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

In the Matter of the Accusation Against: DEBRA LYNNE BUNGER, M.D. Physician's and Surgeon's Certificate No. A 49526 Respondent.	Case No. 800-2017-035950

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 October 8, 2021.

IT IS SO ORDERED September 9, 2021.

MEDICAL BOARD OF CALIFORNIA

Laurie Rose Lubiano, J.D., Chair
Panel A

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

In the Matter of the Accusation Against:

DEBRA LYNNE BUNGER, M.D.,

Physician's and Surgeon's Certificate No. A 49526

Respondent.

Agency Case No. 800-2017-035950

OAH No. 2021020422

PROPOSED DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on July 19 through 22, 2021, by videoconference.

Deputy Attorney General Alice W. Wong represented complainant William Prasifka, Executive Director of the Medical Board of California.

Attorney Cyrus A. Tabari represented respondent Debra Lynne Bunger, M.D., who was present for the hearing.

The matter was submitted for decision on July 22, 2021.

FACTUAL FINDINGS

1. The Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. A 49526 to respondent Debra Lynne Bunger, M.D., on June 11, 1991. At the time of the hearing, this certificate was active and was scheduled to expire on April 30, 2023.

2. Acting in his official capacity as Executive Director of the Board, complainant William Prasifka filed an accusation against respondent on August 17, 2020. Respondent requested a hearing.

3. The accusation alleges that respondent committed unprofessional, negligent conduct, and failed to maintain adequate and accurate medical records, with respect to three patients between 2014 and 2019. In addition, the accusation alleges that respondent committed unprofessional conduct by self-prescribing a controlled substance on three occasions in 2016. Complainant seeks disciplinary action against respondent for these acts.

Professional Experience

4. Respondent graduated from medical school in 1987. In 1991, she completed a residency in psychiatry.

5. Respondent is board-certified as a psychiatrist. She also is a diplomate of the American Board of Integrative Holistic Medicine, which is not a member board of the American Board of Medical Specialties. Respondent prescribes medications to her patients, but also offers recommendations for dietary supplements and other non-drug treatments that she believes have evidentiary support in her patients' circumstances.

6. Respondent has practiced psychiatry at inpatient psychiatric treatment facilities, in partial hospitalization or intensive outpatient programs, and in outpatient private practice. Between April 2005 and June 2017, she had an outpatient adult psychiatry practice in Aptos, near Santa Cruz.

7. In June 2017, respondent closed her California practice and moved, first to Indiana and then to Kentucky. Since September 2017, respondent has used videoconferencing to continue treating some of her California patients. She has not accepted new California patients as telemedicine-only patients.

8. Aside from her telemedicine practice in California, respondent also worked in temporary positions in psychiatric hospitals between September 2017 and June 2019. Between July 2019 and April 2021 respondent was the medical director at a small psychiatric hospital in Owensboro, Kentucky. At the time of the hearing she was awaiting credentialing for a new hospital position in Louisville, Kentucky.

9. Respondent holds medical licenses in Kentucky and Indiana as well as in California. She has not experienced any disciplinary action in any state.

10. Respondent offered reference letters into evidence from almost 40 current patients. Several of these patients' letters state specifically that they have been respondent's patients for many years, and that they see her currently by videoconference. All of the letter writers express gratitude for respondent's care and confidence in her skill.

Patient Treatment

11. Board staff members began their investigation about respondent because of an anonymous complaint accusing her of having a "delusional disorder." Complainant's accusation alleges no such impairment.

12. In the course of their investigation, Board staff members obtained records regarding several of respondent's patients. The evidence did not establish how Board staff members selected these patients. Based on the expert opinions described in greater detail in Findings 45, 47, 50, 57, and 60, below, the accusation alleges several acts of simple negligence, and several instances of inaccurate or inadequate medical record-keeping, for three patients.

PATIENT 1

13. The earliest medical record in evidence for Patient 1 is from a visit in May 2015, although respondent's records regarding Patient 1 show that Patient 1 became respondent's patient in 2013.

14. Between 2015 and 2019, respondent treated Patient 1 for major depressive disorder, bipolar disorder, attention deficit disorder, and generalized anxiety disorder. Respondent prescribed medications during this period including sertraline (an anti-depressant), fluoxetine (another anti-depressant), lamotrigine (a mood stabilizer), Adderall (a stimulant), and alprazolam (an anti-anxiety agent). Prescription records show that other physicians also prescribed controlled substances to Patient 1 during this period, chiefly butalbital with acetaminophen and caffeine (a pain relief medication most commonly used for disabling headaches).

15. Respondent's records for Patient 1 for the period between 2015 and 2019 show that respondent regularly checked the California Controlled Substance Utilization Review and Evaluation System (CURES) to monitor Patient 1's controlled substance use. On several occasions during this period, respondent's records show that she developed concerns that Patient 1 might be misusing medication, and discussed those concerns with Patient 1.

16. Between 2015 and 2019, respondent's records identify each of her meetings with Patient 1 as an "Office Visit." In mid-2017, respondent began seeing Patient 1 exclusively by videoconference, after closing her Aptos practice as described above in Finding 7. None of respondent's records regarding appointments with Patient 1 state explicitly that the appointments occurred by videoconference, although a few include information implying that Patient 1 and respondent were not in the same location during the appointment.[1]

17. Respondent saw Patient 1 approximately monthly between March 2019 and September 2019. Patient 1 had a scheduled appointment for October 2, 2019, but cancelled that appointment.

18. Respondent's chart note regarding Patient 1 for October 2, 2019, states,

> Patient cancelled the day of the appointment. I had received a vicious and accusatory text from a woman who identified herself as [Patient 1's] sister informing me that I

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[1] For example, once in December respondent noted that Patient 1 had said she was attending her appointment from a "Christmas tree farm."

> was negligent, potentially a "shitty doctor" and that she was prepared to take legal action against me because [Patient 1] was abusing her medications. I contacted [Patient 1] by text and told her, and asked for her husband to be at the appointment. She cancelled the appointment by text and told me she needed to get help because she was abusing her meds, primarily her pain meds. I suggested by text that she stay on her lamotrigine and she agreed.

Respondent's records regarding Patient 1 end with this note.

19. Respondent testified credibly that when she contacted Patient 1 on October 2, 2019, she told Patient 1 she had received a text message about Patient 1, but did not describe the message in detail. Respondent took the message seriously, however, and asked Patient 1 to bring her husband to the appointment because respondent intended to discuss with them whether Patient 1 was abusing medication. Respondent testified further that although her note summarized Patient 1 as having said she "needed to get help" to address substance abuse, respondent understood Patient 1 to have a specific plan to enter inpatient treatment. For this reason, respondent did not press Patient 1 to keep her appointment with respondent, but did counsel Patient 1 not to withdraw abruptly from lamotrigine.

20. Respondent testified further that a few months later, she contacted Patient 1 by text message. Patient 1 told respondent that she had undergone inpatient substance abuse treatment and was doing well, but did not make any further appointments with respondent for psychiatric treatment. Respondent did not make a chart entry regarding this brief contact because she did not think of it as medical care for which she had any professional responsibility to keep a record.

PATIENT 2

21. Respondent first saw Patient 2 on September 25, 2013. Patient 2 previously had been in regular care with a different psychiatrist, and had been taking 40 milligrams per day of Adderall for some time. At their first appointment, respondent prescribed a month's supply of Adderall, at this same daily dose.

22. Patient 2 returned on October 21, 2013. After confirming with Patient 2 that she continued to feel stable, respondent gave Patient 2 prescriptions for 60 days' worth of Adderall, still at 40 milligrams per day.

23. Respondent next saw Patient 2 on December 16, 2013. At this appointment, Patient 2 told respondent that Patient 2 recently had miscarried twice, and was undergoing "infertility investigation." Patient 2 also told respondent that the physician treating her apparent fertility impairment had prescribed citalopram "to increase her serotonin levels" in connection with Patient 2's efforts to conceive. Citalopram is an anti-depressant medication that respondent also sometimes prescribes to patients.

24. Patient 2's medical record shows that respondent took several steps in response to Patient 2's description of her efforts to become pregnant. First, respondent asked Patient 2 to authorize respondent to contact Patient 2's fertility specialist (an immunologist) directly about Patient 2's care. Second, respondent recommended that Patient 2 supplement her diet and medications with 5-HTP, an amino acid (5-hydroxytryptophan) that is available over the counter as a dietary supplement. Third, respondent advised Patient 2 to continue using Adderall (and prescribed another 60-day supply), but encouraged her to return "as soon as you would like" to discuss "lifestyle changes and supplement recommendations."

25. Patient 2 returned about three weeks later, on January 6, 2014, to "discuss changes." She reported that day that her immunologist disagreed with respondent's recommendation regarding 5-HTP, because the immunologist did not believe 5-HTP to be safe for a patient who was or who might become pregnant. Patient 2 and respondent "discussed various options," including the option of taking a combination of amino acid supplements (tyrosine and two forms of phenylalanine) "with or instead of" Adderall.

26. Respondent's records show that respondent telephoned Patient 2's immunologist promptly after Patient 2's appointment on January 6, 2014, "to discuss [citalopram] vs 5 HTP for serotonin." The records do not show that they ever connected with one another for that discussion, however, and respondent does not recall ever having spoken directly with the immunologist about Patient 2.

27. Complainant alleges that 5-HTP is a "supplement taken to raise levels of serotonin in the brain." Respondent testified that she recommended 5-HTP to Patient 2 for this purpose, as a potential alternative to citalopram.

28. At Patient 2's next visit, on February 10, 2014, Patient 2 reported that she had "not started the amino acids." The evidence did not establish whether Patient 2 ever took citalopram, 5-HTP, or any other amino acid supplement in late 2013 or in 2014. She did become pregnant in early 2014, however.

29. Respondent did not prescribe Adderall to Patient 2 on February 10, 2014, or at Patient 2's next appointment on April 7, 2014. Respondent's note from April 7

says that Patient 2 "will be trying to get pregnant next month"[2] and "[k]nows the risks and benefits of Adderall" in pregnancy.

30. Patient 2 next saw respondent on January 13, 2015, after delivering her baby. She came to respondent on that date because she had stopped taking Adderall during her pregnancy and wanted to resume. Respondent prescribed 60 days' worth of this medication on January 13, but when Patient 2 returned for a refill about six months later she explained that she had not needed a refill sooner because she "got laid off" and "did not need Adderall." Respondent continued prescribing Adderall regularly to Patient 2 during 2015 and 2016.

31. Respondent's notes from August 17, 2016, document another discussion regarding the potential benefits to Patient 2 of supplementing her diet and medication with tyrosine (but not phenylalanine). According to respondent's note, "Tyrosine can be used with the stimulants to help your brain to make more Dopamine." Respondent also prescribed Adderall to Patient 2 at this appointment.

32. Patient 2 testified that she does not recall whether she ever followed respondent's recommendation regarding tyrosine supplements. Respondent's notes from an office visit on December 22, 2016, state, "Also using Tyrosine which she finds to be very helpful."

33. Patient 2 continues as respondent's patient, and continues to use Adderall as prescribed by respondent. She is very satisfied with respondent's care.

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[2] In light of the matters stated in Finding 30, Patient 2 may have been pregnant already at this appointment.

34. Between 2013 and 2019, respondent's records identify each of her meetings with Patient 2 as an "Office Visit." In mid-2017, however, respondent began seeing Patient 2 exclusively by videoconference, after closing her Aptos office as described above in Finding 7. Records regarding respondent's appointments with Patient 2 on June 1, 2016, and August 17, 2016, state explicitly that the appointments occurred by videoconference.[3] No other records state explicitly that they document videoconference appointments, although a few include information implying that Patient 2 and respondent were not in the same location during the appointment.[4]

PATIENT 3

35. Patient 3 has been respondent's patient for about 10 years. Respondent has treated Patient 3 with stimulant medication (Adderall and Vyvanse) for attention deficit disorder, and for a period with sertraline for an episode of major depressive disorder.

36. Patient 3 testified that she continues to use stimulant medication and is very happy with her treatment. She views her ongoing relationship with respondent as a "great collaborative effort."

37. Respondent's notes from an office visit with Patient 3 on January 4, 2017, document a discussion regarding reducing Patient 3's daily sertraline dose. The notes

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[3] Respondent conducts videoconference appointments using a secure videoconferencing system called VSee.

[4] For example, on one occasion respondent noted that Patient 2 said she was attending their appointment from her gym.

also document a discussion regarding the potential benefits to Patient 3 of supplementing her diet and medications with tyrosine. Respondent prescribed Vyvanse and Adderall to Patient 3 at this appointment.

38. Respondent's records do not document any further discussion with Patient 3 regarding tyrosine supplements. Patient 3 testified that she does not recall discussing tyrosine supplementation with respondent, or taking any dietary supplements at respondent's recommendation.

39. Between 2011 and 2020, respondent's records identify each of her meetings with Patient 3 as an "Office Visit." In mid-2017, however, respondent began seeing Patient 3 exclusively by videoconference, after closing her Aptos office as described above in Finding 7. None of respondent's records regarding appointments with Patient 3 state explicitly that the appointments occurred by videoconference.

Self-Treatment

40. In connection with their investigation of the anonymous complaint described above in Finding 11, Board staff members reviewed CURES records regarding respondent. These records showed her to have self-prescribed an unidentified controlled substance, in compounded form, three times during 2016.

41. In 2015, respondent decided to undertake a weight-loss program involving a very low calorie diet coupled with periodic injections of human chorionic gonadotropin (hCG). HCG is a Schedule III controlled substance under California Health and Safety Code section 11056, subdivision (f)(32). Its usual medical uses are in treating female infertility and male testicular atrophy.

42. Respondent first obtained injectable hCG by ordering it over the Internet from a vendor she knew as "Dr. Emma." Respondent testified that she understood "vaguely" that hCG was a hormone, but that she did not consider the possibility that it might be a controlled substance. Respondent did not explain whether she understood "Dr. Emma" to have acted lawfully by selling respondent an injectable hormone preparation that a licensed physician had not prescribed and that a licensed pharmacy had not dispensed.

43. After obtaining hCG once or twice from "Dr. Emma," respondent decided to obtain it from a local compounding pharmacy in Capitola. On three occasions between October 2015 and September 2016, respondent called the pharmacy and prescribed hCG for herself; she also called in three refills in total.

44. The evidence did not establish whether a reasonably prudent physician would have prescribed hCG to respondent as part of a weight-loss program. Nevertheless, respondent's failure to investigate hCG's potential risks and benefits thoroughly enough to have learned that hCG is a controlled substance in California was unreasonable. Even if respondent did not know that hCG is a controlled substance when she self-prescribed it, she should have known.

Expert Testimony

45. Laura Davies, M.D., reviewed respondent's records regarding Patients 1, 2, and 3, ending for each patient in May 2020. She testified to her opinions regarding respondent's treatment decisions for these patients, and to her opinion regarding respondent's self-prescribing. Dr. Davies is a psychiatrist in private practice in San Francisco.

46. Marvin H. Firestone, M.D., also reviewed respondent's records regarding Patients 1, 2, and 3, and testified to his opinions regarding respondent's treatment decisions and her self-prescribing. Dr. Firestone is a psychiatrist in private practice in San Mateo. In addition, he is an attorney who regularly represents physicians in Board disciplinary proceedings.

FOLLOW-UP CARE FOR PATIENT 1

47. Dr. Davies criticized respondent's response to Patient 1's appointment cancellation on October 2, 2019 (described above in Findings 18 and 19). According to Dr. Davies, a reasonably prudent psychiatrist whose patient suddenly cancelled an appointment under circumstances suggesting prescription drug abuse would have documented and implemented a "follow up psychiatric plan." Dr. Davies expanded on this opinion in testimony, stating that the community standard of care required respondent under the circumstances to send Patient 1 a letter making sure Patient 1 understood that respondent remained available to see her and recommending other treatment providers if Patient 1 preferred to seek care elsewhere. Dr. Davies characterized respondent's actions as "abandoning a patient in crisis," and as a simple (not extreme) departure from the standard of care.

48. Dr. Firestone testified that the community standard of care requires a psychiatrist to give a patient written references to other potential providers only when the psychiatrist, rather than the patient, terminates the treatment relationship. He also testified that the nature and extent of a psychiatrist's duty to follow up with a patient who cancels an appointment, or who fails to make further regular appointments, depends strongly on the context and the overall psychiatrist-patient relationship. Dr. Firestone declined to characterize respondent's communication with Patient 1 on

October 2, 2019, and respondent's lack of documented communication with Patient 1 after that date, as departures from the standard of care.

49. Dr. Davies's opinion is not persuasive, because it mischaracterizes respondent's actions. Respondent's records do not demonstrate that respondent abandoned Patient 1 on or after October 2, 2019. Instead, they demonstrate that respondent communicated with Patient 1 on October 2, 2019, regarding in-person mental health treatment that Patient 1 needed urgently and intended to seek. The records demonstrate further that respondent knew on that date that other members of Patient 1's family were aware of Patient 1's urgent mental health care needs, but mistrusted respondent. In that context, respondent's decision to give Patient 1 advice about continuing lamotrigine, her mood-stabilizing medication, and otherwise to wait for further communication from Patient 1, was not unreasonable. Because Dr. Davies's testimony fails to demonstrate that a reasonably prudent psychiatrist under similar circumstances would have communicated differently or further with her patient, it does not demonstrate that respondent's actions departed from the standard of care.

SUPPLEMENT RECOMMENDATIONS TO PATIENTS 2 AND 3

50. According to Dr. Davies, respondent committed simple departures from the standard of psychiatric care by recommending to Patient 2 that she take 5-HTP (as described above in Findings 23 and 24), that she take tyrosine and phenylalanine supplements "with or instead of" Adderall (as described above in Finding 25), and later that she take tyrosine "with the stimulants" (as described above in Finding 31). Likewise, Dr. Davies believes that respondent committed a simple departure from the standard of care by recommending tyrosine supplements to Patient 3 (as described above in Finding 37).

51. Dr. Davies testified that she is aware of psychiatrists other than respondent who recommend 5-HTP supplementation to increase brain serotonin levels. She did not base her opinion on any medical evidence about the relative risks and benefits of either citalopram or 5-HTP for a patient such as Patient 2, who hopes to become pregnant. Although respondent's records reflect Patient 2's immunologist's opinion that 5-HTP is unsafe during early pregnancy, neither Dr. Davies's testimony nor any other evidence established that this opinion is more persuasive, or more widely held among competent medical professionals, than respondent's opinion that 5-HTP is safe during early pregnancy.

52. Dr. Davies testified that she knows of no reputable medical literature suggesting that tyrosine or phenylalanine may be effective as a treatment for psychiatric disorders. Dr. Davies did not testify to any medical evidence showing that tyrosine would have been harmful to either Patient 2 or Patient 3, however, or that phenylalanine would have been harmful to Patient 2.

53. With respect in particular to Patient 2, Dr. Davies did not testify as to whether tyrosine or phenylalanine supplements are safe for use in pregnancy. Dr. Davies also did not testify as to what advice a reasonably prudent psychiatrist should give to a patient regarding continuing or discontinuing Adderall during the patient's efforts to conceive, or during the patient's pregnancy.

54. Dr. Firestone testified that he knows psychiatrists other than respondent who recommend tyrosine supplements to patients with attention deficit disorder. He understands their benefit, if any, to be mild and temporary. Dr. Firestone testified as well that tyrosine is potentially harmful to patients who take a particular type of anti-depressant medication (monoamine oxidase inhibitors), but that no reason

appeared in either Patient 2's or Patient 3's records to believe tyrosine supplementation would be harmful to them.

55. Dr. Firestone testified to no understanding about the potential risks or benefits of citalopram, 5-HTP, tyrosine, phenylalanine, or Adderall during pregnancy. He did point out that stimulant medications for attention deficit disorder, such as Adderall, are potentially physically harmful (regardless of pregnancy) and carry the risk of misuse. For this reason, he testified credibly and persuasively that psychiatrists who prescribe these drugs should attempt to maintain patients on the minimum effective doses, and always should consider less risky ways to improve the medications' effectiveness before considering dose increases.

56. The matters summarized in Findings 51 through 53 confirm that Dr. Davies did not base her opinions on any medical evidence showing respondent's recommendations regarding amino acid supplementation to have exposed Patients 2 and 3 to harm, either from consuming dangerous dietary supplements or from using ineffective dietary supplements instead of safer and more effective treatment.

57. Instead, Dr. Davies based her opinions on her view that respondent should have explained to Patients 2 and 3 that citalopram, Adderall, and Vyvanse are "FDA-approved" medications in standard use by allopathic and osteopathic physicians, whereas amino acid supplements are "non-allopathic modalities." Moreover, in Dr. Davies's opinion, respondent had a professional obligation not simply to record her supplement recommendations in Patient 2's and Patient 3's medical records, but also to document fully her explanations to them of the philosophical and evidentiary bases for any "non-allopathic" recommendations.

58. Dr. Davies's testimony on this issue demonstrated significant but inexplicable bias against respondent. She referred to respondent's recommendations dismissively as "naturopathic" and even "homeopathic" medicine, refusing to consider the possibility that respondent might have based her recommendations on reputable medical literature or on observations among her own patients. She also characterized respondent's amino acid recommendations as violations of respondent's professional duty to avoid being "a snake oil salesman," and likened these recommendations to discussing "something you heard on Oprah."

59. Moreover, the matters summarized in Findings 50 and 56 confirm that Dr. Davies's opinions fail to reflect the context in which respondent made her recommendations.

a. For both Patient 2 and Patient 3, Dr. Davies ignores the fact that each patient had several years' experience using prescription stimulant medications. Respondent reasonably could have assumed that these patients understood the potential mental health impacts of reducing or discontinuing their prescription medications, and that a discussion regarding treatments to complement their prescription medications did not need to return to first principles.

b. For Patient 2, Dr. Davies ignores the fact that respondent's recommendation about amino acids that Patient 2 might use "instead of" Adderall occurred during a conversation about treatment options immediately before and during pregnancy.

c. For Patient 3, Dr. Davies ignores the fact that respondent's recommendation about amino acid supplementation occurred during a conversation about Patient 3's intention to reduce her sertraline use.

d. For both Patient 2 (after her pregnancy) and Patient 3, Dr. Davies ignores the fact that respondent recommended amino acid supplements for use "with" stimulant medication. On neither occasion (described for Patient 2 in Finding 31 and for Patient 3 in Finding 37) did respondent recommend that the patient discontinue prescription medication that had been effective for the patient for several years, and substitute dietary supplements. In this context, Dr. Davies's concern that respondent might have caused these patients to believe a "false equivalence" between prescription medications on the one hand and over-the-counter dietary supplements on the other is unreasonable.

60. For all the reasons stated in Findings 56 through 59, Dr. Davies's opinion that respondent departed from the standard of care by recommending tyrosine supplements to Patient 2 and Patient 3 in addition to prescription medications, or by recommending 5-HTP, tyrosine, and phenylalanine supplements to Patient 2 in lieu of prescription medications before and during pregnancy, is not persuasive.

CONSULTATION WITH PATIENT 2'S FERTILITY SPECIALIST

61. Dr. Davies also believes that respondent committed a simple departure from the standard of care by recommending 5-HTP to Patient 2 for reasons potentially relating to Patient 2's fertility rather than to her mental health. In light of the matters stated in Finding 51, Dr. Davies did not base this opinion on a concern that respondent's recommendation was unsafe for a patient considering pregnancy. Rather, Dr. Davies characterized respondent's error as having failed to explain to Patient 2, before making the recommendation, that respondent is not a fertility specialist.

62. Dr. Davies's assumption that respondent's 5-HTP recommendation might have confused Patient 2 into thinking that her psychiatrist also was a fertility specialist

is unreasonable. The matters stated in Findings 23 and 24 confirm that the recommendation arose because a physician who Patient 2 believed reasonably to be an expert in fertility but not in psychiatry prescribed psychiatric medication to Patient 2. Patient 2 asked respondent, her psychiatrist, about this prescription, and took respondent's advice back to the fertility specialist for further analysis. No departure by respondent from the standard of care occurred.

TELEMEDICINE DOCUMENTATION

63. Dr. Davies testified to her opinion that respondent's failure to distinguish in her records between in-person office visits and videoconference visits makes respondent's records regarding Patients 1, 2, and 3 inadequate and inaccurate. In Dr. Davies's view, the standard of care among psychiatrists is to indicate the patient's and the physician's locations during an outpatient visit, and in particular to distinguish telemedicine from in-person medical care.

64. Dr. Firestone testified that between 2015 and 2019, many insurance carriers covered telemedicine differently from in-person medicine, and for this reason required psychiatrists to identify telemedicine specifically in patient records. Aside from this billing distinction, however, Dr. Firestone does not believe that the standard of care among psychiatrists requires them to distinguish in records from outpatient office visits between in-person and videoconference visits. He noted that the general consensus in adult outpatient psychiatry is that care through telemedicine is as effective as in-person care, and that no reason exists to distinguish between them in medical records.

65. Dr. Davies provided several persuasive examples of information a psychiatrist might obtain more effectively through an in-person patient visit than

through a videoconference visit (such as information about the patient's physical condition), or more effectively through a videoconference visit than through an in-person visit (such as information about the patient's home). Her testimony was persuasive that psychiatrists using telemedicine should be alert to these differences, and should document relevant observations. Dr. Davies's testimony was not persuasive, however, that the standard of care among psychiatrists treating adults in California is to document outpatient telemedicine visits specifically. The evidence did not establish that respondent departed from the standard of care by failing to identify telemedicine in her records regarding Patients 1, 2, and 3.

SELF-PRESCRIBING

66. Dr. Davies testified that self-prescribing is always a departure from the standard of care, no matter what medication a physician prescribes for herself or under what circumstances she prescribes it. She also pointed out that respondent's training and experience in psychiatry are not likely to have given respondent any knowledge from which to assess whether hCG was safe or appropriate for her during 2015 and 2016. Dr. Davies did not testify to any expertise of her own in prescribing hCG, however.

67. Dr. Firestone acknowledged that California law forbids a physician to self-prescribe controlled substances. He acknowledged as well that a physician prescribing any medication for herself or her family risks departing from the standard of care by prescribing without adequate examination or an appropriate medical indication, because of unavoidable bias in treating self or family. He stated that he did not have enough information, either from available records or from his own expertise, to state an opinion as to whether a reasonably prudent physician would have prescribed hCG to respondent in 2015 and 2016.

68. Dr. Davies's opinion that self-prescribing is invariably a departure from the standard of care is not persuasive. Moreover, although the matters stated in Findings 40 through 43 establish that respondent engaged in unprofessional conduct by self-prescribing a controlled substance, in light of the matters stated in Findings 44, 66, and 67 the evidence did not establish that she departed from the standard of care by doing so.

LEGAL CONCLUSIONS

1. The Board may discipline respondent's physician's and surgeon's certificate only upon clear and convincing proof, to a reasonable certainty, of the facts establishing cause for discipline. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The factual findings above rest on clear and convincing evidence.

Patient Treatment

2. Repeated negligent acts by a physician are unprofessional conduct. (Bus. & Prof. Code, § 2234, subd. (c).)

3. The matters stated in Findings 13 through 20 and 47 through 49 do not establish respondent's negligence in failing to follow up with Patient 1 after October 2, 2019. For this reason, these matters do not constitute cause for discipline against respondent.

4. The matters stated in Findings 23 through 29, 51, 61, and 62 do not establish that respondent made negligent recommendations to Patient 2, exceeding respondent's professional expertise. The matters stated in Findings 24, 26, 28 and 62

also do not establish that respondent failed to consult or confer appropriately with Patient 2's fertility specialist regarding their mutual patient. For these reasons, the matters stated in Findings 23 through 29 do not constitute cause for discipline against respondent with respect to Patient 2's efforts to become pregnant.

5. The matters stated in Findings 30 through 32, 37, 38, 52, and 57 through 60 do not establish that respondent acted negligently by recommending that Patients 2 and 3 supplement their stimulant medications with amino acids. The matters stated in Findings 25, 53, and 57 through 60 also do not establish that respondent acted negligently in recommending to Patient 2 that she consider replacing some or all of her stimulant medication with amino acids during pregnancy. Finally, the matters stated in Findings 25, 30 through 32, 37, 38, 52, 53, and 57 through 60 do not establish that respondent failed to give either Patient 2 or Patient 3 appropriate information with which to decide whether to use amino acid supplements. For these reasons, the matters stated in Findings 25, 30 through 32, 37, and 38 do not constitute cause for discipline against respondent with respect to her amino acid supplement recommendations to either Patient 2 or Patient 3.

6. A physician's failure to maintain adequate and accurate patient care records is unprofessional conduct. (Bus. & Prof. Code, § 2266.) The matters stated in Findings 63 through 65 do not establish that a psychiatrist's failure to identify an outpatient treatment session as having occurred by videoconference makes the psychiatrist's record from that session either inadequate or inaccurate. For this reason, the matters stated in Findings 16, 34, and 39 do not constitute cause for discipline against respondent.

Self-Treatment

7. Self-prescribing controlled substances is unprofessional conduct for a physician. (Bus. & Prof. Code, § 2239, subd. (a); Health & Saf. Code, § 11170.) The matters stated in Findings 40 through 43 constitute cause for discipline against respondent for self-prescribing hCG, a controlled substance.

8. Prescribing drugs to anyone, self or other, "without an appropriate prior examination and a medical indication, constitutes unprofessional conduct" for a physician. (Bus. & Prof. Code, § 2242, subd. (a).) The matters stated in Findings 44 and 66 through 68 do not establish the absence of any medical indication to prescribe hCG to respondent in 2015 and 2016, and also do not establish what prior examination or medical indication, if any, would have been appropriate for prescribing hCG to respondent. For this reason, the matters stated in Findings 40 through 43 do not constitute cause for discipline against respondent for prescribing hCG to herself without an appropriate examination or a medical indication.

Disciplinary Considerations

9. Taken together, the matters stated in Findings 5 through 10, 14, 15, 21 through 33, and 35 through 38 show that respondent practices psychiatry capably and responsibly. The unprofessional conduct described in Findings 40 through 43 and in Legal Conclusion 7 reflects poor judgment with respect to respondent's own health, but this misconduct did not threaten public safety and did not recur after 2016. A public reprimand to respondent (Bus. & Prof. Code, §§ 495, 2227, subd. (a)(4)) is sufficient disciplinary action by the Board.

ORDER

Physician and Surgeon's Certificate No. A 49526, issued to respondent Debra Lynne Bunger, M.D., is hereby publicly reprimanded.

DATE:08/10/2021

Juliet E. Cox

JULIET E. COX

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 Accusation Against: **Debra Lynne Bunger, M.D.** **9057A Soquel Dr. Ste. E** **Aptos, CA 95003-4043** **Physician's and Surgeon's Certificate No. A 49526,** Respondent.	Case No. 800-2017-035950 **A C C U S A T I O N**

PARTIES

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

2. On or about June 11, 1991, the Medical Board issued Physician's and Surgeon's Certificate Number A 49526 to Debra Lynne Bunger, 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 April 30, 2021, unless renewed.

JURISDICTION

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

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

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 that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
>
> (g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2239 of the Code states:

(a) The use or prescribing for or administering to himself or herself, of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of such unprofessional conduct.

7. Section 2242 of the Code states:

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

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

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

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

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

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

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

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

8. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

FACTUAL ALLEGATIONS

9. At all times relevant to this matter, Respondent was a psychiatrist licensed to practice in California.

10. In or about August 2017, Respondent announced on her website via a letter addressed to her patients that she had closed her office in Aptos, California. Respondent described in the letter several disturbing events that led to Respondent's decision to leave Santa Cruz, California. Respondent's letter informed patients that they could continue to have medical visits with Respondent by videoconference and if appropriate, prescriptions can be sent electronically to patients.

PATIENT P-1[1]

11. Patient P-1, a female born in 1986, first saw Respondent in or about December 2013. Respondent diagnosed P-1 with unspecified Bipolar Disorder and prescribed Lamictal[2] at various times. Respondent also diagnosed P-1 with Generalized Anxiety Disorder, Obsessive Compulsive Disorder, Agoraphobia without Panic Disorder, Major Depressive Disorder, and Attention Deficit Disorder. Respondent prescribed various antidepressants over the years in her treatment and care of P-1.

12. During the time period from May 2015 to October 2019, Respondent saw P-1 on a near monthly basis, with some intermittent gaps.

13. Respondent did not document in P-1's medical records that medical visits in 2017 through 2019 were conducted by videoconference.

14. On October 2, 2019, before a scheduled visit date with P-1, Respondent received a text from someone who identified herself as P-1's sister. The text informed Respondent that

[1] The patient is designated in this document as Patient P-1 to protect the patient's privacy. Respondent knows the name of the patient and can confirm the patient's identity through discovery.

[2] Lamictal is a trade name for lamotrigine, used to help adults with bipolar disorder.

Respondent was negligent and legal action would be taken against Respondent because P-1 was abusing her medications. Respondent described the text as "vicious and accusatory." Respondent contacted P-1 to inform P-1 of the content of the text. P-1 decided to cancel the scheduled appointment with Respondent. P-1 informed Respondent that P-1 in fact needed to get help because P-1 was abusing her pain medications. Respondent suggested P-1 stay on her lamotrigine.

15. P-1 did not return to see Respondent after her cancelled appointment on October 2, 2019.

16. Respondent did not follow up with P-1 after October 2, 2019, even though P-1 had disclosed to Respondent that P-1 believed she was abusing her pain medications.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct and/or Repeated Negligent Acts and/or Failure to Maintain Adequate Records)

17. Respondent Debra Lynne Bunger, M.D. is subject to disciplinary action for unprofessional conduct under section 2234 (c) of the Code (repeated negligent acts) and/or 2266 (inadequate records) in that Respondent engaged in the conduct described above, including but not limited to, the following:

a. Respondent failed to follow up on P-1 after the cancelled appointment on October 2, 2019, after P-1 disclosed to Respondent that P-1 believed she was abusing her pain medications.

b. Respondent failed to document in P-1's medical records that medical visits in 2017 through 2019 were conducted by videoconference.

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PATIENT P-2[3]

18. Patient P-2, a female born in 1981, first saw Respondent around September 2013, as a referral visit for ongoing care for Attention Deficit Disorder. Respondent continued P-2 on Adderall[4] for treatment.

19. On December 16, 2013, Respondent discussed fertility issues with P-2, noting P-2 has had two miscarriages and is trying to increase serotonin levels to get pregnant. P-2's primary physician[5] ordered citalopram to increase P-2's serotonin levels.

20. Respondent recommended P-2 add 5HTP [6], 50 mg three times per day between meals, (at least one hour before meals) increasing by 50 mg every 3 or 4 days until P-2 would be taking up to 100 mg three times per day.

21. Respondent did not consult with P-2's primary care physician regarding treatment of P-2, that is outside Respondent's scope of practice for a psychiatrist.

22. Respondent did not obtain informed consent regarding her treatment plans and did not inform P-2 that Respondent is not qualified as an allopathic physician in fertility medicine.

23. On January 6, 2014, Respondent recommended P-2 take supplements "with or instead of Adderall." Respondent listed the amino acid supplements as tyrosine[7], 500 mg, 1-3,

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[3] The patient is designated in this document as Patient P-2 to protect the patient's privacy. Respondent knows the name of the patient and can confirm the patient's identity through discovery.

[4] Adderall is a trade name for dextroamphetamine-amphetamine, used to treat attention deficit hyperactivity disorder (ADHD). Adderall is a Schedule II drug and belongs to a class of drugs known as stimulants which is FDA-approved for the treatment of ADHD and can help increase your ability to pay attention, stay focused on an activity, and control behavior problems.

[5] All references to primary physician is intended to mean P-2's primary care physician, OB/GYN, or another physician caring for P-2, other than Respondent. P-2's medical records indicate another physician prescribed Citalopram to P-2. It is unclear if this physician is P-2's primary care physician, OB/GYN or another physician caring for P-2.

[6] 5HTP is an amino acid and a supplement taken to raise levels of serotonin in the brain.

[7] Tyrosine is an amino acid and a supplement commonly used to improve learning, memory, and alertness.

phenylalanine[8], 500 mg, 1-3, DLPA[9], 500 mg, 1-2 each before breakfast, mid- morning and mid-afternoon.

24. On August 17, 2016, Respondent again recommended tyrosine to P-2, stating tyrosine "can be used with the stimulants to help your brain to make more Dopamine."

25. Respondent's recommendation to replace stimulant treatment, which is FDA-approved and has peer-reviewed studies supporting its use, with amino acids, is not the standard of care for ADHD in treatment or practice.

26. Respondent's recommendation to use tyrosine with stimulants to make dopamine is not the standard of care for ADHD in treatment or practice.

27. Respondent did not obtain informed consent regarding her treatment plans and did not inform P-2 of the non-allopathic modalities of Respondent's practice.

28. Respondent did not document in P-2's medical records that medical visits in 2017 through 2019 were conducted by videoconference.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct and/or Repeated Negligent Acts and/or Failure to Maintain Adequate Records)

29. Respondent Debra Lynne Bunger, M.D. is subject to disciplinary action for unprofessional conduct under section 2234 (c) of the Code (repeated negligent acts) and/or 2266 (inadequate records) in that Respondent engaged in the conduct described above, including but not limited to, the following:

a. Respondent failed to consult with P-2's primary physician regarding treatment of P-2 that is outside Respondent's scope of practice for a psychiatrist.

b. Respondent recommended P-2 replace stimulant treatment, which is FDA-approved and has peer-reviewed studies supporting its use, with amino acids, which is not the current model of ADHD in treatment or practice.

[8] Phenylalanine is an amino acid used to treat depression, attention deficit hyperactivity disorder, pain and other symptoms.

[9] DLPA is a nutritional supplement with 2 different forms of phenylalanine to boost energy, manage pain, and balance mood.

c. Respondent's recommendation that P-2 use tyrosine with stimulants to make more dopamine is not the standard of care for ADHD in treatment or practice.

c. Respondent failed to obtain informed consent regarding her treatment plans and did not inform P-2 of the non-allopathic modalities of Respondent's practice.

d. Respondent failed to document in P-2's medical records that medical visits in 2017 through 2019 were conducted by videoconference.

PATIENT P-3[10]

30. Patient P-3, a female born in 1979, saw Respondent on or about and from January 2011 to January 2020. Respondent diagnosed P-3 with Major Depression and ADHD and treated P-3 with Vyvanse[11], Adderall, and Zoloft[12].

31. On January 4, 2017, Respondent recommended tyrosine to P-3, stating tyrosine "can be used with the stimulants to help your brain to make more Dopamine."

32. Respondent's recommendation to replace stimulant treatment, which is FDA-approved and has peer-reviewed studies supporting its use, with amino acids, is not the current model of ADHD in treatment or practice.

33. Respondent's recommendation to use tyrosine with stimulants to make dopamine is not the standard of care for ADHD in treatment or practice.

34. Respondent did not obtain informed consent regarding her treatment plans and did not inform P-3 of the non-allopathic modalities of Respondent's practice.

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[10] The patient is designated in this document as Patient P-3 to protect the patient's privacy. Respondent knows the name of the patient and can confirm the patient's identity through discovery.

[11] Vyvanse is a tradename for lisdexamfetamine, a stimulant used to treat ADHD and help to increase the ability to pay attention, stay focused, and stop fidgeting.

[12] Zoloft is a tradename for sertraline, used to treat depression, panic attacks, Obsessive Compulsive Disorder, Post-Traumatic Stress Disorder, Social Anxiety Disorder, and Premenstrual Dysphoric Disorder.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct and/or Repeated Negligent Acts and/or Failure to Maintain Adequate Records)

Respondent Debra Lynne Bunger, M.D. is subject to disciplinary action for unprofessional conduct under section 2234 (c) of the Code (repeated negligent acts) and/or 2266 (inadequate records) in that Respondent engaged in the conduct described above, including but not limited to, the following:

a. Respondent's recommendation that P-3 use tyrosine with stimulants to make more dopamine is not the standard of care for ADHD in treatment or practice.

b. Respondent failed to obtain informed consent regarding her treatment plans and did not inform P-3 of the non-allopathic modalities of Respondent's practice.

d. Respondent failed to document in P-3's medical records that medical visits in 2017 through 2020 were conducted by videoconference.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct and/or Self-Prescribing and/or Prescribing Without Prior Examination and a Medical Indication)

35. A review of a Patient Activity Report for Respondent using the Controlled Substance Utilization Review and Evaluation database ("CURES")[13] revealed Respondent self-prescribed a "compound[14]," of unspecified controlled substances, quantity 8 count, 28 day supply, on April 6, 2016, June 24, 2016, and September 27, 2016.

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[13] CURES (Controlled Substance Utilization Review and Evaluation System) is a database of Schedule II, III and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement. CURES is committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care.

[14] It is unclear what "compound" controlled substance was prescribed. Drug compounding is generally regarded as the process of combining, mixing, or altering ingredients to create a medication tailored to the needs of an individual patient. Compounding includes the combining of two or more drugs. Compounded drugs are not FDA-approved. https://www.fda.gov/drugs/human-drug-compounding/compounding-and-fda-questions-and-answers

36. Respondent Debra Lynne Bunger, M.D. is subject to disciplinary action for unprofessional conduct under sections 2239 (self-prescribing) and 2242 of the Code (prescribing without prior examination and medical indication), in that Respondent engaged in the conduct described above, including but not limited to, the following:

a. Respondent prescribed a "compound" of controlled substances to herself on April 6, 2016, June 24, 2016, and September 27, 2016, without prior examination and medical indication.

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 49526, issued to Debra Lynne Bunger, M.D.;

2. Revoking, suspending or denying approval of Debra Lynne Bunger, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Debra Lynne Bunger, 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: AUG 17 2020

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

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