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

In the Matter of the Accusation Against:	)	
JON C. TREFIL, M.D. Certificate No. G-23083	)	No: 12-1997-72833
Respondent	)	

DECISION

The attached Stipulation for Surrender is hereby adopted by the Division of Medical Quality as its Decision in the above-entitled matter.

This Decision shall become effective at 5:00 p.m. on October 29, 1999.

IT IS SO ORDERED October 22, 1999

By: _____
IRA LUBELL, M.D.
President
Division of Medical Quality

BILL LOCKYER, Attorney General
of the State of California
VIVIEN HARA HERSH, Supervising
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **Jon C. Trefil, M.D.,** P.O. Box 328 31475 Albion Ridge Road Albion, CA 95410-0328 Physician's and Surgeon's Certificate No. G23083, Respondent.	Case No. 12-97-72833 **STIPULATION FOR SURRENDER OF LICENSE**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings, that the following matters are true:

1. Complainant, Ron Joseph, is the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board") and is represented by Bill Lockyer, Attorney General of the State of California by Lynne K. Dombrowski, Deputy Attorney General.

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2. John C. Trefil, M.D., aka Jon C. Trefil ,("respondent") understands that he may, but need not, be represented by counsel in this proceeding and has chosen to represent himself in this matter. Respondent's correct mailing address is as it appears in the caption of this stipulation. Respondent agrees that he has carefully read and fully understands this stipulation and its effect on his professional license.

3. Respondent has received and read the Accusation which is presently on file and pending in Case Number 12-97-72833 before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), a copy of which is attached as Exhibit A and incorporated herein by reference.

4. Respondent understands the nature of the charges alleged in the Accusation and admits that, if proven at hearing, such charges and allegations would constitute cause for imposing discipline upon respondent's license issued by the Board.

5. Respondent is aware of each of his rights, including the right to a hearing on the charges and allegations, the right to confront and cross-examine witnesses who would testify against him, the right to testify and present evidence on his own behalf, as well as to the issuance of subpoenas to compel the attendance of witnesses and the production of documents, the right to contest the charges and allegations, and other rights which are accorded respondent pursuant to the California Administrative Procedure Act (Gov. Code, § 11500 et seq.) and other applicable laws, including the right to seek reconsideration, review by the superior court, and appellate review.

6. In order to avoid the expense and uncertainty of a hearing, respondent freely and voluntarily waives each and every one of these rights set forth above. Respondent agrees not to contest that cause exists to discipline his physician and surgeon's certificate pursuant to Business and Professions Code section 2234(b) and hereby surrenders his license o. G23083 for the Division's formal acceptance.

7. Respondent understands that by signing this stipulation he is enabling the Division of Medical Quality to issue its order accepting the surrender of his license without further process. He understands and agrees that Board staff and counsel for complainant may communicate directly with the Division regarding this stipulation, without notice to or participation by respondent. In the event that this stipulation is rejected for any reason by the Division, it will be of no force or effect for either party. The Division will not be disqualified from further action in this matter by virtue of its consideration of this stipulation.

8. Upon acceptance of the stipulation by the Division, respondent understands that he will no longer be permitted to practice as a physician in California, and also agrees to surrender and cause to be delivered to the Division both his license and wallet certificate before the effective date of the decision.

9. Respondent fully understands and agrees that if he ever files an application for re-licensure or reinstatement in the State of California, the Division shall treat it as a petition for reinstatement, that respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and that all of the charges and allegations contained in Accusation No. 12-97-72833 will be deemed to be uncontested by respondent when the Division determines whether to grant or deny the petition.

10. All admissions and recitals contained in this stipulation are made solely for the purpose of settlement in this proceeding and for any other proceedings in which the Division of Medical Quality, Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceedings.

11. Respondent may not petition for reinstatement of a revoked or surrendered license/certificate for two years from the effective date of this Decision. If the Board grants future reinstatement, respondent agrees to reimburse the Board for its costs of investigation and enforcement of this matter in the amount of $19,658.00 (nineteen thousand

six hundred fifty-eight dollars) payable to the Board upon the effective date of such reinstatement decision.

ACCEPTANCE

I, John C. Trefil, having carefully read the above stipulation and entering into it freely and voluntarily and with full knowledge of its force and effect, do hereby surrender my physician's and surgeon's certificate No. G23083, to the Division of Medical Quality, Medical Board of California for its formal acceptance. By signing this stipulation to surrender my license, I recognize that upon its formal acceptance by the Division, I will lose all rights and privileges to practice as a physician and surgeon in the State of California and I also will cause to be delivered to the Division both my license and wallet certificate before the effective date of the Decision.

DATED: September 29, 1999

John C. Trefil M.D.
John C. Trefil, M.D.
Respondent

I concur in the stipulation.

DATED: ~~September~~ October 4, 1999.

BILL LOCKYER, Attorney General
of the State of California

Lynne K. Dombrowski
LYNNE K. DOMBROWSKI
Deputy Attorney General
Attorneys for Complainant

EXHIBIT A

BILL LOCKYER
Attorney General
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Supervising Deputy Attorney General
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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO June 30 19 99
BY _____ ANALYST

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

In the Matter of the Accusation Against: JON C. TREFIL, M.D., 31475 Albion Ridge Road Albion, CA 95410-0328 Physician's and Surgeon's Certificate No. G 23083 Respondent,	Case No.: 12-97-72833 ACCUSATION

The Complainant alleges:

PARTIES

1. Complainant, Ron Joseph, is the Executive Director of the Medical Board of California (hereinafter the "Board") and brings this accusation solely in his official capacity.

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2. On or about August 23, 1972, Physician's and Surgeon's Certificate No. G 23083 was issued by the Board to respondent Jon C. Trefil, M.D. (hereinafter "respondent"), and at all times relevant to the charges brought herein, this license has been in full force and effect. Unless renewed, it will expire on December 31, 1999. There is no Board record of any previous disciplinary action taken against this certificate.

JURISDICTION

3. This accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), under the authority of the California Business and Professions Code (hereinafter "Code")[1/].

4. Section 2001 provides for the existence of the Board and Section 2003 provides for the existence of the Division of Medical Quality (hereinafter referred to as the "Division") within the Board.

5. Section 2004 provides, inter alia, that the Division is responsible for the administration and hearing of disciplinary actions involving enforcement of the Medical Practice Act (section 2000 et seq.) and the carrying out of disciplinary action appropriate to findings made by a medical quality review committee, the Division, or an administrative law judge with respect to the quality of medical practice carried out by physician & surgeon certificate holders.

6. Section 2229 subdivision (a) provides that protection of the public shall be the highest priority for the Division and for administrative law judges in exercising disciplinary authority.

7. Sections 2220, 2234 and 2227 together provide that the Division shall take disciplinary action against the holder of a physician's and surgeon's certificate who is guilty of unprofessional conduct.

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1. All statutory references are to the Business and Professions Code unless otherwise indicated.

8. Section 2227 of the Code provides that a licensee who has been found guilty under the Medical Practice Act by the Division may have his license revoked, suspended for a period not to exceed one year, or placed on probation and required to pay the costs of probation monitoring, or other action may be taken against the license that the Division deems proper.

9. Section 2234 of the Code provides, in pertinent part, that the Division shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

"(b) Gross negligence.

(c) Repeated negligent acts.

(d) Incompetence.

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

10. Section 2238 states that a violation of any federal statute or federal regulation or and statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

11. Section 4022 provides, in pertinent part, the following definition of a "dangerous drug":

" `Dangerous drug'. . . means any drug . . .unsafe for self-use . . .. and includes the following:
"(a) Any drug which bears the legend: `Caution: federal law prohibits dispensing without prescription' or other words of similar import. . . .
"(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."

12. Section 725 states, in pertinent part, that "repeated acts of clearly excessive prescribing or administering of drugs or treatment" constitutes unprofessional conduct for a physician and surgeon.

13. Section 2241 states, in pertinent part, that: "[T]he prescribing, selling, furnishing, giving away, or administering or offering to prescribe, sell, furnish, give away, or administer any of the drugs or compounds mentioned in Section 2239", i.e. controlled

substances, dangerous drugs and/or alcoholic beverages, to "an addict or habitue constitutes unprofessional conduct".

14. Section 2242(a) provides that prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without a good faith prior examination and medical indication therefor constitutes unprofessional conduct.

15. Section 2266 provides that 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.

16. Welfare and Institutions Code section 14124.12 provides, in part, that a physician whose license has been placed on probation by the Medical Board shall not be reimbursed by Medi-Cal for "the type of surgical service or invasive procedure that gave rise to probation."

UNIFORM CONTROLLED SUBSTANCES ACT

17. California Health and Safety Code § 11007 defines a "controlled substance", in pertinent part, as a drug included in Schedules I through V, inclusive, pursuant to Health and Safety Code §§ 110054 through 11058.

18. Health and Safety Code § 11210 states, in pertinent part, that a physician shall prescribe, furnish, or administer controlled substances only in such quantity and for the length of time as are reasonably necessary.

19. Health and Safety Code § 11153 states, in part, that a prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice.

20. Health and Safety Code § 11171 states that no person shall prescribe, administer, or furnish a controlled substance except under the conditions and in the manner provided by this division.

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CONTROLLED SUBSTANCES/ DANGEROUS DRUGS INVOLVED

21. Dalmane, a trade name for flurazepam hydrochloride, is a dangerous drug as defined in section 4022 and a schedule IV controlled substance as defined in Health and Safety Code section 11057(d)(5). It is a benzodiazepine used in the short-term treatment of insomnia. Usage is cautioned in combination with alcohol and other central nervous system depressants.

22. Haldol, a trade name for haloperidol, is a dangerous drug within the meaning of Business and Professions Code section 4022 and is a major tranquilizer used for the management of manifestations of psychotic disorders.

23. Prozac, a trade name for fluoxetine hydrochloride, is an antidepressant and is a dangerous drug within the meaning of Business and Professions code section 4022.

24. Tylenol #3, a trade name for codeine phosphate 30mg and acetaminophen 300mg, is a dangerous drug as defined by section 4211 of the Business and Professions Code and is a Schedule III controlled substance as defined in Health and Safety Code § 11056.

COST RECOVERY

25. Section 125.3 of the Code provides, in part, that the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

ACTS/OMISSIONS RE: PATIENT J.G.[2/]

26. On or about April 7, 1990, respondent began treating patient J.G., a then 41-year-old female, for psychiatric problems. Patient J.G. was referred by her previous mental health counselor, a licensed clinical social worker ("LCSW"), who believed patient J.G. was suffering from a Multiple Personality Disorder.

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2. In order to protect the patient's privacy rights, the patient's name will be revealed to respondent through discovery.

27. At the time of her first visit to respondent, patient J.G. presented to respondent with a history of psychiatric problems, a prior suicide attempt, alcoholism, and child abuse. Patient J.G. had been in therapy at Mendocino County Mental Health Services since about August 1988. Patient J.G. also had a 15-year-old son of whom she had recently lost custody and who was in a foster home because of her physical and emotional abuse and alcoholism. Patient J.G.'s son had been a dependent of the State twice before because of the patient's emotional instability and recurring abuse of alcohol. Patient J.G. also had been married to a man who committed suicide after shooting two people and killing one of them.

28. Shortly after beginning therapy with patient J.G., respondent became aware that the patient's prior therapy relationship with the LCSW had ended destructively and that the LCSW had sought a court-ordered restraining order against patient J.G. to stop her threatening telephone calls.

29. During the course of treatment, from about April 1990 until sometime in or about January 1997, respondent failed to provide a structured therapeutic environment with clear ending times and instead met regularly with patient J.G. for therapy sessions which lasted an open-ended amount of time, usually from between 1 and 3 hours.

30. For much of the time during the course of treatment, starting in April 1990 until sometime after June 1992, respondent met with patient J.G. at least twice weekly. Most of these sessions took place at respondent's home, often on respondent's "days off".

31. For the remainder of the course of treatment between April 1990 and January 1997, respondent met with patient for therapy on a regular weekly basis.

32. Although respondent met with the patient once or twice weekly for between 1 and 3 hours each, respondent never billed the patient for more than one weekly one-hour session. During the course of treatment, respondent billed and was paid by Medi-Cal for one weekly one-hour session with patient J.G.. Respondent told patient J.G. not to worry about paying him for therapy.

33. Respondent's records fail to document any discussion of the setting of limits/parameters on his fees for therapy or any evaluation and discussion with the patient in

therapy about a fee reduction, so that the patient would not feel minimized, singled out, or feel fearful that the therapist would exploit her in another way.

34. Respondent's medical records for his treatment of patient J.G. do not reflect the location or the duration of the therapy sessions.

35. During the course of treatment, from about April 1990 until sometime in or about January 1997, respondent also spoke with patient J.G. regularly, often daily, by telephone. Respondent would speak with patient J.G. by telephone at all hours and would sometimes telephone the patient when he was out-of-town.

36. Respondent's medical records do not document all of the telephone conversations he had with patient J.G. during the course of treatment.

37. Respondent failed to perform an initial psychiatric assessment of patient J.D. including a comprehensive history, a formal mental status examination, a formal evaluation and diagnosis and formulate a formal treatment plan with goals.

38. Respondent's medical records do not contain any record of testing or evaluation and do not document the formulation of a treatment plan and an ongoing assessment of the patient's condition and the treatment goals.

39. Without a record of testing and evaluation, respondent diagnosed patient as suffering from a Multiple Personality Disorder, without considering other diagnoses of patient J.G.'s behavior.

40. During the course of his treatment, between April 1990 and January 1997, respondent prescribed and/or administered controlled substances and dangerous drugs to patient J.G. without adequately documenting and maintaining a record of the prescriptions and the amounts, without performing a physical examination, and without documenting a medical indication therefor.

41. For an almost four year period, from at least March 1993 until about January 1997, respondent regularly and excessively prescribed Dalmane and Tylenol #3 for patient J.G. without documenting a physical examination and a medical indication therefor.

42. Respondent has no record of prescriptions issued to patient J.G. between May 1993 and May 1996, although he continued to regularly prescribe Dalmane and Tylenol #3 for the patient.

43. In or about 1996, respondent also regularly prescribed Prozac and a monthly injection of 100mg Haldol to patient J.G. without a documented medical examination and a medical indication therefor.

44. During the course of treatment and with knowledge that patient J.G. was an alcoholic, respondent prescribed for patient J.G. medications which are contra-indicated for patients suffering from alcoholism, except in extreme and limited circumstances: Dalmane, Tylenol#3 with codeine, and Prozac. Respondent failed to recognize that said prescription medications possibly contributed to the patient's dissociative tendencies and acting out.

45. During the course of treatment, from about April 1990 until sometime in or about January 1997, respondent introduced patient J.G. to his family, particularly his wife and his young daughter. Respondent invited patient J.G. to play with his daughter, to watch videos at his home, and to interact with respondent and his family on a social basis.

46. Although not reflected in the medical records, during the course of treatment, respondent allowed patient J.G. to sleep overnight at his home, for approximately once a week during a more than one year period of time. Patient J.G. slept overnight at respondent's house as late as in October 1993.

47. During the course of treatment, from about April 1990 until sometime in or about January 1997, respondent gave patient J.G. various gifts, including but not limited to: a puppy, stuffed animals, chimes, a wind-up piano, cards, and photographs of respondent and his daughter. Respondent also sent postcards to patient J.G. from his out-of-town trips.

48. In or about April 1995, respondent took patient J.G. out to lunch for a celebration of five years of therapy.

49. During the course of treatment, from about April 1990 until sometime in or about January 1997, respondent would hug patient J.G. during or at the end of therapy.

50. By as early as May 1990 and continuing during the course of treatment, respondent was aware that patient J.G. had sexual feelings for him and believed she had fallen in love with him. During the course of treatment, respondent received numerous cards and letters from patient J.G. that contained expressions of love. Yet, during the course of treatment, respondent did not properly address in therapy the patient's feelings and the dual relationship and transference/counter-transference issues that arose.

51. In or about January 1991, respondent gave patient J.G. a written letter in which he inappropriately responded to the patient's feelings, leaving open the possibility of a relationship after the completion of therapy.

52. During the course of treatment, from about April 1990 until about January 1997, respondent shared inappropriate personal information about himself with patient J.G. which was detrimental to the patient's treatment including, but not limited to, letters dated 8/24/90 and 1/28/97.

53. During the course of treatment, from sometime in or about May 1991 until sometime in or about 1993, respondent employed patient J.G. to work as a billing clerk in his office and to handle the Medi-Cal billing for his patients.

54. During the course of treatment, sometime while the patient was employed as a billing clerk between about May 1991 and sometime in 1993, respondent provided patient J.G. with a $1,000 advance from her $200 weekly salary so that the patient could buy a car.

55. During the course of treatment, sometime between April 1990 and January 1997, respondent allowed patient to "house sit" for several weeks at his home while he was not there.

56. During the course of treatment, between April 1990 and January 1997, respondent discussed with patient J.G. that he planned to write a book about her, that he wanted her to assist with the writing of the book, and that the book could be entitled "A Rose Is A Rose", which title was suggested by the patient J.G. and referred to one of her personalities.

57. During the course of treatment, sometime between April 1990 and January 1997, respondent took photographs of patient J.G. during their social outings. Respondent provided patient J.G. with an album of photographs of himself and of his family along with patient J.G., which album contained the same title as that proposed for respondent's book-in-progress, "A Rose is a Rose".

58. During the course of treatment, sometime between April 1990 and January 1997, respondent inappropriately intervened on patient J.G.'s behalf, beyond the parameters of the therapeutic relationship, with the patient's landlord.

59. In or about September 1990, respondent visited patient J.G.'s residence accompanied by his personal carpenter and met with respondent's landlord. Respondent also spoke with a housing inspector on the patient's behalf. Respondent offered to pay for the cost of repairs to patient J.G.'s rental residence.

60. During the course of treatment, sometime between April 1990 and January 1997, respondent inappropriately intervened on numerous occasions on patient J.G.'s behalf, beyond the parameters of the therapeutic relationship, with the courts and judicial system and with law enforcement.

61. In or about May 1991, respondent intervened with the court on behalf of patient J.G. who was charged with driving under the influence and refusing to take a breath test.

62. In or about January 1995, respondent intervened with the court with regard to patient J.G.'s son recommending treatment for alcoholism and psycho-therapy and, in the process, revealing confidential information about patient J.G without the proper authorization.

63. During the course of treatment, sometime between April 1990 and January 1997, respondent inappropriately intervened on several occasions on patient J.G.'s behalf, beyond the parameters of the therapeutic relationship, with members of her church.

64. During the course of treatment, from sometime in mid-1992 until sometime in late 1995, respondent allowed a third party, patient J.G.'s bible study teacher, to

participate as a "co-therapist" in the therapy sessions with the patient. This third party had no training and was not licensed as a psycho-therapist. This third party was affiliated with the religion, Jehovah's Witness, of which the patient was trying to become a member.

65. Respondent's medical records are incomplete and inaccurate because they fail to document said bible study teacher's participation in the therapy sessions.

66. Sometime in or after 1992, respondent introduced patient J.G. to another one of his patients, whom he had also diagnosed with multiple personality disorder, with the intent that the two patients should develop a friendship. The friendship purportedly lasted for approximately five years, until patient J.G. accused respondent of unprofessional conduct. Respondent continues to treat the other M.P.D. patient.

67. Respondent's medical records do not document his introduction of the two patients and do not document or assess his treatment goals/objectives with regard to this introduction.

68. During the course of treatment of patient J.G., sometime between April 1990 and January 1997, respondent also undertook to treat psychiatrically patient J.G.'s son, J.G.'s boyfriend, and one of J.G.'s friends and obtained information from them which he presented in sessions with patient J.G., thereby placing himself in a conflict of interest situation with his patients and breaching patient confidentiality.

69. During the course of treatment, from about September 1990 until sometime about October 1992, patient J.G. made written threats and threatening calls to respondent's wife.

70. On or about March 26, 1993, patient J.G. allegedly threatened to kill respondent's wife and daughter.

71. During the course of treatment, from about April 1990 until about January 1997, respondent recognized that the therapy was out of control, that he needed supervision, and that he needed to set limits and treatment goals for patient J.G.. Despite this awareness, respondent failed to consult with other qualified psychiatrists and failed to obtain any supervision of his treatment of patient J.G.. Respondent also continued to foster the dual

relationship, blur the psychiatrist-patient boundaries, and proceeded with unstructured therapy sessions with patient J.G..

72. On or about April 11, 1995, patient J.G. presented to the emergency room of the local hospital with symptoms suggesting a drug overdose, which symptoms respondent observed during a therapy session. Respondent's medical records fail to document any re-assessment of his prescriptions for patient J.G. or of his treatment plan after this episode.

73. Between about August 1995 and February 1996, patient J.G. experienced several crises which resulted in two involuntary commitments to the Mendocino County Mental Health Hospital pursuant to Welfare & Institutions Code section 5150.

74. From about August 25, 1995 until about August 28, 1995, patient J.G. was involuntarily admitted to the hospital after she tore up her residence and was found standing naked in the roadway.

75. In or about November 1995, patient J.G. was admitted to the hospital because she experienced hallucinations.

76. From about February 10, 1996 until about February 13, 1996, patient J.G. was involuntarily admitted to the hospital for an overdose of Dalmane.

77. Respondent's medical records fail to document any attempts in therapy to deal with the issues involving patient J.G.'s hospitalizations in 1995 and 1996 or to document any re-assessment of his prescriptions for patient J.G. or of his treatment plan after these crisis episodes in 1995 and 1996.

78. As late as November 19 and 26, 1996, respondent visited patient J.G. at her home.

79. Patient J.G.'s last therapy session with respondent was in or about December, 1996.

80. Patient J.G. was twice hospitalized, in October/November and in December 1996, for pneumonia, severe bronchitis and acute respiratory distress syndrome.

81. On or about December 11, 1996, respondent visited patient J.G. in the hospital.

82. On or about December 20, 1996, respondent received a telephone call from patient J.G. in which she indicated that she no longer wanted to see him.

83. On or about December 31, 1996, respondent sent patient J.G. a letter in which he threatened to immediately terminate therapy unless he received a written apology from the patient regarding her accusations of respondent's unprofessional conduct.

84. On or about January 28, 1997, respondent sent a letter to patient J.G. in which he expressed that he was upset with rumors he had heard about her accusations, improperly reacted defensively to the patient's allegations, and in which he inappropriately shared personal information with the patient.

85. Respondent inappropriately and abruptly terminated his therapeutic relationship with patient J.G. and did not officially terminate the therapeutic relationship in writing until about April 1998.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence/Incompetence)

86. As described in more detail in paragraphs 26 through 85, respondent's conduct constitutes gross negligence and/or incompetence and is cause for disciplinary action pursuant to Section 2234(b) and/or Section 2234(d). Respondent's overall treatment of patient J.G. constitutes an extreme departure from the standard of care and exhibits incompetence and/or a serious lack of knowledge and skill in dealing with basic clinical issues of psychotherapy by failing to establish and maintain a proper therapeutic boundary and framework for conducting treatment in a safe and rational manner. Respondent failed to recognize and maintain the necessary and basic parameters of therapy including, but not limited to, the following: the physical treatment setting; the fee arrangement; the establishment and continual re-assessment of treatment goals; the maintenance of privacy and confidentiality; avoidance of physical and social contact with patients; therapeutic neutrality; setting of therapeutic limits; avoidance of dual relationship and co-dependent pattern of behavior; the

recognition and appropriate addressing of transference and counter-transference issues induced by respondent's treatment; and the sharing of inappropriate personal information with the patient. Also, respondent manifested severely impaired reality testing and clinical judgment and common sense by being unable or unwilling to separate from the patient emotionally and/or professionally even when it became clear that therapy was becoming quite harmful and potentially dangerous to himself as well as to the patient. Moreover, respondent failed to recognize the damage his actions were causing to the patient, to his family and to himself. Said numerous boundary violations and extreme departures tainted the therapeutic relationship on a continuing basis and had ongoing negative impact on patient J.G. throughout the duration of respondent's treatment, from about April 1990 through about January 1997.

87. Respondent, as described in more detail in paragraph 46, incorporated herein by reference, committed a separate extreme departure from the standard of care and exhibited incompetence and/or a serious lack of knowledge and skill by allowing patient J.G. to stay overnight at his home, which is cause for disciplinary action pursuant to Section 2234(b) and/or Section 2234(d).

88. Respondent, as described in more detail in paragraphs 53 and 54, incorporated herein by reference, committed a separate extreme departure from the standard of care and exhibited incompetence and/or a serious lack of knowledge and skill by employing patient J.G. as a billing clerk in his office, which is cause for disciplinary action pursuant to Section 2234(b) and/or Section 2234(d).

89. Respondent, as described in more detail in paragraph 68, incorporated herein by reference, committed a separate extreme departure from the standard of care and exhibited incompetence and/or a serious lack of knowledge and skill by treating psychiatrically other family members and close friends of patient J.G. and obtaining information about patient J.G. from them and using that information to confront patient J.G. in therapy, which is cause for disciplinary action pursuant to Section 2234(b) and/or Section 2234(d).

90. Respondent, as described in more detail in paragraphs 35, 45-46, 47-48, 53, 55, and 57, incorporated herein by reference, committed a separate extreme departure from

the standard of care and exhibited incompetence and/or a serious lack of knowledge and skill by engaging in planned extra-therapeutic contact with the patient outside of therapy sessions, which is cause for disciplinary action pursuant to Section 2234(b) and/or Section 2234(d).

91. Respondent, as described in more detail in paragraphs 45 and 46-48, incorporated herein by reference, committed a separate extreme departure from the standard of care and exhibited incompetence and/or a serious lack of knowledge and skill by socializing with the patient and introducing the patient to his wife and children for socializing, which is cause for disciplinary action pursuant to Section 2234(b) and/or Section 2234(d).

92. Respondent, as described in more detail in paragraphs 59 and 78 incorporated herein by reference, committed a separate extreme departure from the standard of care and exhibited incompetence and/or a serious lack of knowledge and skill by making visits to the patient's home and never addressing in therapy the issues arising therefrom, which is cause for disciplinary action pursuant to Section 2234(b) and/or Section 2234(d).

93. Respondent, as described in more detail in paragraphs 47, 48, 54, and 57, incorporated herein by reference, committed a separate extreme departure from the standard of care and exhibited incompetence and/or a serious lack of knowledge and skill by giving gifts and photographs of his family to the patient, which is cause for disciplinary action pursuant to Section 2234(b) and/or Section 2234(d).

94. Respondent, as described in more detail in paragraph 49, incorporated herein by reference, committed a separate extreme departure from the standard of care and exhibited incompetence and/or a serious lack of knowledge and skill by engaging in regular physical contact with the patient, which is cause for disciplinary action pursuant to Section 2234(b) and/or Section 2234(d).

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SECOND CAUSE FOR DISCIPLINE
(Unprofessional Conduct)

95. Respondent's conduct as set forth in paragraphs 29, 32, 47, 53, 57, and 58-68, incorporated herein by reference, constitutes general unprofessional conduct and/or a breach of confidentiality and is cause for disciplinary action pursuant to Section 2234 of the Business and Professions Code.

THIRD CAUSE FOR DISCIPLINE
(Unprofessional Conduct/Inadequate and/or Inaccurate Records)

96. Respondent's overall treatment of patient J.G., as described in more detail in paragraphs 29-43, 46, 64-67, and 72-77, incorporated herein by reference, constitutes general unprofessional conduct because respondent maintained inadequate and inaccurate records of his treatment of patient J.G. including, but not limited to, the following: failing to document a clinical history, initial impression/diagnosis, testing/evaluation, treatment plan and re-assessments of said plan; failing to regularly maintain clinical notes of therapy sessions; failing to document when therapy occurred at his home, outside of the office setting; failing to document when a third party participated in the therapy sessions; failing to document his telephone calls with the patient; failing to document when the patient slept overnight at this house; and failing to document the quantity and amount of all dangerous drugs and controlled substances prescribed and/or administered. Moreover, many of respondent's notes of therapy sessions are nonexistent, for example treatment notes for the entire year of 1994 appear to be missing, while other chart notes are fragmented, illegible, or indiscernible for documentation of treatment and instead reflect a mere stenographic account of patient's words.

97. Respondent's conduct as set forth in paragraph 96 constitutes unprofessional conduct and the failure to maintain adequate and accurate medical records and therefore is cause for disciplinary action pursuant to Section 2266 in conjunction with Section 2234 of the Business and Professions Code.

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FOURTH CAUSE FOR DISCIPLINE
(Prescribing Without a Good Faith Medical Exam and Medical Indication)

98. Respondent's conduct as set forth in paragraphs 40 through 44, incorporated herein by reference, constitutes prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without a good faith prior examination and medical indication therefor and is grounds for disciplinary action pursuant to Section 2238 in conjunction with Section 2242(a).

FIFTH CAUSE FOR DISCIPLINE
(Excessive Prescribing/ Prescribing to an Addict or Habitue)

99. Respondent's conduct as set forth in paragraphs 41-44 and 72-76, incorporated herein by reference, constitutes unprofessional conduct because of repeated acts of clearly excessive prescribing or administering of drugs or treatment as determined by the standard of the local community of licensees pursuant to Section 725 and/or prescribing to an addict or habitue pursuant to Section 2241.

SIXTH CAUSE FOR DISCIPLINE
(Excessive Prescribing of Controlled Substances)

100. Respondent's conduct as set forth in paragraphs 41-44 and 72-76, incorporated herein by reference, was beyond the authorized scope and constitutes the prescribing of controlled substances in excess of such quantity and length of time as is reasonably necessary and therefore is cause for disciplinary action pursuant to Section 2238 in conjunction with Sections 11210 and 11171 of the Health and Safety Code.

SEVENTH CAUSE FOR DISCIPLINE
(Prescribing Without a Legitimate Purpose)

101. Respondent's conduct as set forth in paragraphs 41-44 and 72-76, incorporated herein by reference, constitutes prescribing, dispensing, or furnishing controlled substances without a legitimate medical purpose and therefore is cause for disciplinary action pursuant to Section 2238 in conjunction with Sections 11153(a) and 11171 of the Health and Safety Code.

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 23083, heretofore issued to respondent Jon C. Trefil, M.D.;

2. Ordering respondent to pay the Division the actual and reasonable costs of the investigation and enforcement of this case and, if placed on probation, the costs of probation monitoring; and

3. Taking such other and further action as the Division deems necessary and proper.

DATED: JUNE 30, 1999

Ron Joseph
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant