A. However, respondent also testified that he knew that once his affair with Sister was public, he would have to refer Patient A to another psychiatrist.

43. Respondent does not believe that his relationship with Sister adversely affected the care of Patient A.

44. In his direct testimony, respondent strongly denied writing a misoprostol prescription for Sister. Respondent was shown a handwritten note dated November 13, 2018, which included Sister's name, the medication name misoprostol, instructions for quantity of tablets and method of administration, the words "indication fetal abortion," respondent's name and the office telephone number at Sequoia Mind Health, a set of unidentified initials, and a typed prescription number. Respondent stated that the handwriting on the note was not his, and the note was not written on a prescription pad form. Respondent was also shown a printed record from the pharmacy, indicating that a prescription for misoprostol with the same prescription number and instructions was filled for Sister on November 13, 2018, with respondent listed as the prescribing doctor. Respondent declined to "speculate" how Sister had obtained the medication from the pharmacy.

On cross-examination, respondent was asked if he called in a prescription to the pharmacy, and he provided the following testimony. Respondent stated that Sister told him what pharmacy she used, and respondent then called and spoke to the pharmacist by telephone. Respondent testified that he discussed with the pharmacist that Sister wanted him to prescribe misoprostol, and that he asked the pharmacist to contact Sister and "do what they could for her," but he had not intended for this conversation

to be interpreted as him authorizing a prescription. Respondent's testimony on this topic is not plausible and not credible.

Respondent acknowledged being aware that state regulations allow him to transmit prescriptions for non-controlled substances by telephone and that a pharmacist receiving such an orally transmitted prescription should reduce it to writing and initial it. (See Cal. Code Regs., tit. 16, § 1717, subd. (c); Bus. & Prof. Code, § 4040.) Respondent was asked whether the telephone number on the handwritten note was his, and evasively said "it might have been." Respondent surely recognized his own office telephone number. Moreover, it is not believable that a licensed pharmacist would dispense this medication to Sister without having received a prescription. Respondent's failure to disclose his telephone conversation with the pharmacist during his direct testimony, while vehemently denying "writing" a prescription, and his non-credible explanation of the telephone conversation, demonstrate a lack of candor.

EXPERT OPINIONS REGARDING THE RELATIONSHIP WITH SISTER

Dr. Sahba

45. Dr. Sahba opined that the standard of care for a psychiatrist includes practicing in accordance with ethical principles and professional standards. He explained the great importance of ethical behavior to the practice of psychiatry, a medical specialty in which the doctor and patient form an intense bond, and in which patients discuss deeply personal and confidential information. Dr. Sahba opined that the AMA Principles of Medical Ethics and the APA Principles with Annotations describe foundational elements of psychiatrists' obligations, and that these principles apply to all physicians regardless of whether they are members of the AMA or APA.

In Dr. Sahba's opinion, the standard of care requires a psychiatrist to be vigilant about maintaining professional boundaries with patients and key third parties. Such key third parties are especially important in the treatment of minors and patients who present similarly to minors, such as patients with schizophrenia who are not able to make many life decisions for themselves.

46. Dr. Sahba opined that Patient A, a young man with schizophrenia who was dependent on his family for care and support, shared many commonalities with minors, rendering the doctor's relationship with key third parties especially important in the success of his psychiatric treatment. Dr. Sahba opined further that Sister was a key third party in Patient A's treatment, based on her arranging for the treatment, meeting with respondent before and after each session, visiting Patient A daily, being the primary point of contact between family and respondent, and making payments.

47. Dr. Sahba opined that respondent's romantic and sexual relationship with Sister was a violation of the standard of care and a violation of ethical and professional boundaries. He characterized this violation as a simple departure from the standard of care. Dr. Sahba also opined that respondent's behavior showed he either had no knowledge of ethical boundaries or chose to ignore them, showing poor judgment and "cluelessness" about the potential adverse effects of having a sexual relationship with Sister, which had the significant potential to compromise Patient A's treatment. Dr. Sahba also noted respondent's letter of January 12, 2018, which confirmed the importance of Patient A maintaining his relationship with his family and avoiding destabilizing situations.

48. Dr. Sahba opined that it was a simple departure from the standard of care for respondent to prescribe abortion medication to Sister, his sexual partner. He noted that prescribing such medication is outside the field of psychiatry, that a doctor

would need to conduct an examination before prescribing this medication, and that the doctor may have formed a doctor-patient relationship by prescribing the medication, meaning that the doctor was then having sex with a patient. Dr. Sahba summarized by stating: "It's wrong on multiple levels." Dr. Sahba also opined that failing to create a medical record when prescribing the medication constituted a simple departure from the standard of care.

Dr. Polfliet

49. Dr. Polfliet opined that the AMA and APA ethical principles are guidelines that apply to members of those organizations, but she also conceded that these principles apply to physicians generally.

50. In Dr. Polfliet's opinion, respondent's treatment of Patient A was within the standard of care. In her report, Dr. Polfliet quoted the APA Ethics Committee Opinion A.1.d and noted that it discussed key third party relationships primarily as they pertain to the treatment of minors. Dr. Polfliet opined that because Patient A was an adult and Sister was not his primary caregiver, respondent's relationship with Sister did not jeopardize Patient A's treatment, and did not violate ethical principles. Dr. Polfliet did not offer an opinion about respondent prescribing medication to Sister.

51. At hearing, Dr. Polfliet was also asked about AMA Opinion 9.1.2 on "Romantic or Sexual Relationships with Key Third Parties." Dr. Polfliet stated that she had taken the opinion's factors into account, and concluded that there was no direct violation because Patient A was dependent on his mother, not Sister. However, Dr. Polfliet conceded that if Sister paid for Patient A's housing, or if Sister was the one who found and retained respondent, or if Sister was present before and after each

treatment session and paid for those sessions with her own money, that each of those factors would make Sister a key third party.

Dr. McCarron

52. Dr. McCarron opined that the AMA and APA ethical principles are guidelines that are designed primarily for members of those organizations. He did acknowledge that respondent was a member of the AMA until 2019 and a member of the APA until 2016. Dr. McCarron agreed that adherence to ethical principles is essential to the safe practice of psychiatry.

53. Dr. McCarron noted that respondent said he had only minimal training on ethics and professionalism in medical school, with no specific course on the topic. Dr. McCarron agreed that professionalism is part of the core curriculum for psychiatric residency programs. The Accreditation Council for Graduate Medical Education (ACGME) is responsible for establishing program requirements for medical residency specialties. Dr. McCarron is an ACGME residency review committee member for psychiatry, and he agreed that the program requirements for psychiatry provide that residents must demonstrate an adherence to ethical principles; and that programs were expected to distribute the Principles with Annotations to their residents.

54. Dr. McCarron stated that respondent told him he had recently taken a course on medical ethics, but he did not ask respondent about the course content.

55. In Dr. McCarron's opinion, respondent's treatment of Patient A was within the standard of care. Dr. McCarron noted that AMA Opinion 9.1.2 suggests third party relationships may detract from patient care, but he opined that in this case, respondent's relationship with Sister did not do so. Dr. McCarron opined that respondent did not violate this ethics opinion because Sister was not the primary

caregiver and there was no indication of exploitation of Patient A or Sister. Dr. McCarron did not provide any opinion about respondent prescribing medication to Sister.

Patient B

56. Patient B was referred to respondent by her therapist for assistance in tapering off her psychiatric medications and alternatives to medication in treating symptoms of anxiety and depression. Respondent began treating Patient B on June 6, 2017, for diagnoses of generalized anxiety disorder and premenstrual dysphoric disorder. Patient B disclosed to respondent that she had experienced past trauma, including multiple sexual assaults. Respondent helped Patient B successfully taper off her medications in July 2017. Respondent did not terminate Patient B's treatment.

57. Respondent then hired Patient B to work part-time at Sequoia Mind Health. She performed administrative duties at the front desk.

58. In August 2017, Patient B had increasing symptoms of anxiety after witnessing a traumatic event, and respondent recommended ketamine treatments. On September 1, 2017, Patient B signed an informed consent for ketamine treatments.

59. Patient B received five ketamine treatments under respondent's care, from September 6, 2017, through October 18, 2017. Patient B's ketamine treatments were administered by respondent via intramuscular injection, without anyone else present. The medical record for the first treatment reflects that Patient B's blood pressure was measured before and after treatment. Subsequent treatment records show pre-treatment blood pressure and pulse readings and a notation that vitals were "in range" post-treatment. None of the records for Patient B's ketamine treatments reflect ongoing monitoring of vital signs during the treatment, and none of the

records reflect that any provider besides respondent was present for the ketamine treatments.

60. Patient B testified credibly that during her ketamine treatments, respondent asked her inappropriate and intimate questions about her sexuality and her relationship with her boyfriend. Respondent also shared personal information about himself, such as having had a prior extramarital affair.

61. On Friday, January 12, 2018, respondent invited Patient B to have a glass of wine in his office after work. They sat on the couch in respondent's office and talked. Respondent told Patient B that he liked her, kissed her, unbuttoned her pants and put his hand in her pants, and penetrated her vagina with his finger. Patient B initially froze at this unwanted sexual contact, not wanting to upset respondent, but then she pushed respondent's hand away and said "no," and left the office. Patient B was frightened. She is 5'1" tall. Respondent is about 6 feet tall, and is a martial artist. Patient B's testimony regarding the events of January 12, 2018, was credible.

62. Patient B quit her job by sending a text message to respondent, stating in part: "As you've probably guessed, I'm no longer comfortable working with you anymore. Your behavior Friday night was completely inappropriate, especially given that I am both your patient and I work for you. In order to protect your family, I'm not saying anything to anyone. What I do need is a letter of recommendation from you, and I need to not in any way be blamed for this. . . ." Patient B stated that it was up to respondent what he told people about her reason for leaving the job. Respondent's reply stated in part: "And you're 100% right. I completely understand. I'll have that letter for you today, and will send it to your house. It will be glowing, because that's what you deserve, and I would give you a glowing recommendation regardless."

63. Patient B explained at hearing that she was concerned about getting a positive letter of recommendation because she was in graduate school studying to become a therapist, and she was applying to traineeships. (Patient B is now a licensed marriage and family therapist.)

64. On January 17, 2018, respondent wrote a letter of recommendation for Patient B, which included many detailed and positive comments regarding her job performance, professional demeanor, personal qualities, and work ethic. Respondent's letter also stated he believed that Patient B would be an excellent psychotherapist.

65. On February 3, 2018, Patient B sent respondent an email message stating:

> I was in shock the day that I was forced to quit my job. I hadn't come to terms with the fact that I had just been sexually assaulted by you. [¶] Now that I have had a few days to reflect and realize that I'm out of work because of your actions and behavior, I need to reach out. [¶] Here are my options now: I can contact an attorney and file a sexual assault lawsuit, or I will request to receive 12 months of full severance pay since I was forced to quit my job due to your behavior and lose my only source of income. Please let me know which you prefer and we can go from there.

The following day, Patient B sent respondent a text message saying, "sorry about that email," and stating that her friend had written the email. Patient B told respondent that "I don't need anything from you but a good reference."

At hearing, Patient B explained that she thought she deserved severance pay, but she confirmed that the email to respondent had been written for her by a friend,

and that she had apologized to respondent for sending it. Patient B did not follow up on any demand for severance pay, or receive any money from respondent.

66. In July 2018, Patient B received a bill from Sequoia Mind Health for treatment in July 2017 that had been denied by her insurance coverage. She sent respondent a text message stating: "Hey! Just received this bill from over a year ago. Due to the circumstances I will not be paying this bill." Respondent replied that he would take care of it.

67. After quitting her job with respondent in January 2018, Patient B did not immediately report that respondent had sexually assaulted her. She did not report the incident to her work supervisor, respondent's mother, because "that would be weird." Patient B credibly testified that she felt traumatized and confused after the sexual assault, was on edge and vigilant, and had problems sleeping.

68. Respondent told the other employees of Sequoia Mind Health that Patient B had quit because of her school work and that she felt badly about it so they should not contact her.

69. In 2019, Pamela Albro, Ph.D., a psychologist who provided therapy at Sequoia Mind Health, contacted Patient B to ask why she had quit. Patient B told her. Dr. Albro asked if she could share Patient B's name with another woman who had a similar experience. Patient B and Patient C subsequently spoke by telephone. Patient C told Patient B that respondent asked Patient C to show him her breasts during a ketamine treatment. (See Finding 95.) Patient B told Patient C that she was submitting a complaint to the Board about respondent, and that it was up to Patient C whether she made her own complaint.

70. Patient B made formal reports about respondent in March 2019. At hearing, Patient B credibly explained that with the passage of time, and having taken a law and ethics course in school that discussed doctor-patient dual relationships, she felt that she had a duty to report respondent's conduct. On March 15, 2019, Patient B made a police report, describing the sexual assault of January 12, 2018. Patient B submitted a similar complaint to the Board on March 30, 2019.

71. Also in Spring 2019, Patient B called Heather (respondent's wife) and told her about respondent's behavior.

72. On May 2, 2019, respondent's attorney sent Patient B a letter noting her email to respondent of February 3, 2018 (Finding 65), and the more recent reports to the police, the Board, and respondent's wife, and threatening Patient B with civil and criminal liability for extortion, intentional infliction of emotional distress, defamation, and libel. Patient B did not receive this letter, because she had moved to a different address.

TESTIMONY OF RESPONDENT AND HEATHER ABOUT PATIENT B

73. In discussing ketamine treatments at Sequoia Mind Health, respondent testified that Heather was present for such treatments, to monitor vital signs during the treatment, act as a chaperone, and escort patients out of the office. Heather testified that she monitored vital signs every 10 minutes during ketamine treatments, and that she was always present for such treatments, though she might step in and out of the room. The testimony of respondent and Heather on these points was inconsistent with Patient B's medical records, which did not reflect that Heather was present or that vital signs were monitored during treatment for any of Patient B's five ketamine treatments. The medical records were consistent with Patient B's testimony.

74. Respondent admitted he should not have hired Patient B or Patient C as employees, and regrets doing so. He stated that at the time, he did not think there was any ethical problem in hiring his patients, because he did not directly supervise them and they were paid by his corporation. Respondent now recognizes that hiring his patients to work for him was a "boundary crossing," which he distinguishes as being less serious than a "boundary violation."

75. Respondent denied that during ketamine treatments, he asked Patient B inappropriate sexual questions and disclosed inappropriate personal information about himself. He stated that if he asked any questions of a sexual nature, they were appropriately related to treatment.

76. Respondent denied making any sexual advance to Patient B, including kissing her or putting his finger in her vagina.

77. When questioned regarding the text messages with Patient B (see Findings 62, 65-66), respondent offered evasive and non-credible testimony that he did not remember these messages, although he admitted having had text message exchanges with Patient B. The text messages were consistent with the other documentary evidence, such as respondent's letter of recommendation, and a "timeline of events" written by respondent in which he noted that Patient B had quit by text message but stated that he no longer had the text messages in his possession (the text messages were produced by Patient B). Respondent did admit that Patient B told him she was not going to pay the late bill she received.

78. Respondent contends that Patient B's email of February 3, 2018, constituted an attempt to blackmail him. He stated that he contacted his attorney, who sent Patient B a cease-and-desist letter. However, the documents reflect that the

attorney's letter to Patient B was in May 2019, shortly after Patient B filed a Board complaint, but long after she sent and then disavowed the email of February 3, 2018. Respondent conceded that a patient who has been sexually assaulted by a doctor has a right to complain to the licensing board.

EXPERT OPINIONS REGARDING PATIENT B

79. Dr. Sahba opined that it was a violation of the standard of care and an ethical boundary violation to hire Patient B as an employee. He characterized this as a simple departure from the standard of care.

80. Dr. Sahba also opined in his report: "The fact that [respondent] chose to intertwine his employer-employee relationship with physician-patient relationship shows poor judgment and lack of awareness of ethical and boundary issues."

81. Dr. Sahba opined that, if the trier of fact determines that Patient B's allegations that respondent kissed her and inserted his finger into her vagina are true, then these acts constitute an extreme departure from the standard of care and a boundary violation. Dr. Sahba opined that any sexual contact with a patient or former patient is an extreme departure from the standard of care, a boundary violation, and unethical and unprofessional conduct.

82. Dr. Sahba's opinions regarding Patient B were uncontroverted.

Patient C

83. Patient C began treatment with respondent on May 11, 2017, following a major depressive episode with a suicide attempt that required hospitalization. Respondent diagnosed Patient C with generalized anxiety disorder, unspecified depressive disorder, panic disorder, and premenstrual dysphoric disorder. Patient C

disclosed to respondent that she had experienced past sexual trauma and assault. Respondent treated Patient C with ongoing medication management and referred her to therapy with Dr. Albro. Patient C received individual therapy from Dr. Albro at Sequoia Mind Health from September 5, 2017, to January 15, 2019.

84. Respondent hired Patient C to work at Sequoia Mind Health starting in September 2017, while he continued to treat her as a patient. Patient C initially performed administrative duties at the front desk, such as answering phones, making appointments, and checking in patients. She worked 32 hours per week, which was considered full-time. Her job duties changed over time to include more responsibility. She administered transcranial magnetic stimulation (TMS) to other patients. Patient C was later trained on duties such as billing, receiving a pay raise and promotion in January 2019 to Medical Biller and Front Office Administrator.

85. In late 2017, respondent discussed with Patient C the potential benefits of ketamine treatment to address her symptoms of depression and anxiety.

86. Patient C received seven ketamine treatments under respondent's care, from December 6, 2017, through April 5, 2019. Patient C stated at hearing that the ketamine treatments helped to temporarily subdue her depression symptoms. Five of the ketamine treatments (including the first treatment) were administered to Patient C by respondent via intramuscular injection, and two treatments (March 18, 2018 and April 5, 2019) were administered by IV. The medical records reflect that Patient C's blood pressure was measured before and after the ketamine treatments. None of the medical records reflect ongoing monitoring of vital signs during the treatment. Heather's presence was documented only for the two treatments administered via IV; the medical records for the other five treatments administered via intramuscular injection do not reflect the presence of anyone other than respondent.

87. Patient C's first ketamine treatment was on December 6, 2017, at 4:00 p.m. Patient C testified credibly, and consistent with her medical records, that only she and respondent were present for this ketamine treatment. Respondent came to the front desk to get Patient C, and they went to respondent's office for the treatment. Respondent had Patient C sign an informed consent form, and he took her blood pressure. Respondent administered the ketamine by giving Patient C an injection in her arm. Respondent then sat in a leather chair and Patient C sat on the couch.

Patient C provided the following testimony as to what happened after respondent administered ketamine to her on December 6, 2017.

Patient C noticed the effects of the ketamine within a few minutes. She described feeling "woozy," not herself, and "out of it." Eventually she felt dissociated from her body. After Patient C began feeling the effects of the ketamine, respondent began asking her questions such as how many sex partners she had had, whether she had ever had sex with women, and what she and her husband did sexually. Patient C answered respondent's questions but she found it increasingly difficult to talk and formulate words, and she felt uncomfortable.

Respondent asked Patient C to remove her top and bra to show him her breasts, which she did, standing in front of the couch. Patient C found it difficult to stand, put her bra and shirt back on, sat down, and curled up into a ball on the couch.

Respondent approached Patient C and placed headphones on her, playing ocean sounds and meditative music. Respondent moved Patient C's legs so that she was lying down on the couch. Respondent then pulled down Patient C's pants and raped her, putting his penis into her vagina. Patient C described her state of consciousness at that time as "barely there," such that she could not move or pick up

her phone to call or text her husband, and could not speak or yell out, although she stated, "I screamed in my head." Respondent then left the room. After Patient C started to regain her bearings, she used tissues to wipe her vagina and pulled up her pants, although she described herself as still not in "full capacity" of her body at that time. Patient C felt afraid, ashamed, and she wanted to go home.

Respondent returned to his office and walked Patient C out of the room to the lobby, where her husband was waiting to drive her home. Patient C's husband corroborated that she was escorted to the lobby by respondent, not Heather.

Patient C's testimony regarding the events of December 6, 2017 was credible.

88. Patient C told her husband that respondent had asked her inappropriate questions and that she had taken off her top at his request. She did not tell her husband at that time that respondent had also raped her. Patient C felt confused and ashamed. Patient C told her therapist, Dr. Albro, the same thing she told her husband, that respondent asked her inappropriate questions and that she had shown him her breasts, but she did not disclose the rape at that time. At hearing, Patient C explained that she did not want the rape to be real, and she would have to face it if she talked about it. She did not want anyone to know about the rape, due to feelings of shame.

89. Patient C did not tell other employees at Sequoia Mind Health about any details of the incident, noting that there was no human resources person other than respondent's mother, and it was not a "safe space" to make such a report.

90. When asked why she continued to work for respondent after the assault, Patient C explained that she liked the job, was receiving pay raises, and appreciated the ability to take time off or work from home if she was ill. She also described this period as a confusing time in her life.

91. Patient C credibly denied ever asking respondent to examine her breasts and render an opinion about the result of breast surgery. Patient C originally had breast augmentation surgery in 2005 or 2006, receiving saline implants. In late September 2017, upon medical recommendation, she had surgery to change her implants from saline to silicone.

As of December 6, 2017, Patient C was not having any breast problems. Patient C's husband corroborated her testimony that she did not experience any complications from the breast surgery until Spring 2018.

In mid-April 2018, Patient C developed a problem with capsular contraction as a reaction to the silicone implants. Respondent's psychiatric progress note for Patient C on April 17, 2018 states: "[W]ants it documented that she is feeling emotionally distressed about her breast implants, and is concerned that nipples are inverted." The note states that Patient C was feeling increasing insecurity, anxiety, and depression about her body image due to this problem. This is the first notation of any issue regarding Patient C's breasts in respondent's medical records.

Patient C had corrective breast surgeries in May 2018 and May 2019.

Patient C's testimony regarding the timeline of her breast surgeries and when she experienced breast problems is consistent with her work absence record, prepared by Melody.

92. In January 2019, Patient C learned about respondent's affair with Sister, when Patient A's family came to the office to confront respondent. Patient C was asked to prepare a billing statement summary for Patient A's home visits.

93. In about February 2019, respondent told Patient C and the other employees of Sequoia Mind Health that he and Heather were separating.

94. Patient C subsequently told Heather that on December 6, 2017, respondent asked her inappropriate questions and asked her to take her top off during a ketamine treatment. Patient C told Heather she was ashamed and felt sorry.

95. In Spring 2019, Patient C learned that another woman had experienced inappropriate conduct by respondent. Dr. Albro asked her during therapy sessions how she would feel if she were not alone, and asked if she was willing to have contact with the other woman. Patient C spoke to Patient B by telephone, and they told each other about their respective experiences with respondent. Patient C told Patient B that respondent asked her inappropriate questions and asked her to show him her breasts during a ketamine treatment, but did not disclose the rape.

96. Patient C resigned from her job at Sequoia Mind Health in July 2019. She gave two weeks' notice on July 10, but then contacted Melody by email on July 16 to say she would no longer be coming in and would return the office key by mail.

97. Patient C was contacted by the Board investigator, and she spoke to him on July 23, 2019. Patient C told the investigator that during a ketamine treatment, respondent had asked her inappropriate questions and asked her to remove her top. She did not tell the investigator that respondent had sexually assaulted or raped her, because she was not prepared to deal with it emotionally at that time.

98. Patient C testified credibly that she regrets not coming forward sooner with the entire account of respondent's assault.

99. Patient C has only recently talked to anyone about the rape. The first person she told was her primary care physician, Federico Leon, M.D., after she received a subpoena in Spring 2021 that sought her testimony in this disciplinary matter. She was afraid, did not know what to do, and decided to confide in Dr. Leon.

100. Patient C's medical records corroborate her testimony. On May 6, 2021, she saw Dr. Leon for increased symptoms of anxiety, depression, and posttraumatic stress disorder (PTSD) in connection with being sexually assaulted by her previous employer, described in the progress note as a psychiatrist in Sonoma. Dr. Leon noted that Patient C's symptoms had worsened and her PTSD was reactivated after she was informed that she would be required to testify against respondent in November. Dr. Leon discussed the matter with Patient C and also referred her to a therapist.

Patient C discussed the sexual assault with a licensed marriage and family therapist the next day. On June 17, 2021, Patient C spoke with behavioral health psychologist Sarah McVay, Psy.D., whose notes reflect Patient C's PTSD symptoms stemming from the sexual assault by her previous employer, and her fear and anxiety about coming forward publicly.

Throughout the Summer and Fall of 2021, Patient C continued to discuss the rape and its effect on her with Dr. Leon, Dr. McVay, and with Michael Gelb, M.D., a psychiatrist to whom Dr. Leon referred her for additional consultation. The medical records reflect Patient C's increasing distress at the prospect of confronting her trauma and testifying at hearing.

At Dr. Leon's urging, Patient C told her husband the complete account of what happened on December 6, 2017.

Dr. McVay's progress note of October 15, 2021 reflected that Patient C's anxiety had increased after receiving a subpoena for the upcoming hearing. Patient C regretted not disclosing respondent's sexual assault when she was interviewed earlier, but she did not feel ready at that time to confront the reality of being raped, so disclosed only part of the experience. Dr. McVay noted that Patient C was now ready to pursue trauma counseling and felt it was time for respondent to be held accountable for his actions.

TESTIMONY OF RESPONDENT, HEATHER, AND MELODY ABOUT PATIENT C

101. As set forth in Finding 74, respondent admitted he should not have hired Patient C, and now recognizes that hiring his patients was a "boundary crossing."

102. Respondent denied being alone with Patient C during ketamine treatments, stating that Heather was present. Heather testified that she was present for Patient C's first ketamine treatment on December 6, 2017, but stepped out at some point. The testimony of respondent and Heather is inconsistent with Patient C's medical records, which only reflected Heather's presence for two later treatments administered by IV rather than intramuscular injection.

103. Respondent denied asking Patient C sexually inappropriate questions. Respondent also denied asking Patient C to take off her top and bra, and he denied sexually assaulting her or raping her.

104. Respondent's testimony was that he did observe Patient C's breasts on December 6, 2017, but that it was at her request, as follows. Respondent stated that before he began the ketamine treatment, while Heather was not in the room, Patient C asked him to give her an opinion about her breast surgery outcome. He agreed, and then Patient C revealed her breasts to him without warning. Respondent testified that

he told Patient C to follow up with her surgeon. Respondent's testimony was that there was no time to call Heather in to act as a chaperone, but that he told Heather afterward that Patient C exposed her breasts and it made him uncomfortable. Respondent did not make any contemporaneous note in Patient C's medical record about this incident.

105. On August 1, 2019, respondent wrote the following addendum to Patient C's medical records relating to the December 6, 2017 treatment:

> ADDENDUM: prior to ketamine treatment, before ketamine was administered, client asked for my medical opinion about breast implant repair, as she was experiencing significant pain and perceived disfigurement after a recent surgery. This required a significant amount of time off work. I agreed to offer her my opinion, though did let her know that obviously surgery is not my area of expertise. I observed on visual inspection that one of her implants was indeed inverting. I validated her emotional experience and distress—which seemed to be the most helpful thing I could do at the time. I opined that this could potentially be repaired with additional surgery, and encouraged her to f/u with her surgeon. There was no physical contact of breasts. [¶] This addendum was not added prior to today's date because it was not pertinent to the treatment.

106. At hearing, respondent stated that it is within his scope as a physician to give an opinion about this medical condition. He admitted, however, that he should have contemporaneously documented such a visual observation of Patient C's breasts.

107. Heather testified that respondent told her on December 6, 2017, that Patient C asked him for an opinion about her breast surgery and exposed her breasts to him before the ketamine treatment. However, an email message offered into evidence by respondent contains Heather's statement to an investigator in May 2019, stating that Patient C called her on April 9, 2019, and told her that respondent asked to see her breasts during a ketamine treatment and she showed him. Heather's statement contains nothing to suggest that respondent had previously told her of the incident.

108. Heather testified that she walked Patient C out to the lobby after her first ketamine treatment. This testimony is inconsistent with the testimony of Patient C and the corroborating declaration of Patient C's husband.

109. Melody was the office manager for Sequoia Mind Health. She testified that she has 37 years of professional experience as an office administrator, including a number of years as executive director of a county medical association. Melody supervised Patient B and Patient C during their employment.

110. Melody testified that Patient C was a problematic employee throughout her time working for Sequoia Mind Health. Melody testified that Patient C was curt to difficult patients in stressful situation; was too friendly and informal with patients; was self-centered and focused on her appearance; needed constant praise; dressed in an overly revealing manner; had jealous interactions with co-workers; and was dishonest. Melody stated that she had counseled Patient C on several occasions regarding patient interactions and her attire, but that verbal counseling did not change her behavior. However, Melody did not document any of the above concerns in writing.

111. In contrast to the picture painted by her testimony, Melody's written documentation of Patient C's job performance was uniformly positive.

Melody prepared a performance evaluation for Patient C for the period from September 2017 to September 2018. Melody gave Patient C satisfactory or higher ratings on all job duties. Comments included: "As the face and voice of [Sequoia Mind Health], you have established great rapport with our clients and you cordially assist all visitors. You are always professional, willing to help, and pleasant." In the overall job performance summary, Melody stated: "You are a tremendous asset to Sequoia Mind Health (SMH). In your first year with us you have helped develop SMH into the effective organization envisioned by Dr. Goodwin and I." When asked at hearing why she had given Patient C this positive evaluation if she had the concerns described in her testimony, Melody's explanation was that Patient C required praise and it was difficult to suggest corrections to her. This testimony was not credible—it is not plausible that Melody, with over 30 years of experience as an administrator, would give a problem employee a positive performance evaluation to avoid hurting her feelings.

On January 22, 2019, Melody wrote a letter offering Patient C a promotion to Medical Biller and Front Office Administrator, with a 14 percent pay raise. When asked at hearing why she would promote Patient C if she was a problem employee, Melody stated that she wanted to get her away from the front desk. This testimony was not credible.

When Patient C provided notice of her intent to resign, Melody wrote a confirming letter on July 11, 2019. Melody's letter stated that as a "gift of appreciation" for her service to Sequoia Mind Health, worth $1,525, Patient C would not be required to pay back the practice for using more paid time off than she had accrued. Melody also wrote: "It's been a pleasure working with you! We appreciate your personable

demean[o]r with clients, and your continual efforts to stream line efficiency, understand billing-related issues, and help out whenever possible. We're happy to provide you a stellar letter of recommendation should you want one."

EXPERT OPINIONS REGARDING PATIENT C

Dr. Sahba

112. Dr. Sahba opined that it was a violation of the standard of care and an ethical boundary violation to hire Patient C as an employee. He characterized this as a simple departure from the standard of care.

113. Dr. Sahba opined that, if the trier of fact determines that Patient C's allegations are true, that respondent asked inappropriate sexual questions and asked her to expose her breasts during a ketamine treatment, then these acts constitute an extreme departure from the standard of care and a boundary violation. Patient C's testimony that respondent also sexually assaulted and raped her was provided after Dr. Sahba rendered his opinions, and he did not specifically address those allegations. However, Dr. Sahba did opine that any sexual advance toward or sexual contact with a patient is an extreme departure from the standard of care, a boundary violation, and unethical and unprofessional conduct. Dr. Sahba also opined that if respondent made sexual advances during a ketamine treatment, the patient would be unable to consent.

114. The above opinions of Dr. Sahba regarding Patient C were uncontroverted.

115. Regarding respondent's statements that he had a medical justification for observing Patient C's breasts and his non-contemporaneous addendum to the medical record, Dr. Sahba stated that it would be "highly unusual" for a psychiatrist to examine

a patient's breasts. Even if the patient had a delusion or depression regarding her breast that related to her mental health treatment and insisted that the psychiatrist view it, Dr. Sahba opined that the standard of care requires the psychiatrist to provide a gender-preferred chaperone and to contemporaneously document the visual observation, why it pertains to the treatment, and who was present as chaperone. Dr. Sahba opined that failure to take these steps is a departure from the standard of care, and that respondent's addendum was inadequate. Dr. Sahba also found it significant that respondent made no contemporaneous documentation of Patient C's purported request for him to view her breasts, and that he then prepared the addendum while the Board was investigating complaints against him.

Dr. McCarron

116. Dr. McCarron repeated respondent's statement that he agreed to visually examine Patient C's breast due to her concern about the result of her surgery. Dr. McCarron opined that such a visual examination was within the standard of care and that there was a medical reason for the examination, to address Patient C's emotional complaints. He also noted respondent's admission that the addendum documenting this explanation was untimely.

Respondent's Additional Evidence

117. Respondent and Heather met in 2001 when she was a high school senior and he was in college. They have been married since 2011, when respondent was in medical school. They have two children; the younger child was born several months before respondent opened his practice in 2016. Respondent opening his own practice had a negative impact on his relationship with his wife and children, due to the number of hours he was working. After respondent's affair with Sister was made public

in early 2019, respondent and Heather separated and began divorce proceedings. They subsequently reconciled after attending counseling.

118. Respondent stated that closing his private practice in 2019 and taking a job where he could focus on clinical practice was beneficial for his work-life balance.

119. Respondent described these disciplinary proceedings as a "wake-up call," stating that he had made some "mistakes" and "errors in judgment."

120. Respondent testified that he had only minimal training on ethics and professionalism in medical school and residency, with no specific course on the topic. However, respondent's medical school transcript reflects that he took four separate semester-long courses entitled "Professionalism." Respondent stated at hearing that he had no recollection of the lecture content or curriculum. Respondent stated that he did not remember whether the AMA or APA ethical principles were covered during his residency program.

121. In 2021, respondent took a course in Practical Ethics and Professionalism from the Western Institute of Legal Medicine. He stated that he learned in this course that hiring patients as employees was a boundary crossing.

REFERENCES

122. In addition to the testimony of his wife, Heather, and his mother, Melody, respondent offered six other witnesses as character and professional references.

123. Timothy Schraeder, L.M.F.T., is respondent's current employer. Schraeder is the CEO of Redwood Quality Management Company, which provides specialty mental health services for Mendocino County. He hired respondent in October 2019. Respondent did not tell Schraeder about the pending Board investigation when he was

hired, but did so after the accusation was filed, stating the allegations of Patient B and Patient C were false and his affair with Sister was unrelated to his care of Patient A. Schraeder told the director of county behavioral health about the accusation, and they decided to place respondent on telehealth services. Schraeder stated that respondent provides a high level of care to patients and he has heard no complaints about him.

124. Leandra Corpuz is a certified medical assistant who works with respondent at Redwood Quality Management Company and supervises its clinic. She stated that respondent has been a positive addition to their clinic, and she believes he is trustworthy. She was told there is a pending accusation, but not the details of it.

125. Michael Medvin, M.D., is the medical director at Mendocino County Jail and Lake County Jail, and has worked with respondent at those jails. Dr. Medvin stated that respondent is an excellent and professional psychiatrist with a strong work ethic, and compassion for the incarcerated patient population. He has read the accusation, and finds its allegations unbelievable.

126. Cheri Stone, R.N., is a psychiatric nurse at Mendocino County Jail, and worked with respondent there. Stone stated that respondent had a good work ethic, and she did not observe any inappropriate or unprofessional behavior.

127. Kimberly Silva, F.N.P., has known respondent since 2012 when he was a psychiatric resident at San Francisco General Hospital and she was a registered nurse. Respondent was also recently Silva's preceptor during her nurse practitioner training. Silva stated that respondent shows empathy for patients and she has observed positive outcomes for patients under his care. She has not observed him engage in any unprofessional behavior.

128. Charles Collins is a retired attorney and has been respondent's friend for more than 15 years. He admires respondent's perseverance, work ethic, and dedication to serving vulnerable populations. Collins has not read the accusation and is not aware of the specific factual allegations in this matter.

Ultimate Factual Findings

CREDIBILITY

129. The facts regarding respondent's relationship with Sister are largely undisputed. Where the testimony of Sister and respondent differed, Sister's testimony was more credible.

130. Respondent testified that he did not know his relationship with Sister was an ethical or boundary violation, but his conduct and statements indicate he did know. Tellingly, respondent testified that he knew once his affair with Sister became public, he would have to refer Patient A to another psychiatrist. (Finding 42.) After Patient A's family discovered the affair and complained to the Board, respondent ghostwrote a letter from Sister to the Board, using language clearly designed to address the ethical standards. (Finding 32.)

131. Sister credibly testified that respondent prescribed abortion medication for her, and this is consistent with the documentary evidence. (Findings 28, 34, 44.) Respondent's testimony that he did not prescribe misoprostol, and his subsequent testimony that his telephone conversation with a pharmacist was misinterpreted, was not credible. (Finding 44.) Moreover, the manner in which respondent presented this non-credible story demonstrated a lack of candor at hearing. (*Id.*)

132. Respondent contends that the sexual misconduct allegations by Patient B and Patient C are false. Respondent argues that Patient B and Patient C conspired to make up and pursue false allegations, to seek revenge against respondent for being unfaithful to his wife, their co-worker Heather, even after Heather reconciled with respondent. This far-fetched theory is not persuasive.

133. Respondent also argues that Patient B and Patient C had financial motives in accusing him, but this is unpersuasive. Patient B disavowed her request for severance pay the day after sending the email that respondent characterizes as a blackmail attempt, and she never followed up on any request for money or received any. (Finding 65.) There is no evidence that Patient C has made any monetary demand of respondent.

134. Alternatively, respondent suggests that Patient B and Patient C were experiencing hallucinations or delusions as a product of their mental disorders, and/or as an effect of ketamine treatment. This is unsupported by the evidence, and unpersuasive.

135. Patient B's testimony was credible and consistent with her medical records and other documentary evidence. Respondent and Heather testified that Heather was present for all ketamine treatments, and that Heather monitored vital signs on an ongoing basis during those treatments. This testimony was inconsistent with Patient B's medical records, which do not show Heather's presence or ongoing monitoring of vital signs during ketamine treatments. (Findings 59, 73.)

136. The testimony of Patient B and Patient C regarding respondent's sexually inappropriate questions during ketamine treatments was consistent, and credible. (Findings 60, 87.)

137. Patient B's testimony that on January 12, 2018, respondent kissed her, put his hand in her pants, and penetrated her vagina with his finger, was credible. (Finding 61.) This incident did not occur during a ketamine treatment; any suggestion that Patient B's sexual assault allegation is a drug-induced hallucination fails.

138. Patient B's testimony about quitting her job, respondent's response, and her subsequent refusal to pay a late bill, is consistent with their text messages. (Findings 62-66.) Respondent's testimony that he did not remember these text messages was evasive and non-credible. (Finding 77.)

139. Melody, respondent's mother, testified at some length that Patient C was a bad employee, in an apparent attempt to undermine Patient C's credibility. But documents created by Melody reflected that Patient C was an excellent employee, and Melody's testimony on this topic was not credible. (Findings 109-111.)

140. Patient C's testimony that respondent was alone with her during her first ketamine treatment on December 6, 2017 was credible and consistent with her medical records. (Finding 86, 87.) Respondent's and Heather's testimony that Heather was present is inconsistent with the medical record and not credible. (Finding 102.) Patient C's testimony that respondent walked her out to the lobby after the treatment was corroborated by her husband. (Finding 87.) Heather's testimony that she escorted Patient C to the lobby after the treatment (Finding 108) was not credible.

141. Patient C's account of when she had breast surgeries, and that she was not experiencing any problems with her breasts in December 2017, was credible and was corroborated by her husband, her medical records, and the absence record prepared by Melody. (Finding 91.)

142. Respondent's testimony that he observed Patient C's breasts on December 6, 2017, but that it was at her request (Finding 104), is not credible. Patient C was not experiencing problems with her breasts in December 2017. Respondent testified that Patient C exposed her breasts to him without warning, which he told Heather about that day. Heather backed up respondent's story, but her testimony at hearing was inconsistent with her prior statement to an investigator. (Finding 107.) Tellingly, respondent did not document that Patient C was having any breast problems prior to April 2018, and he wrote the addendum with his post-hoc explanation on August 1, 2019, while the Board was investigating sexual misconduct allegations against him. Respondent's medical record addendum was not accurate.

143. Respondent contends that Patient C's allegation of rape is not credible because she did not disclose it until her testimony at hearing. This is not persuasive. Considering the evidence as a whole, Patient C's testimony regarding the events of December 6, 2017, as set forth in Finding 87, was credible. Patient C's account of what happened that day has been consistent over time with respect to respondent asking her sexually inappropriate questions and asking her to show him her breasts. She previously gave a truthful, but incomplete, account of events to her husband, her therapist, Patient B, Heather, and the Board investigator. (Findings 69, 88, 94-95, 97.) Patient C's testimony regarding her reasons for not disclosing the rape earlier rang true, was credible, and was consistent with her medical records from 2021. (Findings 88, 97-100.) Moreover, the fact that Patient C was reluctant to provide the full details of the rape until required to testify under oath is consistent with her testimony that she previously was unprepared to emotionally process the events, and is inconsistent with respondent's narrative that Patient C was intentionally fabricating an outrageous story to harm him.

UNPROFESSIONAL CONDUCT

Conduct Regarding Sister

144. Dr. Sahba's opinions regarding respondent's relationship with Sister were more persuasive than the opinions of Dr. Polfliet and Dr. McCarron, which were unconvincing.

145. As was persuasively explained by Dr. Sahba (Finding 45), the standard of care requires that psychiatrists practice in accordance with ethical principles, including the ethical standards set forth in Findings 9 through 11. Dr. Polfliet and Dr. McCarron agreed that the AMA and APA ethical principles apply to physicians generally. (Findings 49, 52-53.)

146. Dr. Sahba's opinions were persuasive that Sister was a key third party in Patient A's treatment; that Patient A shared many commonalities with minors; and that respondent's romantic and sexual relationship with Sister was a violation of ethical standards. (Findings 46-47.) Dr. Polfliet's opinion that there was no ethical violation hinged on the fact that Patient A was an adult, and on her belief that Sister was not the primary caregiver. However, Dr. Polfliet later conceded that various factors made Sister a key third party. (Findings 50-51.) Dr. McCarron's opinion that respondent's relationship with Sister was not an ethical violation similarly depended on Sister not being the primary caregiver—he did not persuasively address the factors making Sister a key third party in Patient A's care. (Finding 55.)

147. Dr. Sahba's opinion that respondent's relationship with Sister was a simple departure from the standard of care was persuasive. (Finding 47.)

148. Dr. Sahba's opinion was also persuasive that respondent's behavior demonstrated a lack of knowledge about ethical boundaries. (Finding 47.)

149. Dr. Sahba's opinions regarding respondent's actions in prescribing misoprostol to Sister without creating a medical record are persuasive, and were uncontroverted by respondent's experts. It was a simple departure from the standard of care for respondent to prescribe abortion medication to his sexual partner, and for him to not create a medical record. (Finding 48.)

Conduct Regarding Patient B

150. The opinions of Dr. Sahba regarding respondent's conduct toward Patient B were uncontroverted, and were persuasive. (Findings 79-82.)

151. Respondent's hiring of Patient B as an employee was an ethical boundary violation, and a simple departure from the standard of care. (Finding 79.)

152. Respondent's hiring of Patient B and forming a dual relationship also showed a lack of awareness of ethical and boundary issues. (Finding 80.)

153. Dr. Sahba opined persuasively that it would be an extreme departure from the standard of care, an ethical boundary violation, and unprofessional conduct for respondent to have sexual contact with Patient B. (Finding 81.) As set forth in Finding 137, Patient B's allegation of sexual assault is found to be credible.

Conduct Regarding Patient C

154. The opinions of Dr. Sahba regarding respondent's conduct toward Patient C were persuasive, and almost entirely uncontroverted. (Findings 112-115.)

155. Respondent's hiring of Patient C as an employee was an ethical boundary violation, and a simple departure from the standard of care. (Finding 112.)

156. Dr. Sahba persuasively opined that it would be an extreme departure from the standard of care for respondent to ask Patient C inappropriate sexual questions and ask her to expose her breasts during a ketamine treatment. (Finding 113.) As set forth in Finding 136 and 143, those allegations by Patient C are found to be credible. Furthermore, Dr. Sahba persuasively opined that any sexual advance toward or sexual contact with a patient is an extreme departure from the standard of care, an ethical boundary violation, and unprofessional conduct. (Finding 113.) As set forth in Finding 143, the allegations of Patient C that respondent sexually assaulted and raped her are found to be credible.

157. Dr. Sahba's opinion that respondent's non-contemporaneous addendum to Patient C's medical records was inadequate and a departure from the standard of care is persuasive. (Finding 115.) Dr. McCarron's opinion, that respondent did not depart from the standard of care in his stated explanation for visually assessing Patient C's breasts, was not persuasive. (Finding 116.) And even Dr. McCarron noted that the addendum was untimely. Moreover, as set forth in Finding 142, respondent's medical record addendum has been found to be inaccurate.

Costs

158. The Board seeks to recover a total of $64,493.50 in costs for investigation and enforcement in this case. These costs include $47,697.50 for attorney and paralegal time from the Department of Justice; $6,696 in investigation costs; and $10,100 in subject matter expert costs. The claim for costs is supported by declarations

that comply with California Code of Regulations, title 1, section 1042, and is found to be reasonable.

LEGAL CONCLUSIONS

1. It is complainant's burden to establish the truth of the allegations by "clear and convincing evidence to a reasonable certainty," and that the allegations constitute cause for discipline of respondent's certificate. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The factual findings above rest on clear and convincing evidence.

2. The burden of establishing rehabilitation is on respondent and the standard of proof is a preponderance of the evidence. (*Whetstone v. Board of Dental Examiners* (1927) 87 Cal.App. 156, 164; Evid. Code, §§ 115, 500.)

3. The Board regulates licensing and discipline of osteopathic physicians and surgeons. (Bus. & Prof. Code, § 2450.)[4] Osteopathic physicians and surgeons are governed by the Osteopathic Act, found at section 3600, et seq.[5] The Board is required to enforce the provisions of the Medical Practice Act (§§ 2220, et seq.) that apply to persons holding certificates subject to the Board's jurisdiction. (§§ 2452, 3600-2.)

4. The Board may discipline respondent's physician's and surgeon's certificate if he has engaged in unprofessional conduct. (§§ 2227, subd. (a) & 2234.)

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[4] Subsequent statutory references are to the Business and Professions Code.

[5] The Osteopathic Act is an initiative measure, set forth in West's Edition of the Business and Professions Code at sections 3600-1 through 3600-5.

Unprofessional conduct includes, but is not limited to, violating the Medical Practice Act, gross negligence, repeated negligent acts, and incompetence. (§ 2234, subds. (a), (b), (c), (d).)

First Cause for Discipline (Patient A's Sister: Gross Negligence, Repeated Negligent Acts, Incompetence, Ethical Violations)

5. Respondent's conduct in having a romantic and sexual relationship with Sister was a violation of ethical standards and constituted unprofessional conduct. (Finding 146.) Cause for discipline for unprofessional conduct exists under sections 2227 and 2234.

6. Complainant alleged that respondent committed gross negligence in having a relationship with Sister. An extreme departure from the standard of care constitutes gross negligence. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) The matters set forth in Findings 144 through 149 did not establish that respondent committed an extreme departure from the standard of care by having a relationship with Sister. Cause for discipline does not exist on this basis under sections 2227 and 2234, subdivision (b).

7. Repeated negligent acts are grounds for discipline, if there are two or more separate and distinct negligent acts. (§ 2234, subd. (c).) Complainant alleges that respondent committed repeated negligent acts in his conduct toward Sister. The evidence established that respondent committed simple departures from the standard of care in having a romantic and sexual relationship with Sister, in prescribing abortion medication to his sexual partner, and in failing to document the prescription or create a medical record. (Findings 147, 149). Cause for discipline exists for repeated negligent acts in connection with Sister under sections 2227 and 2234, subdivision (c).

8. Complainant alleges that respondent is subject to discipline for incompetence in having a romantic and sexual relationship with Sister. The evidence established that respondent's behavior demonstrated a lack of knowledge about ethical boundaries. (Findings 145, 148.) Cause for discipline for incompetence exists under sections 2227 and 2234, subdivision (d).

Second Cause for Discipline (Patient B: Gross Negligence, Repeated Negligent Acts, Sexual Misconduct, Ethical Violations)

9. By hiring Patient B as an employee and creating a dual relationship, respondent violated ethical standards and committed unprofessional conduct. (Finding 151.) Cause for discipline for unprofessional conduct exists under sections 2227 and 2234.

10. Complainant alleges that respondent committed repeated negligent acts in his conduct toward Patient B. The evidence established that respondent's hiring of Patient B as an employee was a simple departure from the standard of care. (Finding 151.) However, the evidence did not establish that respondent committed repeated negligent acts as to Patient B as alleged by complainant. Cause for discipline does not exist on this basis under sections 2227 and 2234, subdivision (c), as to Patient B.

11. Respondent's conduct in making unwanted sexual advances toward, kissing, and sexually assaulting Patient B by penetrating her vagina with his finger, is an extreme departure from the standard of care and constitutes gross negligence. (Findings 61, 137, 153.) Cause for discipline for gross negligence as to Patient B exists under sections 2227 and 2234, subdivision (b).

12. Section 726 provides that a licensee's "commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes

unprofessional conduct and grounds for disciplinary action." Respondent's conduct toward Patient B as described in Findings 61 and 137 constitutes sexual misconduct. Cause for discipline for sexual misconduct exists under sections 726, 2227, and 2234.

Third Cause for Discipline (Patient C: Gross Negligence, Repeated Negligent Acts, Sexual Misconduct, Ethical Violations)

13. By hiring Patient C as an employee and creating a dual relationship, respondent violated ethical standards and committed unprofessional conduct. (Finding 155.) Cause for discipline for unprofessional conduct exists under sections 2227 and 2234.

14. The evidence established that respondent committed simple departures from the standard of care in hiring Patient C as an employee, and in creating an inaccurate and non-contemporaneous addendum to Patient C's medical record. (Findings 142, 155-156.) Cause for discipline exists for repeated negligent acts as to Patient C, under sections 2227 and 2234, subdivision (c).

15. Respondent's conduct in asking Patient C inappropriate sexual questions and asking her to expose her breasts during a ketamine treatment, and then sexually assaulting and raping her, is an extreme departure from the standard of care and constitutes gross negligence. (Findings 87, 143, 156.) Cause for discipline for gross negligence as to Patient C exists under sections 2227 and 2234, subdivision (b).

16. Respondent's conduct toward Patient C as described in Findings 87, 143, and 156 constitutes sexual misconduct. Cause for discipline for sexual misconduct exists under sections 726, 2227, and 2234.

Fourth Cause for Discipline (Patients B and C: Sexual Exploitation)

17. Section 729, subdivision (a), provides that any physician or surgeon "who engages in an act of sexual intercourse, sodomy, oral copulation, or sexual contact with a patient or client . . . is guilty of sexual exploitation." Consent is not a defense. Subdivision (c)(3) defines "sexual contact" as "sexual intercourse or the touching of an intimate part of a patient for the purpose of sexual arousal, gratification, or abuse."

Respondent's conduct toward Patient B in putting his hand in her pants and penetrating her vagina with his finger was sexual contact constituting sexual exploitation under section 729, and unprofessional conduct. (Findings 61, 137.)

Respondent's conduct toward Patient C by putting his penis in her vagina and raping her constitutes sexual exploitation under section 729, and unprofessional conduct. (Findings 87, 143.)

Separate cause for discipline exists for sexual exploitation both as to Patient B and as to Patient C under sections 729, 2227, and 2234.

Fifth Cause for Discipline (Sister and Patient C: Failure to Maintain Adequate and Accurate Records)

18. Failure to maintain adequate and accurate records relating to the provision of services to patients constitutes unprofessional conduct and is grounds for discipline by the Board. (§ 2266.)

19. Respondent failed to maintain adequate and accurate records by failing to document his prescription for Sister or create any medical record for her (Findings 28, 48, 149), and by creating an inaccurate and non-contemporaneous addendum to Patient C's medical record (Findings 105, 115, 142, 157). Separate cause for discipline

exists for failure to maintain adequate and accurate medical records as to Sister and as to Patient C under sections 2227, 2234, and 2266.

Determination of Discipline

20. Protection of the public is the highest priority for the Board in exercising its licensing, regulatory, and disciplinary functions. (Bus. & Prof. Code, § 2450.1.) Whenever the protection of the public is inconsistent with other interests sought to be promoted, public protection is paramount.

21. California Code of Regulations, title 16, section 1663, requires the Board to consider its disciplinary guidelines when determining the appropriate measure of discipline. The guidelines note that individual penalties may vary depending on the particular circumstances of a case, including aggravation or mitigation. Under the guidelines, the maximum discipline for the violations charged is revocation. The minimum discipline for violation of section 2234 (unprofessional conduct) is revocation, stayed, with five years of probation. The minimum discipline for violation of section 726 (sexual misconduct) is revocation, stayed, with 10 years of probation.

22. Apart from the disciplinary guidelines, section 2246 provides:

> Any proposed decision or decision issued under this article that contains any finding of fact that the licensee engaged in any act of sexual exploitation, as described in paragraphs (3) to (5), inclusive, of subdivision (b) of Section 729, with a patient shall contain an order of revocation. The revocation shall not be stayed by the administrative law judge.

Findings of fact have been made in this decision that respondent committed acts of sexual exploitation toward two patients, as described in section 729, subdivision (b)(3). (Findings 61, 87, 137, and 143 and Legal Conclusion 17.) Accordingly, section 2246 requires that the discipline imposed is revocation of respondent's license.

23. However, even if one were to believe respondent's denial of sexual assaults on Patient B and Patient C, his overall course of conduct in committing multiple other ethical violations and violations of the Medical Practice Act in connection with Patient A's Sister, Patient B, and Patient C; his attitude toward and lack of insight into his offenses; and his lack of candor at hearing demonstrate that revocation of respondent's license is required for protection of the public.

Other Matters

24. All contentions raised by the parties were considered, and to the extent those contentions are not expressly addressed in this decision, they were found to be without merit.

Costs

25. A licensee found to have committed a violation of the licensing act may be required to pay the Board the reasonable costs of its investigation and prosecution of the case. (Bus. & Prof. Code, § 125.3.) Respondent has committed violations of the licensing act. (Legal Conclusions 5, 7-9, 11-17, 19.) As set forth in Finding 158, the reasonable costs of investigation and prosecution in this matter are $64,493.50.

26. In *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45, the California Supreme Court set forth standards for determining whether costs

should be assessed in the particular circumstances of each case, to ensure that licensees with potentially meritorious claims are not deterred from exercising their right to an administrative hearing. Those standards include whether the licensee has been successful at hearing in getting the charges dismissed or reduced, the licensee's good faith belief in the merits of his or her position, whether the licensee raised a colorable challenge to the proposed discipline, financial ability of the licensee to pay, and whether the scope of investigation was appropriate to the alleged misconduct. None of these considerations support reducing the Board's cost recovery in this case.

ORDER

1. Osteopathic Physician's and Surgeon's Certificate No. 20A 13049, issued to respondent Cuyler Burns Goodwin, D.O., is revoked.

2. Respondent Cuyler Burns Goodwin, D.O., shall pay to the Osteopathic Medical Board of California $64,493.50 as reimbursement for its costs of investigation and enforcement.

DATE: 02/14/2022

Holly M. Baldwin

HOLLY M. BALDWIN
Administrative Law Judge
Office of Administrative Hearings

DECLARATION OF SERVICE BY MAIL

In the Matter of the Accusation Against:

Cuyler Burns Goodwin, D.O.
Case No: 900-2019-000047

I, the undersigned, declare that I am over 18 years of age and not a party to the within cause; my business address is 1300 National Drive, Suite 150, Sacramento, CA 95834. I served a true copy of the attached:

PROPOSED DECISION
DECISION

by mail on each of the following, by placing it in an envelope (or envelopes) addressed (respectively) as follows:

NAME AND ADDRESS	CERT NO.
Cuyler Burns Goodwin, D.O. 711 Medford Center, Suite 347 Medford, OR 97504-6772	9489 0090 0027 6244 3712 54
Cuyler Burns Goodwin, D.O. [redacted]	9489 0090 0027 6244 3712 61

Each said envelope was then, on March 8, 2022 sealed and deposited in the United States mail at Sacramento, California, the county in which I am employed, with the postage thereon fully prepaid and return receipt requested.

Executed on March 8, 2022, at Sacramento, California.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

James C. Sparks
Typed Name

James C. Sparks
Signature

cc: Holly M. Baldwin, Administrative Law Judge
Jane Zack Simon, Supervising Deputy Attorney General
Marvin Firestone, M.D., Attorney