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

In the Matter of the Accusation Against: **JOHN LEE, M.D.** **(Previously Known As Dirk De Brito, M.D.)** **4358 Chevy Chase Drive** **La Canada, CA 91011** **Physician's and Surgeon's Certificate No. A 66604,** Respondent.	Case No. 800-2019-058671 **ACCUSATION**

PARTIES

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

2. On or about October 2, 1998, the Medical Board issued Physician's and Surgeon's Certificate Number A 66604 to Dirk De Brito, M.D. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2022, unless renewed. On or about March 15, 2022, Dirk De Brito changed his name with the Board to John Lee (Respondent).

JURISDICTION

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

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

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

(b) The administration and hearing of disciplinary actions.

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

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

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

(f) Approving undergraduate and graduate medical education programs.

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

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

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

5. Section 2220 of the Code states:

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

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

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in

damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

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

6. Section 2227 of the Code states:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

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

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

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

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

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

7. Section 2228 of the Code states:

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

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

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

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

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

8. Section 2228.1 of the Code states.

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board and the Podiatric Medical Board of California shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information internet web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information internet web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

STATUTORY PROVISIONS

9. Section 725 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

10. Section 726 of the Code states:

(a) The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for

disciplinary action for any person licensed under this or under any initiative act referred to in this division.

(b) This section shall not apply to consensual sexual contact between a licensee and his or her spouse or person in an equivalent domestic relationship when that licensee provides medical treatment, to his or her spouse or person in an equivalent domestic relationship.

11. Section 729 of the Code states:

(a) Any physician and surgeon, psychotherapist, alcohol and drug abuse counselor or any person holding himself or herself out to be a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor, who engages in an act of sexual intercourse, sodomy, oral copulation, or sexual contact with a patient or client, or with a former patient or client when the relationship was terminated primarily for the purpose of engaging in those acts, unless the physician and surgeon, psychotherapist, or alcohol and drug abuse counselor has referred the patient or client to an independent and objective physician and surgeon, psychotherapist, or alcohol and drug abuse counselor recommended by a third-party physician and surgeon, psychotherapist, or alcohol and drug abuse counselor for treatment, is guilty of sexual exploitation by a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor.

(b) Sexual exploitation by a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor is a public offense:

(1) An act in violation of subdivision (a) shall be punishable by imprisonment in a county jail for a period of not more than six months, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(2) Multiple acts in violation of subdivision (a) with a single victim, when the offender has no prior conviction for sexual exploitation, shall be punishable by imprisonment in a county jail for a period of not more than six months, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(3) An act or acts in violation of subdivision (a) with two or more victims shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for a period of 16 months, two years, or three years, and a fine not exceeding ten thousand dollars ($10,000); or the act or acts shall be punishable by imprisonment in a county jail for a period of not more than one year, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(4) Two or more acts in violation of subdivision (a) with a single victim, when the offender has at least one prior conviction for sexual exploitation, shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for a period of 16 months, two years, or three years, and a fine not exceeding ten thousand dollars ($10,000); or the act or acts shall be punishable by imprisonment in a county jail for a period of not more than one year, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(5) An act or acts in violation of subdivision (a) with two or more victims, and the offender has at least one prior conviction for sexual exploitation, shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for a period of 16 months, two years, or three years, and a fine not exceeding ten thousand dollars ($10,000).

For purposes of subdivision (a), in no instance shall consent of the patient or client be a defense. However, physicians and surgeons shall not be guilty of sexual exploitation for touching any intimate part of a patient or client unless the touching is outside the scope of medical examination and treatment, or the touching is done for sexual gratification.

(c) For purposes of this section:

(1) Psychotherapist has the same meaning as defined in Section 728.

(2) Alcohol and drug abuse counselor means an individual who holds himself or herself out to be an alcohol or drug abuse professional or paraprofessional.

(3) Sexual contact means sexual intercourse or the touching of an intimate part of a patient for the purpose of sexual arousal, gratification, or abuse.

(4) Intimate part and touching have the same meanings as defined in Section 243.4 of the Penal Code.

(d) In the investigation and prosecution of a violation of this section, no person shall seek to obtain disclosure of any confidential files of other patients, clients, or former patients or clients of the physician and surgeon, psychotherapist, or alcohol and drug abuse counselor.

(e) This section does not apply to sexual contact between a physician and surgeon and his or her spouse or person in an equivalent domestic relationship when that physician and surgeon provides medical treatment, other than psychotherapeutic treatment, to his or her spouse or person in an equivalent domestic relationship.

(f) If a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor in a professional partnership or similar group has sexual contact with a patient in violation of this section, another physician and surgeon, psychotherapist, or alcohol and drug abuse counselor in the partnership or group shall not be subject to action under this section solely because of the occurrence of that sexual contact.

12. Section 2234 of the Code, states:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or

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

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

13. Section 2241 of the Code states:

(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

(d)(1) For purposes of this section and Section 2241.5, addict means a person whose actions are characterized by craving in combination with one or more of the following:

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.

14. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of the patient's practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

15. Section 2266 of the Code states:

The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

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CONTROLLED SUBSTANCES/DANGEROUS DRUGS

16. Section 4021 of the Code states:

"Controlled substance" means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

17. Section 4022 of the Code provides:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

DRUG DEFINITIONS

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

"Adderall" and "Adderall extended release," also known by its generic name amphetamine and dextroamphetamine is a stimulant used to treat Attention-deficit hyperactivity disorder (ADHD). It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d)(1), and a dangerous drug pursuant to Code section 4022.

"Acyclovir" is an antiviral drug used to treat infections caused by certain types of viruses. It is a dangerous drug as defined in Code section 4022.

"Amoxicillin Clavulanate" is an antibiotic used to treat bacterial infections. It is a dangerous drug as defined in Code section 4022.

"Cephalexin" is an antibiotic used to treat bacterial infections. It is a dangerous drug as defined in Code section 4022.

"Ciprofloxacin" is an antibiotic used to treat bacterial infections. It is a dangerous drug as defined in Code section 4022.

"Cocaine" is an intense, euphoria-producing stimulant drug with strong addictive potential. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(6), and a dangerous drug pursuant to Code section 4022.

"CURES" means the Department of Justice, Bureau of Narcotics Enforcement's California Utilization, Review and Evaluation System (CURES) for

the electronic monitoring of the prescribing and dispensing of Schedule II, III, IV and V controlled substances dispensed to patients in California pursuant to Health and Safety Code section 11165. The CURES database captures data from controlled substance prescriptions filled as submitted by pharmacies, hospitals, and dispensing physicians. Law enforcement and regulatory agencies use the data to assist in their efforts to control the diversion and resultant abuse of controlled substances. Prescribers and pharmacists may request a patient's history of controlled substances dispensed in accordance with guidelines developed by the Department of Justice.

"Divalproex" is an antiepileptic medication used to treat seizures. It has also been used to treat panic and anxiety disorders. It is a dangerous drug as defined in Code section 4022.

"Gabapentin" is an anticonvulsant medication used to treat partial seizures, neuropathic pain, hot flashes, and restless legs syndrome. It can have potentially harmful effects when combined with stimulants. It is a dangerous drug as defined in Code section 4022.

"Levofloxacin" is an antibiotic used to treat bacterial infections. It is a dangerous drug as defined in Code section 4022.

"Marijuana" is a mind-altering drug that has a high potential for abuse. It is a Schedule I controlled substance pursuant to Health and Safety Code section 11054, subdivision (d)(13), and a dangerous drug pursuant to Code section 4022.

"Methylenedioxymethampheatmine (MDMA)," commonly known as molly or ecstasy, is a psychoactive drug that alters mood and perception and has a high potential for abuse. It is a Schedule I controlled substance pursuant to Health and Safety Code section 11054, subdivision (d)(5), and a dangerous drug pursuant to Code section 4022.

"Oxcarbazepine" is an antiepileptic medication used to prevent seizures. It may also be prescribed "off-label" for nerve pain or as a mood stabilizer. It is a dangerous drug pursuant to Code section 4022.

"Propranolol" is a beta blocker used to treat heart conditions, anxiety, and prevent migraines. It is a dangerous drug pursuant to Code section 4022.

"Strattera" also known by its generic name atomoxetine, is a nonstimulant medication used to treat ADHD. It is a dangerous drug pursuant to Code section 4022.

"Sulfamethoxazole and trimethoprim" is an antibiotic combination used to treat bacterial infections. It is a dangerous drug as defined in Code section 4022.

"Venlafaxine," also known by the brand name Effexor, is an antidepressant and nerve pain medication classified as a selective serotonin and norepinephrine reuptake inhibitors (SNRIs). It is a dangerous drug pursuant to Code section 4022.

"Vyvanse," also known by its generic name lisdexamfetamine, is a stimulant used to treat Attention-deficit hyperactivity disorder (ADHD). It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d)(3), and a dangerous drug pursuant to Code section 4022.

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COST RECOVERY

19. Section 125.3 of the Code states:

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

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

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

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

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

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

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

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

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

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

(j) This section does not apply to any board if a specific statutory provision in

that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FIRST CAUSE FOR DISCIPLINE

(Sexual Exploitation of Patient 1[1])

20. Respondent is subject to disciplinary action under section 729 of the Code in that he engaged in the sexual exploitation of Patient 1. The circumstances are as follows:

21. In response to the Board's investigation of Respondent's care and treatment of Patient 1, Respondent produced certified medical records for Patient 1 from his office reflecting care and treatment rendered to Patient 1 on six occasions. Respondent documented progress notes for office visits on October 5, 2016, November 9, 2016, May 4, 2017, May 17, 2018, October 29, 2018, and November 14, 2018. Respondent electronically signed each of the progress notes on July 2, 2020.

22. Patient 1's certified medical records from Respondent's office also contains an undated patient rights form, consent for protected health information, and a form regarding billing. The forms have signatures reflecting Patient 1's name.

23. For each visit recorded in Patient 1's certified medical records, Respondent documented his assessment as Bipolar II disorder and prescribed oxcarbazepine. On October 5, 2016 and November 14, 2018, Respondent notes that he was acting as a consultant in providing Patient 1's care and treatment. Respondent does not identify Patient 1's primary psychiatrist and does not document any coordination of care with that psychiatrist. In addition to the oxcarbazepine, on October 29, 2018 and November 14, 2018, Respondent documented that he also prescribed amoxicillin. Respondent documented that on November 14, 2018, he discharged Patient 1 from his practice and that she agreed to obtain any refills of medications from her primary care physician.

24. Patient 1 stated to the Board that she never saw Respondent in his office for a medical visit and never had a physical examination or evaluation by Respondent. Patient 1 stated that Respondent prescribed medications for her without being seen in his office. On at least two of the dates Respondent documented that Patient 1 was seen for office visits, Patient 1 was out of

[1] The patients in this Accusation are identified by numbers to protect their privacy.

town. In addition, Patient 1 states the signature on the undated patient rights form, consent for protected health information, and a form regarding billing is not her signature.

25. Respondent issued multiple prescriptions to Patient 1 from February 8, 2015 to August 5, 2020:

a. On May 25, 2015, Patient 1 filled a prescription for Levofloxacin, prescribed by Respondent.

b. On May 27, 2015, Patient 1 filled a prescription for Ciprofloxacin, prescribed by Respondent.

c. On June 18, 2015, Patient 1 filled a prescription for 90 tablets of Divalproex (125 mg), prescribed by Respondent.

d. On September 20, 2015, November 5, 2015, and January 23, 2016, Patient 1 filled prescriptions for Ciprofloxacin, prescribed by Respondent.

e. On May 29, 2016, Patient 1 filled a prescription for Ciprofloxacin prescribed by Respondent.

f. On June 3, 2016 and July 15, 2016, Patient 1 filled a prescriptions for sulfamethoxazole-trimethoprim, prescribed by Respondent.

g. On July 25, 2016, Patient 1 filled a prescription for Amoxicillin Clavulanate, prescribed by Respondent.

h. On November 19, 2016 and December 28, 2016, Patient 1 filled prescriptions for cephalexin, prescribed by Respondent.

i. On November 9, 2016, Patient 1 filled a prescription for three tablets of Oxcarbazepine (300 mg) prescribed by Respondent

j. On April 25, 2017, Patient 1 filled a prescription for Vitamin D2, prescribed by Respondent.

k. On May 23, 2017, Patient 1 filled a prescription for six tablets of Oxcarbazepine (300 mg), prescribed by Respondent.

l. On October 29, 2018, Patient 1 filled a prescription for Amoxicillin, prescribed by Respondent.

m. On January 27, 2019, Patient 1 filled a prescription for Oxcarbazepine prescribed by Respondent.

n. On April 23, 2019, Patient 1 filled a prescription for Acyclovir, prescribed by Respondent.

26. Patient 1 stated that she had an intimate relationship with Respondent for approximately five years and that the relationship ended after a domestic violence incident in May of 2019.

27. Patient 1 stated that she had a sexual relationship with Respondent while she was his patient, and that they continued to have a sexual relationship after she no longer was his patient.

28. Patient 1 stated that she was also in a romantic relationship with Respondent. On November 11, 2016, Respondent sent Patient 1 an email referring to her as "sweetie." On June 12, 2017, Respondent sent Patient 1 an email stating "love you!!!!" On their trip to Greece in 2018, Patient 1 and Respondent memorialized a kiss on video. On April 6, 2019, Respondent sent Patient 1 an email denying being involved in a romantic relationship with another woman and told Patient 1, "I DEFINITELY love you." In that email, he also mentioned a ring, suggesting that he had an engagement ring for Patient 1.

29. Patient 1 stated that during the time that she was in a relationship with Respondent, he shared information with Patient 1 about his medical practice, discipline being sought against him by the Medical Board, and issues he was having at Huntington Memorial Hospital. In addition, Respondent had multiple financial arrangements with Patient 1. Respondent bought Patient 1's daughter a cell phone. Patient 1 assisted Respondent with a property lease agreement and discussed personal matters regarding his property. Patient 1 wrote Respondent a $7,000 check. Respondent and Patient 1 made arrangements to rent a yacht together. They discussed payment for a boat charter. Patient 1 made flight arrangements for Respondent.

30. Patient 1 stated that during the time that she was in a relationship with Respondent, they went on multiple vacations together, including San Francisco in 2015, Tiburon in 2016, the Virgin Islands in 2017, Seattle, Rome and Greece in 2018, and the Virgin Islands in 2019.

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31. On May 4, 2019, Patient 1 traveled with Respondent to the Virgin Islands. They sailed to and from various islands on Respondent's catamaran for two weeks. On the morning of May 16, 2019, Patient 1 stated that she was physically assaulted by Respondent when she did not follow his instructions for handling the boat. She stated that Respondent called her derogatory names, punched her in the mouth with a closed fist, threw her down a set of stairs and pushed her to the ground while on his boat in waters off the Virgin Islands. Respondent delayed returning to shore, despite her requests that he allow her off the boat. Later that evening, Respondent docked the boat at shore and Patient 1 immediately went to the Royal Virgin Islands Police Station to report that Respondent assaulted her. The police observed that Patient 1's lip was swollen, and she appeared to have bruises on her arms, back, leg, and neck. The police deemed Patient 1's report to be "genuine." After completing a report, police officers took Patient 1 to the British Virgin Islands Health Services Authority at Pebbles Hospital for emergency department treatment. The medical records reflect that she had multiple bruises and sustained injuries to her eye, lip, back, gluteal area, loin, hip and foot.

32. When Patient 1 returned to the United States, she sought a restraining order against her ex-boyfriend, Respondent, based upon the May 16, 2019 incident. Following a hearing in the Los Angeles Superior Court wherein both Respondent and Patient 1 testified, the Court issued a one-year restraining order against Respondent.

33. Sexual activity with current and former patients is unethical. Even the possibility of a future sexual or romantic relationship contaminates clinical treatment. Likewise, occasions in which psychiatrists interact with current or former patients in a way that can prelude a more intimate relationship must be avoided.

34. Respondent had an established doctor-patient relationship with Patient 1. Respondent sexually exploited Patient 1 by having an intimate relationship with her for approximately five years, which ended in May 2019.

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SECOND CAUSE FOR DISCIPLINE

(Sexual Misconduct with Patient 1)

35. Respondent is subject to disciplinary action under section 726 of the Code in that he committed sexual misconduct with Patient 1. The circumstances are as follows:

36. The allegations in the First Cause for Discipline above are incorporated herein by reference as if fully set forth.

37. Respondent had an established doctor-patient relationship with Patient 1. Respondent committed sexual misconduct with Patient 1 by having an intimate relationship with her for approximately five years, which ended in May 2019.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence in the Care and Treatment of Patients 1 and 2)

38. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in his care and treatment of Patients 1 and 2. The circumstances are as follows:

Patient 1:

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

Duel Relationship with Patient 1:

40. The standard of care requires that a psychiatrist render medical care in the patient's best interest while respecting the patient's goals and autonomy. Patients lack medical expertise and can struggle with symptoms that affect decision-making. Psychiatric patients share sensitive details of their lives with psychiatrists and are thus especially vulnerable to undue influences. Psychiatrists must be careful that their conduct does not physically, psychologically, or financially exploit patients. It is not ethical for a physician to engage in sexual activity with current or former patients.

41. Boundary violations are transgressions that are harmful, are likely to cause future harm, or are exploitative of the patient. Boundary crossings are deviations from customary behavior that do not harm the patient and on occasion, can facilitate the therapeutic process.

Because boundary crossings have the potential to erode the therapeutic relationship, any undertaking of that nature should be performed in an intentional manner when the benefits outweigh the risks. The psychiatrist must evaluate each situation and ensure that the conduct is not misconstrued and in the best interest of the patient.

42. There were many instances of dual relationship between Respondent and Patient 1. A financial dual relationship existed when Respondent and Patient 1 discussed his personal financial matters, discussed renting a yacht together, discussed payment for a boat charter, and discussed a flight arrangement that Patient 1 made for Respondent. A dual relationship also existed when Respondent shared a letter he sent to another physician regarding personal professional issues at Huntington Memorial Hospital and when he discussed personal professional matters he was undergoing with the Medical Board of California. A romantic dual relationship existed when Respondent went on multiple traveling trips with Patient 1, sent Patient 1 an email stating "love you!!!!", he kissed her in Greece, and sent Patient 1 an email denying being involved in a romantic relationship with another woman, telling Patient 1 that "I DEFINITELY love you" and mentions a ring, suggesting an engagement ring. A sexual dual relationship existed when Respondent had an intimate relationship with Patient 1 for approximately five years. A violent dual relationship existed when Respondent engaged in derogatory language and physical violence against Patient 1 on May 16, 2019.

43. The nature, scope, and extent of the dual relationship between Respondent and Patient 1, as demonstrated in the numerous instances of dual relationship, represent clear boundary violations and an extreme departure from the standard of care.

Failure to Maintain Accurate Records of the Nature of Respondent's Relationship with Patient 1:

44. The standard of care requires that psychiatrists maintain adequate and accurate records of patient care and treatment, including whether boundary violations have occurred that alter the nature of the doctor-patient relationship, and the presence of dual relationships that have the potential to affect a patient's care. Psychiatrists should describe the dual relationships as well

as define and establish appropriate boundaries for those relationships. Psychiatrists should document providing and obtaining appropriate patient consent regarding dual relationships.

45. Respondent provided certified medical records indicating that he saw Patient 1 for visits on October 5, 2016, November 9, 2016, May 4, 2017, May 17, 2018, October 29, 2018, and November 14, 2018. Respondent admitted that his relationship with Patient 1, outside the doctor-patient relationship, pre-existed the October 5, 2016 visit. Respondent had a financial, romantic, sexual, and other relationships with Patient 1 during the time-period Respondent states he saw Patient 1 for medical care and treatment.

46. Respondent failed to document the presence of any dual relationships with Patient 1 in her medical records and failed to document education and consent of Patient 1 regarding dual relationships. The omission of the dual relationship from Patient 1's medical record is an extreme departure from the standard of care.

Documentation of Patient 1's Care and Treatment:

47. The standard of care requires that a physician document in the patient's medical chart, the patient's symptoms, evaluations, assessments, and treatment plans. The patient evaluation should include a mental examination for psychiatric encounters, and accurate medications lists. The patient assessment should include an explanation and justification of diagnoses.

48. Patient 1 stated that she was not seen, evaluated or examined by Respondent in his office. Patient 1 stated that her alleged signature on documents in the chart were forged. Patient 1 stated that she was out of town on the date of two of the visits. Falsification of medical records is an extreme departure from the standard of care.

49. The certified medical records for Patient 1 that Respondent provided to the Medical Board of California fail to include notes relating to prescriptions he issued to Patient 1 prior to October 5, 2016; fail to include notes relating to prescriptions he issued to Patient 1 subsequent to November 9, 2016; fail to document the nature of the dual relationships between Respondent and Patient 1; fail to document the identity of Patient 1's primary psychiatrist and the coordination of care between Respondent and that psychiatrist; and, fail to document the reasons for prescribing

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cephalexin on November 19, 2016, cephalexin on December 28, 2016, and vitamin D2 on April 25, 2017. This lack of documentation represents an extreme departure from the standard of care.

Patient 2:

50. Respondent provided psychiatric care and treatment to Patient 2, a 22-year-old male, from approximately March 15, 2018 to August 20, 2019.

51. At the time of Patient 2's initial medical visit with Respondent on March 15, 2018, Patient 2 complained of poor concentration. Patient 2 reported that he had been treated for ADHD since the age of 12 or 13. He indicated having poor results on Vyvanse and Strattera, but good results with Adderall.

52. It was documented that the patient reported that he had been in a detoxification program. He reported having had significant use of MDMA and alcohol, but was currently sober except for continued use of cannabis. Patient 2 admitted to using methamphetamine once. He admitted to having used cocaine three times but also during that same visit, denied using cocaine. He was also noted to have had previously used additional doses of Adderall.

53. Respondent diagnosed Patient 2 with attention-deficit hyperactivity disorder and other psychoactive substance abuse. He prescribed Adderall extended release (30 mg) to be taken in the morning and Adderall (15 mg) to be taken at noon. The progress note was electronically signed by Respondent on July 3, 2020 at 3:24 p.m.

54. On April 12, 2018, Patient 2 presented to Respondent with a chief complaint of trouble with focusing and "some anxiety." With respect to substance use, the patient stated that he was sober. He denied alcohol, cocaine and benzodiazepine use but admitted that he was tempted due to his anxiety. Respondent's mental status exam noted "highly unusual" appearance but appropriate orientation, speech, memory, behavior, mood, affect, thought process, thought content, insight, judgment, attitude, perceptions, and impulse control. Respondent's diagnoses were ADHD and substance abuse. Respondent continued the patient on Adderall extended relief (30 mg) in the morning and Adderall (15 mg) at noon. The progress note was electronically signed by Respondent on July 3, 2020 at 3:23 p.m.

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55. On May 8, 2018, Patient 2 presented to Respondent with a chief complaint of more anxiety and difficulty focusing. The patient stated that he felt more anxiety, tried not to use benzodiazepines off the street and felt huge pressure at work to "be perfect." Respondent's mental status exam noted "highly unusual" appearance, "anxious" mood, the patient stated that "it's tiring and hard not to smoke pot" but that he otherwise had appropriate orientation, speech, memory, behavior, affect, thought process, thought content, insight, judgment, attitude, perceptions, and impulse control. In addition to the previously noted diagnoses of ADHD and substance abuse, Respondent added a new diagnosis of anxiety order. Respondent prescribed Adderall extended release, (30 mg) to be taken in the morning and Adderall, (15 mg) to be taken at noon. He also added gabapentin (300 mg) to be taken three times a day. The progress note was electronically signed by Respondent on July 3, 2020 at 3:23 p.m.

56. Patient 2 was next seen by Respondent on June 14, 2018. He complained of being anxious, having trouble focusing and mood swings. Respondent's assessment and treatment plan remained unchanged. Respondent continued to prescribe Adderall extended release (30 mg) to be taken in the morning, Adderall (15 mg) to be taken at noon, and gabapentin (300 mg) to be taken three times a day. The progress note was electronically signed by Respondent on July 3, 2020 at 3:22 p.m.

57. On July 12, 2018, Patient 2 was seen by Respondent with complaints of anxiety and lack of focus. The mental status exam noted a "highly unusual" appearance, but otherwise appropriate orientation, speech, memory, behavior, mood, affect, thought process, thought content, insight, judgment, attitude, perceptions, and impulse control. The diagnoses no longer listed a substance use disorder and only included ADHD and anxiety disorder. The treatment plan is unchanged. Respondent continued to prescribe Adderall extended release (30 mg) to be taken in the morning, Adderall (15 mg) to be taken at noon, and gabapentin (300 mg) to be taken three times a day. The progress note was electronically signed by Respondent on July 3, 2020 at 3:21 p.m.

58. On August 9, 2018, Patient 2 was seen by Respondent with a complaint of focus issues. He denied any new medical issues. With respect to the patient's mental status exam,

Respondent noted a "highly unusual" appearance but otherwise appropriate orientation, speech, memory, behavior, mood, affect, thought process, thought content, insight, judgment, attitude, perceptions, and impulse control. Respondent's assessment no longer listed an anxiety disorder, only ADHD. The treatment plan is unchanged. Respondent continued to prescribe Adderall extended release (30 mg) to be taken in the morning, Adderall (15 mg) to be taken at noon, and gabapentin (300 mg) to be taken three times a day. The progress note was electronically signed by Respondent on July 3, 2020 at 3:21 p.m.

59. On September 6, 2018, Patient 2 was seen by Respondent with complaints of being "scattered, anxious." With respect to the patient's mental status exam, Respondent noted a "highly unusual" appearance but otherwise appropriate orientation, speech, memory, behavior, mood, affect, thought process, thought content, insight, judgment, attitude, perceptions, and impulse control. This visit, Respondent's assessment was ADHD and unspecified anxiety disorder. Respondent prescribed Adderall extended release (30 mg) to be taken in the morning, Adderall (15 mg) to be taken at noon, and gabapentin (300 mg) to be taken three times a day. The progress note was electronically signed by Respondent on July 3, 2020 at 3:20 p.m.

60. On October 8, 2018, Patient 2 was seen by Respondent with complaints of mood swings and difficulty focusing. He requested a mood stabilizer for difficulty controlling anger and racing thoughts. Patient 2 also reported that he "still has benzodiazepines, used pot twice." Under the mental status exam portion of the note, Respondent documented that Patient 2's appearance was "highly unusual" and "INTENSE," his mood was "up and down," his affect was "slightly irritable," but with appropriate orientation, speech, memory, behavior, thought process, thought content, insight, judgment, attitude, perceptions, and impulse control. Respondent's diagnoses for this visit included ADHD in addition to substance abuse, and bipolar disorder. Respondent prescribed Adderall extended release (30 mg) to be taken in the morning, Adderall, 15 mg, to be taken at noon, and gabapentin (300 mg) to be taken three times a day. In addition, he prescribed a titration of oxcarbazepine (150 mg) one tablet every night before bed for five nights, then twice a day for five days, and then one tablet every morning and two tablets every

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night before bedtime. The progress note was electronically signed by Respondent on July 3, 2020 at 3:19 p.m.

61. On November 5, 2018, Patient 2 was seen by Respondent and complained of having mood instability and focus issues. The patient stated that the oxcarbazepine helped greatly. Respondent's mental status exam noted a slightly irritable affect but appropriate appearance, orientation, speech, memory, behavior, mood, thought process, thought content, insight, judgment, attitude, perceptions, and impulse control. The patient denied alcohol use but admitted using cannabis "once this time." Respondent's assessment was ADHD, substance abuse, and bipolar disorder. Respondent continued the patient's oxcarbazepine and gabapentin. He decreased the Adderall extended release to 20 mg in the morning and decreased Adderall to 10 mg at noon. The progress note was electronically signed by Respondent on July 3, 2020 at 3:19 p.m.

62. On January 29, 2019, Patient 2 was seen by Respondent. The patient stated that he had continued improvement in mood, was not using gabapentin, and again reported using "pot once." The patient's current medications were listed as Adderall extended release (20 mg) in the morning and Adderall (15 mg) at noon despite treatment plan at last visit indicating that Adderall extended relief was 20 mg in the morning and Adderall 10 mg at noon. With respect to the mental status exam, Respondent noted that the patient had an anxious affect but appropriate appearance, orientation, speech, memory, behavior, mood, thought process, thought content, insight, judgment, attitude, perceptions, and impulse control. Respondent's diagnoses was ADHD, substance abuse, and bipolar disorder. Respondent discontinued the gabapentin and continued the oxcarbazepine. He also prescribed Adderall extended release (20 mg) in the morning and Adderall (10 mg) at noon. The progress note was electronically signed by Respondent on July 3, 2020 at 3:18 p.m.

63. On February 21, 2019, Respondent checked Patient 2's CURES Report.

64. On March 18, 2019, Patient 2 was seen by Respondent. The patient reported continued improvement in mood and denied drug use. The patient's current medications were listed to include Adderall extended release (30 mg) in the morning and Adderall (15 mg) at noon. Respondent's mental status exam noted that the patient's affect was anxious but with appropriate

appearance, orientation, speech, memory, behavior, mood, thought process, thought content, insight, judgment, attitude, perceptions, and impulse control. Respondent's diagnoses remained ADHD, substance abuse, and bipolar disorder. Respondent prescribed Adderall extended release (20 mg) in the morning, Adderall (10 mg) at noon, and oxcarbazepine (300 mg) one tablet in the morning and two tablets before bedtime. The progress note was electronically signed by Respondent on July 3, 2020 at 3:17 p.m.

65. On May 21, 2019, Patient 2 was seen by Respondent with a chief complaint of mood issues and lack of focus. Respondent noted that the patient admitted to using pot, denied using cocaine and admitted using alcohol socially. The patient stated that he wishes to be sober and he will possibly bring his parents to the next session to assist with his sobriety. Respondent's assessment remained attention-deficit hyperactivity disorder, substance abuse, and bipolar disorder. Respondent prescribed Adderall extended release (20 mg) in the morning, Adderall (10 mg) at noon and oxcarbazepine (300 mg) one tablet in the morning and two tablets before bedtime. The progress note was electronically signed by Respondent on July 3, 2020 at 3:17 p.m.

66. On June 19, 2019, Patient 2 was seen by Respondent with a chief complaint of substance use and focus issues. He brought his mother to the visit. She expressed concern about Patient 2's substance use, which was reported to be higher than previously admitted to by the patient. The patient's current medications were listed as Adderall extended release (30 mg) in the morning and Adderall (15 mg) at noon. With respect to the patient's mental status exam, Respondent noted that he was anxious but with appropriate appearance, orientation, speech, memory, behavior, mood, thought process, thought content, insight, judgment, attitude, perceptions, and impulse control. Respondent's assessment remained ADHD, substance abuse, and bipolar disorder. The treatment plan was unchanged. Respondent prescribed Adderall extended release (20 mg) in the morning, Adderall (10 mg) at noon and oxcarbazepine (300 mg) one tablet in the morning and two tablets before bedtime. The progress note was electronically signed by Respondent on July 3, 2020 at 3:16 p.m.

67. On July 12, 2019, Patient 2 was seen by Respondent and complained of anxiety with near panic attacks happening an average of three times a week. He admitted that he "smokes pot

often," abused Xanax, and "sometimes used extra doses in past of stimulant." [2] Respondent noted that the patient's current medications listed include Adderall extended release (30 mg) in the morning and Adderall (15 mg) at noon. The note included a psychiatric history, social history, family history, and substance history, and a suicide risk assessment. Included in the Social and Family History section of the note, Respondent noted that the patient was "employment: works at Katsuya as busboy." Respondent's mental status exam reflected that the patient's affect was anxious but with appropriate appearance, orientation, speech, memory, behavior, mood, thought process, thought content, insight, judgment, attitude, perceptions, and impulse control. Respondent's assessment and diagnoses remained unchanged. The treatment plan included discontinuing oxcarbazepine, starting venlafaxine (37.5 mg), starting propranolol (20 mg) twice a day as needed, and continuing Adderall extended release (20 mg) in the morning and Adderall (10 mg) at noon. The progress note was electronically signed by Respondent on July 3, 2020 at 3:16 p.m.

68. On August 6, 2019, Patient 2 was seen by Respondent and complained about his anxiety and focus. The patient requested that he restart oxcarbazepine. Respondent noted that the patient's current medications listed include Adderall extended release (30 mg) in the morning and Adderall (15 mg) at noon. Respondent's assessment was attention-deficit hyperactivity disorder and bipolar disorder. He prescribed propranolol (20 mg) twice a day as needed for anxiety, oxcarbazepine (300 mg) one tablet in the morning and two tablets at bedtime, Adderall extended relief (30 mg) in the morning, Adderall (10 mg) at noon. Venlafaxine was not listed as being prescribed this visit. The progress note was electronically signed by Respondent on July 3, 2020 at 3:15 p.m.

69. In correspondence addressed "To Whom it May Concern" dated August 2, 2019, Respondent stated that Patient 2 was under Respondent's care and Respondent had diagnosed him with attention-deficit hyperactivity disorder and bipolar disorder. Respondent set forth that Patient 2 has been treated approximately weekly from April 2, 2019 to August 4, 2019, that his

[2] At the time of Respondent's August 4, 2021 interview with the Medical Board, Respondent stated that Patient 2 was "sober" during the time of Respondent's care and treatment.

treatment consisted of medication management and talk therapy with a psychotherapist, and that he has been entirely compliant with all treatment.

70. On August 30, 2019, Patient 2 was seen by Respondent and complained about his focus and mood. The patient stated that he wanted to continue oxcarbazepine, would start seeing an in network therapist, and had no substance use. Respondent noted that the patient's current medications listed include Adderall extended release (30 mg) in the morning and Adderall (15 mg) at noon. Respondent noted that Patient 2 was "apologetic to author – reassured." Respondent also noted that Patient 2 stated that he appreciated Respondent's treatment. Respondent documented that the patient's mental status exam was within normal limits and that the patient had an appropriate appearance, orientation, speech, memory, behavior, mood, affect, thought process, thought content, insight, judgment, attitude, perceptions, and impulse control. Respondent's assessment was attention-deficit hyperactivity disorder and bipolar disorder. Respondent prescribed oxcarbazepine (300 mg) one tablet in the morning and two tablets at bedtime, Adderall extended relief (30 mg) in the morning, and Adderall (10 mg) at noon. Propranolol was no longer listed as a prescribed medication. The progress note was electronically signed by Respondent on July 3, 2020 at 3:14 p.m.

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

72. In addition to providing psychiatric care and treatment to Patient 2, Respondent employed him from approximately June 14, 2019 to August 1, 2019. At the time of a medical appointment, Respondent offered Patient 2 a job performing office manager responsibilities and carrying out personal and work related errands. While acting as Respondent's employee, Patient 2 has stated that he was asked to forge signatures on company checks, taught to write prescriptions and mail them to patients, was given the code for a safe with prescriptions, some of which were pre-signed, given keys to Respondent's car and house, was called a "moron" by Respondent, and witnessed Respondent's inappropriate language to his employees.

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73. While acting as Respondent's employee, Patient 2 stated that he witnessed Respondent's angry outbursts in which Respondent used derogatory names and profanities at him and other employees, including calling Patient 2 a moron. Patient 2 also stated that Respondent would make Patient 2 work more than six hours without a break and that when Patient 2 would ask for a break, Respondent would respond "I'm hungry too but we have all this work to get done" or "this is healthcare, why don't you stop thinking about yourself for once and do the work I'm asking you to do and then you can go home when it's done."

74. Patient 2 stated that Respondent taught him how to forge Respondent's signature on checks. In addition, Patient 2 was given access to Respondent's office safe, which had multiple prescription pads, including pre-signed prescriptions. Respondent also gave Patient 2 keys to his house, car, and office.

75. At his interview with the Board on August 4, 2021, Respondent stated that the patient saw Respondent's employment advertisement seeking an employee for the office and said that he could "help out" while Respondent was interviewing individuals for the job. In response, Respondent said "sure" and employed Patient 2 on a temporary basis while Patient 2 remained a patient. Respondent stated that he carefully explained to Patient 2 that the employment was part-time as an assistant and entirely separate from his care and treatment as a patient. Respondent maintained that Patient 2 worked for him for less than a month answering phones. Respondent admitted that he gave Patient 2 access to his safe in his medical office where Respondent kept blank checks, and pre-signed blank prescriptions. Respondent denies asking Patient 2 to complete any prescriptions, fill out any prescriptions, or sign any prescriptions. Respondent also gave Patient 2 access to his personal automobile for the purpose of running errands for a few days while Respondent was out of town. Also, when Respondent went out of town, he needed Patient 2 to give a person a prescription that Respondent had written but that Patient 2 "kind of screwed that up" and he asked Patient 2 to help with a couple things and that, too, went badly. After the prescription "debacle," Respondent fired Patient 2 as an employee but continued to treat him as a patient. Respondent described his employing of Patient 2 as "generous." He denied asking Patient 2 to sign any checks. He admitted that he asked Patient 2 to sign a letter to the Medical

Board. With respect to writing prescriptions, Respondent maintains that he asked Patient 2 to give a prescription to a patient, not write it and that he did not ask Patient 2 to alter a prescription.

Dual Relationship with Patient 2:

76. It is not ethical for a physician to have dual roles of physician and employer with a patient. There is an inherent inequality in the physician-patient relationship, which may lead to exploitation if the psychiatrist rendering medical care fails to maintain patient boundaries and engage in compromising dual relationships.

77. The standard of care requires that a psychiatrist render medical care in the patient's best interest while respecting the patient's goals and autonomy. Patients lack medical expertise and can struggle with symptoms that affect decision-making. Psychiatric patients share sensitive details of their lives with psychiatrists and are thus especially vulnerable to undue influences. Psychiatrists must be careful that their conduct does not physically, psychologically, or financially exploit patients. It is not ethical for a physician to switch a physician–patient relationship to an employer–employee relationship.

78. There were many instances of dual relationship between Respondent and Patient 2. An employment dual relationship existed when Respondent hired Patient 2 as an employee and gave Patient 2 the code for his safe that had prescriptions. An illegal dual relationship occurred when Patient 2 was asked to forge signatures on company checks and was taught to write prescriptions. An unprofessional dual relationship existed when Patient 2 witnessed Respondent's inappropriate language to his employees and Respondent disregarded labor laws. A demeaning dual relationship existed when Respondent directed profanities at him and called him a moron. A personal dual relationship existed when Respondent gave Patient 2 keys to his house and car and asked Patient 2 to perform personal errands for him.

79. The nature, scope, and extent of the dual relationship between Respondent and Patient 2, as demonstrated in the numerous instances of dual relationship, represent clear boundary violations and an extreme departure from the standard of care.

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Failure to Maintain Accurate Records of the Nature of Respondent's Relationship with Patient 2:

80. At the time Respondent saw Patient 2, for psychiatric care and treatment, on July 12, 2019, Patient 2 was employed by Respondent. By the time Respondent saw Patient 2, for psychiatric care and treatment, on August 6, 2019 and August 30, 2019, Respondent had terminated Patient 2's employment. Respondent failed to document the presence of a dual relationship in Patient 2's medical records. Adequate education and consent of Patient 2 regarding the dual relationship was not included in the record. The omission of the dual relationship from Patient 2's medical record is an extreme departure from the standard of care.

Inappropriate Delegation of Tasks to Patient 2:

81. The standard of care requires that psychiatrists only make referrals or delegate care to persons, who, based on their training and inexperience, are, competent to deliver the necessary treatment and intervention.

82. Respondent tasked Patient 2 with handling another patient's prescription. While Respondent maintains that he asked Patient 2 to give the patient a prescription that had been written by Respondent, Patient 2 maintains that Respondent asked him to complete the prescription. Respondent characterized the incident as the prescription "debacle." Patient 2 did not have the medical training and experience required to complete prescriptions and placed the patient receiving the prescription at risk by having the prescription written by someone without the knowledge, experience, or medical training to write such prescriptions.

83. Respondent's delegation of tasks associated with prescriptions for other patients is an extreme departure from the standard of care.

Respondent's Treatment of Patient 2's Substance Use Disorder:

84. A physician should not prescribe medications that are dangerous or addicting without a medical indication. Careful monitoring, including monitoring for dangerous side effects, is necessary when a physician prescribes dependence causing medications. When treating a patient with a substance use disorder, the standard of care requires that the physician perform an appropriate prior medical examination, identify a medical indication, keep accurate and complete

medical records, including treatments, medications, and periodic reviews of treatment plans, as well as, provide ongoing and follow up medical care as appropriate and necessary.

85. During Respondent's care and treatment of Patient 2, he failed to appropriately intervene despite Patient 2's risks factors of continuing and worsening substance use disorders. Respondent failed to obtain any urine drug screens for Patient 2. Respondent only obtained one CURES Report for Patient 2, almost one year after he began treating Patient 2. Respondent failed to enter into a treatment agreement with Patient 2 to limit the prescription of controlled substances despite being aware of the patient's ongoing misuse of controlled substances. Respondent failed to appropriately document Patient 2's substance use disorder. He failed to specify the patient's particular drug of abuse and failed to include substance use disorder as a diagnosis on multiple visits, including July 12, 2018, August 9, 2018, September 6, 2018, August 6, 2019 and August 30, 2019.

86. Patient 2 exhibited multiple risk factors of continuing or worsening substance use disorder and Respondent failed to intervene. On March 15, 2018, Respondent documented Patient 2's continued use of cannabis, inconsistent report of cocaine use, and use of Adderall other than prescribed. On April 12, 2018, Respondent documented that Patient 2 had a highly unusual appearance and reported struggling with sobriety as well as using illicit benzodiazepines. On May 8, 2018, Respondent documented that Patient 2 had a highly unusual appearance and stated that he had difficulty maintaining sobriety from cannabis. On June 14, 2018, Respondent documented that Patient 2 reported mood swings. On July 12, 2018, August 9, 2018 and September 6, 2018, Respondent documented that Patient 2 had a highly unusual appearance. On September 6, 2018, Respondent also described Patient 2 as scattered. On October 8, 2018, Respondent described Patient 2 as intense, irritable, and had a highly unusual appearance. He also noted that the patient stated that he continued to use illicit benzodiazepines and cannabis. On November 6, 2018, Respondent described Patient 2 as irritable and noted that he continued to use cannabis. On May 21, 2019, Respondent documented that the patient reported continued use of cannabis and alcohol. On June 19, 2019, Respondent documented that the patient's' mother

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stated that the patient's use of substances was higher than previously admitted. On July 12, 2019, Patient 2 reported continued use of cannabis and illicit benzodiazepines to Respondent.

87. Despite caring for a patient with ongoing misuse of illicit substances, Respondent placed Patient 2 in a position where he was taught how to write prescriptions, given access to blank and pre-signed prescriptions, taught how to forge signatures and given access to blank checks.

88. Respondent failed to recognize signs of continued substance use disorder, continued to prescribe medications that had been previously misused by the patient, failed to properly intervene in response to those risk factors, and placed the patient in precarious employment with access to prescriptions despite inadequate training and continued illicit drug use. Respondent's treatment of Patient 2's substance use disorder is an extreme departure from the standard of care.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

89. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he engaged in repeated acts of negligence in the care and treatment of Patients 1 and 2. The circumstances are as follows:

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

91. Each of the alleged acts of gross negligence set forth above in the Third Cause for Discipline is also a negligent act.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Prescribing without Examination and/or Medical Indication)

92. Respondent is subject to disciplinary action under Code section 2242, subdivision (a), in that he committed unprofessional conduct when he prescribed dangerous drugs to Patients 1 and 2 without an appropriate prior examination and/or medical indication. The circumstances are as follows:

93. The allegations of the First, Second, Third, and Fourth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth. During the time Respondent

treated Patients 1 and 2, he failed to perform an appropriate corresponding prior examination and determine a medical indication for each dangerous drug that he prescribed to each patient.

SIXTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

94. Respondent is subject to disciplinary action under Code section 725, in that he excessively prescribed dangerous drugs to Patient 2. The circumstances are as follows:

95. The allegations of the Third, Fourth, and Fifth Causes for Discipline, as to Patient 2, are incorporated herein by reference as if fully set forth. During the time Respondent treated Patient 2, he excessively prescribed dangerous drugs to him.

SEVENTH CAUSE FOR DISCIPLINE

(Prescribing to an Addict)

96. Respondent is subject to disciplinary action under Code section 2241, in that he prescribed controlled substances to Patient 2, who had a substance use disorder and relapsed following Respondent's care and treatment. The circumstances are as follows:

97. The allegations of the Third, Fourth, Fifth, and Sixth Causes for Discipline, as to Patient 2, are incorporated herein by reference as if fully set forth.

EIGHTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

98. Respondent is subject to disciplinary action under Code sections 2234 and 2228.1, in that his action and/or actions represent unprofessional conduct and patient harm to Patients 1 and 2 occurred as a result. The circumstances are as follows:

99. The allegations of the First, Second, Third, Fourth, Fifth, Sixth, and Seventh Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

100. In addition, patient harm occurred as to Patient 1 when Respondent engaged in sexual misconduct with Patient 1 by having an intimate relationship with her for approximately five years.

101. Patient harm also occurred as to Patient 1 and 2 when Respondent inappropriately prescribed to them without an appropriate prior examination and/or medical indication.

NINTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

102. Respondent is subject to disciplinary action under Code sections 2227 and 2266 in that he failed to maintain adequate and accurate records. The circumstances are as follows:

103. The allegations in the First, Third and Fifth Causes for Discipline above are incorporated herein by reference as if fully set forth.

DISCIPLINARY CONSIDERATIONS

104. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about October 4, 2017, a full interim suspension order was issued prohibiting Respondent from practicing medicine. On or about October 24, 2017, a termination of that full interim suspension was issued.

105. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about May 2, 2017, in the case of *The People of the State of California v. Dirk De Brito,* Los Angeles Superior Court Case No. GA097514, Respondent pled nolo contendere to making criminal threats and assault. He was sentenced to three years of summary probation with terms and conditions, including attending a 52-week anger management course. That matter is now final and is incorporated by reference as if fully set forth.

106. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about December 27, 2018, in a prior disciplinary action entitled, *In the Matter of the Accusation Against Dirk De Brito, M.D.* before the Board in Case No. 800-2015-018088, Respondent's Physician's and Surgeon's Certificate was revoked, but that revocation was stayed, and he was placed on probation for three years, with terms and conditions, including an anger management program, ethics course, psychotherapy, and practice monitor, for conviction of a crime, mental impairment, and gross negligence in the care and treatment of one patient. That decision is now final and is incorporated by reference as if fully set forth.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 66604, issued to Respondent John Lee, M.D., previously known as Dirk De Brito, M.D.;

2. Revoking, suspending or denying approval of Respondent John Lee, M.D.'s, previously known as Dirk De Brito, M.D.'s, authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent John Lee, M.D., previously known as Dirk De Brito, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

4. Ordering Respondent John Lee, M.D., previously known as Dirk De Brito, M.D., if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and

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

DATED: JUL 13 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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