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

In the Matter of the First Amended Accusation Against:	)	
James William McCarrick, III, M.D.	)	Case No. 800-2017-033405
Physician's and Surgeon's Certificate No. A 60133	)	
Respondent	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on November 8, 2019.

IT IS SO ORDERED: October 9, 2019.

MEDICAL BOARD OF CALIFORNIA

Kristina D. Lawson, J.D., Chair
Panel B

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

In the Matter of the First Amended Accusation Against:

JAMES WILLIAM McCARRICK, III, M.D., Respondent

Physician's and Surgeon's Certificate No. A 60133

Case No. 800-2017-033405

OAH No. 2019030437

PROPOSED DECISION

Administrative Law Judge Diane Schneider, State of California, Office of Administrative Hearings, heard this matter on July 9, 10, 11, and 26, 2019, in Oakland, California.

Carolyne Evans, Deputy Attorney General, represented Kimberly Kirchmeyer, Executive Director of the Medical Board of California, Department of Consumer Affairs.

Michael Firestone, Attorney at Law, Marvin Firestone & Associates, LLP, represented respondent James William McCarrick, III, M.D.

The record closed and the matter was submitted for decision on July 26, 2019.

FACTUAL FINDINGS

Procedural History and Summary of Allegations

1. Complainant Kimberly Kirchmeyer issued the First Amended Accusation in her official capacity as Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On May 21, 1996, the Board issued Physician's and Surgeon's Certificate (Certificate) No. A 60133 to James William McCarrick, III, M.D. Respondent's Certificate was in full force and effect at the times of the acts set forth below and will expire on March 31, 2020, unless renewed.

3. On June 6, 2017, the Board received an anonymous complaint against respondent alleging sexual misconduct. The Board investigated and filed an Accusation, and later, a First Amended Accusation against respondent. The First Amended Accusation alleges that respondent committed unprofessional misconduct and sexual misconduct in connection with Patient A.[1] Respondent admits that he exchanged graphic messages and photographs of a sexual nature with Patient A via texts, a practice commonly referred to as "sexting." He asserts, however, that he did not commit any misconduct because Patient A was a former patient at the time they engaged in sexting.

4. At hearing complainant deleted the word "or" on page 6, line 24, of the First Amended Accusation.

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[1] The patient is not identified by name in order to protect her privacy.

Complainant's Evidence

RESPONDENT'S TREATMENT OF PATIENT A AT SANTA CLARA VALLEY MEDICAL CENTER

5. Patient A, a 30-year-old woman, was referred to respondent by her primary care physician, Anna Hui, M.D., for a pap smear and pelvic examination. Patient A was first examined by respondent, an obstetrician and gynecologist at Santa Clara Valley Medical Center (SCVMC), on August 22, 2016. The examination included a pap smear and screening for sexually transmitted diseases and infections. Patient A wrote respondent in the patient email portal at SCVMC ("My Health Online"), asking respondent if the test results were ready. On September 27, she wrote to respondent that she wanted to make sure that she would be able to view the test results from the patient email portal, since she was moving[2] in early October. Respondent wrote back on My Health Online, and indicated that he could still answer her questions on My Health Online. On September 29, respondent wrote to Patient A on My Health Online that her pap test showed mildly atypical cells. He recommended a procedure called colposcopy, to check her cervix with a magnifying scope for signs of abnormalities. Patient A wished to have the colposcopy prior to her move, and respondent accommodated her request to expedite the procedure.

6. On September 30, 2016, respondent performed a colposcopy, including a biopsy, on Patient A. In a note to Patient A in My Health Online, on October 4, 2016, respondent informed Patient A of the results of the colposcopy. Respondent wished

[2] Patient A moved to Washington to attend school.

her the best on her move and recommended that Patient A return for a pap test in six months to a year. Their last contact on My Health Online occurred on October 5, 2016.

7. On October 14, 2016, Patient A signed an authorization for SCVMC to release her medical records because she was moving and needed the records for her new doctors.

PATIENT A CONTACTS RESPONDENT ON LINKEDIN

8. On October 15, 2016, Patient A contacted respondent on LinkedIn. She stated that she found respondent's personality and looks extremely attractive and asked if they could talk some time and get to know each other. Respondent replied that he was happy to talk when things settled down with Patient A's move. On October 20, 2016, respondent and Patient A spoke on the telephone for 27 minutes.

9. About two weeks after respondent and Patient A connected on LinkedIn, they began texting each other. The texts included graphic sexual texts and photographs. The texts also included sharing their feelings about work, family, pets, and life generally, and a number of exchanges in which Patient A asks respondent for medical advice. The texts span a six-month period between the first week[3] of

[3] As early as November 7, 2016, the two referenced prior sexual photographs they had exchanged. During one text, respondent asked Patient A to delete his picture; Patient A responded that she would not delete it until he visited her.

November 2016 through the first week of May 2017. Respondent is 29 years older than Patient A.[4] The texts are voluminous; pertinent texts are reproduced below.

GRAPHIC SEXUAL TEXTS AND PHOTOGRAPHS

10. On November 4, 2016, respondent and Patient A discussed the exchange of photographs. He wrote:

> I can take spicy one when you're in the mood. (I didn't save yours btw; staying discrete)

Later that day, respondent texted:

> That was really nice It's silly but I feel like I'm missing you I guess I'm feeling like I want closeness Goodnight Naughty dreams

11. On November 20, 2016, Patient A sent respondent a picture of her breasts. Respondent responded with the following texts:

> So beautiful! Yes I want my mouth and tongue all over them. Might fuck between them too. Cum on your pretty neck. You're killin me And yes will send pic And now I need new pic of your sweet pussy, I think But yes. Things are settling down here now at work. So let's chat more. I'm on call later today but off tmoro afternoon.

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[4] This difference was acknowledged between them in a text dated December 17, 2016.

12. On November 20, Patient A responded by sending respondent a picture of her naked vulva. Respondent wrote:

> Omg. Wanna be inside you [three cat emojis] I'll give you all my cum.

Patient A texted back:

> wish we could meet at your office one day and fuck I've squirted before but even if I don't I'm always wet.

Respondent texted back:

> Omg. That would be ridiculously sexy and risky. Hot!

Patient A responded:

> Yeah but it'd be so fun! Me walk in with a short skirt on and no panties, pull it up. You bend me over your desk and fuck me doggy style

Respondent texted back:

> We'll call it special internal exam. Extra deep.

During this exchange, respondent texted that he had to go to work. Patient A wrote:

> Naughty boy, on your break go jerk off in the bathroom and send me a pic while you're in there and cum. I wanna see that you did do it at work thinking of me.

Respondent responded:

> I will. A huge load Xoxo.

13. On November 21, 2016, respondent texted:

> Omg. Just heard your yummy wet pussy. Bad girl. Make me want to cum in you.

On the same day he sent Patient A a picture of his naked erect penis, surrounded by what appeared to be ejaculate, taken in the "on call" room at work.

14. On February 19, 2017, respondent texted Patient A a picture of himself in front of the mirror, bearing his naked torso and what appears to be tight underwear or biking shorts. Above the picture, he wrote: "Haha I'm trying to reverse time."

MEDICAL ADVICE

15. During the period of time in which they sexted, Patient A asked respondent medical questions. Respondent provided her with answers, as well as medical advice, a diagnosis, and an offer to examine her and treat her with medications.

16. On December 4, 2016, Patient A wrote respondent about what she described as "a weird lump" near the opening of her vagina, that she thought might be a Bartholin's abscess. That day the two exchanged a series of texts. Patient A texted that she was asking respondent for advice because she could not get in to see a local physician until January or February. Respondent wrote back, stating that it did sound like Bartholin's. He wrote:

> Does sound like possible bartholin's. Not fun! So if it's a cyst it might be a little tender but not too bad. If it's an abscess it's usually big (like golf ball size) and really painful, swollen and red. Either way you can try warm soaks a few times a day. Like a washcloth with really warm water held to the area a few minutes and . . . re-warm it a few times. They'll often get better with that treatment and time

Patient A followed up with a question as to whether she could cut and drain it like a pimple. Respondent replied:

> Just warm moist heat with wash cloth or sitz bath is fine. Cut and drain is really unpleasant unless it's already coming to a head.
>
> Wish I was closer by. I could do quick check If it gets worse, I can send antibiotic for you too. Sometimes helps.

17. On December 23, 2016, Patient A asked respondent for information about Ambien to help her sleep. She also asked him to send her some, and explained that:

> I'd ask you to call in a prescription but idk if my Medicaid will cover it and I desperately need to sleep.

On the same day, respondent replied that Ambien "is good." He suggested that she try Melatonin as an alternative since he did not have any Ambien to send her, and she could purchase Melatonin in the supplement section of her pharmacy.

18. About one week later, on December 31, Patient A texted respondent, asking for a referral to a physician to perform laser removal of tattoos. Respondent said he would look into it.

19. On February 23, 2017, Patient A texted respondent with a question as to whether it was safe to have candle wax in her vagina. On the same day, respondent texted back: "sure it will get hard and then you can get it out."

20. On May 1, 2017, Patient A wrote respondent asking if he "had an injectable that can help swelling and soreness" from a mosquito bite. Respondent wrote back, suggesting that she treat the bite with ice, Claritin and Benadryl cream.

OTHER TEXTS REFERENCING THEIR DOCTOR/PATIENT RELATIONSHIP

21. Patient A makes reference to respondent as her doctor on several occasions. For example, on November 7, 2016, she wrote:

> do you have feelings for me other than sexual, other than as a person, other than as a dr to any patient, but as a potential?

22. On November 21, 2016, she texted respondent "night naughty dr."

23. On December 7, 2016, Patient A wrote:

> Now you won't even reply to me. :-(. Hmm I should've kept our relationship dr and patient. I'll reframe [sic] from contacting you other than those reasons (dr and patient), from now on. wish you well.

Over the ensuing months, the two continued sexting, which included discussions about meeting and having sex, and other personal matters.

PLANS TO MEET IN PERSON AND MEETING AT SCVMC

24. In February 2017, respondent and Patient A made plans to meet while Patient A was in the Bay Area, but the plans never materialized. Patient A indicated that she would be moving back to the Bay Area from Washington. In one text, she asked respondent if he knew anyone with a home that she could live in with her big dog, or if he was planning on "getting a condo/home and aren't opposed to a roommate with a big dog . . . . "

25. On March 24, 2017, Patient A alluded to her returning to SCVMC for a pap smear. Respondent wrote that he was "happy to check if you need it. just lmk." Patient A asked respondent how he was feeling about their relationship. Respondent replied: "I'm feeling fine with it. chill in a good way. how about you?"

26. On April 10, 2017, the My Health Online[5] sent Patient A a message that she had a follow-up appointment with respondent on April 13, 2017. Patient A rescheduled the appointment for June 2017, with another gynecologist at SCVMC.

27. On May 5, 2017, Patient A went to SCVMC for an appointment with her primary care physician. Patient A wrote respondent that she would be at the clinic, and

[5] Although the evidence was not clear as to how the appointment was made, respondent's expert, who is familiar with SCVMC, postulated that the appointment was automatically scheduled by the software system.

suggested they meet. They met briefly, and afterwards, exchanged texts. Patient A wrote:

> I honestly loved how your body felt pressed on mine. Least I know what you'd feel like on top of me whenever we do fuck.

After an exchange of sexually provocative texts, respondent wrote:

> You bring out my horniness You are too sexy Partly was thinking how I wanted to push up against you when I hugged you. Just a little dry hump. Your eyes and lips looked very nice today too.

Patient A wrote that respondent would have to "do better" than a "dry hump." Respondent replied that was the best he could do at the office unless they found a nearby closet. Respondent went on to say that next time they met at the clinic he would find an "unmonitored corner," where he could "feel [her] then."

Respondent's Evidence

BACKGROUND, TRAINING AND EMPLOYMENT

28. Respondent has been licensed to practice medicine in California since 1994. He received his medical degree from the University of Pennsylvania. He completed his internship and residency in Obstetrics, Gynecology and Reproductive Sciences at University of California, San Francisco. He is board-certified by the American Board of Obstetrics and Gynecology, and is a fellow in the American College of Obstetrics and Gynecology (ACOG). Between 1998 and 2014, respondent practiced at the Palo Alto Medical Foundation (PAMF).

In 2014, he left PAMF and began working at SCVMC. In addition to practicing as an obstetrician and gynecologist at SCVMC, respondent also was the Director of Resident Research. Respondent resigned from his position at SCVMC on October 28, 2018. In January 2019, he began working at Athena Medical Specialists (Athena). Athena provides ambulatory women's health care to a population that respondent describes as largely Hispanic. He works at Athena one to two days each week, mostly performing wellness check-ups.

TREATMENT OF, AND RELATIONSHIP WITH, PATIENT A

29. Respondent's first appointment with Patient A, on August 22, 2016, was routine, and lasted about five minutes. Patient A made it clear, in the course of her inquiries regarding the lab results, that she was moving to another state. At her request, respondent and his staff compiled her medical records. Their second appointment on September 30, for the colposcopy, lasted about 10 minutes. The visit was unremarkable. Respondent sent Patient A the results and recommended she return for pap smear in six months to one year. (The usual amount of time between pap smears is one year, but he thought she might want to have one sooner.) He did not schedule her for another visit; he presumes that the computer system scheduled Patient A for a follow up appointment in April 2017. Respondent's understanding was that Patient A was not going to be his patient after their contact on My Health Online, on October 5, 2016.

30. When Patient A contacted him on LinkedIn, he did not regard her as a current patient. During the end of October 2016, respondent's relationship with Patient A became friendly; and shortly thereafter, became provocative and sexual in nature.

31. When respondent answered Patient A's medical questions, which he characterizes as "random, general questions," he did not "feel" like he was "in the role of a physician." People routinely ask respondent questions about their medical concerns, and he tries to answer their questions. In respondent's view, Patient A's questions and his advice regarding her vaginal cyst, Ambien, her mosquito bite, tattoo removal, and the safety of putting wax in her vagina, were no different than the types of exchanges he has with people who are not his patients.

32. Respondent considers his advice to Patient A regarding the Bartholin's cyst was consistent with what Patient A could have found online at the Mayo Clinic website. Respondent was asked about his offer to send Patient A antibiotics if the cyst near her vagina worsened. He testified that he was not actually going to send her antibiotics because it was illegal to do so; and that he made the offer "to keep the peace." Respondent explained that "sometimes he promises things that he knows he cannot do." He was firm in his assertion that his advice to Patient A was akin to "BBQ or cocktail party conversation." Respondent was also asked about his statement to Patient A that he could do a "quick check" if he was closer by. Respondent acknowledged that he would not offer to examine someone that he met at a cocktail party.

33. Respondent believes that Patient A left his practice as a patient, and for this reason, he did not think that he needed to engage in the formalities involved when a doctor wishes to, in his words, "fire" a patient.

REHABILITATION EVIDENCE

34. Respondent has completed a large volume and variety of medical education courses, because, in his words, he is presently "underemployed."

35. Respondent completed a course entitled *PBI Professional Boundaries and Ethics Course: Enhanced Edition* on December 2, 2018, and generated a boundary protection plan for his current employment at Athena Medical Specialists. Respondent testified that he has also participated in "some phone counseling," which he describes as a peer group that is moderated by a group leader. On July 12, 2019, respondent signed up to complete *PBI Maintenance and Accountability Seminars.* The latter course is a required follow-up component for physicians who are mandated by the Board to complete a professional boundaries course.

36. Respondent offered several reasons why he embarked on a sexting relationship with Patient A: He lives alone and is vulnerable to feeling lonely; he welcomed the attention from Patient A, who he thought liked him. Respondent calls the circumstances leading to his relationship with Patient A as a "perfect storm of [his] vulnerability." Respondent does not see Patient A as being vulnerable; and while he describes her as "pushing" him to get involved with her, he is not excusing his behavior.

37. Respondent testified that he did not think that sexting a photograph of his penis to Patient A was inappropriate, but minutes later, testified that it was inappropriate. When given an opportunity to clarify his answer, he again waffled: He testified that it was not appropriate to send a picture of his penis to a patient he treated one month prior, but if the patient was a former patient then texting a picture of his penis one month after the doctor-patient relationship terminated was not inappropriate. He further testified that the "timing seems close," but added that he "did not feel that it was too close."

38. Respondent is remorseful for his actions. He has come to realize that the burden is on him, as a doctor, to maintain appropriate boundaries with his patients.

Because he is now "acutely aware of boundary issues and will not have communication with anyone" outside of work, he "cannot imagine this would come up again."

CREDIBILITY FINDING

39. Respondent's testimony, on balance, was credible and candid. That said, portions of respondent's testimony lacked credibility and candor. For example, as set forth above, respondent vacillated as to whether his sending a picture of his penis to Patient A was appropriate. He appeared unwilling or unable take an unequivocal stand on this question.

40. Respondent was also asked about the volume of the texts between himself and Patient A. His answers to this line of questions were vague and indirect; again, suggesting that he was unwilling or unable to acknowledge the volume of his texts. He also professed that he did not remember if he was wearing his "scrubs" in the picture of his penis that he sent to Patient A from work. He was asked if he provided medical advice to Patient A during their sexting relationship; his answers to these questions were, at times, dodgy, particularly regarding his offer to prescribe Patient A antibiotics and examine her if he lived closer. Additionally, portions of respondent's testimony regarding his May 5, 2017, encounter with Patient A at SCVMC lacked candor: when asked to explain what he meant in his text to Patient A that next time she came to the clinic, he would find an "unmonitored corner," respondent replied that he did not know what he meant. (His texts quoted in Factual Finding 27 about wanting to find an "unmonitored corner" next time they met at the clinic were highly sexually suggestive.)

41. Thus, while respondent impressed as basically honest and well-meaning, portions of his testimony strongly suggest that he has not fully come to terms with, and accepted responsibility for, his misconduct.

Ethical Principles Promulgated by ACOG

42. As a member of ACOG, respondent is obligated to follow the ethical rules promulgated by ACOG.

ACOG'S ETHICAL GUIDELINES REGARDING SEXUAL RELATIONSHIPS WITH PATIENTS AND FORMER PATIENTS

43. ACOG's ethical rules provide guidance regarding sexual relationships between doctors and patients, and certain steps that should be taken in cases where a doctor seeks to begin a sexual relationship with a former patient. According to the ACOG Committee Opinion, in effect at the time of respondent's sexual relationship with Patient A, it is always unethical for a doctor to engage in a sexual relationship with a patient. A sexual relationship with a former patient may also be unethical if the doctor uses or exploits his power, knowledge or influence derived from the previous doctor-patient relationship.

44. A doctor's ethical duties under ACOG's Guidelines require the doctor to terminate the doctor-patient relationship before beginning a sexual relationship with a patient. While there is no bright line for determining the ethics of sexual relationships after a doctor-patient relationship is terminated, factors germane to determining whether such relationships are ethical include: the length of time and intensity of the prior doctor-patient relationship; the amount of time that has passed since the doctor-patient relationship was terminated; age differences between the doctor and patient; and the patient's feelings of dependency, obligation or gratitude.

ACOG GUIDELINES REGARDING TERMINATION OF THE DOCTOR-PATIENT RELATIONSHIP

45. According to ACOG's ethical guidelines, in order to properly terminate a doctor-patient relationship, a doctor should: provide the patient with written notice that the doctor-patient relationship is terminated; include the reasons for the termination; note the patient's medical condition and the need for ongoing care; provide information to the patient to help him or her find another doctor; offer to provide the patient's new doctor with his or her medical records; and retain a copy of the letter and document that it was received by the patient.[6]

Expert Opinions

EXPERT TESTIMONY AT HEARING

46. The experts who testified at hearing were familiar with the standard of care, laws, and ethical principles applicable to the professional conduct of obstetricians and gynecologists in California. Each expert reviewed pertinent medical records, text exchanges, and other documents, as well as applicable ethical guidelines. Each expert offered an opinion as to whether respondent committed unprofessional conduct in connection with his sexting relationship with Patient A.

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[6] The Board's website also contains guidelines for doctors who wish to terminate the doctor-patient relationship. While the Board's guidelines are not exactly the same as ACOG's, central to both guidelines are the requirements of notice, referral to other doctors, and assistance with providing medical records to the patient.

47. The experts agreed that a doctor's exchange of sexually graphic photographs and texts such as those in the instant case, with a current patient, constitutes unprofessional conduct. The experts disagreed, however, on two questions: first, did respondent and Patient A have a doctor-patient relationship at the time of their sexting; and, even if the relationship was terminated, did a sufficient amount of time pass after the cessation of the relationship to allow respondent to engage in a sexual relationship without violating his legal and ethical obligations?

BOARD'S EXPERTS

Albert J. Phillips, M.D.

48. Albert J. Phillips, M.D., has been licensed to practice medicine in California since 1982. He graduated from University of Southern California (USC) Medical School and completed his internship and residency in Obstetrics and Gynecology at USC Medical Center. He is board-certified by the American Board of Obstetrics and Gynecology, and is a fellow in the American College of Obstetrics and Gynecology. Dr. Phillips is the Medical Director of Woman's Health Services at Providence Saint John's Health Center in Santa Monica. Dr. Phillips also works as a hospitalist/laborist in Saint John's Obstetrics and Gynecology Department, and has a private practice.

49. Dr. Phillips opined that respondent and Patient A were engaged in a sexual relationship by reason of the exchange of sexually graphic texts and photographs on multiple occasions; and that during the time of their sexting relationship, their relationship as doctor-patient remained. Dr. Phillips pointed to multiple interactions between the two where Patient A sought and received medical advice from respondent. In particular, he noted that respondent offered Patient A a

diagnosis, treatment options, offered to send antibiotics, and said he wished he could do a quick examination. Dr. Phillips observed that a doctor would not "offer to write a prescription for someone who wasn't his patient."

Dr. Phillips also noted that Patient A's multiple medical questions to respondent, which included questions regarding her vaginal lump, Ambien and treatment for a mosquito bite, showed that she still regarded him as her doctor. And, his conclusion was reinforced by the fact that Patient A returned to respondent's clinic for a gynecological examination in June 2017, with another gynecologist.

50. According to Dr. Phillips, conduct that is an extreme departure from the standard of care is care that "no reasonably prudent doctor would engage in." Dr. Phillips concluded that respondent's conduct was "the most extreme example of inappropriate behavior." Dr. Phillips found that his conduct violated ACOG's ethical guidelines, was an extreme departure from the standard of care,[7] and also constituted sexual misconduct.[8] In analyzing respondent's conduct, Dr. Phillips remarked that it is particularly important for gynecologists to maintain appropriate boundaries with their patients because the nature of gynecological examinations makes patients particularly vulnerable. Dr. Phillips stressed that it is the doctor's burden to maintain appropriate boundaries because he or she is in a powerful position and controls the interactions. Thus, where a patient initiates sexual contact, the doctor is ethically obligated to take the "higher ground" and not respond to sexual overtures.

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[7] Dr. Phillips used the phrase "extreme departure from the standard of care" synonymously with the term "gross negligence."

[8] See Business and Professions Code section 726.

51. Dr. Phillips emphasized that the fact that Patient A moved out of state and requested her medical records from SCVMC did not operate to terminate the doctor-patient relationship. Instead, the standard of care required respondent to provide Patient A with written notice that the doctor-patient relationship was terminated and provide her with options for emergency care and referrals to other providers. Dr. Phillips agreed that in some cases, the passage of time alone would be sufficient to allow a doctor to "safely assume" that the doctor-patient relationship terminated. He firmly believed that such was not the case here.

52. Dr. Phillips explained that if respondent believed that the doctor-patient relationship was terminated with Patient A, he was obligated to provide her with notice, decline to provide her with medical treatment, and refer her to another provider. He observed that instead, respondent's conduct fostered Patient A's belief that he was her doctor.

53. Dr. Phillips added that even if the doctor-patient relationship between respondent and Patient A had terminated in the beginning of October, after respondent notified her of the colposcopy results, an insufficient amount of time had passed between the termination and the time they began sexting for respondent to ethically engage in a sexual relationship with Patient A. The standard of care and ACOG's ethical guidelines do not delineate what amount of time should pass between the termination of a doctor-patient relationship and the commencement of a sexual one. However, in Dr. Phillips's view, it is an extreme departure from the standard of care and a violation of ACOG's ethical guidelines for a doctor to commence a sexual relationship with a patient only four weeks after the doctor-patient relationship is terminated.

Michael L. Krychman, M.D.

54. Michael L. Krychman, M.D., has been licensed to practice medicine in California since 1995. He graduated from McGill University Medical School and completed his internship and residency in Obstetrics and Gynecology at Cedar Sinai Medical Center. He is board-certified by the American Board of Obstetrics and Gynecology, and is a fellow in ACOG. Dr. Krychman has completed extensive advanced training in the field of Human Sexuality. He is the Executive Director of the Southern California Center for Sexual Health and Survivorship Medicine in Newport Beach, where he specializes in the evaluation, assessment and treatment of sexual health issues, including those pertaining to gynecology, cancer, and sexuality.

55. Dr. Krychman described the relationship between Patient A and respondent as a "highly sexualized relationship" that was also emotionally intimate, based upon their sharing of emotions, sexual thoughts and feelings, as well as daily life concerns. The fact that they did not have actual physical contact does not diminish the essential sexual nature of their relationship. Conduct is either sexual or not; and in this case, respondent's conduct with Patient A was clearly sexual. Dr. Krychman opined that the erotic and sexually explicit relationship between respondent and Patient A occurred in the context of their relationship as doctor and patient.

56. In forming his opinion, Dr. Krychman emphasized that during the time of their sexual relationship, respondent had not terminated the doctor-patient relationship. Dr. Krychman explained that the standard of care for terminating a doctor-patient relationship is consistent with the Board's publication on its website and ACOG's guidelines. The publication on the Board's website pertaining to terminating the doctor-patient relations requires the doctor to provide the patient with: written notice of the last day that medical treatment will be available; provision

of at least 15 days of emergency treatment and prescriptions before the relationship is terminated; alternative sources for medical care; and instructions as to how the patient may obtain his or her medical records. Respondent did not comply with any of the Board's guidelines, or ACOG's ethical criteria for the termination of doctor-patient relationships.[9]

57. Dr. Krychman emphasized that the fact that Patient A moved away and signed a release for her medical records did not operate to terminate the doctor-patient relationship. Additionally, because patients can seek medical care from multiple providers in different states, the fact that Patient A might have seen another doctor while she lived out of state did not operate to terminate her status as respondent's patient. Indeed, respondent had advised her to return to the clinic for a follow-up examination in six months to a year.

58. Dr. Krychman opined that Patient A's conduct made it clear that she continued to regard respondent as her doctor. Patient A continued to seek respondent's professional advice, and respondent continued to provide Patient A with medical guidance and recommendations for therapeutic interventions regarding the management of a number of medical conditions. With respect to Patient A's queries regarding the lump outside of her vagina, Dr. Krychman noted that respondent offered to prescribe antibiotics for her and said that if he were closer he could examine her. And, the fact that some of respondent's recommendations directed Patient A to take over-the-counter remedies does not transform the nature of the doctor-patient interactions between them. Dr. Krychman roundly disagreed with the notion,

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[9] ACOG's ethical guidelines for terminating the doctor-patient relationship are found at Factual Finding 44.

propounded by respondent's experts, that respondent's responses to Patient A's questions constituted nonmedical advice akin to what a doctor might provide to non-patients in social situations.

59. Dr. Krychman concluded that respondent's participation in a romantic and sexually explicit relationship with Patient A, concurrent with their doctor-patient relationship, constituted an extreme departure from the standard of care.

60. Dr. Krychman explained that if a doctor is going to embark in a sexting relationship with a former patient, a "significant amount of time has to pass" before doing so. In the instant case, the parties began their sexual relationship about one month after respondent provided Patient A with the results of her colposcopy. Dr. Krychman found that even if it was assumed their doctor-patient relationship terminated before they began sexting, one month is clearly an insufficient amount of time to wait before commencing a sexual relationship with a former patient. Thus, even if Patient A could be considered a former patient, respondent's failure to wait a sufficient amount of time before commencing the relationship constituted an extreme departure from the standard of care. In rendering his opinion, Dr. Krychman noted that Patient A was particularly vulnerable in that she had gynecological issues leading to her colposcopy one month before they began sexting; and as a result, she was not on "equal footing" with respondent. Under these circumstances, respondent's involvement with her constituted a "misuse of trust."

RESPONDENT'S EXPERTS

John Daniel Byrne, M.D.

61. John Daniel Byrne, M.D., has been licensed to practice medicine in California since 1992. He graduated from Loyola University Chicago, Stritch School of

Medicine. He completed his residency in obstetrics and gynecology at USC School of Medicine. He is board-certified by the American Board of Obstetrics and Gynecology in obstetrics and gynecology and maternal fetal medicine. Dr. Byrne is a fellow in ACOG and the Society for Maternal Fetal Medicine. Dr. Byrne is the Chair of the Obstetrics and Gynecology Department, and Chief of Obstetrics and Maternal-Fetal Medicine, at SCVMC. Between 2004 and 2011, Dr. Byrne served as a medical reviewer for the Board.

62. Dr. Byrne supervised respondent's work at SCVMC between 2014 until respondent's resignation in 2018, and, as Chair of the Obstetrics/Gynecology Department, was involved in SCVMC's investigation of respondent's conduct. On October 22, 2018, after the Board filed charges against respondent, he was placed on unpaid administrative leave by SCVMC Medical Director John Funkhauser, M.D. About one week later, respondent resigned from his position at SCVMC.

63. In addition to testifying as an expert, Dr. Byrne testified to his opinions regarding respondent's professional ethics and character. Dr. Byrne considers respondent a "work friend" and has socialized with respondent. While Dr. Byrne's expert fees are between $500 and $600 per hour, he did not charge respondent for his time as an expert.

Dr. Byrne never received any reports that respondent had acted inappropriately with patients. He believes that respondent's "character is of the highest caliber." Dr. Byrne also praised respondent for his excellent clinical skills, for the kindness and respect he demonstrated when caring for patients, and for the excellent mentorship he provided to residents and medical students. Dr. Byrne described respondent as someone with an "impeccable reputation with patients and staff." Dr. Byrne found it "very disturbing" that the Board published the accusation against respondent on its

public access website prior to a final resolution of the charges against respondent. He believes that this has significantly damaged respondent's personal and professional reputation.

64. While Dr. Byrne explained that neither the American Medical Association nor ACOG provides clear guidelines as to when a patient is a current versus a former patient. Dr. Byrne strongly believes that at the time respondent and Patient A began their sexting relationship, she was respondent's former patient. Dr. Byrne disagreed with the Board's experts that respondent was required to provide Patient A with written notice and formally document the termination of the doctor-patient relationship before embarking on a sexual relationship with her.

Additionally, in forming his opinion that Patient A was a former patient of respondent's at the time that they commenced their sexting relationship, he relied on the fact that Patient A had moved out the area and requested copies of her medical records for her providers in Washington. In Byrne's view, these facts establish Patient A's intention to terminate the doctor-patient relationship. Additionally, Dr. Byrne noted that Patient A had only two visits with respondent and was not a long-term patient of his. He also noted that respondent acted professionally during the medical appointments and in his messaging Patient A on My Health Online regarding her medical issues.

65. Dr. Byrne discussed each of the instances in which Patient A asked respondent questions regarding her various medical concerns. Dr. Byrne opined that respondent's answers to Patient A's questions during their sexting relationship did not constitute a continuation of medical care or re-establish their doctor-patient relationship. In Dr. Byrne's view, because respondent did not examine Patient A, provide a diagnosis, prescribe her medications, or document his medical care, his

interactions with her did not rise to the level of practicing medicine. He did not view respondent's offer to prescribe antibiotics for Patient A's vaginal cyst as practicing medicine because it was not an "action." On cross-examination, however, Dr. Byrne agreed that it would be inappropriate for a doctor to offer to write a prescription for a person who was not his patient. Dr. Byrne also opined that respondent's statement that he wished that he was closer so that he could "check" Patient A, did not constitute the practice of medicine since it was not an "action."

66. Dr. Byrne also discussed the circumstances in which he believes that doctors may engage in sexual relationships with former patients. While Dr. Byrne agreed that the rules are not clear as to when a doctor may commence a sexual relationship with a former patient, Dr. Byrne opined that respondent's conduct was within the standard of care. He reasoned that Patient A was the one who initiated contact, and in a number of instances, initiated the sexualized texting. Dr. Byrne also cited one instance in which Patient A refused to delete a picture respondent sent until respondent visited her; he described this conduct on the part of Patient A as "exploitive." Under these circumstances, he concluded that respondent was not exploiting his power and position as her former doctor, and that the sexual relationship with Patient A was, therefore, not unethical or unprofessional in any way. The fact that the relationship began four weeks after Patient A's last office visit did not alter his opinion that the sexual relationship between Patient A and respondent occurred outside of their doctor-patient relationship.

Eric S. Colton, M.D.

67. Eric S. Colton, M.D., has been licensed to practice medicine since 1992. He first became licensed in Missouri, and in 2015, became licensed in California. He graduated from St. Louis University School of Medicine and completed his residency in

obstetrics and gynecology at St. John's Mercy Medical Center in St. Louis. He is board-certified by the American Board of Obstetrics and Gynecology and is a fellow in ACOG. Dr. Colton is in private practice in San Luis Obispo. He is also an expert reviewer for the Board.

68. Dr. Colton opined that respondent did not commit any breach of his ethical or professional obligations by having a sexual relationship with Patient A because, at the time, she was no longer his patient. In Dr. Colton's view, Patient A discharged respondent and the entire SCVMC when she moved out of state and requested that her medical records be sent to her out-of-state providers. In forming the opinion that Patient A was not a current patient of respondent's when they began their sexting relationship, Dr. Colton noted that Patient A had only had two medical appointments with respondent; and, she moved out of state, requested her medical records, and made attempts to see another medical provider. These factors led Dr. Colton to conclude that she "dismissed herself" from respondent's medical practice, and terminated the doctor-patient relationship. Under these circumstances, Dr. Colton opined that respondent's exchange of sexually explicit texts and photographs occurred outside of the purview of his professional duties because it occurred in his private life.

69. Dr. Colton also found that respondent's replies to Patient A's medical questions did not re-establish their relationship as doctor and patient because respondent did not examine, diagnose or treat her during this time. In support of his point of view, he points out that respondent did not physically examine Patient A, or order tests; and he believes that the feedback respondent gave to Patient A did not include diagnosing or discussing various treatment options. Instead, he viewed respondent's responses to Patient A's questions in the same way he would regard a doctor providing a friend with medical information. Dr. Colton points out that Patient

A could have gotten the same information about her medical questions from an online site such as "Web M.D."

70. Dr. Colton also opined that, for several reasons, respondent was not obligated to follow the Board's or ACOG's guidelines pertaining to the termination of the doctor-patient relationship in the instant case. In his view, ACOG's guidelines pertain to situations where a doctor is changing practices or where a patient is disruptive; and neither situation was present in the instant case. Elsewhere in his testimony, Dr. Colton stated that respondent terminated the doctor-patient relationship by providing her with her medical records and that Patient A terminated the doctor-patient relationship on her own.

71. In Dr. Colton's view, the doctor-patient relationship between respondent and Patient A terminated as of their last contact on My Health Online, on October 5, 2016. Like the other experts, Dr. Colton noted that ACOG's ethical guidelines are not clear on the amount of time that should pass before a doctor may commence a sexual relationship with a former client. He believes that the 10-day lapse of time between October 5, 2016 and October 15, 2016 (when they made contact on LinkedIn) was a sufficient amount of time for respondent to commence a social relationship with Patient A, and that the four-week time period between their last appointment and when they began sexting was also appropriate. In forming his opinion that respondent did not "use his position as a doctor to influence [Patient A] whatsoever," he took into account that Patient A initiated the texting and was, in his words, in the "driver's seat."

72. Dr. Colton's perspective is that "as consenting adults we have the ability to make choices," and "life happens."

Ultimate Findings

73. While the experts provided considered opinions,[10] the opinions of Board experts Dr. Phillips and Dr. Krychman that respondent's sexting relationship with Patient A was grossly negligent, unethical and amounted to sexual misconduct, were most convincing. In particular, their analysis that a doctor-patient relationship existed at the time respondent and Patient A were involved in their sexting relationship was persuasive. As they point out, the texts from Patient A made it clear that she continued to view respondent as her doctor. And, as these experts observed, neither respondent nor Patient A terminated the relationship. Although respondent testified to his belief that Patient A was no longer his patient, his belief was insufficient to terminate the doctor-patient relationship with Patient A. Additionally, the fact that Patient A had only been a patient of respondent's for a short amount of time did not diminish his duty to refrain from engaging in a sexual relationship with her while she was his patient.

74. The standard of care and applicable ethical guidelines required respondent to formally terminate his relationship with Patient A prior to commencing a sexual relationship with her. Respondent was obligated to take further action, such as notifying Patient A that he was no longer her doctor and referring her to other providers for advice and treatment, but he failed to do so. Moreover, instead of taking

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[10] It is noted that in spite of Dr. Byrne's impressive credentials and extensive experience, the strength of his expert testimony was significantly undermined by his testifying in dual roles as an expert and as a professional and personal reference for respondent.

action that made it clear to Patient A that he was no longer her doctor, respondent fostered Patient A's perception that he was her doctor by providing her with medical advice regarding treatment for a number of ailments. In one instance, respondent diagnosed Patient A with Bartholin's and made treatment suggestions; he expressed regret that he could not examine her out since he was not close by, and he offered to prescribe antibiotics if the condition did not improve. The record below is replete with instances in which respondent provided Patient A with medical advice, and instances where her texts made it clear that she continued to regard him as one of her medical providers.

75. Dr. Colton and Dr. Byrne stressed that respondent's relationship with Patient A should not be viewed as running afoul of his legal and ethical obligations because as two consenting adults, they should be free to engage in a sexting relationship. This line of reasoning does not square with the facts because it rests on the premise – a slim reed – that the doctor-patient relationship had terminated after respondent informed Patient A about the results of her colposcopy.

76. In a similar vein, the characterization by Dr. Colton and Dr. Byrne of respondent's medical advice as akin to what a doctor might say when asked by someone at a cocktail party or a barbeque simply does not square with the facts in the instant case. Clearly, a doctor who is socializing at a party, when asked a medical question, would not offer to prescribe medicine for, or examine, the individual soliciting the doctor's opinion. Their suggestion that Patient A's questions and respondent's answers should be viewed through the narrow prism of a typical interchange between doctors and the general public is unconvincing. And, as the Board's experts noted, the fact that a doctor provides medical advice or a diagnosis that is also available to a patient online does not alter the essential character of the

doctor-patient relationship when the doctor provides advice, diagnoses or suggestions for treatment to the patient.

77. Contrary to the opinions expressed by Dr. Colton and Dr. Byrne, the fact that Patient A moved out-of-state and arranged for her medical records to be sent to the providers that she planned on seeing in her new home was insufficient to sever the doctor-patient relationship. In the instant case, respondent was on notice as early as February 2017 that Patient A was returning to the Bay Area. Yet, he continued his sexting with her, up to and including the day that she visited his clinic for an appointment with another doctor. The fact that Patient A initiated the contact between the two, and often instigated their sexting is irrelevant because as a doctor, respondent had a duty to maintain appropriate boundaries and decline Patient A's sexual overtures.

78. The opinions expressed by Dr. Phillips and Dr. Krychman that respondent's behavior was grossly negligent and unethical even assuming, arguendo, that the doctor-patient relationship was terminated as of their last visit, were also persuasive. Both experts acknowledge that there is no bright line as to how long a doctor must wait before it is deemed appropriate to begin a sexual relationship with a former patient. As these experts point out, however, a reasonably prudent gynecologist would wait more than one month before commencing a sexual relationship with a former patient. They aptly observed that a longer time frame is required in cases such as this, where a doctor performs a gynecological exam on a patient. This placed Patient A in a particularly vulnerable position, thereby increasing the extent of the power disparity between her and respondent.

79. It is found that at the time of their sexting relationship, respondent and Patient A were doctor and patient; and accordingly, respondent's sexual relationship with Patient A was grossly negligent, unethical, and constituted sexual misconduct.

LEGAL CONCLUSIONS

Cause for Discipline (Unprofessional conduct/sexual misconduct/gross negligence/violation of ethical standards)

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

2. Unprofessional conduct is grounds for discipline of a physician's certificate pursuant to Business and Professions Code section 2234. Unprofessional conduct includes gross negligence (Bus. & Prof. Code, § 2234, subd. (b)), sexual misconduct (Bus. & Prof. Code, § 726, subd. (a)[11]), and general unprofessional conduct (Bus. & Prof. Code, § 2234).

3. By reason of the matters set forth in Factual Findings 73, 74, 77 and 79, it was established that at the time respondent engaged in his exchange of graphic sexual photographs and texts with Patient A, that the doctor-patient relationship existed

[11] Business and Professions Code section 726, subdivision (a), provides that the commission of any act of sexual misconduct with a patient constitutes unprofessional conduct and grounds for disciplinary action.

between them. The factors supporting such a finding include: Respondent provided Patient A with medical advice on a number of occasions, offered to prescribe her antibiotics, and suggested that he could examine her if she was close by. Patient A continued to view respondent as her doctor, as evidenced by her asking him for medical advice, and from various texts in which she referred to their doctor/patient relationship.

4. Accordingly, the evidence established that respondent's sexting relationship with Patient A, during the time period when she was his patient, amounted to gross negligence and sexual misconduct. (Factual Findings 73-74 and 78-79.) Additionally, insofar as respondent's sexting relationship with Patient A violated the ethical principles promulgated by the American College of Obstetricians and Gynecologists (ACOG), his conduct also constituted general unprofessional conduct. (Factual Findings 73.)

Disciplinary Determination

5. As cause for discipline has been established, the appropriate level of discipline must be determined. The Board's Manual of Disciplinary Orders and Disciplinary Guidelines (Guidelines) (12th ed., 2016), recommends, at a minimum, stayed revocation and five years' probation, subject to appropriate terms and conditions, for respondent's misconduct under Business and Professions Code section 2234. The minimum discipline for respondent's violation under Business and Professions Code section 726, subdivision (a), is stayed revocation with seven years' probation. The maximum discipline for respondent's misconduct is revocation of his Certificate.

6. In determining whether or not a licensee is sufficiently rehabilitated to justify continued licensure, it must be kept in mind that, in exercising its disciplinary authority, protection of the public is the Board's highest priority. (Bus. & Prof. Code, § 2229, subd. (a).) The Board seeks to ensure that its licensees will discharge the responsibilities they bear by reason of their licensure, in a manner consistent with public safety.

7. In the instant case, respondent exercised extremely poor judgment when he exchanged sexually graphic texts and photographs with Patient A. In short, he allowed his sexual interest in Patient A to take precedence over his professional obligations to her. This is respondent's first disciplinary matter before the Board. While complainant does not suggest that revocation is warranted, she asserts that a minimum probationary term of seven years, as required by the Guidelines for violations of Business and Professions Code section 726, is necessary to protect the public.

8. Respondent's misconduct appears to be an isolated series of transgressions in his otherwise successful, unblemished and lengthy career as an obstetrician/gynecologist. Respondent appears genuinely remorseful and ashamed of his behavior. At the time he engaged in his misconduct, he was lonely and enjoyed the attention from Patient A. Respondent has taken steps towards rehabilitating himself. The educational courses he has taken have impressed upon him the importance of maintaining appropriate boundaries with his patients.

9. Although respondent has taken several steps towards his rehabilitation, portions of his testimony indicate the need for further rehabilitation, particularly in regards to fully accepting responsibility for his misconduct. While the evidence did not suggest that respondent is a sexual predator, portions of his testimony show that he

continues to minimize his misconduct and/or does not totally believe that he acted inappropriately by exchanging highly graphic sexual texts and photographs with his patient. His testimony was at times vague, at times dodgy, and at times plainly inconsistent, on key issues surrounding whether Patient A was his current patient and whether his sexting her photographs of his penis was appropriate.

10. While respondent maintains that at the time of his misconduct, he believed that Patient A was no longer his patient, the evidence clearly established that a doctor-patient relationship existed between them at the time he sexted with her. Respondent failed to appreciate that by providing medical advice and offers to treat Patient A, he fostered her perception that he was willing to take care of her medical needs. He was also unwilling or unable to see that A's conduct clearly suggested that she continued to view him as her doctor.

11. Respondent failed to take action to either terminate the doctor-patient relationship, or remove himself from the personal relationship with her. Instead, he continued to provide Patient A with diagnoses, suggestions for treatment (including an offer to prescribe antibiotics), and even offered to examine her. His testimony that at the time he offered to prescribe her antibiotics he never intended to do so suggests an insincerity that is concerning.

12. Complainant does not request suspension or revocation of respondent's Certificate, and it is found that the record does not support suspending or revoking respondent's Certificate. Instead, complainant requests a seven-year probationary term, pursuant to the Board's Guidelines for violations of Business and Professions Code section 726. It is found, however, that a five-year term of probation, as prescribed by the Guidelines for grossly negligent conduct, is sufficient to protect the

public. Five years is also a sufficient amount of time for respondent to gain further insights as to why he exercised such poor judgment.

13. The terms and conditions of probation set forth below include conditions requested by complainant. Two conditions specifically requested by complainant – solo practice prohibition and a third party chaperone – are not imposed because the facts and circumstances surrounding respondent's misconduct and other evidence at hearing did not demonstrate that such conditions are necessary to protect the public.

ORDER

Physician's and Surgeon's Certificate No. A 60133, issued to respondent James William McCarrick, III, M.D., is revoked; however, revocation is stayed and respondent is placed on probation for five years under the following terms and conditions.

1. Patient Disclosure

Before a patient's first visit following the effective date of this order and while respondent is on probation, respondent must provide all patients, or patient's guardian or health care surrogate, with a separate disclosure that includes respondent's probation status, the length of the probation, the probation end date, all practice restrictions placed on respondent by the Board, the Board's telephone number, and an explanation of how the patient can find further information on respondent's probation on respondent's profile page on the Board's website. Respondent shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure. Respondent shall not be required to provide a disclosure if any of the following applies: (1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign a copy of the disclosure 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) Respondent is not known to the patient until immediately prior to the start of the visit; or (4) Respondent does not have a direct treatment relationship with the patient.

2. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations, section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the First Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program

or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. Professional Boundaries Program

Within 60 calendar days from the effective date of this Decision, respondent shall enroll in a professional boundaries program approved in advance by the Board or its designee. Respondent, at the program's discretion, shall undergo and complete the program's assessment of respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24-hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the Decision(s), Accusation(s) and any other information that the Board or its designee deems relevant. The program shall evaluate respondent at the end of the training and the program shall provide any data from the assessment and training as well as the results of the evaluation to the Board or its designee.

Failure to complete the entire program not later than six months after respondent's initial enrollment shall constitute a violation of probation unless the Board or its designee agrees in writing to a later time for completion. Based on respondent's performance in and evaluations from the assessment, education, and training, the program shall advise the Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that respondent can practice medicine safely. Respondent shall comply with program recommendations. At the completion of the program, respondent shall submit to a final evaluation. The program shall provide the results of the evaluation to the Board or its designee. The professional boundaries program shall be at

respondent's expense and shall be in addition to the Continuing Medical Education requirements for renewal of licensure.

The program has the authority to determine whether or not respondent successfully completed the program.

A professional boundaries course taken after the acts that gave rise to the charges in the First Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

If respondent fails to complete the program within the designated time period, respondent shall cease the practice of medicine within three calendar days after being notified by the Board or its designee that respondent failed to complete the program.

4. Psychiatric Evaluation

Within 30 calendar days of the effective date of this Decision, and on whatever periodic basis thereafter may be required by the Board or its designee, respondent shall undergo and complete a psychiatric evaluation (and psychological testing, if deemed necessary) by a Board-appointed board certified psychiatrist, who shall consider any information provided by the Board or designee and any other information the psychiatrist deems relevant, and shall furnish a written evaluation report to the Board or its designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not be accepted towards fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations and psychological testing.

Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the Board or its designee.

5. Psychotherapy

Within 60 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval the name and qualifications of a California-licensed board certified psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the Board or its designee deems that no further psychotherapy is necessary.

The psychotherapist shall consider any information provided by the Board or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the Board or its designee. Respondent shall cooperate in providing the psychotherapist any information and documents that the psychotherapist may deem pertinent.

Respondent shall have the treating psychotherapist submit quarterly status reports to the Board or its designee. The Board or its designee may require respondent to undergo psychiatric evaluations by a Board-appointed board certified psychiatrist. If, prior to the completion of probation, respondent is found to be mentally unfit to resume the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over respondent's license and the period of probation

shall be extended until the Board determines that respondent is mentally fit to resume the practice of medicine without restrictions.

Respondent shall pay the cost of all psychotherapy and psychiatric evaluations.

6. Notification

Within seven days of the effective date of this Decision, respondent shall provide a true copy of this Decision and First Amended Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities, or insurance carrier.

7. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

8. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. General Probation Requirements

Compliance with Probation Unit:

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes:

Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice:

Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal:

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California:

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice,

respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

13. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

14. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his certificate. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms

and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

DATE: September 4, 2019

DocuSigned by:
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for DIANE SCHNEIDER
Administrative Law Judge
Office of Administrative Hearings

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

In the Matter of the First Amended Accusation Against: **James William McCarrick III, M.D.** **810 Cambridge Ave.** **Menlo Park, CA 94025-5306** **Physician's and Surgeon's Certificate No. A 60133,** Respondent.	Case No. 800-2017-033405 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about May 21, 1996, the Medical Board issued Physician's and Surgeon's Certificate Number A 60133 to James William McCarrick III, M.D. (Respondent). The

Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2020, unless renewed.

JURISDICTION

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

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

5. 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 which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

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

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated 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."

6. 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."

ETHICAL PRINCIPLES

7. The American College of Obstetricians and Gynecologists (ACOG) has promulgated ethical standards which were in place and which applied in this situation. The (ACOG) Code of Professional Ethics states that: "Sexual misconduct on the part of the obstetrician-gynecologist is an abuse of power and a violation of patient trust. Sexual contact or a romantic relationship between a physician and current patient is always unethical."

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CAUSE FOR DISCIPLINE

(Unprofessional Conduct/Sexual Misconduct/Gross Negligence/Violation of Ethical Standards)

8. Respondent is subject to disciplinary action under Sections 2234 (a) and (b) for unprofessional conduct and/or gross negligence and/or Section 726 and/or for violating ethical standards in that he engaged in sexual misconduct with respect to a patient. The circumstances are as follows:

Patient A

9. Patient A[1] was a 30 year-old female when she became a patient of Respondent, a board certified obstetrician and gynecologist. Respondent first saw Patient A, on or about August 22, 2016, and performed a routine gynecologic examination on her that included a pap smear, Human Papillomavirus[2] analysis, and sexually transmitted disease studies. On or about September 30, 2016, Patient A returned to see Respondent and he performed a colposcopy[3] on Patient A.

10. During the course of treatment, Respondent and Patient A communicated by text message, sometimes regarding Patient A's medical condition and other times regarding non-professional, personal topics.

11. On or about, November 4, 2016, Respondent was texting with Patient A regarding the exchange of photographs. Respondent texted to Patient A: "I can take spicy one when you're in the mood" and "I want to know you more." Patient A texted in response: "You gotta stop calling it spicy pic. Lol." Respondent texted back: "Hah. Sexy provocative dick pic then." Later in that same conversation, Respondent and Patient A agreed that the picture should be called "naughty." Respondent also texted: "It's silly but I feel like I'm missing you I guess I'm feeling like I want closeness, Goodnight Naughty dreams."

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[1] The patient is referred to as Patient A to protect her privacy.
[2] Human papillomavirus is a sexually transmitted infection.
[3] A colposcopy is a procedure to closely examine the cervix, vagina, and vulva for signs of disease.

12. On or about November 5, 2016, in another series of texts, Respondent texted: "Wow. Looking forward to being next to you" and "Yes I had steamy dreams last night. Woke up aroused. B/c of you..." Later in the conversation, Patient A wrote: "Oh I should let you know one thing though. I don't do FWBs (friends with benefits). It's either, in a relationship or that one occasion of sex and that's it. But then idk [I don't know] how long you're here for so if we do have sex, may just be this one visit and that's it." On the following day, Respondent texted: "Ok I think I get it. Thanks for connecting before. It's had it very fun moments. Thank you..."

13. On or about November 7, 2016, Respondent and Patient A texted about prior sexual pictures that they have exchanged. Respondent texted: "Please delete my pic as I did yours."

14. On or about November 9, 2016, Patient A sent to Respondent sexually explicit texts along with a picture of herself with only her underwear on. Respondent replied: "Nice pic! So pretty and hot" and "Love the pic." Respondent also texted Patient A: "Do you have any sex toy to help you out a bit?" Respondent and Patient A made arrangements to meet in person.

15. On or about November 20, 2016, Patient A sent to Respondent a picture of her naked breasts. Respondent replied: "Omg your breasts are gorgeous! Definitely getting hard now." Respondent texted: "Omg. Wanna be inside you[r] [Respondent inserted a cat emogi]. I will give you all my cum" and "Ok. I'll spread your legs and butt. Will lick and suck you hard." Patient A asked Respondent if she could see a picture of his genitalia. Respondent texted to Patient A a message about sexual activity with her breasts and wrote: "and yes will send pic and I need a new pic of your sweet pussy." Patient A sent a picture of her naked vulva. Respondent texted Patient A that he would send a sexually explicit picture of himself from the call room at his work.

16. On or about, November 21, 2016, Patient A sent an audio recording to Respondent and told him it was her masturbating. Respondent replied with a picture of an erect penis in his hand with secretions consistent with ejaculate. Respondent and Patient A continued to text about graphic sexual activity.

17. On or about December 4, 2016, Patient A texted to Respondent a question about swelling in her vulva; Respondent texted in reply, offering a medical diagnosis and treatment advice.

18. On or about December 15, 2016, Patient A texted to Respondent: "... if we had sex would it be in your house?" Respondent replied: "Well of course if we got together it would be at your house or mine. So it seems so obvious that it makes me wonder what the real question is."

19. On or about December 23, 2016, Patient A texted to Respondent about whether he would send her Ambien[4] and Respondent replied that Ambien was good but that he could not send it to her because he did not have any, and instead recommended that she take melatonin instead, and that melatonin was available in the pharmacy.

20. On or about February 2, 2017, Respondent and Patient A made plans to meet; However, Patient A cancelled because her credit card was stolen.

21. On or about February 19, 2017, Respondent sent a picture of himself that revealed a naked torso and did not show his face.

22. On or about February 23, 2017, Respondent and Patient A texted each other about making arrangements to meet in person. Respondent also texted: ... with you and me, I'm not sure what to expect. Such an unusual relationship."

23. On or about May 5, 2017, Patient A and Respondent met at his clinic and after their meeting, Patient A texted to Respondent: "You looked so delicious today you make me thirsty I honestly loved how your body felt pressed on mine." Respondent replied: "You felt pretty good yourself."

24. In sending sexually explicit, suggestive, and inappropriate messages and photographs of his genitals to Patient A, Respondent exploited the trust, knowledge, emotions and influence derived from his position as a physician, violated professional boundaries and betrayed the trust of his patient. Respondent's conduct, as described above, constitutes unprofessional conduct and/or gross negligence, and is cause for discipline pursuant to Sections 2234 and/or 2234 (b) and 726 and/or ethical standards.

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[4] Ambien (Zolpidem) is used to treat insomnia.

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 60133, issued to James William McCarrick III, M.D.;

2. Revoking, suspending or denying approval of James William McCarrick III, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering James William McCarrick III, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: June 4, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant