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

In the Matter of the Accusation Against:	)	
NELSON F. LEONE, M.D. License No. G-24538	)	No. 10-90-965
Respondent	)	

ORDER GRANTING STAY ORDER

The Respondent in this matter has filed a request for a stay of execution of the Decision with an effective date of September 1, 1995

Execution is stayed until September 11, 1995.

This stay is granted solely for the purpose to allow time for Panel A of the Division of Medical Quality to review and act on a Petition for Reconsideration.

Dated: August 28, 1995

By Pamela L. Mosher
PAMELA L. MOSHER
Enforcement Program

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

In the Matter of the Accusation Against:	)	
NELSON F. LEONE, M.D. Certificate No. G-24538	)	No. 10-90-965
Respondent	)	

DECISION

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

This Decision shall become effective on September 1, 1995

IT IS OR ORDERED August 2, 1995

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

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

In the Matter of the Accusation Against:	)	Case No. D-5508
Nelson F. Leone, M.D.	)	OAH No. L-62677
Respondent.	)	

PROPOSED DECISION

On October 11, 12, 13, 17, 19, 20, 21, 25, November 21, 23, 28, 29, 30, December 1, 5, 6, 8, 9, 12, 13, 14, 1994, and January 5, 6, 9, 12, 17, 18, 19, 20, 23, 24, 25, 26, 30, 31, February 1, 2, 7, 15, 1995, in San Diego, California, Stephen E. Hjelt, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter.

Richard D. Hendlin, Deputy Attorney General, represented the complainant.

Respondent Nelson F. Leone, M.D., was represented by John Mitchell, Esquire, and Gaston Bebi, Esquire.

Testimony began on October 11, 1994 and concluded on February 7, 1995. Closing argument was made orally on February 15, 1995. Because of the complexity of the case and the volume of information presented at trial the administrative law judge ordered post trial briefs and requested that the parties respond to specific questions posed by the court. The record remained open for the submission of post trial briefs. On April 7, 1995

complainant filed its post trial brief which was marked for identification only as exhibit 141. On April 7, 1995 respondent filed his post trial brief which was marked for identification only as exhibit V. Also marked for identification in order to complete the record are the following:

142. Complainant's Memorandum of Points and Authorities in Opposition to Respondent Motion to Dismiss.

143. Statement of Statute Authorizing Request for Costs.

144. Complainants Hearing Brief.

145. Points and Authorities in Opposition to Respondent's Motion to Exclude Deposition and Declaration of Richard Hendlin.

146. Points and Authorities in Response to Respondent's Objections to Complainant's Statement of Statute Authorizing Costs.

147. Deposition of S[redacted] S[redacted] 2 Volumes.

148. Supplemental Declaration of Richard Hendlin in Support of Complainant's Request for Costs.

W. Motion to Dismiss with Points and Authorities 9/30/94.

X. Objection to Complainant's Statement of Statute Authorizing Costs.

Y. Reply to Complainant's Opposition to Motion to Dismiss.

Z. Reply to Complainant's Points and Authorities Regarding Statute Authorizing Costs.

AA. Motion to Exclude Deposition and Confidential Settlement Agreements.

BB. Reply to Supplement Points and Authorities in Opposition to Respondent's Motion to Dismiss regarding laches.

On April 7, 1995, the record was closed and the matter was submitted for decision.

FINDINGS OF FACT

I

Dixon Arnett is the Executive Director of the Medical Board of California. He filed the Accusation, the Supplemental Accusation and the Second Supplemental Accusation in his official capacity as the Executive Director and not otherwise.

II

Respondent Nelson F. Leone, M.D., was first licensed by the Medical Board of California (hereinafter the "Board") on June 6, 1973. The Board issued Physician's and Surgeon's Certificate No. G 24538 to respondent and by doing so authorized him to practice medicine in the State of California. At all times relevant to the Determination of Issues herein this certificate was in full force and effect. It will expire, unless renewed, on November 30, 1996.

Respondent has been licensed as a physician in California for 22 years. He has never, previously, been the subject of Board discipline.

III

On November 15, 1993, an Accusation was filed against respondent Nelson F. Leone, M.D., charging him with numerous serious violations of the California Business and Professions Code. On July 14, 1994 a Supplemental Accusation was filed against respondent charging him with additional violations of the Business and Professions Code. On January 17, 1995 a Second Supplemental Accusation was filed against respondent charging further violations of the Business and Professions Code.

The California Business and Professions Code establishes the framework within which the discipline of physicians takes place.

Business and Professions Code section 2220 provides, in pertinent part, that the Division of Medical Quality may take action against all persons guilty of violating any of the provisions of the Medical Practice Act, which is contained in Chapter 5 of Division 2 of that code.

Business and Professions Code section 2227 provides that the Board may revoke, suspend for a period not to exceed one year, or place on probation, the license of any physician who has been found to have violated the Medical Practice Act.

Business and Professions Code section 2234 mandates that the Board take action against any licensee who is charged with unprofessional conduct. This section states that unprofessional conduct includes, but is not limited to,

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

b. Gross negligence.

c. Repeated Negligent acts.

d. Incompetence.

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

f. Any act or conduct which would have warranted the denial of a certificate.

Business and Professions Code section 726 provides that any act of sexual abuse, misconduct, or relations with a patient which is substantially related to the qualifications, functions, or duties of the occupation for which the license was issued constitutes unprofessional conduct.

Business and Professions Code section 725 provides that repeated acts of clearly excessive prescribing or administering of drugs or treatment is unprofessional conduct.

Business and Professions Code section 2261 provides that knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts constitutes unprofessional conduct.

Business and Professions Code section 2903 provides that it is a violation of law for anyone to engage in the practice of psychology or to represent oneself to be a psychologist, without a license. Section 2902(c) states that a person "represents himself or herself to be a psychologist" when the person holds themselves out to the public by any title or description of services incorporating the words "psychologist" or when the person holds himself or herself out to be trained, experienced, or an expert in the field of psychology.

Business and Professions Code section 2630 provides, in pertinent part, that it is unlawful for any person or persons to practice physical therapy for compensation received or expected, or to hold himself or herself out as a physical therapist, unless at the time of so doing such person holds a valid, unexpired and unrevoked license issued under Chapter 5.7 of the Code. In addition, a physical therapist aide authorized under section 2630 "shall at all times be under the orders, direction, and immediate supervision of [a] physical therapist" and, at no time, may a physical therapist aide perform physical therapy or render any physical therapy procedure independently.

IV

The relationship of a physician to a patient is by its nature a fiduciary one. The physician is held to the highest ethical standard and is compelled to act in the best interest of the patient. The relationship of psychiatrist and patient creates a special type of intimate bond. The therapist/patient relationship in psychiatry involves establishing a working alliance with two complementary components:

1. The patient has the responsibility to come to and participate fully and honestly, and

2. The psychiatrist has the duty to understand and define the patients' presenting complaints and to then diagnose and manage the course of treatment.

The therapeutic relationship exists solely to address the symptoms and complaints of a patient and the psychiatrist is trained to recognize and treat the symptoms and complaints.

A misalliance or failure of treatment can occur when the therapist loses track of the objectives of treatment or fails to understand the information presented by the patient or finds himself or herself confused by the course of the therapy or the therapist's own feelings. A misalliance can occur because of the psychiatrist's failure to effectively deal with his or her own feeling during the course of therapy. This results in a loss of professional focus and the breakdown of the boundaries that must be maintained for effective therapy to take place.

Transference is the term used to describe the feelings of a patient toward the psychiatrist which are feelings and impressions transferred from earlier attitudes toward important figures in the patient's life. Its development, appreciation and resolution is at the heart of most traditional psychotherapy. Transference is not tangible. It is a state of mind of the patient. It develops during the course of therapy as the patient displaces onto the therapist impressions and feelings that derive from previous figures in the patient's life.

The transference phenomenon can and does take many forms during therapy such as anger, hate, love, jealousy, envy and sexual attraction. It is ubiquitous and unavoidable. It is the automatic tendency of a patient to transfer feelings the patient had in childhood, particularly to parents, onto the therapist.

In a simplistic example, a patient may have had a brutish, harsh, and demanding father that the patient rebelled against. The patient may have adjustment problems later in life with teachers and bosses who, like the father, stand in the position of authority. If this person sees a therapist (another authority figure) the patient may transfer onto the therapist those feelings or impressions that existed toward the father. The patient may experience the therapist as unkind, unreasonable and threatening when in fact the therapist has no agenda and is committed totally to being professionally helpful. The fulcrum on which the therapeutic process turns is this basic distortion of transference.

Psychiatrists are trained to recognize and understand this phenomenon. They know that the patient's feelings are not real in the sense that the anger or resentment, for example, are unconscious expressions of the ongoing relations to the brutish father. This occurs in the same way when a patient expresses sexual attraction or love for the therapist. The therapist knows from his or her extensive training that these attractions and feelings of love are not really toward him or her. They are transferred unconsciously from the patient's past. Feelings of sexual attraction and desire are so common and expected that no mental health professional escapes learning about it in school and training.

A patient brings to therapy the essential interpersonal conflict or emotional baggage of his or her life and transfers that conflict and baggage to his or her relationship with the therapist. Relief from the symptoms come from working through and understanding the transference. Transference, thus, is the catalyst and its successful utilization allows a patient to understand and correctly interpret his or her experiential reality. A large portion of the therapeutic goal is for a patient to understand why he or she feels the way they do.

The feelings that a patient experiences through the transference phenomenon are powerful and primal. They are distortions, not delusions. They are unconscious triggers, not dreams or fantasies. A patient experiencing a transference reaction has not lost contact with reality. In the earlier example the patient knows full well that a therapist is sitting on the other side of the desk. The patient doesn't know or understand why he is angry, resentful or rebellious when the therapist suggests some course of conduct or makes some observation. The therapist may have said, "You haven't been very successful in dealing with this problem." The patient's rage and rebellion may have as its trigger the years of abuse from a father who continually harshly criticized. There was no distortion of the fact that the therapist said, "You haven't been very successful in dealing with this problem." The patient's distorted reaction was caused by the transference phenomenon.

The State of California has determined that some professions are so important, because of the good they do when performed properly and the harm they do when done poorly, that they should be regulated. High standards for entrance are maintained and strict adherence to a high level of care is required. The mental health field, in this case psychiatry, is one such profession. It is a clear and unambiguous statement of public policy that the diagnosis and treatment of mental and emotional problems is a legitimate professional exercise. What a psychiatrist does is not faith healing, clairvoyance or crystal ball gazing. It is the application of a body of accepted knowledge, in the hands of a wise and compassionate practitioner, to the alleviation of human distress and suffering.

There are many different styles, techniques and emphasis in the treatment of mental illness. All require mutual communication, disclosure of self by the patient and the establishment of a special relationship between the caregiver and

the patient. This special relationship when viewed in a legal context is referred to as a fiduciary relationship. When viewed in a therapeutic context it is referred to as having been built on a foundation of deep and unconditional trust. The therapeutic process involves by definition the sharing of the most intimate secrets of a person.

The professional relationship commences when a patient, distressed or troubled by problems (from learning to cope with a child's messy room to often times disabling problems like schizophrenia or other psychoses) seeks help. By definition the patient is needy and in distress. The process moves by communication and disclosure of information from the patient to the therapist. This self-disclosure is a form of emotional nakedness that has profound consequences. A patient goes to a psychiatrist and by his or her complete and total disclosures states in effect, "I trust you with my failure, my fears and my own self-perceived inadequacy and ugliness. I trust you with all my secrets."

A psychiatrist uses his or her education, training and experience to help a patient understand, accept, grow and change. The establishment of trust by the therapist opens the door to the therapeutic process. It also establishes the vulnerability of the patient and the ultimate power of the therapist. In ongoing therapy, as the trust relationship develops, the patient and the therapist are on a very unequal power footing. The patient is in a position of need, dependence and vulnerability. Patients in this position are open to manipulation and they may do things they would not otherwise do.

Transference is the term used to describe the central phenomenon of therapy. Psychotherapy involves, at its core, communication and self disclosure. The process of communication and self-disclosure create and develop the transference. The

psychiatrist's knowledge of the existence and meaning of the transference phenomenon grants him tremendous power over the patient and places added responsibility on the psychiatrist not to abuse his position. This is so even in types of therapy that do not attempt to work through the transference phenomenon.

Respondent is a psychiatrist who has practiced this particular specialty and none else for the last twenty years. He is not an internist or a general practitioner and this fact has unavoidable consequences in terms of the methods of treatment he utilizes with his patients.

A psychiatrist specializes in the diagnosis and treatment of psychological disorders/mental illness. There are a variety of different theoretical approaches to the treatment of psychological problems but they all occur within a framework of systematic interactions between the psychiatrist trained to treat psychological problems and the person to be helped. The context of this systematic interaction is referred to as psychotherapy. Irrespective of the theoretical approach of the psychiatrist, there are basically only two goals of this interaction; the first is to help the patient understand his or her motive for behaving in a certain way; the second is to change the patient's behavior directly, paying little or no attention to underlying motives. Whatever the theory behind any particular school of therapy, the various approaches share common features. All psychiatrists offer support along with a willingness to listen to the patient's problems and take them seriously. All psychiatrists offer patients the notion of hope. Those with mental illness come to a psychiatrist feeling damaged and demoralized. The psychiatrist helps combat these negative feelings by offering hope for improvement if not a cure.

The term patient is simple and obvious. However, its implications in the psychiatric setting are extremely important.

A patient invariably goes to a psychiatrist because he or she is in distress. The distress is caused by factors a patient is unable to either understand or change through his or her own efforts or the efforts of friends or family. Psychological problems are disturbing and troubling and frightening and imply a neediness and vulnerability on the part of the patient at the inception of the relationship. The patient turns himself over to the care of the person with the special expertise and knowledge and this creates a power differential that vests tremendous responsibility in the psychiatrist and tremendous vulnerability in the patient.

The four patients who complained against respondent were all seriously mentally ill and had suffered from these afflictions long before they came under his care. They all sought respondent's help for the treatment of their serious psychological problems.

Psychopharmacology is the study of the interaction of drugs on the thoughts, feelings and behaviors of humans. This scientific endeavor has a crucial practical application in psychiatry. Drug therapy is used increasingly to treat mental disorders. It is the use of chemical agents to modify and correct damaging or pathologic thoughts, feelings and behaviors.

Respondent claimed that he practiced psychopharmacology. In part this is true. He did in fact rely heavily on the use of drugs to treat his mental patients. However, he did much more. Although he did not practice traditional, insight oriented psychotherapy, he did engage in psychotherapeutic interactions regularly with his patients. He did attempt to treat, by psychological as well as chemical means, problems of an emotional nature, by establishing a professional relationship with a patient whose object was to remove or modify

existing psychological symptoms, eliminate disturbed patterns of behavior and promote positive personality growth and development.

The term boundary as used in the mental health field, is a term of art. It is conceptual rather than tangible and refers to how one defines ones relationships with other people and objects in the external world. Boundaries refer to the line where the therapist begins and the patient ends. Neighbors are separated by a fence and this fence in its own way represents and signifies the separateness and uniqueness of each. In the same way therapy boundaries constitute the fence between the therapist and patient and define the role each is allowed to play. These boundaries are communicated to the patient by the therapist and must be maintained by the therapist. It is the psychiatrist's job to communicate these ground rules for behavior in therapy that define for the patient the role of the therapist, the role of the patient and the methodology of the treatment process.

The terms boundary and boundary violation are of recent vintage. However, these concepts are as old as the healing arts and harken back at least to the Hippocratic Oath with its injunctions against doing harm and avoiding sexual exploitation of the vulnerable. The issue of boundaries is central to the understanding of this case. Boundaries exist in every relationship and the concept of boundaries and boundary violations does apply to respondent's patient population.

These patients because of their emotional illness, are most in need of well-defined, consistently applied boundaries. They need structure not confusion.

A dual relationship in the psychiatrist/patient setting is any secondary relationship between the psychiatrist and patient that exists in addition to the primary one. Examples are psychiatrist/friend, psychiatrist/business partner,

psychiatrist/lover, psychiatrist/student or trainee. Dual relationships, in a most basic sense, are an unavoidable part of the psychiatrist/patient relationship. Nevertheless, they are disfavored for very sound reasons and should be avoided.

In everyday life, dual relationships are ever present. People are expected to be able to figure out and successfully negotiate the shifting nature of these relationships. One of the crucial prerequisites for this to occur is a certain equality of footing in which there is no inherent power differential - people aren't forced to make decisions and choices due to their lack of capacity or power.

The psychiatrist/patient relationship by its very nature creates a power differential that makes the fostering of dual relationships a very risky business. The standard of care for a psychiatrist regarding dual relationships is clear - they are to be avoided. The abstract principle is that the psychiatrist/patient relationship should be solitary, pure and unadulterated by other secondary connections. As you deviate from this ideal, as all psychiatrist/patient relationships do to some extent, you increase the risk of exploitation of the patient. Exploitation of the patient is the antithesis of patient autonomy. Anything done in the treatment that does not have as its goal the autonomy of the patient is suspect. Dependence and vulnerability and neediness are the enemies of psychological well-being and treatments that foster these dependencies and neediness through dual relationships are toxic and anti-therapeutic.

Community psychiatry and community mental health are terms used to describe an approach to the treatment of serious mental illness that emphasizes comprehensive treatment in the community. Conceptually, it includes all areas of care including hospitalization, day treatment, and supportive living

arrangements within the community. It had its birth in the early 1960s with the passage of the Community Mental Health Centers Act and its theories and practice continue to exert a strong influence on the way mental health services are provided today. Unfortunately, lack of funding has limited the provision of services, and community mental health has never lived up to its ambitious goals.

Community mental health is a complete system that relies on a team concept to deal with the problem of mental illness. It includes not only the psychiatrist but also the psychologist, social worker, nurses, administrators and liaisons to the various ancillary agencies in the community for jobs, schooling, housing and other basic human needs.

Medication management with supportive psychotherapy are the terms used by respondent to describe the type of practice he has. The object of supportive psychotherapy is to restore a patient to some sort of emotional equilibrium with alleviation of symptoms so that the patient can once again function at his or her norm. It attempts to restore a person to a level of adequate functioning. It aims to alleviate symptoms rather than root causes. It does not attempt to use the transference phenomenon as the fuel to operate the therapy engine; it recognizes that some patients are too ill to benefit from the painful reconstructive work of intensive insight oriented psychotherapy. It relies on guidance by the psychiatrist which involves active help in the form of fact giving and interpretation, in such matters as education, employment, health, and social relationships. It is based on an authoritarian relationship established between the patient and the therapist. It therefore has inherent limitations, one of them being the fostering of dependence on the part of an already dependent person.

Family systems theory is an approach to the treatment of individual psychiatric problems that is based on the assumption that the family is a dynamic system in which each action in the family causes a reaction in one or more of the family members. Every family member assumes a role and in order to understand and treat the designated patient you must understand the patient as a structural unit in the dynamic family.

Board and Care and Independent Living reference two different types of group living arrangements for the mentally ill. They were both developed within the context of the community mental health movement and are community based.

The fundamental difference between the two relates to the amount of structure and supervision provided. A Board and Care facility provides care for those who cannot satisfactorily take care of their own needs. All facets of daily living including food, finances and medication management are provided.

Independent Living, on the other hand, has far less structure and supervision. The residents are able to take care of their own basic needs and share the chores of the residence such as cooking, cleaning, etc. These patients are able to take care of their own affairs.

The dividing line between the two is generally the degree to which mental illness interferes with a patient's ability to take care of his or her basic everyday life chores. The sicker a patient the more structure and supervision that patient requires and hence Board and Care facilities are operated for those most debilitated by mental illness.

Board and Care facilities are licensed by the State of California. However, in the context of this case the fact that

the Peerless facility was not licensed did not make it other than a Board and Care. Its dominant character was that of a Board and Care. The medications were kept locked; there was a manager who provided supervision.

Co-Morbid Dual Diagnosis (CMDD) refers to a patient who is appropriately diagnosed as having more than one significant mental disorder. Dual diagnosis refers to a patient who, in addition to having a serious mental disorder, also has a substance abuse or dependence problem.

The four complaining witnesses in this case could properly be characterized as CMDD. They are complicated, difficult and challenging patients. The substance abuse problems always complicate the treatment picture for these patients.

Despite the fact that all four of these patients were CMDD, they were not legally or factually incompetent. They were maddening, frustrating and often self-destructive. But all of them were capable of employment, marriage, parenthood and friendship, although each struggled mightily against their own demons.

D[redacted] S[redacted] had several disorders, including Bi-polar, possibly Attention Deficit Disorder, poly substance abuse, borderline personality disorder. M[redacted] H[redacted] at various times was diagnosed as Bi-polar, schizoaffective, alcohol abuser and possibly borderline personality. V[redacted] M[redacted] was schizoaffective, substance abuser, severe personality disorder and eating disorder. S[redacted] S[redacted] was paranoid schizophrenic tied to psychostimulant abuse.

The standard of care is defined by the core elements of ethical practice established by the medical profession. These

core elements are the same irrespective of the particular specialty. They are founded on the basic principle of providing competent medical service with compassion and respect for human dignity.

The standard of care establishes a framework within which a professional can ethically practice. The standard of care at its core is unchanging. However, at its margin it is dynamic and must always reflect the development of new treatments and therapies as the frontier of medical science continues to expand.

Psychiatry has its own set of principles that mandate the type of conduct that is professionally permissible. These principles should be well known to all practitioners irrespective of their theoretical orientation or their membership or non-membership in the various professional psychiatric associations. These principles are embodied in the Canon of Ethics of the American Psychiatric Association, the professional psychiatric literature, what is being taught in medical schools, and the standards being applied and followed in peer review situations. The standard of care is always one of consensus.

When stripped of its veneer, respondent's practice is far outside the norm. It took a giant step beyond medication management with supportive psychotherapy and in doing so created a therapeutic milieu unrecognized by any reputable school of psychiatric practice.

Respondent's own expert recognized that there were no boundaries in respondent's relationship to his own practice. He was always available 24 hours a day. His beeper (for emergencies) went off constantly. There was and is no time for a private life. It is no wonder that respondent maintains a practice where there are no boundaries. Respondent became

enmeshed with his patients; they, in turn, became mired in a therapeutic quicksand.

Both sides in this case were using the same terms but were speaking different languages. Despite their diametrical opposition in terms of characterizing respondent's conduct, they both implicitly agree that there must be some distance between psychiatrist and patient. The fundamental disagreement is over what the appropriate distance is. Dr. Rusk, respondent's expert, argues that these patients who are CMDD require active intervention and proactive involvement in every aspect of the patient's life. His characterization is overbroad and distorts the picture. In a subtle intellectual slight of hand, he has moved from the concepts of community mental health to the notions of medication management with supportive psychotherapy and arrived at a justification for respondent's practice which turns appropriate psychiatric practice on its ear.

However, even judged by the principles of community mental health and the standards of supportive psychotherapy, respondent remains one step beyond and below the standard of care. What respondent did in these cases is take over virtually total control of his patient's lives. He paid their bills, gave them work, hired attorneys for them, borrowed or invested or gambled with them and had social relationships with them and their families. This can be characterized in a number of different ways but it is not the practice of psychiatry. Indeed, it is not the practice of medicine.

Mental Health professionals classify abnormality into various categories. The most widely accepted classification is found in the Diagnostic and Statistic Manual of Mental Disorders (DSM) published by the American Psychiatric Association. It consists of highly detailed descriptions of virtually all known forms of psychological disorders. When diagnosing patients in

terms of the DSM, mental health professionals evaluate them on five axes: the problem for which the patient is being diagnosed; any accompanying long term psychological disorder; any relevant physical problem; current sources of stress; and an overall rating of the patient's current functioning in the areas of work, social relationships, and leisure activities.

The DSM first appeared in 1952 as the DSM-I. Since that time four updated editions have been published: DSM-II (1968), DSM III (1980), DSM III-R (1987) and DSM IV. The DSM is widely used and almost universally accepted in the mental health field. However, there is still disagreement in the profession over how to define abnormal behavior and then to assess and categorize it.

Benzodiazapines are a class of drugs sharing a similar chemical structure that are characterized as anxiolytic or sedative drugs. They are the most widely used drugs in medical and psychiatric practice.

Atavan is a benzodiazapine, short to intermediate acting and is used for sedation in agitated people.

Xanax is a benzodiazapine, very rapid acting and is used for patients who have panic attacks. However, its level in the blood drops rapidly and a patient can get a rebound of anxiety and therefore it has a high potential for addiction.

Restoril is a benzodiazapine that has a long duration of action and is used as a hypnotic to induce sleep.

Klonopin is very powerful and very long acting. It is often used for maintenance and has the least addiction potential of the four. It does not drop rapidly in blood level.

Cylert is a psychostimulant approved for use in treating attention deficit-hyperactivity disorder.

Ritalin is a psychostimulant typically used in the treatment of attention deficit-hyperactivity disorder.

Mellaril is an anti psychotic used more commonly in the 1970's than today.

V

M[redacted] H[redacted] is fifty years old and currently resides in New Mexico. She describes a hellish life that began with her birth in San Francisco in 1944. She last saw her mother when she was four years old. She was raised in a variety of non-nurturing settings. At various times she lived in an orphanage, foster homes and two different adoptive homes. As a child she was physically and sexually abused.

When she was nine years old she moved to San Diego with a family that had adopted her. She graduated from Grossmont High School and studied music at San Diego State University. Because of emotional problems she was unable to succeed in college.

After she left San Diego State University she went to work and got married. She married in 1966. She had three children in the late 1960s. She also had another child she gave up for adoption. She was hospitalized 2 or 3 times for severe depression in or about 1970-1971. One such hospitalization was at Patton State Hospital. Over the years she has had many hospitalizations for serious mental disorders.

She first met respondent in the emergency room of El Cajon Valley Hospital in 1973. She was in the midst of a divorce and had attempted suicide by taking an overdose of drugs. Dr.

Leone was on-call. When she was released from the hospital she began a long term psychotherapeutic relationship with him that lasted for ten years.

From 1973 to approximately 1980 she would see him on a very regular basis. In the early years she remembers that they talked a lot about her past.

She understood the purpose of the therapy was to straighten out her life and help her find out about herself and why she was the way she was. It was to find out why she was so depressed so much of the time. She felt so terrible about herself; she always wanted to be a good mom but felt she was not. She wanted someone to help her understand why she had such terrible thoughts.

She saw respondent and received therapy and also medication. She was always on medication. In the 1970's she was on Mellaril which had side effects. However, she admitted that the medications prescribed sometimes helped.

At the outset of her therapy there was a lot of talking; however, over time the focus changed to mainly dispensing of medication.

She identified a change in her life while she was under Dr. Leone's care. Her behavior changed and her life became more chaotic. She didn't have a very stable environment to live in so she let her three children go and live with her ex-husband. She had no self esteem left and did not feel like a very good person.

Over time she became very dependent on respondent. She was doing what he wanted her to do. Her main goal was to please him. Eventually, no one else mattered to her but Dr. Leone. She

had an extremely intense connection with respondent. He was the only one who would pay attention to her.

After she left his care in 1983 she saw a psychologist, Ina Weitzman, for a brief time. She then saw Dr. Sharon McClure from 1983 until she left the state in 1994.

She testified that respondent offered to adopt her son J[redacted]. J[redacted] was 15 and she was at respondent's house on Fuerte Drive helping people get ready for a wedding. J[redacted] was there as well. She was doing general housework at the house. J[redacted] was having problems because he didn't get along with his step mom. Respondent talked of adopting J[redacted]. He knew from IQ tests that J[redacted] was very bright. Respondent also offered to adopt him during a session at respondent's office. This made her feel like Dr. Leone was the greatest person in the world.

M[redacted] H[redacted] on occasion cleaned respondent's house or the house of respondent's parents. Sometimes she was paid; sometimes she was not. Her idealization of him at the time was so great that she considered it an honor to do so and getting paid was almost an insult.

She has had shock therapy (ECT) many times over the years. She acknowledges having some memory loss due to it although she feels it doesn't make her forget events, but rather impairs her chronologic memory.

Peerless Street is a place that has a prominent place in this case. M[redacted] H[redacted] lived there at some time while she was respondent's patient. She initially went there because she wasn't doing well on her own. She was living in an apartment by herself and was very depressed. She called respondent's office and they came and picked her up and took her to a house like Peerless. She was afraid to live alone. Respondent asked her to

help out around the Peerless facility. On at least one occasion she took her disability check and used it to buy food for everyone. She didn't have a bedroom so she slept on the couch. She remembers 6 of 7 bedrooms.

When she first moved to Peerless there were approximately 6 to 8 people living there. However, she was never certain who would be there because the turnover was so rapid. She felt the place was one of chaos. She never knew who was coming or going or who was supposed to be there. H[redacted] C[redacted] was the manager when she first moved there. H[redacted] C[redacted] distributed the medications when she first arrived; however, after a while she did this. The medications were in a locked cabinet in H[redacted]'s room.

M[redacted] H[redacted] started taking care of dispensing medications because H[redacted] C[redacted] was impaired on occasion. This was very stressful to her. She described getting up in the middle of the night to give people their medication. She felt overwhelmed because she did not know the meaning of all the terms on the medication containers. Once one of the tenants tried to get the key away from her and she ended up wrestling on the floor with him.

Eventually H[redacted] C[redacted] moved to another facility.

She told respondent that living at Peerless was stressful for her. He kept reassuring her that she was doing a wonderful job. These comments always fortified her. Her purpose in life was to get his approval. She felt that Peerless was a Board and Care facility for people who couldn't take care of themselves. In fact, M[redacted] H[redacted] was correct. The Peerless facility operated as a Board and Care facility.

Some of the people at Peerless were very sick. One was retarded and couldn't go across the street without help.

When H[redacted] C[redacted] left some of the people went with her. M[redacted] H[redacted] took over the cooking and the giving of medications and cleaning house, until she "fell apart."

While she was at Peerless she had sex with some of the people living there. This was the start of a very sexually chaotic time in her life. She discussed this with respondent. He told her this was probably helping her and he knew it was good for them.

She reported to respondent on more than one occasion that she was becoming sexually promiscuous. He would make light of it and tell her about his sexual experiences.

On at least one occasion she went to the Del Mar racetrack with respondent. She and V[redacted] M[redacted] were both patients of respondent and were in the Mental Health Unit at Grossmont Hospital in the early 80's. Respondent arranged for their release on a pass. While there they didn't gamble because they had no money. Respondent told them he had bet on a horse and if it won he would split the winnings with them.

While she was respondent's patient she occasionally would do errands around his office. She would go get the snacks for the employees. One day she brought one of the workers a beer for her birthday.

M[redacted] H[redacted] had an incident with respondent after she left his care. She encountered him at Alvarado Parkway Institute (API) in 1986. Dr. McClure was her doctor at the time. She was in the hospital for depression. She was on the elevator with respondent when he told her she needed to write a retraction

letter. She had filed a complaint against respondent with the San Diego Psychiatric Society. In the elevator he asked her why she was trying to hurt him and his family.

A hearing had been set which respondent told her was on his birthday. She asked him what she should say in the retraction letter and she wrote it as he directed. He came to the hospital the next day and picked it up.

Shortly before the scheduled ethics committee hearing M[redacted] H[redacted] had another contact with respondent. They discussed how much it would cost for her to get out of town. The overwhelming weight of the evidence supports a finding that respondent gave her $1500 to insure that she would not be present to testify against him at the ethics committee hearing. She did not appear and testify.

After the date of the hearing, respondent had another face-to-face encounter with M[redacted] H[redacted]. He asked for repayment of the $1,500. Later, he hired an attorney to seek collection from M[redacted] H[redacted].

On occasion, respondent asked her to make arrangements for events for his son. She arranged a party at a pizza parlor for his son. She also went to restaurants with respondent and others and had meals.

Respondent did give her money whenever she needed it for food for her kids. Respondent also gave her $250. on two different occasions while she was his patient to help with other expenses she had.

In terms of her history she was hospitalized as many as thirteen times, maybe more, from 1975 to 1980 for major depression, suicidal ideation and other diagnoses. In 1980 and

1981 she was hospitalized numerous times for similar things as well.

She admits to having a history of auditory and visual hallucinations.

She admits to being hospitalized by Dr. McClure many times and that one of them was as much as three months in length.

She had approximately 12 shock treatments with Dr. McClure after she left respondent's care. She had shock treatments at Patton in the early 1970s.

She first met V[redacted] M[redacted] when they were both in the hospital. They both had the same civil attorney. She saw Dr. Koshkarian at the request of Mr. Daley, her civil attorney, on three or four occasions in 1988. She admitted telling him that she questioned her memory of having sex with respondent. She did tell Dr. Koshkarian she might be confused about the claim of oral sex against respondent.

She did work briefly at Naugles, a fast food restaurant, while she was treated by respondent. She was manager and in charge of night deposits. She "goofed" and didn't get a night deposit in once. She called respondent and said I have $1500.00 of Naugles' money. She told respondent she was going to walk down the middle of street and kill herself. Respondent and another person came and got her.

In her deposition, taken in the civil action she filed against Dr. Leone, she stated that she could not say under oath that she had sex with respondent.

Respondent did go to the Peerless facility while she was there on 3 or 4 occasions. He would walk through, talk to patients and eat something.

It was not established by clear and convincing evidence that respondent was or is guilty of sexual misconduct or sexual relations with M[redacted] H[redacted]. The overwhelming weight of credible evidence strongly supports a finding that respondent did not engage in any sexual misadventure with M[redacted] H[redacted] at any time under any circumstances.

It was established by clear and convincing evidence that respondent failed to recognize the needs of his patient and that her condition worsened as a result of his actions. The appropriate boundaries required to be maintained by respondent were for the most part non-existent.

It was not established that respondent's conduct fell below the standard of care for a psychiatrist in his charting of M[redacted] H[redacted]' significant past history.

It was not established by clear and convincing evidence that respondent was incompetent by virtue of his alleged excessive prescribing of Mellaril and or Ritalin to M[redacted] H[redacted].

It was established by clear and convincing evidence that respondent was grossly negligent in his conduct surrounding the retraction he demanded from M[redacted] H[redacted] of her complaint to the San Diego Psychiatric Society in 1986. His conduct in securing the retraction and in asking that she repay the sum of $1,500.00 is shameful as well as unprofessional and is only exceeded by his profound lack of awareness of why his actions were unprofessional.

It was not established by clear and convincing evidence that respondent breached the confidentiality of patient M[redacted] H[redacted] when he responded to her phone call announcing she was going to walk down the center of a busy street and try to kill herself.

VI

V[redacted] M[redacted] is a 36 year-old native of Detroit, Michigan. She now lives in Florida. She worked at respondent's office off and on from 1980 to 1984, doing reception, filing, typing, and secretarial. She is fifth of six children in a chaotic family. She was abused and beaten primarily by her mother. She saw respondent as her psychiatrist from 1979 to 1985. She was hospitalized over 20 times while seeing respondent. Respondent flirted with her, made eye contact, and once told her she looked sexy. It made her feel very special, especially when he said, "Hi beautiful."

In 1980 or 1981 he suggested to her if she weren't so crazy maybe they would be involved. In 1983 or 1984 he told her she was so sick no one else would put up with her except him. He once introduced her as his sickest patient to another patient's father in a restaurant.

She went with respondent on numerous occasions to a restaurant where respondent did discuss his personal life with her. She felt special and that he was sharing special information with her and she felt like a confidante.

Respondent did introduce her as his daughter on occasion.

She saw Dr. Broeckel who was a consulting doctor. From August, 1980, to January, 1981, she saw and had sex with Dr.

Broeckel. None of the charges regarding respondent's actions concerning Dr. Broeckel were substantiated by the evidence.

On occasion she went to the race track with respondent and other people. However, it was not established by clear and convincing evidence that while she worked at respondent's office she did physical therapy, massage therapy, range of motion and ultrasound.

None of the charges regarding V[redacted] M[redacted] improperly writing her own progress notes were substantiated by the evidence.

She gave birth to a child on October 13, 1981. Respondent was the godfather.

She did get paid when she worked at respondent's office anywhere from $5.00, to $20.00, to $100.00. There was no set schedule of payments. Respondent let her use his credit card. She used it to pay to have her car fixed once. Respondent paid approximately $300.00 for her maternity clothes.

Respondent had a birthday party for her son E[redacted] and respondent paid for it at Chuck E. Cheese.

Once respondent sent her home with a syringe of pain medication. She was having pelvic pain and low back pain. She had worked the whole day and he didn't want to give her a shot and then have her drive home so he showed her how and gave her 2 mg. of Stadol. It was not established to clear and convincing certainty that this was grossly negligent. It is as likely as not that she had instructions regarding self-administration and that a home health nurse was at her home for assistance.

As treatment progressed she felt confused, angry, upset. Her life was getting worse and she was furious with him.

She did live in respondent's house for less than one month in October 1981, while her son was in the hospital.

She admitted on cross-examination she was using street drugs while treating with respondent and that in 1979 to 1981 there were times when she was hallucinating. From 1979 to 1985 she was hospitalized in San Diego County approximately 26 times at least half for drug overdose or misuse and the other half for depression, suicide attempts, and being out of control.

She felt in love with respondent at times - not father daughter love but adult love.

She admits to having been blacklisted at various hospitals.

In the beginning she felt respondent really cared and felt he was making an honest attempt to help with her problems.

She admits to assisting the licensed vocational nurse at respondent's office in doing physical therapy.

She once told respondent she was having problems with her car and respondent paid to have it repaired.

She admits after she stopped seeing respondent she called him and asked him to intercede to keep her out of San Diego County Mental Health in March, 1985. He said no and she was very angry with him.

She admits she came in and took some of her records to her attorney and never told anyone.

She admits it was kind of like a big family in the office. They all went out together and occasionally had lunch or dinner together and celebrated birthdays.

In terms of respondent, she feels he did treat her like a daughter. She felt he was looking out for her when her child was ill.

She admits to being so sick she couldn't drive a car when her child was ill.

Respondent on more than one occasion asked her to put her thoughts on paper.

V[redacted] M[redacted] was under treatment with respondent from September, 1979, until March, 1985. During that time respondent engaged in numerous repeated boundary violations that were inimical to the patient's best interest. These boundary violations involved having relationships other than professional and therefore hopelessly confusing the patient and the course of treatment.

It was not established by clear and convincing evidence that respondent engaged in acts of sexual abuse or sexual misconduct with patient M[redacted].

VII

D[redacted] S[redacted] was born in San Diego and has lived her entire life here. She has a 10th grade education. She is not employed and has never been employed. She is now single but has 3 prior marriages and 4 children from them.

She first met respondent in the 1970s through her sister H[redacted]. H[redacted] was a patient of respondent for

approximately 20 years. H[redacted] lived in the guest house at Fuerte Drive in 1985 to 1986. D[redacted] S[redacted] sister, E[redacted] J[redacted], was also a patient of respondent from 1988 to 1990.

D[redacted] S[redacted] was the patient of Dr. Shrift for 10 years, from 1976 to 1986. He retired and she began seeing Dr. Kaplan for about 3 months. Dr. Kaplan hospitalized her in 1987 at Alvarado Hospital but through her sister's urging she consulted with respondent.

Respondent on occasion revealed personal details of his own life to D[redacted] S[redacted] while she was a patient. The first instance of self disclosure was at a Baker Square Restaurant with L[redacted] B[redacted] and respondent. He told her he had sex with a social worker in medical school and that a woman once offered him $350,000.00 to marry him and he sat down and figured he made that much anyway. This was at a lunch in 1988. He made comments about his wife, that she called the police on him and she was manic depressive.

D[redacted] S[redacted] had an auto accident on November 25, 1987 as a pedestrian. She was a patient of respondent at the time. There was litigation and she received a settlement. She got 2 checks, one for $10,294.74 and one for $8,333.33. She gave the money to respondent. The understanding was he would help her with her finances.

Joe Silence at Georgin and Shan was her accident attorney. She also had Gordon Madison who represented her on the underinsured motorist case.

Respondent during the time D[redacted] S[redacted] was his patient entered into a multitude of financial dealings with and for her. These took many forms but all had the same result. Respondent took charge of her financial dealings. His office

paid all her bills. His office invested her money for her. At no time did respondent ever suggest that she meet with an attorney or financial advisor to get any independent advice about the wisdom or propriety of these financial arrangements.

In June, 1988, her ex-spouse quit-claimed their house to her. On approximately June 24, she took a third trust deed for $10,000.00. She signed a promissory note in respondent's office on June 29 (ex 3). She understood it to be an investment in a restaurant. Respondent told her she would get a job at this restaurant as well as payback of the loan.

He told her he always had his property work for him. Respondent did not suggest a consult with an attorney before she signed Exhibit 3.

She was on SSI when she took this loan out. She was receiving about $500.00 per month. She had direct deposit and would use the money for her living expenses.

She would have to report periodically to SSI to keep qualifying. She learned in 1988 that SSI was cut off. Because of the loan (Exhibit 3) she no longer qualified. It was a problem because it was her sole source of income. When she told respondent her SSI was cut off he said tell them you owe me money. But she didn't owe him anything.

She followed his advice and told Social Security that she owed him money.

Respondent never informed her regarding the financial position of any investment, or what his own personal involvement in any business was.

I[redacted] H[redacted] was the co-owner of the Boulevard Club Card room. D[redacted] S[redacted] used to go there and gamble.

In June 1989, she was in a rear-end accident driving a 1977 Mercury. She was injured and hospitalized.

In March and April, 1989 she was taking street drugs as well as prescription drugs and was in and out of control.

D[redacted] S[redacted] hatred for respondent has no limit. She testified, "I was in hell with the devil. He slaughtered me with every intent to do that and with a smile on his face."

She stopped seeing respondent in May, 1991. She has gone to other mental health professionals since leaving respondent's care and feels she is better.

She recalls visiting Dr. Grygorcewicz at some time. Tests were given. She didn't do all the tests but did as much as she could. She recalls doing a Rorschach test.

She did meet respondent's mom, C[redacted], to buy a juice called KM from her. In 1988 D[redacted] S[redacted] was purchasing these drinks from respondent's mother. It was a powdered health drink.

She once met respondent at the races with respondent and respondent's brother S[redacted]. Also Dr. Grygorcewicz was there. She talked with respondent briefly. It was between June and September, 1989.

She once went shopping with respondent's mom and another patient at Parkway Plaza.

She had an auto accident on June 15, 1989. She was driving and was on speed (amphetamines) and Valium. She doesn't

remember when she first told respondent she was using street drugs.

As a result of the accident of June, 1989, she ended up in jail. It was a very serious case. It was her third serious DUI and there was concern she would end up in state prison. Respondent went to court for her. He testified for her. She denies asking respondent to say she got the speed from him. It was Judge Kapiloff who sentenced her. Respondent got up and spoke and asked the judge to consider home confinement with an ankle bracelet. The District Attorney wanted state prison. She was sentenced to one year home confinement.

It was not established by the evidence to a clear and convincing level that respondent failed, in his initial treatment sessions, to take an adequate mental or psychological history.

It was established by the evidence to a clear and convincing certainty that respondent failed to timely diagnose D[redacted] S[redacted]' chemical dependency, and that he consistently misdiagnosed frontal lobe syndrome and that he failed to address her Axis II pathology.

It was established by the evidence that respondent did over-prescribe benzodiazepines to D[redacted] S[redacted]. Respondent did so during her hospitalizations of October 1988 and September 1989. Respondent's general prescribing pattern regarding D[redacted] S[redacted] over the years was also grossly excessive.

It was not established by clear and convincing evidence that respondent took no action to dissuade D[redacted] S[redacted] to stop using the street drug crystal nor was it proved that he in fact encouraged her to use it.

It was established that respondent failed to adequately chart important data regarding his patient D[redacted] S[redacted] while she was his patient. Respondent failed to note any history of violent acting out by D[redacted] S[redacted]. However, the fact that the results of psychological tests were not in her chart notes was not a violation of anything.

It was established that respondent failed to discourage D[redacted] S[redacted] from coming to his home which she did on occasion. He never told her this was inappropriate nor did he instruct her not to come to his home. This was a blurring of appropriate boundaries and was in the context of the treatment of D[redacted] S[redacted] grossly negligent.

It was established by clear and convincing evidence that on occasion respondent socialized with D[redacted] S[redacted] at restaurants. In the context of the treatment of D[redacted] S[redacted] this was grossly negligent

It was not established that respondent on any occasion ever told D[redacted] S[redacted] that he loved her.

It was established that respondent on occasion revealed inappropriate information to D[redacted] S[redacted] regarding his personal life. These acts of self-disclosure were therapeutically improper. They included statements regarding sleeping with a social worker to get extra food stamps when he was in medical school and revealing to D[redacted] S[redacted] that he earned $350,000.00 a year and that his wife was manic depressive. These incidents of inappropriate self disclosure were gross negligence.

It was established that respondent paid D[redacted] S[redacted]' gambling debts. As other findings indicate this payment of her gambling debts was an outrageous violation of therapeutic

boundaries. Respondent made payments on D[redacted] S[redacted]' home equity line of credit and many other personal bills. These payments made for D[redacted] S[redacted] were, in the context of her psychiatric treatment, grossly negligent.

Respondent engaged in dishonest activities in regard to a $3,500.00 he accepted from D[redacted] S[redacted]. He misrepresented to the Social Security Administration that the transfer constituted payment for services rendered, when in fact respondent had told D[redacted] S[redacted] that he would not charge her for past services. The scheme was intended to conceal the nature of D[redacted] S[redacted] assets so that she would have her Supplemental Security Income benefits reinstated.

Respondent's office fabricated a billing statement dated August 8, 1988, in the amount of $23,030.00. It was then provided to a law firm representing D[redacted] S[redacted] in a personal injury matter and it was represented to be the amount due for medical care D[redacted] S[redacted] was given by respondent as a result of the auto accident of November 15, 1987. The billing was corrected on March 27, 1992 reflecting the correct amount of $2,100.00. This was gross negligence.

Respondent prepared a medical report dated May 10, 1989, (exhibit 29) regarding D[redacted] S[redacted] and her injuries and condition as a result of the auto accident of November 15, 1987. In that report he grossly minimized her past history and the severity of D[redacted] S[redacted]' psychiatric disorders prior to the accident and shifted the entire weight of causality for her disorders to the accident. This was gross negligence.

Respondent engaged in a long and convoluted series of financial transactions with and for D[redacted] S[redacted]. These transactions involved respondent taking possession and control of approximately $18,000.00 of D[redacted] S[redacted]' money she received

from personal injury settlements and $3500.00 from one of D[redacted] S[redacted]' real estate transactions. Respondent took possession of this money, placed it in his general business account and managed the money for D[redacted] S[redacted] while she was his patient. Not only did he pay her monthly expenses (including on occasion her gambling debts) he also engaged in other transactions that had the appearance of loans (complete with promissory notes). These activities, as more fully set forth elsewhere, are so far outside the standard of care, and so improper as to defy belief. Respondent's actions were improper and unjustified and constituted the maintenance of a damaging dual relationship with his patient. These activities were egregious violations of the permissible boundary between a psychiatrist and a patient. They cannot be justified by reference to any reputable school of psychiatric practice.

It was not established that respondent, through his authorized staff, repeatedly fraudulently prepared and submitted medical claims for payment to insurance companies regarding D[redacted] S[redacted]. Respondent's billing practices were shrewdly sloppy. However, his misconduct does not involve billing for phantom visits. Indeed, he probably saw D[redacted] S[redacted] on more occasions than he billed.

VIII

S[redacted] S[redacted] was a patient of respondent from approximately 1980 to 1990. He is a native of Iraq and his native tongue is Arabic. He speaks and understands English but he is functionally illiterate because he cannot read English. He is currently in prison at the California Mens Colony in San Luis Obispo, California. He has, from before he first saw respondent in 1980 to the present, suffered from paranoid schizophrenia. During this entire period of time he has never been symptom free.

Even now he takes Thorazine and Sinequal to treat his mental illness.

It was established by the evidence that respondent paid S[redacted] S[redacted]'s personal expenses and bills at numerous different times while S[redacted] was his patient.

Respondent claims that the therapeutic relationship with S[redacted] S[redacted] ended on August 4, 1990 (Exhibit 111). The overwhelming weight of credible evidence is to the contrary. This is a phantom termination created after the fact by respondent to justify his gambling/business dealings with his patient. There was no termination of the psychiatrist/patient relationship with S[redacted] S[redacted] on August 4, 1990. Even if there had been a termination on that date, respondent's conduct in gambling with and sharing profits with S[redacted] S[redacted] would still violate the standard of care.

He was born in Baghdad, Iraq, in 1953. He left there when he was 13 and came to the United States. The highest grade completed in school was sixth grade. He had various jobs growing up in Detroit. He worked on the assembly line at Chrysler and as a stock boy in a grocery store. He then moved to San Diego in 1976. In 1980 he married K[redacted] S[redacted]. One of his brothers, R[redacted], became a patient of respondent. His mother and father were also treated by respondent. His mother saw respondent for a few years. His dad saw respondent about the same time but his dad died in 1980.

He first met respondent through respondent's brother, S[redacted] L[redacted], in around 1978. He and S[redacted] L[redacted] became very close friends. He met respondent at respondent's house socially.

He was on disability while he was seeing respondent.

S[redacted] S[redacted] is naive, simple, and totally defenseless. He is very childlike.

At respondent's urging S[redacted] S[redacted] went to see David Branson, respondent's personal attorney, after winning the big spin. There was talk about putting things in respondent's name because of tax considerations.

Respondent engaged in multiple and repeated acts of gross negligence in his relationship with S[redacted] S[redacted]. These impermissible acts occurred both while S[redacted] was a patient as well as afterward. Respondent paid personal bills of S[redacted] while he was a patient. He also had S[redacted] collecting payments for rentals owned by respondent. In December, 1990, S[redacted] S[redacted] won $500,000 in the California Lottery. Respondent had entered into an agreement with S[redacted] to become partners in a gambling venture wherein respondent would put up the money for lottery gambling and they would be partners in any winnings. After S[redacted] won the $500,000 in the big spin, he and respondent opened joint bank accounts and pursued various business ventures together.

In 1991 respondent and S[redacted] jointly borrowed $5,000. The money was used to provide spending money for gambling on the lotto and for S[redacted]'s personal expenses. The $5,000 was placed directly in respondent's personal account and he had complete control over it.

IX

Nelson F. Leone is 52, married and the father of one child, a boy. He is a native of Niagara Falls, New York. He earned his B.S. from Niagara University in 1964, and medical degree from Creighton University in 1969. Medical school was a

traditional curriculum. He then took a joint residency program at Creighton and the University of Nebraska.

He defines psychotherapy as the communication between doctor and patient in a contract to effect change through verbal and non verbal interchange with the goal to change maladaptive behavior.

He studied the principles of family therapy in New York. As part of the training, psychiatrists would go and live with a family for a weekend. The focus was on how the family effects mental illness and vice versa. The psychiatrist would treat the entire family. The designated person has an illness but this illness effects the balance of the family. To treat the designated patient you bring the entire family together.

He was in a fellowship at Yale University in 1972-73. While there he was employed at the Connecticut Mental Health Center at New Haven. He was the chief resident. He worked at the Brief Psychiatric Intervention Program. Psychiatry was practiced both at the hospital and in the community. The patient would stay for three to five days in the hospital and then a treatment plan would be developed and the patient would go back into the community and be maintained there. He treated patients in their home, halfway houses and residential treatment facilities.

In Connecticut doing family therapy he did see patients in their home and would sometimes have family members, neighbors and extended family there to talk about the illness and try to develop a support system. It was an integrative system using the whole environment and the psychiatrist was involved in this program directly.

There were occasions where the patient could not get to the treatment center and he or a community member would pick them up and give a ride.

He was in school at the height of the community mental health movement. The goals behind the legislation in 1963 were to avoid long term institutionalization, to treat mental patients in their community, give them a sense of dignity as well as educate the public and remove the stigma of mental illness. One of the goals was to give patients a sense of responsibility and a sense that they are helping provide for themselves instead of being dependent.

Some patients had money they couldn't manage so a case manager or payee was assigned who would pay for housing, help with budget for food, etc. These case management people were employed at the center.

From his earliest days of schooling and work he has never felt that traditional one on one psychotherapy worked well with the seriously chronically mentally ill.

He treats the poor and the very mentally ill. He claims his practice has developed using the concepts of general systems theory in an environment which is secure and protective to allow for treatment. He sought to develop a system that provides comprehensive service from the hospital to the center to the half way house to the board and care to the residential care facility i.e. to bring treatment to the community. A tenet of systems theory is that everything impacts on the other - from the individual to the family to the extended family. When one gets sick it effects the surrounding environment.

In 1975 he set up the psychiatric unit at El Cajon Valley Hospital and became the medical director.

From 1975 to the present his goal has been to create a community mental health practice on a private basis. The evidence reveals his idea was an excellent one; his implementation was another matter.

His patient population is heavily chronically mentally ill; heavily lower economic strata; and heavily medical/medicare.

He has seen between two and three thousand patients over the last 22 years. He now sees an average of 20 to 30 patients a day sometimes more. On a given day he has 12 to 16 patients in the hospital. He works seven days a week. He wears a beeper always and has approximately three acute emergencies a day. In terms of seeing a patient in public he acknowledges them as a person.

He has assisted patients with money to buy food, written reports to Social Security and DMV, assisted in managing their money and has patients to his home. He claims it is all a matter of being a real person. He doesn't deal with transference and what patients project on to him.

He admits he was the godfather to V[redacted] M[redacted]'s child. She was a very sick patient he acknowledges.

He believes sending cards to a patient helps patients self-worth. When they get sick no one cares so a therapist sends a card for their self-esteem. They have no support system and are alone. They feel loneliness, neglect and no one cares. He has been the godfather for about five patients. He feels this does no harm and in fact is good for self-esteem.

Over the years he has developed a policy of keeping the doors open to his office. It cuts down on acting out by patients.

Over the years he purchased many homes for his patient population. The first was at 1736 Peerless in approximately 1980. He did this because so many patients were homeless and nothing was being done in the community for them. His wife owns it today. He has sent patients there ever since he purchased it. Other doctors do as well.

His goal has always been to operate a community mental health service in his private practice. He has no sociologist, no social worker, no special administrator, no expert in various programs like Social Security and housing. He does it all himself.

V[redacted] M[redacted] was blacklisted at both Alvarado and Grossmont Psychiatric hospitals. Her behaviors were disruptive. She failed to follow the rules and attacked the staff.

He first met D[redacted] S[redacted] in the 1980s in a coffee shop in Mission Valley. She came up and talked to him; after her ride left she asked for a ride home. He gave her a ride home. She pulled a knife on him and held it to his throat. She finally exited the car and went into her home. She was not his patient then. It was a number of years before she became his patient. Dr. Shrift was her psychiatrist for many years. Respondent believes he saw her in August 1987 as he was covering for Dr Kaplan who was her psychiatrist at the time. She was in the hospital at the time for bipolar affective disorder and generalized anxiety disorder. He reviewed her API records and also saw the records at Grossmont Hospital. These records revealed that she had been seriously mentally ill for a long time. From Dr. Shrift's records he determined that she had been prescribes Librium, Cylert and Dexedrine. The records also showed a diagnosis of Attention Deficit Disorder. She was under Dr. Shrift's care for a long time and her psychiatric history dated back to her teen years.

She had not been hospitalized from 1981 to 1987 while being cared for by Dr. Shrift. During that time she was on a medication regimen of benzodiazepines (Librium and Tranzene) and psycho-stimulants (Dexedrine and Cylert).

She became respondent's patient in October, 1987. At her initial visit he did not write out a detailed history. He already knew her history and had talked to Dr. Schrift after her office visit and discussed her past treatment-what worked and didn't.

In October, 1987, D[redacted] S[redacted] did have problems with alcohol and street drugs. Periodically she would abuse speed because she said it would calm her down and she would drink too much when she got agitated. Respondent was well aware of her tendencies. D[redacted] S[redacted] was a serious drug and alcohol abuser and respondent was on notice of this propensity.

Respondent testified that every medication has risks. The potential benefit is a healthier person. You must gauge drugs. You evaluate disease and make a clinical judgment and maybe use a different medication with more risk because other medications have failed. If the condition is refractory then you take more risks with the medications.

D[redacted] S[redacted] was never in remission while under his care.

Respondent did make an Axis I diagnosis of D[redacted] S[redacted] which was borderline personality disorder. He deferred making an Axis II determination because right after she started with him she had an auto accident and was knocked unconscious. Respondent acknowledges discussing handling D[redacted] S[redacted] money for her. She had some money and she approached him about holding it for her because she was concerned about making her payments

and also fearful people would take advantage of her (family and friends). She didn't trust any family member to help her. He agreed and it was structured in Exhibit 3. The intention in June, 1988, according to respondent, was to hold her money so she wouldn't squander it or lose it by manipulation of others.

The medical report (Exhibit 29) is a collaborative finding of respondent and Dr. Grygorcewicz re D[redacted] S[redacted] and they discussed the substance of her case both before and after writing.

In 1989, D[redacted] S[redacted] had an auto accident and was arrested. Respondent helped her get an attorney. Respondent appeared in court for her before Judge Kapiloff. Respondent made the suggestion to the court that she be sentenced with house arrest and the court followed his recommendation.

Respondent admits D[redacted] S[redacted] visited Fuerte Drive home at least two times. She also came over at other times to buy KM from respondent's mom. He never told D[redacted] S[redacted] not to come to his house.

He denies going from the office to socialize with D[redacted] S[redacted], but she did follow him a couple of times to Godfathers Restaurant. Respondent was at the restaurant with Dr. Kaplan. She sat down and respondent didn't ask her to leave.

He claims he told her often that he would be good for the money she gave to him. He claims he told her money was safe and she was never in any danger of losing it. D[redacted] S[redacted] was not truthful and very manipulative according to respondent. She tended to blame others and never took responsibility. She blamed her daughter, ex-husband, C[redacted] D[redacted], respondent, and S[redacted] R[redacted]. Whoever she interacted with, it was their fault. She would manipulate to see how far she could go. He claims he

continued to see her because he is a committed psychiatrist and people like her need to be understood. He kept treating her out of dedication as a doctor and concern for her welfare.

He knows what a conservatorship is and has been involved in many. He considered it for D[redacted] S[redacted]. He felt that to have a conservator you must prove a person gravely disabled and unable to provide for themself and therefore felt she wouldn't qualify. While he treated D[redacted] S[redacted] she was living in her own home and had her own checking account and drove a car. She was able to communicate and understand what respondent was saying. Respondent didn't feel she needed one but the question in his mind was how can you prevent the probable consequences of her behavior and try to convince her to manage her own life to prevent self destructive acts and loss of her home.

M[redacted] H[redacted] was his patient from approximately 1973 to 1984. When she started she had severe depression, felt worthless with severe identity problems. His first diagnosis was schizoaffective disorder. He hospitalized her at least 10 times for things like basic depression, suicidal ideation, thought confusion and hallucinations.

He claims he used medication management with supportive psychotherapy. She was able to work during some periods of time. At Naugles she was assistant night manager and she also took care of an elderly man. At one time she had a home. She lived with her four children in an apartment. She gave one up for adoption and lost custody of the other three to her ex-husband. This was traumatic.

She was prescribed Mellaril by respondent for her severe agitated depression. It is a phenothiazine used for

agitated states, emotional discontrol, hallucinations and delusions.

She worked for Naugles for six months and this ended in the walking in the street incident. He went out to pick her up with patient M[redacted] C[redacted], who knew M[redacted] H[redacted].

While she was his patient respondent prescribed Ritalin for her refractory depression. The chloral hydrate he gave for a sleep disorder.

Mellaril is for impulsive behavior and it also has an anti-depressant effect and a major component of her disease was depression. Ritalin was for depression and was meant to augment the other anti depressant medication. It was used to boost the effect of the other anti depressant med which weren't working. Chloral Hydrate was for the sleep problems which caused increased restlessness, agitation and depression.

He did see her hallucinate. She would see things that weren't there. She had visual and auditory hallucinations.

M[redacted] H[redacted] told respondent of having sex with patient M[redacted] P[redacted] at Peerless. He listened but didn't approve or disapprove.

He claims he learned she became a prostitute but he did not encourage it.

Respondent confirms that after she left his care she filed an ethics complaint against him. She was at API and he confronted her. He said he was amazed and said how could you do this to me. Respondent asked her to rescind it and she was apologetic and said she would.

Respondent saw V[redacted] M[redacted] from 1977 to the mid-1980s. Depression was her first big problem along with severe somatic complaints. He hospitalized her at least twenty times. She had multiple suicide attempts, at least ten. She was blacklisted, on the no admit list at Grossmont and at API. While a patient of respondent he considered her a danger to herself.

She did perform tasks in his office but she was never authorized to type any patient charts other than her own.

He tried to set up a day treatment program for her in his office. She had unpredictable behavior and would constantly be on drugs. She had an auto accident and was in much pain. She had a very hard time organizing her day. So he devised a way to set up the day treatment program in his office. She would come in and sit and write out a treatment plan which would include her pain and symptoms and a plan for that day.

She had an auto accident and was represented by attorney Frank Crudo. She was pregnant while in his office. She was a high suicidal risk. She had auditory and visual hallucinations and delusions.

She had a separate chart because she was a very difficult case and respondent was trying to be creative in treating her. He devised this treatment plan - when she came in she would sit with the transcriptionist and write out or verbalize what her symptoms were which would help her focus on her complaints but try not to utilize medications and assess where she was and where she was going. It would be typed out and then respondent would see her and go over the chart.

He did have V[redacted] M[redacted] type her own progress notes so she would focus on her problems and situation. One of her problems was she would deny her illness and her chemical

dependency. He was trying to restore her reality testing by having her document on a daily basis how she was thinking and feeling.

Respondent would occasionally give her money for food for her child. He also fixed her car when she had an accident.

Respondent claims the doctor/patient relationship with S[redacted] S[redacted] ended in August, 1990. S[redacted] S[redacted] was a patient since 1979. Before S[redacted] S[redacted] became a patient respondent knew S[redacted] S[redacted] and S[redacted] S[redacted]'s dad. S[redacted] S[redacted]'s mom had been a patient for depression. Respondent also treated S[redacted] S[redacted]'s brother R[redacted] for schizophrenia and drug dependency. S[redacted] S[redacted] was a friend of S[redacted] L[redacted] before respondent became his doctor. S[redacted] S[redacted] had been to respondent's home socially before doctor/patient relationship began.

S[redacted] S[redacted] came to respondent for help because he was having problems. S[redacted] S[redacted] was diagnosed as schizophrenic, paranoid type. He was on disability while he was treated by respondent. After S[redacted] S[redacted] was disabled S[redacted] S[redacted] did do work for respondent such as general cleanup around the office. Respondent did pay him.

S[redacted] S[redacted] won the lottery in December, 1990. Before this date respondent did help S[redacted] S[redacted] get an auto. S[redacted] S[redacted] was convicted of burglary before December, 1990, and started on work furlough in about January, 1990. On work furlough S[redacted] S[redacted] would come to the office and respondent would give him jobs. S[redacted] S[redacted] wanted to start a shoe business and respondent loaned him $500. Respondent also gave S[redacted] S[redacted] money to pay for an immigration attorney. S[redacted] S[redacted] had the immigration problem as a result of his criminal conviction.

After August, 1990, respondent did engage with S[redacted] S[redacted] in acts involving the lottery. He gave S[redacted] S[redacted] money to buy lottery tickets every week. They had an agreement to be partners. S[redacted] S[redacted] used respondent's home address on the tickets.

S[redacted] S[redacted] went to the big spin with S[redacted] L[redacted]; respondent may have paid plane fare but he is not sure.

S[redacted] S[redacted] won $500,000 and respondent understood they were partners as a result of the many discussions they had.

S[redacted] S[redacted] got his first check for $40,000 and it was deposited in an account at First California Bank where they were both signatories. It was opened in January, 1991. As to the first $40,000 respondent got 0. S[redacted] S[redacted] went and gambled it away at the various casinos. This was all spent by March, 1991. By then S[redacted] S[redacted] needed a place to live so he lived with respondent and then with respondent's brother S[redacted]. S[redacted] S[redacted]'s behavior was getting unruly and he moved from Fuerte Drive address around early 1992. He moved to an apartment near the beach owned by respondent's wife and was there for about 6 months. Respondent had patients living there in transition from hospital to recovery homes. S[redacted] S[redacted] had authority to buy food from the nearby store for the patients and he did so.

Respondent helped negotiate an agreement regarding back child support owed by S[redacted] S[redacted] to his ex-wife K[redacted]. The second payment of $40,000 was December, 1991, and K[redacted] had a lien for back support. S[redacted] S[redacted] got between ten and fifteen thousand and deposited it into respondent's general account and it was used to support S[redacted] S[redacted].

While S[redacted] S[redacted] was a patient respondent helped him with attorney fees and S[redacted] S[redacted] did collect rent payments for respondent while living at the beach.

Respondent proudly admits there is no one in San Diego with a practice like his.

He has practiced since 1973 as a general psychiatrist. He resigned from the APA in 1986 after an investigation of complaints by V[redacted] M[redacted] and M[redacted] H[redacted]. The ethics committee hearing was in November, 1986, but he does not know for sure when he resigned. He never went for a hearing but did go for an interview with two doctors. He decided to resign rather than proceed with the hearing.

Respondent has had a number of patients who have worked at his office - T[redacted] F[redacted], L[redacted] L[redacted], and P[redacted] B[redacted]. P[redacted] did work there but respondent didn't pay her. He did help buy eye glasses and fix her teeth. She needed her teeth to be reconstructed for $3600 and he paid. She worked there from 1980 to 1984 without other compensation. L[redacted] A[redacted] was a patient and worked in the front office.

Respondent had the M[redacted] H[redacted] retraction typed at his office across the street from the hospital. M[redacted] H[redacted] was an inpatient at the time, being treated for her mental illness. Respondent didn't talk to Dr. McClure and didn't ask her permission to speak with M[redacted] H[redacted]. Respondent doesn't have a copy of the retraction. Respondent claims he didn't ask McClure permission because he wasn't seeing M[redacted] H[redacted] as a physician but rather in a social or friend capacity. This is the most ludicrous bit of self-serving testimony in the entire trial. RESPONDENT CONDUCT WAS CLEARLY INTENDED TO BENEFIT HIMSELF.

On a later date respondent discussed with M[redacted] H[redacted] going out of town. $1500 cash was given to her the day before the ethics committee hearing.

V[redacted] M[redacted] had worked in his office before 1984-85. She worked there during her pregnancy, answering phones, filing and following a licensed vocational nurse around who was in charge of V[redacted] M[redacted]. This was Mary Ann Linker. Respondent thinks V[redacted] M[redacted] got paid something but knows no tax was withheld. She would have been paid in cash.

Respondent was told by V[redacted] M[redacted] that she was having sex with Dr. Broeckel but he never wrote it in her chart.

He admits he may have taken a patient to the race track, but doesn't remember if took V[redacted] M[redacted].

Respondent denies taking V[redacted] M[redacted] out for her birthday but admits buying her a plant. He gave her $300 to buy maternity clothes, and did pay her car repair bills and this was a quid pro quo for typing her chart notes.

He admits he knew his office was paying D[redacted] S[redacted]' gambling debts but this did not strike him as unusual.

S[redacted] S[redacted]

On September 5, 1989, S[redacted] S[redacted] was hospitalized at Grossmont in ICU; respondent admitted and attended. Respondent found him psychotic, agitated and delusional with little insight into his illness. His judgment was impaired. S[redacted] S[redacted] had a past history of schizophrenia, paranoid type with history of amphetamine dependence. S[redacted] S[redacted]'s behavior was such that he needed seclusion and restraint to control him. He was agitated,

delusional, paranoid and refused to sign any forms or take any medications. He was labile in affect.

His diagnoses on discharge was Axis I schizophrenia, paranoid type with exacerbation with history of poly substance abuse. The date of discharge was September 12; he was in for a week. See exhibit 111.

S[redacted] S[redacted] was depressed and worried about being deported to Iraq, his divorce, going to jail, the need for a job and lack of money. He didn't want the stigma of being a mental patient, he wanted to be normal. So respondent said follow up with your attorney, keep off drugs, stay out of trouble. S[redacted] S[redacted] was given volunteer work at respondent's office and respondent also promised to help him out financially with the attorney.

On August 4, 1990, respondent claims he and S[redacted] S[redacted] reached an agreement that this would be the last therapy session. There is no reference to termination in the chart and respondent made no referral of S[redacted] S[redacted] to another psychiatrist.

Respondent was asked whether termination with S[redacted] S[redacted] was a significant event. Not really, according to respondent, because he would still have my support as a friend and I'd be there for help if he relapsed. The evidence is clear, S[redacted] S[redacted] did relapse.

On August 21, 1991, S[redacted] S[redacted] became psychotic. He called respondent talked about deportation and not seeing his kids, babbling about persecution, deportation, was quite delusional. Respondent asked him to come in for a shot.

On January 16, 1992, $15,000 from the lottery was deposited into respondent's own checking account and S[redacted] S[redacted]

wasn't authorized to sign on it so S[redacted] S[redacted] had no control other than respondent's promise to do what he wanted.

A Mr. Branson was both attorney and accountant of respondent, not S[redacted] S[redacted], and S[redacted] S[redacted] met and discussed giving the tax break concerning the $40,000.00 to respondent. There was no protection for S[redacted] S[redacted] and very unequal bargaining power.

Respondent did go gambling with S[redacted] S[redacted]. The first time was at Sycuan in February/March, 1991, possibly January. Respondent went there and got S[redacted] S[redacted] a line of credit; he co-signed because they were partners, so S[redacted] S[redacted] was technically responsible for respondent's debts.

Respondent felt he had a 50/50 interest in the $40,000.00 that came in December, 1990. In November, 1991, he got $15,000.00 and put in his personal account. This was the last sum respondent got because S[redacted] S[redacted] dissolved the partnership.

Respondent felt that on August 4, 1990, when he saw that S[redacted] S[redacted] no longer needed his services or the services of any psychiatrist. Respondent felt S[redacted] S[redacted] had adequately resolved his anxiety, paranoia, etc. This is self serving and dishonest and not supported by the record.

He never returned any of the $15,000.00 to S[redacted] S[redacted] nor ever prepared an itemized accounting of what was spent on S[redacted] S[redacted] or taken by respondent!

S[redacted] S[redacted] could not read English. This only increased his dependence and vulnerability.

Respondent did try to get a loan using as collateral the total winnings from the lottery to start a business with S[redacted] S[redacted].

He referred to S[redacted] S[redacted] publicly as his partner. They were partners in Lotto gambling and in Michael's Deli and also the shoe business called Sam Sports.

Respondent and S[redacted] S[redacted] looked into and started negotiations to become managers of a gaming casino.

By March, 1992, respondent understood that S[redacted] S[redacted] was not happy with him. Respondent felt S[redacted] S[redacted] was doing drugs and confronted him and said he would no longer give him money.

X

EXPERT WITNESSES

The trial of this action involved testimony by four expert witnesses. Three testified for the complainant and one for the respondent. All four were well credentialed and all four were of assistance to the court in understanding the technical aspects of this case.

A. BRUCE HUBBARD

Bruce Hubbard, M.D., is a San Diego psychiatrist with a 1972 medical degree from Vanderbilt Medical School. He did his internship and residency at UCSD, completing them in 1975. He is a professor at UCSD Medical School and is a member of the customary mainstream psychiatric associations.

He has a general psychiatric practice with a subspecialty in psychopharmacology and the treatment of substance abuse. Ten to fifteen percent of his work involves forensics.

His testimony established convincingly that it is never proper for a psychiatrist to take responsibility to manage and maintain the assets or funds of a patient. This is so irrespective of the particular theoretical orientation of the psychiatrist. It is improper professional behavior whether one is a traditional, insight oriented psychotherapist or a psychopharmacologist. Respondent's financial dealings with D[redacted] S[redacted], whether they were managing her funds or borrowing from her, were an extreme departure from the standard of care.

It was established by Dr. Hubbard's expert testimony that respondent failed to diagnose D[redacted] S[redacted] chemical dependency or her borderline personality disorder. There were clear indicators she was drug abusing and chemically dependent but respondent failed to adequately address this in any treatment plan. Dr. Hubbard confirmed that boundary violations are particularly damaging with borderline patients because they have great problems with boundaries themselves and therefore any therapy should scrupulously avoid them. Borderline personalities have extremely intense and chaotic relationships and this is how therapy becomes unless the psychiatrist is extremely careful.

It was established by Dr. Hubbard's expert testimony that respondent's prescribing practices with respect to D[redacted] S[redacted] were an extreme departure from the standard of care. Respondent was grossly negligent in prescribing benzodiazapines on a continuing basis where there were clear indications of chemical dependency as well as the number of benzodiazapines at any one time. The records show that respondent prescribed four different benzodiazapines within a few days time. Sometimes it

may be appropriate in rare cases to prescribe two at a time but never three or four. There was no medical justification for more than two here.

Dr. Hubbard testified and established that respondent mishandled the transference. A dependent personality like D[redacted] S[redacted] will try to develop such a relationship in therapy. Respondent furthered the psychopathology of D[redacted] S[redacted] by furthering her chemical dependency and her psychological dependence. By intervening in her life so directly he became enmeshed. He consistently misdiagnosed her chemical dependency and her borderline personality disorder.

Dr. Hubbard further established that respondent was not fully honest in evaluating and reporting D[redacted] S[redacted] injuries from her auto accident. This refers to exhibit 29, the report of May 10, 1989. Respondent improperly minimized D[redacted] S[redacted]' mental and emotional difficulties before the accident. Her prior history is summarized in one sentence. The picture thus created in the report is distorted. Her life course was far from stabilized. Respondent characterized all her problems as related to the auto accident. The second area is attributing to her a frontal lobe or organic brain syndrome. This diagnosis was not at all supported by the testing that was done. In fact, the results of the tests done contradict his finding. There was no evidence from the tests done that D[redacted] S[redacted] had frontal lobe syndrome.

Dr. Hubbard also established that respondent's conduct involving D[redacted] S[redacted] and the Social Security office was far beyond what was appropriate behavior for a psychiatrist. It was manipulation to beat the system by changing documents and facts.

Dr. Hubbard also established that with respect to the issue of boundaries, there is no difference in the standard of care between a psychopharmacologist and a general psychiatrist.

Dr. Hubbard confirmed on cross examination that a patient with an Axis I diagnosis of Bi Polar and Axis II of Borderline Personality Disorder is a patient who is very difficult to treat. He also confirmed that medication management is crucial for such a patient and that no psychotherapy approach has much success alone in treating such a patient.

Dr. Hubbard also established that respondent not only excessively prescribed benzodiazapines to her as an inpatient but also excessively prescribed benzodiazapines to her on an outpatient basis.

B. JAMES L. RICE

Dr. Rice is a psychiatrist in private practice in La Jolla. For the last six years he has been an assistant professor at UCSD Medical School. He has significant experience treating serious psychiatric disorders at Hillcrest Manor Sanitarium. He also does peer review. He has been board certified since 1971.

He is familiar with the community standards for psychiatry in Southern California as they existed in the early 1980s. He is also familiar with the community mental health system in San Diego over the last 20 years.

Dr. Rice established by his expert testimony that in general respondent's practice is an extreme departure from the standard of care. This is so because of the multiple levels of dual relationship he maintains. These dual relationships confuse the clinical picture. Letters and cards, for example, indicate a parental role as well as becoming intimately involved in a

patient's family by becoming a godfather. Respondent also employed patients to work in his office sometimes paying them and sometimes not.

It was and is the standard of care to maintain a treatment relationship as free as possible of personal contacts. To actually plan an outing with a patient, as in taking them to the race track, was way outside the standard of care.

Dr. Rice convincingly established that a psychiatrist is responsible for one thing only - to provide effective treatment to his patient. There is a treatment contract that is implied i.e. what is expected from the doctor and the patient. It is a crucial issue to define the goals and objectives of the relationship. The activities undertaken are done and evaluated on the basis of how you are moved toward the goal and objective. A patient, especially in psychiatry, is very vulnerable emotionally. The need to maintain a clear separation between doctor and friend, lover, father, financial advisor, or employer is paramount in psychiatry. These other relationships contaminate and confuse the therapy relationship.

All patients and people have a variety of needs. A psychiatrist's job is to help a patient so the patient can become more able to meet their needs. Dr. Rice opined that instead of more independence and freedom from illness respondent's patients became more slaves to their illness and problem behavior. Rather than enlarging the patients sphere of resources in the community it shrunk because all patient needs were focused on the respondent and his staff. The goal of treatment is to free the patient from the therapy, to end the treatment with the patient being as free of the bad behaviors as possible. The patient is to learn how to get needs met and pursue an independent life. When the psychiatrist interrupts and inhibits this it is anti-therapeutic.

The sources of the standard of care for ethics for psychiatrists are as follows:

-the principals of the APA and AMA i.e. the Canons of ethics;

-the psychiatric literature. There are frequent articles about what is ethical and what is proper treatment;

-awareness of what others are doing in the treatment community;

-what is being taught in the medical schools;

-what standards are being followed in peer review situations.

If a doctor is doing things different than anyone else he must ask why am I the only one.

Dr. Rice is not aware of any respected minority school of opinion regarding the boundary violations he found. There is nothing to support the clinical efficacy or the ethical propriety of respondent's behavior.

Psychopharmacology is the study of the effects of drugs on people and their psychiatric disorders. It is the study of chemical agents used to treat psychiatric disorders and how they work. Boundaries exist for a psychopharmacologist in the same way they do for any other psychiatrist.

There is no evidence in the record Dr. Rice reviewed to support the contention that respondent is a psychopharmacologist. In the review he did it is clear that respondent does what all psychiatrists do. He has a busy hospital practice-he admits

patients, treats and releases them and follows them as outpatients. He uses medications as all psychiatrists do and uses various psychotherapeutic techniques. He does garden variety hospital psychiatry.

Dr. Rice established that with respect to the standard of care there is no difference in the standard of care whether a patient is suffering from a severe disorder such as schizophrenia of less extreme problems like generalized anxiety. It is more important to maintain boundaries with sicker patients who have less ego strength, who have problems making good independent judgments.

It is <u>always</u> the responsibility of the psychiatrist to prevent boundary violations. It happens often that a patient is demanding or initiating boundary violations. The patient often wants to expand the psychiatrist function beyond treatment. It is the psychiatrist's duty to remind the patient of the contract- what are we doing here, what have we agreed on. You teach the patient what is best in the long term not short term gratification.

There is no doubt that V[redacted] M[redacted] was a very needy person. She needed money, affection and direction. Unfortunately respondent often attempted to gratify these needs directly rather than deal with the contract. He should have said my job is to help you find how to get money, affection, etc.

Respondent introduced V[redacted] M[redacted] as her sickest patient. This is demeaning and expresses the patient's worst fear and opinion of themselves. The goal is to support self-esteem. The statement is very demeaning and confirms the opinion the patient already has of themselves. Patients often wonder if they are even worthy of breath.

It is never proper to employ a patient's family member even if a patient needs training or employment. The patient's need for a job is an issue for discussion in the treatment and nothing else.

Respondent employing the ex-wife of a patient (in this case S[redacted] S[redacted]) who is a paranoid schizophrenic is gross negligence. You must always put yourself in the shoes of the patient. It is wrong to put family members or an ex wife in position to have access to patient records. This will have a negative effect on the program and treatment.

Dr. Rice established that respondent was grossly negligent in the payment of D[redacted] S[redacted]' bills. It violated boundaries by creating a dual role. The psychiatrist became the bank, a role that is antithetical to the goal of treatment, of developing patient autonomy. What respondent did here was infantilize the patient and exacerbate the patient's dependent position in treatment. It is gross negligence even if the patient would otherwise gamble or squander their money on drugs. If a patient is incompetent then there are two possibilities, 1. a fiduciary conservator; or, 2. You could suggest that patient make a contract with a private person other than the psychiatrist to manage money. If competent then the only recourse is to talk to the patient about the meaning of money and what the consequences of gambling or use drug use are and how it fits with the goals of treatment.

Having a patient enter into a business deal with a friend or relative of the psychiatrist is gratifying the needs of the doctor and exploiting the neediness of the patient.

Providing a car to D[redacted] S[redacted] with his own money is still gross negligence by respondent. It blurs the roles. The psychiatrist is the banker or the philanthropist or the

moneylender. It confuses and creates or extends dependency on the part of the patient toward the doctor and defeats the goal of increased autonomy and self sufficiency.

Having lunch with or having patients to home for social occasions is gross negligence. It blurs the treatment role and creates alternate role of friend and social companion that is antithetical to the treatment and the forming of other healthy relationships. Having a patient to his home for the holidays fosters dependency. It invites the patient to fulfill social needs through the doctor rather than encourage the patient to form outside social relationships.

Revelations of details of the psychiatrist's personal life to the patient is burdensome and exploits the patient's need to be needed and creates rather than lessens the patient's dependence. The psychiatrist is telling the patient, "Not only am I your doctor but you are my confidante." It creates a parallel relationship that is antithetical.

Dr. Rice confirmed on cross-examination the use of the term ego. The term is used in traditional psychodynamic formulation to mean a group of mental functions including perception, judgment, processing, input and decision making that have to do with a persons ability to relate to and assess reality and formulate appropriate responses to situations and environments. Some of the patients a psychiatrists sees have weaknesses in one or more of these areas. The use of the term auxiliary ego describes one of the functions of the mental health professional in dealing with a patient with such a deficit. The psychiatrist supports or fills in the area of weakness or deficit.

He established that in a general sense that in a psychiatric medication management practice there is less psychotherapy but still there is talk.

A patient with Bipolar at Axis I and Personality Disorder at Axis II would be a seriously ill patient - a dual diagnosis patient. Bipolar has a hereditary component and is life long although episodic.

Dependency describes the state of emotional needfulness that is almost always present and a part of a treatment relationship between therapist and patient. It is not unusual for a patient to become dependent on a psychiatrist nor to feel in love.

Dependency is usually part of the treatment relationship and describes a feeling a child has toward a parent that is recreated in the doctor patient relationship. This is part of the concept of transference. Real dependency needs to be discouraged. Therapy should clarify these feelings and where they come from. Trust is important in relationship between a psychopharmacologist and a patient. A patient must be candid and tell the psychiatrist what is happening in the patient's life. The patient must feel the doctor has the patient's best interest at heart.

He admitted under cross-examination that V[redacted] M[redacted] was a highly disordered person. He is aware of prior diagnoses such as Axis I paranoid schizophrenic and Axis II borderline personality disorder.

He confirmed that an idiosyncratic reaction is a very unusual response to a drug either an extreme sensitivity or insensitivity to effects or a very unusual allergic response.

C. HAIG KOSKKARIAN

Haig Koshkarian is a San Diego Psychiatrist on the faculty of the San Diego Psychoanalytic Institute. He confirmed the expert opinion of Dr. Hubbard and Rice that in terms of ethical issues it is the same standard of care irrespective of the psychiatric orientation. All patients regardless of their financial background or the degree of illness deserve the same degree of ethical behavior from their psychiatrist.

He interviewed M[redacted] H[redacted] in March and April, 1989. He prepared a report, exhibit 57, as part of her personal injury case. He made a diagnoses of bipolar, depressed. It is Dr. Koshkarian's opinion that respondent was grossly negligence in the treatment of M[redacted] H[redacted] based on sexual misconduct. His testimony and opinion in this regard were unpersuasive. He did find, and the record amply supports this, that respondent encouraged and involved M[redacted] H[redacted] in a very dependent relationship. Her life revolved around him. The focus of her life was respondent, his family and his office and staff. The standard of care for any patient then and now is you attempt to support the patient to function optimally, get them to feel better about themselves by increasing feeling of self esteem. The psychiatrist becomes a reliable and trusted figure. But he does not become a God and he is not the focus and center of the patient's life so that the patient almost becomes a member of a family. The experience of M[redacted] H[redacted] was almost cult like. The psychiatrist should not be an employer, friend, social director, dating service or buddy sharing sex secrets. M[redacted] H[redacted] needed a psychiatric relationship with respondent that was clear, not blurred.

She had clear dependency needs. The goal should have been to get her to be fully functioning, feeling good about herself and demonstrating insight. What happened instead was

respondent let her be more dependent which met her short term needs only. It actually made her feel more negative and helpless. Her treatment did not undo the past, it repeated it.

Dr. Koshkarian established that respondent's demand for a retraction was gross negligence and abusive. To use money to get a patient to retract a complaint is unprofessional conduct and gross negligence. Respondent's demand for repayment was a continuation of the transaction and gross negligence.

Dr. Koshkarian also established that respondent was grossly negligent in allowing M[redacted] H[redacted] to stay at the Peerless facility. She lived in the facility that she believed respondent owned and she felt responsible to manage and had the key to medications and was in charge of dispensing. Placing her in such a position was unprofessional conduct because she was not trained and this was gross negligence.

Dr. Koshkarian admitted under cross-examination that in an appropriate setting with the right type of patients medication management alone might not violate the standard of care. He admitted M[redacted] H[redacted] has a severe case of a serious illness. It was his opinion that M[redacted] H[redacted] had sex with respondent. What he has done is make a credibility determination re M[redacted] H[redacted] and respondent without ever talking to respondent. Dr. Koshkarian's professional arrogance was palpable. He was the only expert who felt compelled to be an advocate for a position and maintained this position in the face of a mountain of evidence to the contrary.

D. THOMAS RUSK

Thomas Rusk has been a physician since 1963, a psychiatrist since 1966 (24 years) in the San Diego area. He has

taught at UCSD from 1971 to the present and at USD Law School. He has been board certified since 1969.

His medical education was in the community mental health area. It was the core training he had in medical school at University of Cincinnati.

He defined terms in ways that were quite helpful to the Court.

Psychotherapy - no absolute definition but is the attempt to constructively influence another person using verbal and non verbal communication to get them to lead healthier, more constructive lives.

Psychoanalytic psychotherapy - is a form of treatment adapted from psychoanalysis i.e. a watered down and abbreviated form of psychoanalysis developed after WW II.

Psychopharmacology - the field of research and clinical application where medications that effect the brain and mind are used to ameliorate mental distress and disorder. The term is synonymous with medication management.

Supportive psychotherapy-describes a manner of treatment that is akin to counseling rather than exploratory or depth or psychoanalytic therapy. In supportive psychotherapy you don't try to get under the patients defenses or uncover or get to the roots of the problem. You try to bolster and keep the patient going instead of reconstruction. To a medication management psychiatrist the conversation with a patient is supportive psychotherapy.

The fifty minute hour - is the traditional amount of time used by a psychoanalytic therapist. It is the length of the traditional exploratory session.

Transference - is very sloppily defined these days. Originally, in psychoanalysis it described the transfer or projection of feelings from important people in childhood (brother, mom, dad) onto current people who remind you consciously or unconsciously of them. You transfer onto new people feelings from the past. You relate and react now as a result of experiences and feelings from early in life. You transfer onto the analyst the feelings and behaviors of the past. It is critical that they emerge and are dealt with.. The concept was applied to psychodynamic therapy developed after WW II as well. The term has been used and misused often. The real guts of meaning of these terms has become diffused and lost. The concepts of transference and counter-transference clearly apply to the traditional form of 50 minute hour psychotherapy of today as well as the original psychoanalytic concept.

Transference is inevitable in all relationships. Dr. Rusk admitted that there is some kind of transference even in a medication management supportive psychotherapy practice.

Boundaries - as related to the practice of psychiatry refers to what actions and words are appropriate to the therapeutic role. A violation would be words or deeds that are outside. Boundary is synonymous with limit. The notion of boundaries comes from the original theories of psychoanalysis. The goal was to have as uncontaminated a transference as possible. The attempt by the analyst was to be a blank screen. The less the doctor is "real" the more the patient can transfer their past life on to him. If a psychiatrist reveals too much of self he becomes too "real" and the screen is less blank and you interfere with the clean transference that helps patient

understand self i.e. if you exchange gifts, have coffee with. It dirties the screen and interferes with this theoretical approach to therapy.

Dr. Rusk confirmed research over the years revealed a correlation between blurring of boundaries and the use of patients for the gratification of the therapist. To some any violation of a boundary is per se an ethical violation. But not to him-you must know the context.

He identifies a range of patients from moderately ill to very ill to co-morbid dual diagnosis.

Dr. Rusk testified that in his opinion the traditional concept of boundaries does not apply in a medication management with supportive psychotherapy setting for a seriously mentally ill patient. Dr. Rusk's testimony and opinion was not persuasive in this regard. He is correct that the blank screen of psychoanalysis or insight oriented psychotherapy is not the treatment of choice for these very seriously mentally ill patients. He is correct that with such patients insight oriented psychotherapy that attempts to plumb the depths of the unconscious is not the treatment of choice. He is also correct that some form of intervention or involvement is appropriate with these patients. Yes, they deserve and are entitled to have help in addressing issues such as the need for housing and employment. But that is discharged appropriately by the psychiatrist's referral of the patient to the appropriate expert in the community. This is what the community mental health system does. But even in the community mental health model the psychiatrist does not satisfy the needs of his patients directly.

He describes respondent practice as "remarkable." Respondent specializes and has a market niche involving patients who have multiple severe diagnosed mental illnesses. Respondent

sees the most severely ill people in the community. In Dr. Rusk's 24 years in San Diego he knows no other who has or would be willing to have such a practice.

There are some mental disorders where traditional psychotherapy is inappropriate and at times destructive. As to some patients traditional insight oriented psychotherapy is inappropriate. He feels that traditional psychotherapy was not appropriate for any of these four patients. What was appropriate was medication management with supportive psychotherapy. This is the correct approach and has been used by all their prior doctors.

Respondent's practice is 90% CMDD. This practice is the least desirable. In any field there are more and less desirable clientele. Respondent selected a niche where there is no competition among private practitioners. His only competition is public. Other private practitioners do not want this practice because the hours are endless, he must be available at all hours, the beeper never stops, you often don't get paid and the paperwork is endless. The patients are extremely demanding, often a danger to self and others. There is little opportunity for a private life. It is thankless, exhausting, dangerous, enervating and hard work.

Benzodiazepines can be used in a patient with a prior history of drug abuse but one must have good reason and use them cautiously because of the risk of initiating or perpetuating addiction. You must as always do a risk benefit analysis. Benzodiazepines are drugs that have abuse potential (not the highest) but people do get dependent on them because they like the effects. There is a difference between addiction and abuse. Cocaine is a drug of abuse and addiction. You get high and get hooked. Barbiturates are sedatives and you get high. One of the advantages of benzodiazepines is very few people get really high.

But, once you start using them it is hard to get off. It causes a dependency rather than a high. His opinions regarding respondent's prescribing practice with benzodiazepines were not persuasive.

However, his testimony regarding the respondent's use of Cylert for D[redacted] S[redacted] was cogent and persuasive. It is more likely than not that D[redacted] S[redacted] has a paradoxical reaction to Cylert. Further, a doctor can safely rely on the successful treatment regimen of a prior medical doctor. He learned that D[redacted] S[redacted] got Cylert from respondent in October, 1987. In the context of her history and previous history with other doctors it had good rationale and good sense. There were good indications for it and it was worth a try. Dr. Shrift had prescribed it over the years and D[redacted] S[redacted] had not been hospitalized for six and one half years. The proof is in the pudding according to Dr. Rusk.

Dr. Rusk testified and established that Mellaril is an anti- psychotic drug and has been around a long time. It has its own characteristics and side effects. Its heyday was 1975 to 1981. Back then in addition to use as an anti-psychotic it was also used for depression and for sedation. It was appropriate to use on a patient like M[redacted] H[redacted] (schizoaffective). There were good solid indications for use here.

Ritalin is a psychostimulant and was appropriate for patient like M[redacted] H[redacted] in 1975-1977. He understands that she did not respond well to more standard agents and this can be used when other things are not working well. It is not a routine use by the average psychiatrist but a sophisticated use when patient does not respond to usual things. Chloral hydrate was a sedative hypnotic, now out of fashion but not in 1975-1977 as a sleeping medication and it was appropriate to prescribe back then to M[redacted] H[redacted]

Self-esteem is an important concept in supportive psychotherapy. It is the attitude and feeling that a person has toward the self in terms of inherent sense of worth or worthlessness. People with these severe problems, without exception, have low self worth and self-concept. They feel bad about themselves and this is both a source of the original problem and one of the effects of their problem. It is both cause and effect.

Charting - A psychiatrist should not put all he knows about a patient into a chart. We live in a time where confidentiality has all but disappeared. Psychiatrists are time stressed and must be selective about what is important and what isn't. However, respondent's charting practices, as noted in other findings, were not adequate.

It is clearly not proper for a psychiatrist to advise a patient to invest in something from which the psychiatrist would get a fee or otherwise benefit.

It is outside the standard of care for a psychiatrist to demand a retraction of a complaint by a patient to the psychiatric society. This is because of the personal benefit derived.

It is gross negligence to pay $1500 to a patient the day before the patient or former patient was to testify before the ethics committee re the complaint with the understanding that the patient would not attend.

He agrees with the tenet that a psychiatrist must avoid using a patient to satisfy the psychiatrist's needs. The agreed upon fee and the satisfaction of helping another are all a psychiatrist can ethically get from a patient.

He admitted on cross-examination that it would sometimes be appropriate to get a conservator for a D[redacted] S[redacted] type. However you are taking civil rights away and this is a significant matter. He admits that if D[redacted] S[redacted] had no family or friends and he believed that she would squander money on gambling and on drugs, he would consider a conservator. This is the safest way for the psychiatrist but the danger is that the patient would be humiliated and D[redacted] S[redacted] would find it a massive rejection. This is the biggest problem with the whole conservatorship business. It makes the situation for some patients worse.

Self-esteem is very important to all people and a goal of therapy. Dr. Rusk admitted that if some of V[redacted] M[redacted] accounts are true they would be detrimental to her self esteem. Telling V[redacted] M[redacted] she is so sick only he could tolerate is gross negligence if true.

To have a current patient who is chronically mentally ill with the kind of problems M[redacted] H[redacted] had and ask her to be manager and to take responsibility and in charge of medications, even if she were licensed as Licensed Vocational Nurse, is inappropriate.

In psychiatric practice the term denial is the conscious or unconscious refusal to admit. In a chart in regard to drug intake it would mean they were minimizing or denying some or all of their drug use.

Sex and money are only two of many needs that a doctor can satisfy through a patient. These are also power, control, admiration and need for prestige.

XI

The administrative law judge, in making the findings herein, has considered and evaluated the testimony of the witnesses in the light of the factors enumerated in Evidence Code section 780. This case is a smorgasbord of deceit and distortion and presents the trier of fact with a choice between testimony by fantasy and vendetta versus testimony by whitewash.

The four complaining witnesses were all seriously mentally ill. Their ability to perceive and recollect was and is flawed and highly questionable. Distortion, misperception, hallucinations and outright dishonesty permeate their testimony. No one deserves to be convicted and lose their medical license on the basis of the uncorroborated testimony of these four alone.

However, these four witnesses are not evil people and do not deserve to be blamed or condemned because their ability to perceive and recollect is impaired. In fact BAJI 2.21 wisely instructs the finder of fact that discrepancies in a witnesses testimony are normal and innocent misrecollection is not uncommon.

M[redacted] H[redacted]

Separate and apart from the fact that most of the events involved here are ancient, she is an unreliable witness in many ways. She has been the recipient of shock treatment (ECT) over the years, at Patton State Hospital in the 1970s and with Dr. McClure after she left the care of respondent. There is no question that ECT has as a nasty side effect memory loss. She has been on heavy duty, mind altering medications for the past 20 years. She has had hallucinations. She has admitted on more than one occasion that she had doubts about whether she did have sex with respondent. In the past she has questioned whether she

confused the oral sex with respondent with oral sex she had with her adoptive father. In her deposition taken in October, 1989, she admitted that she could not say under oath she had sex with respondent. She testified in her deposition that respondent gave her a shot on the night of the guest house incident and that she began hallucinating. She doesn't remember the circumstances, just the feeling. She admitted to signing exhibit D knowing it was untrue, knowing she was perjuring herself.

D[redacted] S[redacted]

Her testimony was confused, disorganized and in many particulars not believable. It disclosed someone whose memory is definitely impaired. She is great at blaming others. She is a poor historian. Even the Board expert, Dr. Hubbard, agreed with the characterization of D[redacted] S[redacted] as a person with paranoid ideation who has false attributions of causation and responsibility and a tendency to always need someone else to blame.

V[redacted] M[redacted]

Some of the events are from 1979-80 and therefore 15 years ago. From 1979 to 1985 she was hospitalized approximately 26 times for serious incidents like suicide attempts, drug overdoses and major depression. She was and is a very unstable, fragile person. Her testimony regarding her baby and the issue of respondent discouraging her from pursuing Dr. Broeckel is most instructive. The weight of the evidence is very clear that respondent and his office encouraged her to pursue the matter with the District Attorney. But she is on a mission to settle the score with respondent for all the real and imagined hurts he has visited on her. Her testimony was filled with exaggeration, twists and distortions. She is an assassin, an unreliable

witness giving self-serving answers.
S[redacted] S[redacted]

His story was told in a 478 page deposition taken in the civil suit and in the reconvened hearing at the California Men's Colony State prison on November 21, 1994. The Administrative Law Judge ruled that the testimony taken on that day be stricken from the record because it was not reliable and that S[redacted] S[redacted] was not capable of responding to questions in a way that gave the trier of fact any assurance that he understood what he was doing by giving testimony. A careful reading of his deposition and the observations of S[redacted] S[redacted] at San Luis Obispo reveal a naive, simple, and totally defenseless person. He is very childlike and dependent.

Nelson Leone

Respondent in a subtle and very sophisticated way blames his patients and deflects any responsibility off himself for his extremely unorthodox manner of practice. Rather than sincerely acknowledge that perhaps he may have overstepped his professional limits he explains away everything. The scenario involving the retraction letter demanded by respondent from M[redacted] H[redacted] is a classic example. Respondent engaged in a form of bribery with his former mental patient who was hospitalized and under the treatment of another psychiatrist when he asked her for a retraction of her ethics complaint against him. His explanation makes him out to be the victim of a cunning and manipulative person. M[redacted] H[redacted] had many facets of her personality that were not terribly desirable but she was the needy, vulnerable victim of respondent's manipulative self-interest. The transactions involving D[redacted] S[redacted] are another example of respondent deflecting responsibility onto others. He claimed the idea of D[redacted] S[redacted] investing in his restaurant was her idea and that he wasn't keen on the idea but that others

i.e. C[redacted] D[redacted] and or L[redacted] B[redacted] and or D[redacted] S[redacted] came up with the idea of the loan format.

K[redacted] S[redacted]

K[redacted] S[redacted] testified and established convincingly that she is a liar, unworthy of belief or trust. She was totally uncooperative while being questioned by the complainant and had a miraculous retrieval of memory when examined by respondent's counsel. This is not to say she was completely supportive of respondent's position. However, her bias was palpable and obvious. Her attempt to disavow authorship and responsibility for exhibit 46 (basically that she was angry and said things she didn't mean or know anything about) is ludicrous. Her demeanor and manner of acting in court on October, 21, 25, and November, 28, 1994, make it clear that she is neither an amnesiac nor have the events of the last ten years been so traumatic that their memory has been driven from her consciousness. She worked for respondent for a number of years on three separate occasions during the eighties and the nineties. She was a frequent social guest at respondent's home over the years. She remains close to and has frequent contact with respondent's office manager, C[redacted] D[redacted]. She was a percipient witness and not only wrote Exhibit 46 received as administrative hearsay but also gave testimony under oath at her deposition in the civil case in which respondent was a defendant, taken August 20, 1993. Exhibit 46 supplements and explains and is completely consistent with a wealth of other direct evidence in the record. Despite respondent counsel's argument that exhibit 46 is filled with conjecture (restating the conclusions of others without any personal knowledge to do so) it is a document rooted in personal knowledge which K[redacted] S[redacted] did a thoroughly unpersuasive job trying to disavow.

C[redacted] D[redacted]

C[redacted] D[redacted] has worked almost continuously for respondent for nearly 20 years. She is respondent's most trusted employee and one respondent delegated a great deal of the operation of the office to. She handles and has handled most of the operation of his medical office including billing. Her loyalty to respondent is beyond question. She is totally financially dependent on respondent and her often self-serving and exculpatory answers in testimony are understandable. However, she was not a very credible witness. She heroically tried to take the fall for respondent regarding the original $23,000. bill re D[redacted] S[redacted]. It is clear that she was trying to protect her job and her boss.

XII

Respondent's psychiatric practice pays lip service to the principles of community mental health. However, with respect to the treatment of these four patients, it is a perversely distorted caricature. Rather than being guided by family systems theory or any other accepted psychiatric body of knowledge, respondent established in his practice the one big happy family model. Everybody was related to everyone else and patients co-existed together in various stages of perpetual patienthood, ex-patienthood, friendship, employment, or business partnership. It was a commune in which the seriously mentally ill patients became trapped in a sticky spider web of dependence, controlled by respondent.

Respondent is not predatory in the sense that he intentionally seeks to harm his patients. But, somewhere along the way he lost his professional compass and fell victim to the caregiver's delusion of magical healing power. Respondent operated a psychiatric practice in which he was the grand

patriarch of an elaborate extended family. The way that people appeared and then reappeared over the years, indeed over the decades, in various and sundry poses was reminiscent of a long running daytime soap opera. Unfortunately, these were real patients whose distress and difficulty continued long after respondent ceased treating them.

In fairness to respondent these were extremely difficult patients to treat. Their prognosis was not good even if they had been treated properly by respondent. These patients had diagnoses for which the term "cure" was inapposite. However, respondent engaged in a type of practice that failed to recognize the need for autonomy and self determination of each of these patients. What respondent did was practice a form of therapeutic adhocery that ignored the most fundamental notions of boundaries.

Respondent claimed he wanted to be real to his patients and this was a form of treatment which helped them understand relationships. Respondent's relationship with his patients was anything but real. What he was to them was a super hero, giving them money, paying their bills, taking them on outings, investing their money, being their partner, being godfather to their children. Respondent created in his patients an idealized, godlike image of a super benefactor. Unfortunately, what he did was intensify an idealized and parasitic dependence on him. By being a glorified big daddy respondent created relationships with his patients that required from them no accountability.

There is a huge difference between one isolated act of human kindness which might otherwise blur the boundary line and the repeated actions of respondent which accomplished nothing more than to confuse the patients and make them more, not less, dependent on him.

What respondent was to these patients was a puppeteer, a grand Geppetto to his at the time adoring Pinocchios. He stole from them the tiny bit of dignity they had and made them into little stick figures whose strings he pulled.

Dr. Rice very accurately described the various ways respondent clearly stepped over the line delineating good psychiatric practice.

It was and is the standard of care to maintain a treatment relationship as free as possible of other personal connections. A psychiatrist is responsible for one thing - to provide effective treatment to a patient. There is a treatment contract implicit in any psychiatrist/patient relationship which delineates what is expected from the doctor and the patient. The crucial question is what is the goal of the professional relationship. Any activity undertaken is done and evaluated on the basis of how you are moved toward your goal. A patient, especially in psychiatry, is very vulnerable emotionally. The need to maintain a clear separation between doctor and friend, lover, father, financial advisor, employer is paramount in psychiatry. These other relationships contaminate and confuse the therapy relationship.

All patients come to the therapy relationship with a variety of needs. A psychiatrist's job is to help a patient so the patient can become more able to meet their needs. Instead of more independence and freedom from illness these four patients became more slaves to their illness and problem behavior. Rather than enlarging the patient's sphere of resources in the community it shrunk because all of their needs were focused on the respondent and his staff. The goal of treatment is to free the patient form the treatment-to end the treatment with the patient being as free of the bad behaviors as possible. The patient is to learn how to get needs met and pursue an independent life.

When the psychiatrist interrupts and inhibits this it is anti-therapeutic.

There is no difference in the standard of care whether a patient is suffering from a severe disorder such as schizophrenia or less extreme problems like generalized anxiety. It is more important to maintain boundaries with sicker patients who have less ego strength and have problems making good independent judgments. Often, a psychiatrist must function as an auxiliary ego. This happens when a patient is very unclear about the reality of his or her situation, not knowing whether their experiences are real or products of internal mental processes like hallucinations. The psychiatrist job with patients like this is to be clearly allied with that functioning part of their ego that is able to make judgments about what is real. In order to do this the relationship must be free of other contaminating issues. By definition the patient has demonstrated an inability to handle the complexity and richness and variability of normal human interactions. The last thing this patient needs is another relationship that is complicated by more than one contract. The treatment contract with its well defined goal is challenge enough for such a patient and a wise practitioner. A therapy relationship that fosters and indeed promotes multiple contracts regarding employment, investing or friendship injects a virus that kills progress toward the treatment goal.

If a patient has delusions regarding the psychiatrist that he is an all powerful deity, it is important that the psychiatrist limits his role in the patient's life. You must as the psychiatrist help the patient in treatment to distinguish between what is real and what is imagined. You assist the fragile ego of the patient in making accurate judgments.

It is always the responsibility of the psychiatrist to prevent boundary violations. It happens often that a patient is

demanding or initiating boundary violations. (D[redacted] S[redacted] coming to respondent's home.) The patient often wants to expand the psychiatrist function beyond treatment. It is the psychiatrist's duty to remind the patient of the contract-what are we doing here, what have we agreed on. The psychiatrist must teach the patient what is best in the long term, not promote short term gratification.

All four of these complaining witnesses were very needy people. Unfortunately, respondent attempted to gratify these needs directly rather than deal with the treatment contract. He should have said, "My job is to help you find how to get money, lodging friendship and affection." Giving all these things directly discouraged each of them from going out and finding ways to satisfy their own needs.

When respondent opened his home to various patients over the years for holiday celebrations and birthday parties, he simply blurred the treatment role and created an alternate role of friend and social companion that is antithetical to the treatment and the forming of other healthy relationships. Having a patient to his home for the holidays fosters dependency. It invites the patient to fulfill social needs through the doctor rather than encourage the patient to form outside social relationships.

Revelations of details of the psychiatrist's personal life to the patient is burdensome and exploits the patient's need to be needed and creates rather than lessens the patient's dependence. The doctor in effects says, "Not only am I your doctor but you are my confidante." It once again creates a parallel relationship that is antithetical to the treatment goal.

Dr. Rice confirmed and corroborated the testimony of Dr. Rusk and respondent regarding the history of community

psychiatry. The goal of community psychiatry is to treat mental patients in their community rather than in large state hospitals. It coincided with the development of new anti-psychotic medications that allowed patients to be treated in less restrictive ways. The community mental health program was under-funded and patients were often discharged from the state mental hospitals but had no access to community treatment.

Dr. Rice also confirmed the crucial importance of medication management in a psychiatric practice. Medication management was one of the biggest challenges after deinstitutionalization. In the hospital setting it was very easy to monitor drug dispensing. Discharging patients to home, board and care or independent living situations created great problems. It became much more difficult to monitor a patient's compliance with a medication regimen. With the severely mentally ill medication management is of great importance because it is a necessary prerequisite to the use of other palliative measures. Quite simply, if the patient does not take medication in the correct amounts the patient cannot be reached by other forms of treatment.

XIII

V[redacted] M[redacted] filed a complaint against respondent with the San Diego Psychiatric Society in or about October 1985. She sued respondent civilly for professional negligence in the San Diego Superior Court in 1986. There is no credible evidence from any source nor can a reasonable inference be drawn that the Medical Board of California knew or should have known of her complaint or the facts associated with it before mid to late 1989. V[redacted] M[redacted] signed a consumer complaint on May 12, 1989, and sent it sometime thereafter to the Medical Board. It was assigned to Board investigator Cynthia Brandenburg shortly after November 6, 1989.

M[redacted] H[redacted] filed a complaint against respondent with the San Diego Psychiatric Society at some time in 1986. She also sued respondent civilly in San Diego Superior Court in 1987. She filled out a consumer complaint dated October 17, 1989 which was filed with the Medical Board at some time before the end of 1989. There is no credible evidence from any source nor can a reasonable inference be drawn that the Medical Board of California knew or should have known of her complaint or the facts associated with it before late 1989. The investigation of the M[redacted] H[redacted] complaint was also assigned to investigator Brandenburg.

Brandenburg had both complaints before January 1, 1990. Her first action on these files took place on January 2, 1990. Her file log reflects actions taken on this investigation (the H[redacted] and M[redacted] matters) on April 26, June 12, September 7, October 30 and November 14, 1990, January 14, 30, August 5, 14 1991, and February 21, 26, 1992. She completed her investigation and referred it to the Attorney General's office for prosecution on March 5, 1992. It was actually sent to the Attorney General's office in June 1992. The original Accusation was filed on or about November 15, 1993.

The time Brandenburg spent from November 1989 until March 1992 investigating these two complaints was not, under the circumstances, unreasonable. These were complex matters and her testimony reveals the investigation progressing through the stages of information and data collection, interviewing, expert review both by outside medical experts and in-house Board medical consultant. During this time Brandenburg was investigating a third complaint against respondent involving a Mr. P[redacted]. This required information collection and submission to experts for review and analysis which required additional time and effort. Ultimately, the P[redacted] complaint was not referred to the Attorney General's office for action. During this time respondent was

well aware that investigations were ongoing. He was involved also as a defendant in the two civil malpractice lawsuits filed.

XIV

Jesse Grygorcewicz was born in 1953 in England. He came with his parents to the United States when he was three. Shortly after arrival in the U.S. he contracted polio. Unfortunately, this was shortly before the discovery of the Salk and Sabin vaccines and the disease took a devastating toll on him. He has been confined to a wheelchair since.

Despite the long odds and daunting obstacles he graduated from college and earned a Masters Degree in Developmental Psychology from the University of Texas in 1982 and a PhD in Psychology from U.S.I.U. in 1988. Upon completion of his Ph.D. he began accumulating the clinical hours required before he could qualify for licensure as a psychologist in the State of California. While earning hours toward licensure at Alvarado Parkway Institute he met respondent. Sometime thereafter he moved into respondent's office and was being supervised by James Kleckner, Ph.D. While officed with respondent, Jesse Grygorcewicz was a post doctoral intern, obtaining hours toward licensure as a psychologist. He was not employed by respondent or anyone else during this time, getting, as he describes it, the richness of experience but no pay.

Grygorcewicz was first licensed by the California Board of Psychology as a psychologist on August 5, 1991. Before this date, he was unlicensed and was not authorized to hold himself out or represent himself to be a psychologist. Specifically, he was not entitled to hold himself out to the public using any title or description of services incorporating the word psychology, or psychologist.

Respondent's office had stationary prepared for Dr. Grygorcewicz which was used from time to time while he was officed there. This stationary contained a letterhead that improperly identified him as a clinical psychologist. The address and telephone number on the stationary were the same as respondent's.

On May 29, 1989 respondent and Dr. Grygorcewicz signed a report on Dr. Grygorcewicz stationary regarding D[redacted] S[redacted]. This report, exhibit 29 in evidence, was not, as respondent asserts, solely for in house office use. It was intended to be used and in fact was used for the purpose of assisting D[redacted] S[redacted]' lawyers in her personal injury claims. This report was sent to attorney Gordon Madison (who was representing D[redacted] S[redacted] at the time in an accident claim) along with a billing charge for $450 for the report cosigned by respondent and Dr. Grygorcewicz and a charge for $1,500 for the psychological testing performed by Dr. Grygorcewicz on D[redacted] S[redacted].

In August of 1989 Dr. H. C[redacted] was a patient of respondent's. In connection with certain court proceedings against Chaker respondent signed an eight page "psychological evaluation" on the letterhead of Jesse M. Grygorcewicz, Ph.D., clinical psychologist. This report cosigned by respondent and Dr. Grygorcewicz was meant to be used and relied upon regarding important issues. Respondent knew at the time that Dr. Grygorcewicz was not licensed as a psychologist.

On May 20, 1993, respondent testified under oath in a proceeding before the Medical Board of California entitled In the Matter of the Petition for Reinstatement of License of Henry Chaker, M.D., OAH No. L-59932, No. D-4104. During his testimony respondent was asked regarding psychological tests given in 1989 by Dr. Grygorcewicz. He was asked, " Did you have a psychologist

licensed by the State of California administer those tests?" Respondent answered, "Yes."

On January 30, 1992 respondent submitted to the Medical Board of California a letter of recommendation for the reinstatement of Dr. Henry Chaker, exhibit 108 in evidence. The letter is signed under penalty of perjury "Nelson F. Leone, M.D." However, respondent did not in fact sign it; rather he gave his secretary authorization to sign his name.

XV

Complainant established that it incurred $46,860.85 as and for the actual and reasonable costs of investigation and prosecution of the action herein. These costs and expenses are as follows: cost of investigation:

1989 - 1994: $13,060.35
and costs of enforcement: (Attorney General time)
1992 - 1994: $33,800.50

XVI

The standard of proof applied in this case is the standard required by Ettinger v. BMQA (1982) 135 Cal.App.3d 858, and except as herein above found to be true, all other factual allegations of the Accusation and its supplemental filings and assertions by the respondent are found to be unproved or surplusage. All motions, defenses, and arguments not herein determined, or disposed of in the hearing record, are found to be not established by the facts or law.

DETERMINATION OF ISSUES

I

Respondent failed to establish the equitable defense of laches. He contends that the common law doctrine of laches bars the action because the delay between the acts and omissions alleged and the hearing on the Accusation constitutes prejudicial delay and has denied him his rights to due process of law, in violation of the Fourteenth Amendment of the United States Constitution. Both parties concede implicitly that there is no applicable statute of limitations that could limit or bar the action.

"The defense of laches requires unreasonable delay plus either acquiescence in the act about which plaintiff complains or prejudice to the defendant resulting from the delay." Brown v. State Personnel Board (1985) 166 Cal.App.3d 1151, 1159; Conti v. Board of Civil Service Commissioners (1969) 1 Cal.3d 351, 359. "Delay is not a bar unless it works to the disadvantage or prejudice of other parties." Brown, p. 1159. (Emphasis original.)

"Prejudice may not be presumed from delay alone." Shea v. Board of Medical Examiners (1978) 81 Cal.App.3d 564, 581, citing Conti, supra, p.362. "The equitable doctrine of laches is designed to promote justice by preventing surprises through the revival of claims that have been allowed to slumber until evidence has been lost, memories have faded and witnesses have disappeared." Brown, supra, p. 1161. "Where there is no showing of manifest injustice to the party asserting laches, and where application of the doctrine would nullify a policy adopted for the protection of the public, laches may not be raised against a governmental agency." Morrison v. California Horse Racing Board (1988) 205 Cal.App.3d 211, 219.

The appellate decisions agree that the actions of an administrative agency such as the Medical Board of California are subject to the doctrine of laches, with the limitation set forth in Morrison, above. There is a very strong public policy at work in this action, that of protecting the public from incompetent or unethical mental health practitioners, as described in Shea v. Board of Medical Examiners, supra, p. 577, and Dresser v. Board of Medical Quality Assurance (1982) 130 Cal.App.3d 506, 511-514. Absent a showing by Dr. Leone that the delays complained of in this case resulted in "manifest injustice", he may not prevail upon his claim that the action is barred by laches, due to the strong public policy that prevails in matters such as this, which would be nullified if the claim were to be sustained.

Laches in this matter must be evaluated in two parts, for the delay attributable to complaining witnesses M[redacted] H[redacted] and V[redacted] M[redacted], and that attributable to the Board, after its receipt of the complaints.

A. DELAY ATTRIBUTABLE TO M[redacted] H[redacted] AND V[redacted] M[redacted]

It is not disputed that M[redacted] H[redacted] and V[redacted] M[redacted] waited some period of time from the incidents and events complained of, to report Dr. Leone to the Board and complain of his conduct. A four year delay in the bringing of the complaint was not found to be unreasonable in Vaughn v. State Bar (1973) 9 Cal.3d 698, 702, nor was an almost 15 year delay held unreasonable in Rudolph v. Athletic Commission (1960) 177 Cal.App.2d 1, 21-22, absent proof of prejudice. "There is no fixed rule as to the circumstances that must exist or as to the period of time which must elapse before the doctrine of laches can be appropriately applied." Brown v. State Personnel Board (1985) 166 Cal.App.3d 1151, 1159. "That is so because what generally makes delay unreasonable is that it results in prejudice. These two factors are interrelated. It is not so

much a question of the lapse of time as it is to determine whether prejudice has resulted. If the delay has caused no material change in statu quo, ante, i.e., no detriment suffered by the party pleading the laches, his plea is in vain." Brown, p. 1159, Conti v. Board of Civil Service Commissioners (1969) 1 Cal.3d 351, 360.

Under the circumstances of this case the delay by M[redacted] H[redacted] and V[redacted] M[redacted] in bringing their complaints was not unreasonable.

Respondent failed to demonstrate any significant actual prejudice due to M[redacted] H[redacted] or V[redacted] M[redacted] delay in making their complaints. His allegations of prejudice consist predominately of speculations and the implicit assumption that the great length of this delay alone ipso facto prejudiced his ability to defend himself.

Respondent's claims that the delay caused memories to fade, evidence to have been lost and that witnesses have

disappeared had very little actual substantive merit that could clearly be identified as harmful to respondent's defense in its absence. The potential value of these items lost or denied to respondent's defense due to the delay was largely speculative, leaving open contrary speculative inferences that the missing evidence, had it been available at the hearing, could have been as much or more harmful than helpful to the defense. No key essential witness was missing, as was the case in Getty v. Getty (1986) 187 Cal.App.3d 1159, 1170, where the original trustees, essential witnesses, had died during the 39 year delay. No important, crucial evidence was lost. Memories for the most part were quite intact, in contrast to the situation in Gates v. Department of Motor Vehicles (1979) 94 Cal.App.3d 921, where the Department investigator, a key witness, had absolutely no actual

recall of the events due to the delay, and his memory could not be refreshed with a review of his report and the documents. The nature and quality of the prejudice that was found in the decisions concluding prejudice existed are conspicuously absent in this matter.

Respondent's memory was quite good and fully intact. He had little difficulty remembering significant events in the relationships with the complaining witnesses. The delay did not prejudice in any significant fashion respondent's most important line of defense, his own memory of the events.

B. POST-COMPLAINT AND PRE-ACCUSATION DELAY

Respondent contends the Board's delay in investigating and prosecuting the complaint of M[redacted] H[redacted] and V[redacted] M[redacted] has created prejudicial delay. However, respondent did not establish that the Board failed to proceed in a timely fashion with the investigation and prosecution of the matter, as set forth in Finding XIII.

There were no unreasonable delays of any significance after the investigation began. The matter was thoroughly investigated, and experts were retained in order to evaluate the conduct against the relevant standards. This process was expeditious within reason, and was not demonstrated to have been otherwise.

Respondents motion to dismiss regarding laches is made in respect to the H[redacted] and M[redacted] claims only. It is clear, after approximately 40 days of testimony, that respondent has not established the equitable defense of laches.

It is not in dispute that the H[redacted] and M[redacted] claims are quite old. However, the fact in and of itself, is not

determinative. The crucial issue is whether respondent has been prejudiced in a meaningful way by the passage of time.

The fact that respondent is charged with breaches of his professional obligations to H[redacted] and M[redacted] cannot be a surprise to him. He was on notice that H[redacted] had complained about the actions as a psychiatrist to the San Diego Psychiatric Association back in 1986. He was similarly aware of M[redacted] complainant to the Medical Board in 1989 and her civil lawsuit filed in 1986.

Respondent was sued civilly by both H[redacted] and M[redacted] in the 1980's. His attorneys had ample opportunity to investigate and defend. In fact, they took M[redacted] H[redacted] deposition on (4) separate occasions in late 1988 and early 1989. They took M[redacted]'s deposition on (3) separate occasions in 1986, 1987, and 1988.

The passage of time, on balance, has benefited respondent. Both M[redacted] and H[redacted] made charges of sexual misconduct against respondent. These specific allegations of sexual misconduct were not established to a clear and convincing certainly. The factual record was overflowing with information about the alleged events and about the believability and reliability of these two complaining witnesses. The passage of time simply allowed for a broader and more detailed canvass upon which to view these two claims.

The passage of time can be the enemy of the fact finder. It was not in this case. The passage of time created, not confusion, but essential context so that the allegations of sexual misconduct could be fairly assessed.

The issues regarding dual relationship and boundary violations were in many particulars admitted by respondent. In

fact the conduct for which respondent's license is revoked, is not substantially in dispute.

II

It was established by the evidence that respondent aided and abetted another person, Jesse Grygorcewicz in the unlawful practice of psychology and therefore was guilty of unprofessional conduct within the meaning of Business and Professions Code section 2234 by virtue of Finding of Fact XIV. Under different circumstances, this allegation and the facts supporting it might be trifling. However, in the context of this case and respondent's practice, this takes on larger significance. Respondent conducted a medical practice in which the operative mantra was "ignorance is bliss." The totality of the facts in this case reveal a practice totally out of control, where major mistakes are made with regularity. There was and is no oversight or control over the operation of this medical practice where clerical employees write letters for patients, sign respondent's name and bill for $23,000 of medical services for D[redacted] S[redacted] under patently improper circumstances. The hallmark of this type of operation was respondent's pattern of making excuses, blaming others and explaining away wrongdoing with an "I didn't know." This is a medical practice where respondent was and is asleep at the wheel.

Respondent was responsible for providing Dr. Grygorcewicz with the stationary in question and knew full well that it was being prepared for use in litigation. When he sent the amended bill for approximately $2000 he knew what he was doing when he billed $450 for the report and $1500 for the testing.

Respondent did not sign the letter, exhibit 108, but rather had his secretary do so. It was not established by clear and convincing evidence that this was a violation of law.

Respondent did in fact answer yes to the question, "Did you have a psychologist licensed by the State of California administer those tests?" when he testified on behalf of Dr. Chaker in May of 1993. However, there is enough ambiguity in the question to justify respondent's answer. Dr. Grygorcewicz was certainly licensed when the question was asked. Therefore, this does not constitute a violation of law.

III

M[redacted] H[redacted]

It was established by clear and convincing evidence that respondent engaged in grossly negligent conduct in violation of Business and Professions Code section 2234 in his treatment of M[redacted] H[redacted] by failing to recognize her needs and by engaging in a treatment protocol that was antitherapeutic. Respondent violated the appropriate professional boundaries in his dealings with M[redacted] H[redacted].

It was not established by clear and convincing evidence that respondent engaged in acts of sexual abuse and sexual misconduct with M[redacted] H[redacted].

It was not established by clear and convincing evidence that respondent was grossly negligent or negligent in his charting of M[redacted] H[redacted] past history.

It was not established by clear and convincing evidence that respondent was guilty of incompetence in his prescribing of Mellaril or Ritalin to M[redacted] H[redacted].

It was established by clear and convincing evidence that respondent engaged in grossly negligent conduct in violation of Business and Professions Code section 2234 regarding the retraction letter he demanded from M[redacted] H[redacted]. Respondent's actions were, further, acts of dishonesty and corruption related to the qualifications, functions and duties of a physician. Respondents act were clearly motivated by self interest; they directly benefitted him and they were egregious violations of the ethical standards of his profession. This was a cold and calculated act of manipulation of a former mental patient. Respondent knew and took advantage of M[redacted] H[redacted]' weakness, vulnerability, and desire to please him and her fear of his disapproval. His behavior in this regard was reprehensible.

IV

V[redacted] M[redacted]

It was not established by clear and convincing evidence that respondent engaged in sexual misconduct or sexual relations with V[redacted] M[redacted].

It was established by clear and convincing evidence that respondent engaged in grossly negligent acts in violation of Business and Professions Code section 2234 by failing to recognize the needs of his patient and by engaging in a treatment protocol that was anti-therapeutic. His entire professional relationship with V[redacted] M[redacted] was one of blurred boundaries, dual relationships and mixed messages that were completely confusing to his mental patient.

It was not established by clear and convincing evidence that respondent engaged in acts of dishonesty and corruption in his billing practices regarding V[redacted] M[redacted]. Furthermore, it was not established that respondent knowingly made or signed

medical records falsely representing the existence of a state of facts as alleged in paragraph 38 of the Second Supplemental Accusation.

It was established by clear and convincing evidence that respondent has engaged in general unprofessional conduct as defined in Business and Professions Code section 2234 in that he has committed numerous breaches of the rules and ethical code of the medical profession and has acted professionally in ways which are unbecoming a member in good standing of the medical profession and this conduct demonstrates an unfitness to practice medicine.

V

D[redacted] S[redacted]

It was established by clear and convincing evidence that respondent was grossly negligent in his care and treatment of D[redacted] S[redacted] in violation of Business and Professions Code section 2234 by failing to recognize her needs and engaging in a treatment protocol that was anti-therapeutic. Respondent engaged in a course of professional misconduct so outside the limits of professional behavior for a psychiatrist that it boggles the mind. Respondent engaged in multiple, repeated, flagrant boundary violations and impermissible dual relationships with D[redacted] S[redacted]. This course of conduct was particularly inappropriate because of the features of her mental disorder which made her want to test and breach boundaries. Respondent's dealings with D[redacted] S[redacted] did nothing but promote her further dependence on him and frustrated the goals of autonomy and independence.

Respondent's financial dealings with D[redacted] S[redacted] were outrageous and foolhardy. Even taking respondent'

explanations of these transactions at face value, they remain the antithesis of what a mental health professional must be ethically driven to do. D[redacted] S[redacted] was a challenging patient. However, she owned property, raised children, had bank accounts and drove a car. She was ill but she was not incompetent. She had a variety of important needs when she first came to see respondent. The psychiatrist job was to help her, using accepted techniques, so she could become more able to meet her needs. Instead of giving D[redacted] S[redacted] more independence and freedom from illness she became more of a slave to her illness and problem behavior. His tactics rather than enlarging her sphere of resources in the community shrunk it by focusing everything on him and his staff. The goal of treatment is to free the patient from the psychiatrist, to end the treatment with the patient as free of maladaptive behaviors as possible. The patient is to learn how to get needs met and pursue an independent life. Respondent's relationship with D[redacted] S[redacted] inhibited this learning.

It was respondent's professional obligation and responsibility to prevent boundary violations. D[redacted] S[redacted] was the type of patient who was very demanding and tried to initiate breaches of the appropriate boundaries. She tried to expand the relationship beyond therapy. That is why she was initially very willing to have respondent handle her financial affairs and play investment games with him. That is why she showed up often at his home and at the restaurants that he frequented. Respondent, unfortunately, fostered this sick connection and intensified her dependence. He took her autonomy and freedom from her, all in the name of knowing what was best for her.

It was unprofessional conduct for respondent to pay D[redacted] S[redacted] bills. It was a clear violation of the therapy contract by the maintenance of a dual relationship. He became

the banker. He infantilized D[redacted] S[redacted] role and intensified her dependent position in treatment. It was grossly negligent to control her money even if she might have otherwise wasted it on booze, drugs of gambling. Perhaps no clearer example of respondent's double talk is his paying of her gambling debts. If he was holding her money so she wouldn't squander it or gambling, why was he paying her gambling debts at the Boulevard Club. What role was he playing here? The role he most certainly was not playing was the role of the psychiatrist engaged in treatment of his patient.

What respondent did with D[redacted] S[redacted] was to engage in a variety of transactions involving her money with no proper or appropriate purpose. Respondent explained that these transactions were to help her avoid squandering her money and to learn to manage her funds (from picking up the monthly check from S[redacted] R[redacted]). He also told her that all her money was safe despite all these "investments," that she would not be at risk even if they fell through. The truth of the matter is that respondent couldn't, while testifying, keep these transactions straight. He didn't know what they were all for nor did he know what D[redacted] S[redacted] was to get from them. If respondent is unclear and confused and uncertain regarding these transactions, is it any wonder that they were confusing and contradictory and crazy - making for D[redacted] S[redacted]. Respondent, instead of wearing the hat of the mental health professional, was a chameleon with D[redacted] S[redacted]. He was the stern parent, the banker, the philanthropist the moneylender, the friend. He engaged in a course of conduct guaranteed to foster and intensify dependence and defeat the goal of increased autonomy and self sufficiency.

Respondent further shared the details of his own personal life with D[redacted] S[redacted] and this was burdensome and exploited her need to be needed. It furthered rather than lessened her dependence.

It was established by clear and convincing evidence that respondent engaged in dishonest activities in regard to the $3,500 he accepted from D[redacted] S[redacted] by virtue of his misrepresentations to the Social Security Administration. It is well within the standard of care for a physician to assist a patient in report writing. However, respondent's actions regarding Social Security were far beyond the ancillary assistance a doctor's office gives a patient. Respondent was quite simply dishonest in his dealings with the Social Security Administration. The fact that respondent was doing this for the benefit of his patient does not make it proper. Respondent was not "just following orders" as he testified. It was not a misunderstanding as claimed in exhibit 6 in evidence. It intentionally mischaracterized what the $3,500 transaction was. It wasn't "payment for medical services owed to Nelson F. Leone, M.D." as claimed in exhibit 6. Respondent told the Social Security representative that his office staff made an error. In truth the only error that was made was going so far beyond what was appropriate for a patient. It is unprofessional conduct to lie, even if you are doing it for your patient. Somewhere along the line respondent lost his moral compass. In some ways, this issue speaks volumes about respondent's own need to be all powerful and God like to his patients. D[redacted] S[redacted] had a problem. Respondent directly intervened and made the problem go away. He did this by changing the facts, transforming what had been a loan (although to him it wasn't really a loan) into a payment for services rendered which wasn't owed to respondent until he decided to call it payment for past due services. Respondent played fast and loose with the facts here obviously believing that it is alright to lie because you are dealing with a ponderous federal bureaucracy.

Respondent had his own need to be all powerful and all knowing to his patients. He was certainly anything but real to them. He loaned them money, bought them gifts, lied for them,

paid their bills, invested their money, gambled with them, gave them free lodging. His office was not the place that patients came to review their progress or discuss the problems of their heart or mind. It was a cocoon that provided some temporary comfort but no chance for growth. It was a therapeutic dead end for D[redacted] S[redacted] and the other three complaining witnesses.

It was not established by clear and convincing evidence that respondent fraudulently prepared and submitted medical claims for payment to insurance companies regarding patient D[redacted] S[redacted]. The respondent's billing practices were far from ideal and oftentimes downright appalling but the state of the evidence did not sustain a finding to clear and convincing certainty.

It was established by clear and convincing evidence that respondent violated Business and Professions Code section 725 in that he excessively prescribed benzodiazapines to D[redacted] S[redacted] both as un inpatient and an outpatient.

VI

S[redacted] S[redacted]

It was established by clear and convincing evidence that respondent was grossly negligent in violation of Business and Professions Code section 2234 in his treatment of S[redacted] S[redacted] by failing to recognize his needs and engaging in a treatment protocol that was anti-therapeutic. Respondent entered into and maintained multiple dual relationships and serious boundary violations with his patient, and later former patient S[redacted] S[redacted]. Respondent paid his patient's bills, gave him work, paid for lottery tickets, gave him lodging, entered into a partnership, and managed lottery winnings. Respondent made most of S[redacted]'s major life decisions. It is undisputed that S[redacted] had a serious mental illness but it is also clear that he was not

incompetent. He was needy, dependent, vulnerable, easily led, a frightened little man who idealized respondent.

Respondent's testimony that he was in remission and ready to be released, and by implication of course, ready to engage in business deals and investments in lottery betting with respondent is not supported by the weight of the evidence. Rather, this is just another example of respondent's self serving explanation to justify conduct that was unprofessional.

VII

Respondent's conduct as a psychiatrist can be the subject of discipline if he has engaged in acts which are defined as "unprofessional conduct." Unprofessional conduct in the context of administrative discipline refers to acts or omissions which are grossly negligent or incompetent or repeated negligent acts.

Respondent had a duty to perform professional mental health services for clients with that degree of learning and skill ordinarily possessed by reputable psychiatrists practicing in the same or similar locality and under similar circumstances. It was his further duty to use the care and skill ordinarily used in like cases by reputable members of his profession practicing in the same or similar locality under similar circumstances and to use reasonable diligence and his best judgment in the exercise of his professional skill and in the application of his learning, in an effort to accomplish the purpose for which he was consulted. A failure to fulfill any such duty is negligence. Keen v. Prisinzano (1972) 23 Cal.App.3d 275, 279, 100 Cal.Rptr. 82, 84; Huffman v. Lundquist (1951) 35 Cal.2d 465, 473, 234 Pac.2d 34, 38; BAJI 7th Ed. No. 6.00, 6.37. ???

A psychiatrist is not necessarily negligent because he errors in judgment or because his efforts prove unsuccessful. He is negligent only if his error in judgment or lack of success is due to a failure to perform any of the duties required of reputable members of his profession practicing in the same or similar locality under similar circumstances. Norder v. Hartman (1955) 134 Cal.App.2d 333, 337, 285 Pac.2d. 977, 980; Black v. Caruso (1960) 187 Cal.App.2d 195, 9 Cal.Rptr. 634.

A lack of ordinary care defines negligent conduct. Gross negligence, on the other hand, is defined by an error or omission that is egregious and flagrant. "Gross negligence has been said to mean the want of even scant care or an extreme departure from the ordinary standard of conduct." Van Meter v. Bent Construction Co. (1946) 46 Cal.2d. 588, 297 Pac.2d 644. Attempting to categorize degrees of negligence is difficult and oftentimes it is hard to distinguish an act that is very underline negligent from an act that is slightly grossly negligent. Nevertheless, a distinction has been recognized in the law between ordinary and gross negligence and this distinction forms the basis upon which administrative jeopardy attaches to a respondent's conduct.

In this administrative proceeding the complainant has the burden of proof. The term burden of proof has been used in two different contexts. It has been used to refer to the burden of initially producing or going forward with the evidence. It has also been used to mean the burden of proving the issues of the case. It is this second meaning, i.e., the burden of proving the issues of the case that this term is properly used here. Some commentators and experts in the field have suggested substituting the term "burden of persuasion" for the traditional term "burden of proof." Irrespective of the term of art used, this burden means "the obligation of a party to establish by evidence a requisite degree of belief concerning a fact in the

mind of the trier of fact or the court." California Evidence Code section 114. California Evidence Code section 115 further provides that, unless a different degree of proof is required, "a preponderance of evidence is sufficient."

Administrative proceedings are civil in nature and in most situations the standard of proof used is a preponderance of the evidence. Skelly v. State Personnel Board (1975) 15 Cal.3d 194, 124 Cal.Rptr. 14; Perales v. Department of Human Resources Development (1973) 32 Cal.App.3d 332, 108 Cal.Rptr. 167.

However, in proceedings that involve the revocation or suspension of professional licenses, a higher degree of proof is required. This higher degree of proof is "clear and convincing proof to a reasonable certainty." Furman v. State Bar (1938) 12 Cal. 2d 212, 229, 83 Pac.2d 12, 21; Ettinger v. Board of Medical Quality Assurance (1982) 135 Cal.App.3d 853, 185 Cal.Rptr. 601. The application of this higher standard of proof is justified in cases where vested rights are at stake such as the revocation or suspension of existing professional licenses. Clear and convincing evidence is a higher standard than "preponderance of the evidence" but a lower one than "beyond a reasonable doubt." See Evidence Code section 502. "Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind." In re David C. (1984) 152 Cal.App.3d 1189, 1208, 200 Cal.Rptr. 115, 127.

A party to an action meets or establishes its burden of proof by producing evidence. Evidence is defined in California Evidence Code section 140 as follows: "Evidence means the testimony, writings, material objects, or other things presented to the senses that are offered to prove the existence or nonexistence of a fact." Evidence may be either direct or

circumstantial. Direct evidence proves a fact without an inference and, if true, conclusively establishes that fact. Circumstantial evidence proves a fact from which an inference of the existence of another fact may be drawn.

An inference is a deduction of fact that may be logically and reasonably drawn from another fact or group of facts.

There is no distinction in the law between direct and circumstantial evidence as to the degree of proof required; each is a reasonable method of proof. Each is respected for such convincing force as it may carry. BAJI 7th Ed. No. 2.00; Witkin, California Evidence 3d. Ed. section 284.

Although application of the technical rules of evidence is somewhat relaxed in an administrative proceeding, there are still substantial fundamental requirements. Government Code section 11513(c) provides:

> "The hearing need not be conducted according to technical rules relating to evidence and witnesses, except as hereinafter provided. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of the evidence over objection in civil actions. Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions. The rules of privilege shall be effective to the extent that they are otherwise required by statute to be recognized at the hearing

and irrelevant and unduly repetitious evidence shall be excluded."

Relevant evidence is that evidence which has any tendency in reason to prove or disprove any disputed fact that is of consequence to the determination of the action. Evidence Code section 210. Taken together, the Government Code and the Evidence Code create a standard of admissibility that requires the information to be 1) factually important to the determination of a disputed issue; and 2) reliable and trustworthy information that a reasonable person would use in situations where serious decisions were being made.

The Administrative Law Judge, as the trier of fact, must weigh conflicting testimony. As BAJI 7th Ed. No. 2>01 points out, "The testimony of one witness worthy of belief is sufficient to prove any fact. . . The test is not the number of witnesses, but the convincing force of the evidence." See Evidence Code section 411.

The Administrative Law Judge has considered, relied upon and applied the law above cited in finding the facts and determining the issues in this case.

VIII

Despite the approach of the 21st century and the progress of science and technology in advancing our knowledge and understanding of the human body we continue as a culture to struggle with the issue of mental illness and related issues of the human psyche.

Our everyday conversations are replete with the buzzwords of the mental health field-neurotic, Freudian, psychotic, dysfunctional-but many continue to harbor the most

primitive and outlandish views about those who visit a psychiatrist or other mental health professional. Many people discount the words, impressions, opinions of those who have sought treatment for mental or emotional distress. At the same time we are bombarded with the psychobabble of a thousand and one self-help programs in books, magazines or tabloid-type television hawking a cure for what ails ones spirit through this "step" or that "step" or discovering an "inner child" or a "separate reality." Along with this we are constantly reminded in Hollywood movies that falling in love with your therapist is pretty common and pretty o.k.

It is no wonder that as a culture we are so confused about mental health and illness, and the large grey area between the two. We tend to romanticize the almost magical power and efficacy of the therapist and fail to understand that there is an accepted and proved body of knowledge regarding the treatment of mental illness. A psychiatrist does not cure or heal or ameliorate through the force of his love or caring or any other power of personality. A psychiatrist cures or heals or ameliorates through the application of accepted principles of treatment. This is what respondent, in the last analysis, failed to do. He established a standard of care unto himself. He alone practiced this brand of psychiatry. He alone determined what was appropriate for his patients totally disregarding the sound counsel of his peers. Respondent in his therapeutic practices is a maverick but psychiatry is not the wild west nor are its ethics that of the frontier.

There is no doubt that the standard of care is evolving and not static. Respondent would have one believe he is a pioneer, a champion of those shunned and forgotten by this society. He is certainly correct about the shunned and forgotten part of it. But the nature of his practice is not revolutionary

or cutting edge. It is chaotic and inconsistent and by his own expert's candid admission his patients are at risk of harm.

Respondent's transgressions are not limited to the four patients who testified. He candidly admits that his practice does not respect the customary boundaries of traditional psychiatric practice. Respondent argues that boundaries are fluid rather than rigid and this is in some sense true. But for respondent there are no real boundaries-they simply do not apply to his practice. He is thus free to create his own idiosyncratic standard of care and justify it on the basis of his "clinical experience" and vague references to community psychiatry.

Respondent admitted to being a psychiatrist of sorts. He was a psychiatrist when it suited him such as when he billed insurance companies for psychotherapy. He was a psychiatrist when he made entries in his patient's medical chart such as Exhibit 83, where he wrote his plan for M[redacted] H[redacted] as "total image and ego reconstruction." He was a psychiatrist when he wrote to the Department of Motor Vehicles regarding V[redacted] M[redacted] in Exhibit 84 and described what he was doing with her as "intensive psychotherapy." He was, in truth, a psychiatrist at all times. He has conducted a busy hospital and outpatient practice for many years and has used the standard weapons of psychiatry throughout this time. He uses medication and talking. Those are the two basic tools of the psychiatrist. He uses these two tools in a proportion weighted heavily toward medication. However, it is inescapable that the talking part of his practice is of crucial importance to the mental health and growth of his patients. They come to him to talk of the central issues of their existence-their thoughts, feelings and behaviors. The only distinguishing thing about respondent's practice is that he does not do the intensive, insight oriented psychotherapy done by many psychiatrists. Many, although not all, of his patients would not benefit from this intense working through of the

transference. But he does take part in the creation of a professional relationship with all the essential hallmark features of the mental health professional. He claims to provide an environment that fosters and promotes trust and vulnerability and exploration of the issues of his patients thoughts, feelings and behaviors with a goal of patient autonomy and freedom from symptoms. This powerful force of transference and countertransference remain ever present in his practice even though their resolution is not central to his type of practice. What respondent did with his patients is ignore the impact of transference and countertransference on the therapeutic relationship. He pretended they didn't exist. Dr. Rusk, respondent's own expert, admitted that respondent's practice is "unlike any he had ever seen" and that was an "understatement." He also acknowledged that seriously mentally ill patients can respond to psychotherapy during periods of remission. He most eloquently reflected that even severely emotionally distressed people can have moments of compassion and self insight and islands of calm.

Respondent claimed he practiced medication management with support psychotherapy. Unfortunately, he did not practice within the parameters of these well defined modalities. Supportive psychotherapy is directive, persuasive and gives advice. Respondent took this a giant step further. In the guise of helping his patients he made the decisions, he orchestrated their lives. Rather than assisting the patients in learning how to meet their needs, he satisfied them directly by entering into multiple dual relationships with them.

IX

It was established by the evidence that complainant incurred actual reasonable costs for investigation and prosecution of this action in the amount of $46,860.85, pursuant

to Business and Professions Code section 125.3, according to Finding of Fact XV.

Business and Professions Code section 125.3 applies to all investigations and prosecution costs incurred both before and after January 1, 1993.

New (or amended) statutes for recovery of litigations costs will be applied retroactively at any time during the pendency of the case, absent legislative intent to the contrary. (Coast Bank v. Holmes (1971) 19 Cal.App.3d 581, 594.) Litigation cost recovery statutes belong to a subcategory of procedural statutes which can have no effect on substantive rights or liabilities...such statutes are not governed by the presumption against retrocative application of new provisions of law. (Beeman v. Burling (1990) 216 Cal.App.3d 1586, 1606-07.)

Several cases approve retroactive application of new provisions regarding litigation costs. In Olson v. Hickman (1972) 25 Cal.App.3d 930, the case involved a brand new attorney's fee recoupment statute which took effect not only after trial court proceedings were concluded, but also after an appeal had been decided. While the parties awaited finality of the decision, plaintiff was allowed to obtain a stay of the remittitur and bring a motion for award of attorney's fees under newly effective statute. (See also Harbor View Hills Community Assn. v. Torley (1992) 5 Cal.App.4th 343.)

Statutes which increase or decrease allowable litigation costs, even if silent concerning retroactivity, have been consistently applied to cases pending when the statutes became effective. (Id. at p. 347.) This statutes became effective January 1, 1993. This case was pending at that time, and the case still is pending. Accordingly, even the principle

enunciated in the Harbor View Hills case should be applied to the present case.

Respondent argue this is an Ex Post Facto law which precludes retroactive application. However, Ex Post Facto clauses apply only to acts which are the subject of criminal prosecution. They do not apply to civil or administrative proceedings. (Gary v. State Bar (1988) 44 Cal.3d 820, 827-828. Greenbaum v. State Bar (1987) 43 Cal.3d 543, 550.)

Business and Professions Code section 125.3 is procedural, in that it neither creates a new cause of action nor deprives defendant of any defense on the merits. (Strauck v. Superior Court (1980) 107 Cal.App.3d 45, 49.)

Therefore complainant is entitled to recover the reasonable costs of investigation and enforcement.

ORDER

I

Physician and Surgeon's certificate number G 24538 issued to Nelson F. Leone, M.D. is revoked.

II

Respondent shall reimburse complainant Medical Board of California the sum of $46,860.85 as and for the actual cost for investigation and prosecution of this action.

Dated: July 6, 1995

STEPHEN E. HJELT
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant

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

In the Matter of the Accusation Against: NELSON F. LEONE, M.D. 6505 Alvarado Road, Suite 103 San Diego, California 92120 California Physician's and Surgeon's Certificate No. G 24538 Respondent.	CASE NO. D-5508 **ACCUSATION**

COMES NOW complainant Dixon Arnett, who as cause for disciplinary action against the above-named and -encaptioned respondent, charges and alleges as follows:

1. Complainant is the Executive Director of the Medical Board of California, Department of Consumer Affairs, State of California (hereinafter the "Board"), and makes and files this Accusation solely in his official capacity as such and not otherwise.

2. License Status. On or about June 6, 1973, Nelson F. Leone M.D., herein and hereinafter referred to as "respondent," was issued Physician's and Surgeon's Certificate No. G 24538 by the Board, authorizing him to practice medicine in the State of California. At all times herein relevant said certificate was, and now is, in full force and effect.

3. Jurisdiction. This Accusation is made in reference to the following statutes of the California Business and Professions Code ("Code"):

a. Section 2220 of the Code provides, in pertinent part, that the Division of Medical Quality may take action against all persons guilty of violating any of the provisions of the Medical Practice Act, i.e., Chapter 5 of Division 2 of the Code.

b. Section 2227 provides that the Board may revoke, suspend for a period not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act.

c. Section 2234 provides that unprofessional conduct includes, but is not limited to, the following:

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

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(d) Incompetence.

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

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

d. Section 726 provides that any act of sexual abuse, misconduct, or relations with a patient which is substantially related to the qualifications, functions, or duties of the occupation for which the license was issued constitutes unprofessional conduct.

e. Section 725 provides that excessive prescribing of drugs is unprofessional conduct.

4. Summary Of Allegations. This Accusation is brought, and respondent is subject to disciplinary action, pursuant to sections 2234, and 726,[1/] as a result of sexual misconduct and gross negligence during the treatment rendered to patients M.H. and V.M. Respondent is also subject to further disciplinary action pursuant to section 725 as a result of the excessive prescribing of drugs to M.H.

CHARGES & ALLEGATIONS

5. Factual Predicate re: Patient M.H.

a. M.H. began treatment with respondent in 1973 shortly after her divorce from her husband.

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1. In light of the fact the acts alleged to have occurred between respondent and M.H. and V.M. predated 1989, respondent has not been charged with violating section 729, which was amended to the Code in 1989.

b. Respondent treated M.H. for the next ten years. During that period of time, M.H was hospitalized on a number of occasions for depression and suicidal ideation.

c. M.H. became extremely dependent on respondent, working hard to seek his approval.

d. Respondent offered to adopt M.H.'s son, James.

e. M.H. worked for respondent's mother on a number of occasions, cleaning house at one time in preparation for a wedding. M.H. began doing various things for the people working in respondent's office. She would bring food and beer to the staff at night.

f. In 1980 M.H moved into a board and care facility owned by respondent which was located on Peerless Street. Everybody in the facility was a patient of respondent's. M.H. lived there for two years. M.H became the "manager" of the facility, cooking and cleaning up, and taking care of patients. She became distressed by the lack of care being received by the patients at the home. When respondent opened another board and care facility the people who had been in charged at Peerless were moved to the new facility and M.H. was left in complete control of the facility. Respondent had M.H. dispense medications to the patients even though she was untrained to do so.

During this two-year period, M.H. began having sex with the patients. When M.H. told respondent about the first incident during a therapy session, he proceeded to graphically detail his own sexual relationships with women to M.H. M.H. then began having sex with other patients at the facility in an attempt to

please respondent. In her discussions with respondent, he encouraged M.H. to continue to have sex with the patients.

i. M.H. became involved in prostitution. She related this to respondent who, on one occasion asked what she would charge for oral sex.

j. M.H. had sex with respondent on two occasions; once she had oral sex in his office and once she had sexual intercourse in his guest house by the pool. The night of the sexual intercourse, M.H. had a late appointment with respondent during which he gave her a shot for depression. He then took her to his home where she stayed in the guest house and engaged in sex with M.H.

k. In March 1984, M.H left respondent's "care" and began treatment with another doctor.

l. Respondent prescribed Mellaril for M.H. almost consistently from May 1975 through May 1981. From October 1975 on respondent prescribed Ritalin, to which chloral hydrate was added in 1976.

6. Sexual Misconduct As Unprofessional Conduct/Gross Negligence. Business and Professions Code section 726, as well as section 2234, provides that disciplinary action may be taken against any licensee who is guilty of unprofessional conduct. Under section 726, unprofessional conduct includes any act of sexual misconduct or sexual relations with a patient, which is substantially related to the qualifications, functions, or duties of the occupation for which the license was issued.

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Section 2234 subdivisions (b), (c), and (d) provide that unprofessional conduct includes gross negligence, repeated negligent acts, and incompetence.

Respondent is subject to disciplinary action pursuant to Code sections 726 and 2234 by reason of, but not limited to, his conduct in the treatment of M.H., more specifically alleged in paragraph 5, *supra*.

7. Gross Negligence/Repeated Negligent Acts In The Treatment Of M.H. Respondent's conduct constitutes unprofessional conduct/gross negligence within the meaning of section 2234(b) and (c) by reason of, but not limited to, the following: Respondent failed to recognize the needs of his patient, and during the years of his treating M.H. her condition worsened as a result of respondent's actions. The entire relationship with M.H. had blurred boundaries as a result of respondent's actions, such as: M.H working in the board and care facility run by respondent; M.H. bringing food and drink to the staff; respondent encouraging M.H. to have sex with his patients in the board and care; having M.H. work for his family.

8. Failure To Chart M.H.'s Significant Past History - Negligence. Neither respondent's office records, nor the hospital records contained important details of M.H.'s childhood.

9. Excessive Prescribing - Incompetence. Both the Mellaril and the Ritalin were prescribed without appropriate indication and were excessive in amount. Respondent is, therefore, subject to disciplinary action pursuant to Code section 725 by reason of, but not limited to, his conduct in the

treatment of M.H., as specifically alleged in paragraph 5, subdivision (l), *supra*.

10. Factual Predicate re: Patient V.M.

a. V.M. was under the treatment of respondent from September 1979 until March 1985.

b. During the therapy, respondent told V.M. he was interested in her personally.

c. Respondent told V.M. she was sexy, would flirt with her, and said that if she wasn't so sick they, perhaps, would have been together.

d. Respondent told V.M she was so sick only respondent would tolerate her.

e. Respondent introduced V.M. as his daughter to another of respondent's patients.

f. Respondent was V.M.'s son's godfather.

g. Respondent had V.M. working in his office, and had her write in her own progress notes in the chart, as well as a recommendation for treatment.

h. Therapy sessions often involved V.M. and respondent embracing and kissing to the point of respondent getting sexually aroused and telling V.M. he was turned on. Respondent told V.M. during one such hug "I've got a hard-on."

i. Respondent would discuss his relationships with his girlfriends with V.M.

j. Respondent gave V.M. money when she was in financial need.

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k. Respondent gave V.M. cards, letters, and pictures from him signed "your second father," or "Love, Nelson."

l. Between August 1980 and January 1981, V.M. had sexual intercourse on several occasions with a doctor friend of respondent's. When V.M. enlisted respondent's help in the matter, respondent asked her what his friend was like in bed. When in March 1981 V.M. discovered she was pregnant, respondent advised V.M. not to pursue the matter as "it would ruin him."

m. V.M. went with respondent and others from the office to the race track.

n. Respondent had birthday parties for V.M.'s son, and V.M. attended birthday parties for respondent's child.

o. Office visits with respondent often lasted no more than one to five minutes although she was charged for a full session.

p. On one occasion respondent sent V.M. home with a syringe of pain medication she was to administer to herself.

q. When V.M. left respondent's care in March 1985 she was suffering from anorexia nervosa, bulimia, and drug addiction, all of which subsequently improved.

11. Sexual Misconduct as Unprofessional Conduct/Gross Negligence. Business and Professions Code section 726, as well as section 2234, provides that disciplinary action may be taken against any licensee who is guilty of unprofessional conduct. Under section 726, unprofessional conduct includes any act of sexual misconduct or sexual relations with a patient, which is

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substantially related to the qualifications, functions, or duties of the occupation for which the license was issued.

Section 2234 subdivisions (b), (c), and (d) provide that unprofessional conduct includes gross negligence, repeated negligent acts, and incompetence.

Respondent is subject to disciplinary action pursuant to Code sections 726 and 2234 by reason of, but not limited to, his conduct in the treatment of V.M., more specifically alleged in paragraph 10, *supra*.

12. Gross Negligence In The treatment Of V.M. Respondent's conduct constitutes unprofessional conduct/gross negligence within the meaning of section 2234 (b), (c) and (d) by reason of, but not limited to, the following: Respondent failed to recognize the needs of his patient, and during the years of treatment with V.M. her condition worsened as a result of respondent's actions. The entire relationship with V.M. had blurred boundaries as a result of respondent's actions, such as: being the godfather of V.M.'s son; calling her his daughter; signing cards "Love, Nelson"; loaning her money; inviting her to social functions outside the realm of psychotherapy.

WHEREFORE, complainant requests that the Board hold a hearing on the matters alleged herein, and following said hearing, issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 24538 heretofore issued to respondent Nelson Leone, M.D., and/or

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2. Directing respondent to pay the Board the actual and reasonable costs of investigation and prosecution incurred in this case; and

3. Taking such other and further action as the Board deems appropriate to protect the public health, safety and welfare.

DATED: November 15, 1993

DIXON ARNETT
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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

In the Matter of the Accusation Against: NELSON F. LEONE, M.D. 6505 Alvarado Road, Suite 103 San Diego, California 92120 California Physician's and Surgeon's Certificate No. G 24538 Respondent.	CASE NO. D-5508 L-62677 **SUPPLEMENTAL ACCUSATION**

Complainant Dixon Arnett, as further causes for disciplinary action against Nelson F. Leone, M.D. ("respondent"), alleges as follows:

20. Paragraphs 1 through 3 of the original Accusation in the above entitled matter are hereby incorporated by reference as if fully set forth herein.

21. Summary Of Allegations. Respondent is further subject to disciplinary action, pursuant to Code section 2234, as

a result of repeated acts of negligence and gross negligence in his treatment of patients D.S., P.M., H.I., S.S., J.L., B.H. and M.B. Respondent is also subject to further disciplinary action, pursuant to Code section 2234, for the commission of acts involving dishonesty and corruption in the treatment of patient D.S. Finally, respondent is further subject to disciplinary action pursuant to section 725 as a result of the excessive prescribing of drugs to D.S.

ALLEGATIONS

22. Factual Predicate re: Patient D.S.

a. Respondent provided psychiatric treatment for D.S. between April, 1988 and October 30, 1991.

b. Respondent failed, in his initial treatment sessions with D.S., to take an adequate medical or psychological history. In fact, respondent failed to ask D.S. any question regarding her psychological history.

c. Respondent failed to timely diagnose D.S.'s chemical dependency, consistently misdiagnosed frontal lobe syndrome, and did not address her Axis II pathology.

d. In addition to failing to recognize D.S.'s chemical dependency, respondent contributed to the problem by over prescribing the drug group Benzodiazepine. In September of 1989, there were four (4) separate cross-tolerant Benzodiazepines prescribed by respondent for D.S. at one time; Ativan, Xanax, Restoril and Klonopin. In October 1988, there was a prescription of three (3) Benzodiazepines at one time; Restoril, Xanax and Klonopin.

e. When D.S. informed respondent that she was taking the street drug "crystal," [methamphetamine] respondent took no action to dissuade her. In fact, respondent encouraged her use, stating "if it works do it."

f. Respondent failed to do adequate charting regarding his treatment of D.S. For example, D.S. exhibited violent behavior during her treatment with respondent. On one occasion she placed a knife to respondent's throat. On other occasions D.S. would physically grab respondent. Although respondent believed that these actions indicated that D.S. could be violent and that she could probably, at an impulse, strike out and stab him, he failed to note any of that history of violence in D.S.'s chart. Also, although D.S. was supposedly the subject of no less than eight (8) psychological tests during her treatment with respondent, none of their results were included D.S.'s chart notes.

g. When D.S. visited respondent at his homes, including on Fuerte Dr. and at 3034 Helix in Spring Valley, respondent never told her that it constituted inappropriate behavior, never asked her to stop showing up at his house, and never asked her to leave. Respondent failed to realize that by not telling D.S. to stop showing up at his home he was fostering a dependency relationship.

h. On four (4) or five (5) occasions, respondent and D.S. went out directly from his office to restaurants to socialize. While there, respondent would drink and play cards with D.S. Respondent failed to realize that engaging in this

type of social behavior with D.S. further fostered her dependency on him.

i. On occasion, respondent told D.S. that he loved her.

j. Respondent revealed an inappropriate amount of details about his own personal life to D.S. Examples include: (1) claiming that he had to sleep with his social worker to get extra food stamps when he was in medical school; (2) telling D.S. that he now made $350,000.00 a year; (3) claiming that a women had offered him $350,000.00 if he would marry her; and (4) stating that his wife was a manic depressive.

k. On occasion, respondent would pay D.S.'s gambling debts.

l. Respondent's office made payments on a home equity line of credit D.S. had taken on her residence from the Federal Home Loan Corporation. Respondent's secretary, Connie Dawson, actually held the booklet of mortgage payment coupons for D.S.'s home equity line.

m. Respondent engaged in fraudulent activities in regards to $3,500.00 he accepted from D.S. Respondent misrepresented to the Social Security Administration that the transfer constituted payment for services rendered, when in fact respondent had told D.S. that he would not charge her for past services. The fraud was a scam intended to hide D.S.'s assets so that she would have her Supplemental Security Income benefits reinstated.

n. Respondent also engaged in fraudulent activities

by fabricating billing statement dated August 8, 1988, totaling $23,030.00. He then provided the bill to the Law offices of Georggin & Shann, and represented it to be the amount due for medical care D.S. had received as a result of an automobile accident on November 15, 1987. When the billing was corrected by respondent on March 27, 1992, reflecting the correct amount of $2,100.00, respondent failed to notify Georggin & Shann regarding the overbilling.

o. Respondent further engaged in medical fraud in his report concerning D.S.'s medical disorder following the November 15, 1987 accident. In that report respondent grossly minimized the past history and the severity of D.S.'s psychiatric disorders prior to the accident, and shifted the entire weight of the causality of her disorders to the accident.

p. When D.S. eventually received two (2) settlement checks, in the amounts of $8,333.37 and $10,294.79 respectively, for her injuries resulting from the automobile accident of November 15, 1987, respondent exploited his influence to persuade her to sign the checks over to him.

q. Respondent provided D.S. with an attorney, Joe Bryans, to defend her against driving under the influence charges in 1989. Respondent paid D.S.'s legal fees regarding the matter.

r. When, as a result of a driving under the influence conviction in 1989, D.S. was ordered to wear an anklet as an electronic monitoring device, respondent's office paid for the expense. Respondent continued this practice for one year.

s. On or about June 29, 1988, while D.S. was his

patient, respondent borrowed $3,500.00 from D.S. on behalf of Mickey McGuire's Restaurant, 3746 Mission Boulevard. Respondent used his influence to persuade D.S. that loaning the loan would be a good investment. The agreement was memorialized by a document, signed by respondent, entitled "Promissory Note." That note identified the borrower as "Mickey McGuire's Restaurant aka Nelson Leone." To the extent that D.S. was repaid, the money came from respondent's account. Respondent failed to realize that signing the promissory note between himself and D.S. fostered their dependency relationship.

t. On August 22, 1989, also while D.S. was his patient, respondent borrowed another $2,900.00 from D.S. This time the loan was on behalf of respondent's brother Sam Leone and another individual, Sam Rahib, to help finance another restaurant, Mickey's Pizzeria. In this transaction respondent was actually representing D.S. At time respondent persuaded D.S. to make this loan, he was aware that D.S. was suffering from a bipolar affective disorder and that he had prescribed valium for her on an as-needed basis.

u. During a period of time he was treating D.S., respondent regularly paid for many of D.S.'s living expenses. Such expenses included, but were not limited to, her cable, water and phone bills. Respondent has testified he paid such expenses in excess of twenty (20) times.

v. Respondent provided $1,000.00 of his own money for D.S. to acquire a Gran Torino automobile from an individual named Leroy Ceresa.

w. Later, respondent gave D.S. another automobile, a 1977 Mercury, which he had acquired in lieu of fees from another patient, J.L. Respondent led D.S. to believe that he was also providing automotive insurance for the Mercury.

x. Respondent would have D.S. run errands to Mission Beach to pick up money from his associate, Sam Rahib.

y. Respondent arranged for many of his other patients to live in D.S.'s residence. On at least three (3) occasions D.S. expressed her dissatisfaction with the arrangement to respondent. However, respondent would assure her that he would talk to his secretary, Connie Dawson, and they would take care of the problems.

23. Factual Predicate re: Patient P.M. Respondent has testified he paid personal expenses and bills on behalf of P.M. during the time in which P.M. was his patient.

24. Factual Predicate re: Patient H.I.

a. Respondent has testified he paid personal expenses and bills on behalf of H.I. during the time in which H.I. was his patient.

b. Respondent had H.I. live in homes which he owned while she was under his treatment.

25. Factual Predicate re: Patient S.S.

a. Respondent has testified he paid personal expenses and bills on behalf of S.S. during the time in which S.S. was his patient.

b. On or about 1991 respondent entered into an oral agreement with S.S. whereby S.S. was to collect payments for

rentals owning to respondent and pay them over to respondent, for which respondent promised to compensate S.S.

c. On or about December 1990, S.S. won $500,000. in the California lottery. Respondent having gained the confidence of S.S., promised S.S. that S.S. would be a 50/50 partner with respondent in all of respondent's real estate holdings and businesses, and based thereon obtained S.S. delivered his lottery winnings to respondent at respondent's direction. Respondent opened joint bank accounts with S.S. in which lottery funds were deposited. Respondent did not transfer half of the ownership of all his real estate holdings and businesses to S.S.

d. On or about 1990 and 1991 respondent entered into an oral agreement to jointly engaged in gambling in the State of California Lottery/Lotto/Big Spin games with each party agreeing to share costs of tickets and winnings. Respondent would gamble with S.S. and introduced S.S. to gambling at an Indian reservation.

e. On or about 1991 and 1992, respondent loaned money to S.S.

f. On or about 1991, respondent had S.S. live at respondent's home for a period of months.

26. **Factual Predicate re: Patient J.L.** On or about May 15, 1989, respondent purchased an a 1977 Mercury from his patient, J.L., for the price of $1.00. The steep discount reflects the fact that respondent accepted the automobile as appreciation for services he had render to J.L.

27. **Factual Predicate re: Patient B.H.** In 1989,

during a period of time when both B.H. and D.S. were his patients, respondent arranged for B.H. to stay at the home D.S.

28. Factual Predicate re: Patient M.B. Respondent also arranged for another patient of his, M.B., to stay at D.S.'s house to take care of D.S. while she was his patient.

29. Gross Negligence/Repeated Negligent Acts - Unprofessional Conduct. Respondent has further subjected his license to disciplinary action under Code section 2234 on the grounds of unprofessional conduct, as defined by section 2234 subdivisions (b) and (c) of the Code, in that he is guilty of repeated negligent acts and gross negligence as more particularly alleged hereinafter: Paragraphs 22(b), 22(c), 22(d), 22(e), 22(f), 22(g), 22(h), 22(i), 22(p), 22(q), 22(r), 22(s), 22(t), 22(u), 22(v), 22(x), 22(y), 23, 24(a), 24(b), 25(a), 25(b), 25(c), 25(e), 25(f), 26, 27 and 28 above, are incorporated by reference and realleged as if fully set forth herein.

30. Commission of Acts Involving Dishonesty and Corruption - Unprofessional Conduct. Respondent has further subjected his license to disciplinary action under Code section 2234 on the grounds of unprofessional conduct, as defined by section 2234 subdivision (e) of the Code, in that he is has committed acts of dishonesty and corruption which are substantially related to the qualifications, functions and duties of a physician as more particularly alleged hereinafter: Paragraphs 22(m), 22(n), 22(o) and 22(p) above, are incorporated by reference and realleged as if fully set forth herein.

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31. Excessive Prescribing - Incompetence.

It is an extreme departure from the standard of care to prescribe Benzodiazepines to someone who is chemically dependent, and regardless of a patients chemical dependency, to prescribe more than one Benzodiazepine at the same time. Respondent is, therefore, further subject to disciplinary action pursuant to Code section 725 by reason of, but not limited to, his conduct in the treatment of D.S., as specifically alleged in paragraph 22(d), *supra*.

WHEREFORE, complainant again requests that the Board hold a hearing on the matters alleged herein and in the original Accusation, and following said hearing, issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 24538 heretofore issued to respondent Nelson Leone, M.D.; and

2. Directing respondent to pay the Board the actual and reasonable costs of investigation and prosecution incurred in this case; and

3. Taking such other and further action as the Board deems appropriate to protect the public health, safety and welfare.

DATED: July 14, 1994

Richard D. Hendlin FOR
DIXON ARNETT
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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

In the Matter of the Accusation Against: NELSON F. LEONE, M.D. 6505 Alvarado Road, Suite 103 San Diego, California 92120 California Physician's and Surgeon's Certificate No. G 24538 Respondent.	CASE No. D-5508 OAH No. L-62677 SECOND SUPPLEMENTAL ACCUSATION [Cal. Gov. Code, § 11507]

Complainant Dixon Arnett, as further causes for disciplinary action against Nelson F. Leone, M.D. (hereinafter "respondent"), alleges as follows:

33. Complainant incorporates and realleges each and every allegation of paragraphs 1 through 12, and each subpart thereof, of the Original Accusation in the above-entitled matter as if fully set forth herein.

34. Complainant incorporates and realleges each and every allegation of paragraphs 20 through 31, and each subpart thereof, of the Supplemental Accusation filed July 14, 1994, in the above-entitled matter as if fully set forth herein.

STATUTES:

35. This Second Supplemental Accusation is made in reference to the statutes set forth in paragraph 3 of the original accusation and the following statutes of the California Business and Professions Code (hereinafter "Code"):

(a) California Business and Professions Code section 2261 provides that knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine which falsely represents the existence or nonexistence a state of facts constitutes unprofessional conduct.

(b) California Business and Professions Code section 2903 provides in part that "No person may engage in the practice of psychology, or represent himself to be a psychologist, without a license ...."

(c) California Business and Professions Code Section 2902(c) provides in part that "A person represents himself or herself to be a psychologist when the person holds himself or herself out to the public by any title or description of services incorporating the words '...psychologist' or when the person holds himself or herself out to be trained, experienced, or an expert in the field of psychology."

(d) California Business and Professions Code section 2234 provides that the Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct is that conduct which breaches the rules or ethical code of the

medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine.

(e) California Business and Professions Code section 2630 provides, in pertinent part, that it is unlawful for any person or persons to practice physical therapy for compensation received or expected, or to hold himself or herself out as a physical therapist, unless at the time of so doing such person holds a valid unexpired and unrevoked license issued under Chapter 5.7 of the Code. In addition, a physical therapist aide authorized under section 2630 "shall at all times be under the orders, direction, and immediate supervision of [a] physicial therapist" and, at no time, may a physical therapist aide perform physical therapy or render any physical therapy procedure independently.

SUMMARY OF ALLEGATIONS:

36. Respondent has further subjected his license to disciplinary action pursuant to Business and Professions Code sections 2234 and 2261 for the commission of unprofessional conduct in that he committed acts involving gross negligence, repeated acts of negligence, dishonesty or corruption which are substantially related to the qualifications, functions, or duties of a physician and surgeon and knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine which falsely represents the existence or nonexistence a state of facts as more particularly alleged hereinafter.

//

FACTUAL ALLEGATIONS:

37. Patient M.H.:

(a) The allegations of paragraph 5 of the original accusation regarding patient M.H. are incorporated by reference and realleged as if fully set forth herein.

(b) On October 29, 1986, respondent confronted patient M.H. while at Grossmont Hospital. Respondent was angry and told her that the San Diego Psychiatric Society has set a hearing date for November 5, 1986 to investigate him. Respondent demanded that patient M.H. write a retraction to a statement she had earlier written regarding respondent's conduct.. Respondent told patient M.H. what to write down and patient M.H. did as respondent demanded.

(c) The day before the November 5, 1986 hearing by the San Diego Psychiatric Society at which patient M.H. was scheduled to testify, respondent met with patient M.H. at Grossmont Hospital and he demanded she not appear at the hearing. They discussed how much money it would take for her to leave town and respondent took her to his office where he gave her $1,500 in cash to not show up at the San Diego Psychiatric Society hearing and to leave town. Thereafter, patient M.H. did not appear at the hearing.

(d) On September 19, 1987, while patient M.H. was walking to the office of her new psychiatrist located near the Alvarado Parkway Institute, respondent confronted patient M.H. in public in a loud and threatening manner. Respondent demanded that patient M.H. return the $1,500 that he had given her so she would not testify before the San Diego Psychiatric Society in November 1986.

(e) In approximately 1980, respondent took another patient of his, "patient Doe", with him to respond to call from patient M.H. in which she stated she was going to walk down the middle of the street to his office. In so doing, he breached the confidentiality of patient Doe and patient M.H.

38. Patient V.M.:

(a) The allegations of paragraph 10 of the original accusation regarding patient V.M. are incorporated by reference and realleged as if fully set forth herein.

(b) Respondent, through his authorized employees, submitted claim forms to Medi-Cal, Medicare and insurance providers for services he purportedly rendered to patient V.M. which, in truth and fact, were never performed. The dates for which respondent claimed payment for services that were not rendered to patient V. M. include: July 6, 13, 20, 27, August 28, and September 4, 25, 1982, and October 17, 24, 28, 31, November 4, 7, 11, 1983.

(c) Respondent directed patient V.M. to create her own false medical records for various dates including: July 6, 13, 20, 27, August 28, September 4, 25, 1982, October 17, 24, 28, 31, and November 4, 7, 11, 1983. Respondent thereafter initialed said false medical records. Respondent then filed fraudulent claims for payment for services purportedly rendered to patient V.M. on October 17, 24, 28, 31, November 4, 7, and 11, 1983.

(d) Respondent created false medical records regarding treatment of patient V.M. claiming patient V.M. received hot packs, massage, acupuncture, and/or electrical stimulation and psychotherapy on the dates of July 31, August 6, 7, 8, 9, 10, 13, 28, 30, 31, September 4, 7, 11, 14, 18, 21, 25, 28, October 2, 5,

9, 12, 16, 19, 23, November 9, 13, 16, 20, 23, 27, 30, December 4, 7, 11, 14, 18, 21, 24, 1984 and January 8, 11, 15, 18, and February 11, 1985, when, in truth and fact, patient V.M. receive no such treatment on those dates, except as to no more than five (5) of the dates when she may have receive some treatment.

(e) During the time that patient V.M. was respondent's patient, respondent had her working in his office performing physical therapy, including range-of-motion testing and ultrasound, on respondent's other patients even though patient V.M. was unlicensed as a physical therapist or as a physical therapist assistant. On some occasions, patient V.M. was performing physical therapy independently, without supervision of any qualified, licensed physical therapist.

39. Patient D.S.:

(a) The allegations of paragraph 22 of the Supplemental accusation regarding patient D.S. are incorporated by reference and realleged as if fully set forth herein.

(b) Respondent, through his authorized staff, repeatedly fraudulently prepared and submitted medical claims for payment to insurance companies regarding patient D.S.. Respondent used billing codes reflecting respondent had seen patient D.S. for 45 to 50 minutes in psychotherapy at the rate of $110.00 per service. In truth and fact, respondent saw patient D.S. for only five (5) minutes to no more than fifteen (15) minutes. The dates for which respondent fraudulently over-billed insurance companies for services regarding patient D.S. include: October 8 and 23, 1987; January 20, 22, 25, 27, 29, February 1, 2, 3, 4, 5, 8, 10, 12, 15, 17, March 18, May 6, 10, 23, 10, 13, 16, 18, 20, 23, 26,

31, June 2, 7, 9, 14, 16, 18, 20, 23, 23, 27, 30, July 1, 6, 8, 11, 14, 18, 21, 26, August 31, October 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 31, 1988; March 28, April 28, September 23, 24, 25, 26, 27, 28, 29, 1989.

40. Patient S.S.:

(a) The allegations of paragraph 25 of the Supplemental accusation regarding respondent's patient S.S. are incorporated by reference and realleged as if fully set forth herein.

(b) In 1991, respondent and patient S.S. co-signed a $5,000 loan from a Mrs. Horton. The loan was to provide spending money for gambling on the Lotto and for patient S.S.'s personal expenses. Mrs. Horton's check for $5,000 was made payable to respondent who deposited the $5,000 into his personal account and had complete control over it. Respondent may have used some of the money for himself. Respondent never gave patient S.S. any records or reporting regarding the loan which patient S.S. had co-signed.

41. J.G., Ph.D.: Respondent aided and abetted another person, J.G., Ph.D., in the unlawful practice of psychology and thereby committed unprofessional conduct within the meaning of Business and Professions Code Section 2234 by the following acts:

(a) During 1989 and 1990, J.G., Ph.D., was working in respondent's office. During 1989 and 1990, respondent knew that J.G., Ph.D., was not a licensed psychologist.

(b) J.G., Ph.D., was registered as a psychological assistant, under the supervision of James H. Kleckner, Ph.D., from February 1, 1989 to January 21, 1990. Such registration was cancelled effective January 31, 1990. J.G., Ph.D., was

issued a psychologist license by the California Board of Psychology on August 5, 1991.

(c) On May 10, 1989, respondent co-signed a report concerning respondent's patient, D.S., in which respondent and J.G., Ph.D., falsely represented that J.G., Ph.D., was a "Clinical Psychologist", on letterhead falsely identifying J.G., Ph.D., as a "Clinical Psychologist" [hereinafter referred to as "May 10, 1989 report"].

(d) On or about March 27, 1992, respondent sent a bill to attorney Gordon Madison in which respondent included a charge for $450 for the May 10, 1989 report co-signed by respondent and J.G., Ph.D., as well as a charge of $1,500 for psychological testing performed by J.G., Ph.D.

(e) On August 9, 1989, in connection with court proceedings regarding criminal charges against respondent's patient, H.C., M.D., respondent signed an eight-paged "Psychological Evaluation" report regarding respondent's patient, H.C., written on stationary which falsely identified J.G., Ph.D., as a "Clinical Psychologist", and in which appearing immediately above respondent's signature was the signature line for J.G., Ph.D., falsely identifying him as a "Clinical Psychologist." J.G.'s, stationary had the same address and telephone number as respondent's. The letter referred to contacting "our office" at any time.

42. On January 30, 1992, respondent submitted to the Medical Board of California a letter of recommendation for the reinstatement of H.C. (a revoked physician), purportedly signed by respondent under penalty of perjury. In truth and fact,

respondent had not signed the letter but rather had had his secretary sign respondent's name under penalty of perjury. There was no indication on the letter on respondent's stationary that he had not personally signed the letter.

43. On May 20, 1993, respondent testified under oath in a proceeding before a panel of the Medical Quality Review Committee for District XIV of the Medical Board of California in the case entitled In the Matter of the Petition for Reinstatement of License of H. C., M.D., OAH No. L-59932, No. D-4104. During his testimony, in reference to psychological tests given in 1989 by J.G., Ph.D., to respondent's patient H.G., respondent was asked: "Did you have a psychologist licensed by the State of California administer those tests?" to which respondent falsely answered "Yes." In truth and in fact, in 1989, J.G., Ph.D., was not a psychologist licensed in the State of California and this fact was known by respondent.

ADDITIONAL DISCIPLINARY CHARGES:

44. Gross Negligence/Repeated Negligent Acts: Respondent has further subjected his license to disciplinary action under Code section 2234 on the grounds of unprofessional conduct, as defined by section 2234 subdivisions (b) and (c) of the Code, in that he is guilty of repeated negligent acts and gross negligence as more particularly alleged hereinafter: Paragraphs 37, 40 and 41 above, are incorporated by reference and realleged as if fully set forth herein.

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45. Dishonesty and Corruption: Respondent has further subjected his license to disciplinary action under Code section 2234 on the grounds of unprofessional conduct, as defined by section 2234 subdivision (e) of the Code, in that he is has committed acts of dishonesty and corruption which are substantially related to the qualifications, functions and duties of a physician as more particularly alleged hereinafter: Paragraphs 37, 38, 39, 41, 42, and 43 above, are incorporated by reference and realleged as if fully set forth herein.

46. Knowingly Making and Signing Medical Records Falsely Representing the Existence of a State of Facts: Respondent has further subjected his license to disciplinary action under California Business and Professions Code section 2234 on the grounds of unprofessional conduct as defined by section 2261 of the Code in that he knowingly made and signed medical records falsely representing the existence of a state of facts, as more particularly alleged hereinafter: Paragraphs 38, 39 and 41 are realleged and incorporated by reference as if fully set forth herein.

47. General Unprofessional Conduct: Respondent has further subjected his license to disciplinary action under California Business and Professions Code section 2234 on the grounds of general unprofessional conduct as defined by section 2234 of the Code in that he has committed conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged hereinafter: Paragraphs 37, 38, 39, 40, 41,

42, and 43, above, are realleged and incorporated by reference as if fully set forth herein.

PRAYER:

WHEREFORE, complainant again requests that the Board hold a hearing on the matters alleged herein and in the original Accusation, and following said hearing, issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 24538 heretofore issued to respondent Nelson F. Leone, M.D.; and

2. Directing respondent to pay the Board the actual and reasonable costs of investigation and prosecution incurred in this case; and

3. Taking such other and further action as the Board deems appropriate to protect the public health, safety and welfare.

DATED: Janaury 17, 1995.

Richard D. Hurdle, D.A.S. for
DIXON ARNETT
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant