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

In the Matter of the Accusation Against:	)	
	)	
	)	
John Edward Massey, M.D.	)	**File No. 800-2014-005108**
	)	
Physician's and Surgeon's Certificate No. G76734	)	
	)	
	)	
Respondent.	)	
	)	

DECISION EFFECTIVE DATE AFTER JUDICIAL REVIEW

On April 9, 2018, the Medical Board of California issued its Decision in the Matter of the Accusation against John Edward Massey, M.D. with an effective date of May 9, 2018.

On July 7, 2017, respondent filed a Petition for Writ of Administrative Mandamus and Request for Stay in the Superior Court of the State of California in and for the County of Sacramento, Case No. 17CV312747. On or about September 21, 2017, the matter was transferred to the Superior Court of the State of California in and for the County of San Francisco and assigned Case No. CPF-18-516157. On May 3, 2018, the Superior Court issued an Order Granting Request for Stay staying the Medical Board's Decision during the writ proceedings. On July 8, 2019, the Superior Court issued an Order Denying the Petition for Writ of Administrative Mandate. The stay issued on May 3, 2018 remained in place until August 5, 2019, in order to allow respondent time to appeal the Superior Court's ruling to the District Court of Appeal.

On August 1, 2019, the Court of Appeal of the State of California, First Appellate District, Division One, issued an Order denying respondent's Petition for Writ of Mandate and Request for Stay. Since no additional Stays have been granted by any higher Court, the Stay, issued on May 3, 2018, was dissolved and the **Decision became effective August 5, 2019**.

THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF SAN FRANCISCO

JOHN EDWARD MASSEY,

Petitioner,

vs.

MEDICAL BOARD OF CALIFORNIA,

Respondent.

No. CPF-18-516157

ORDER GRANTING REQUEST FOR STAY

The Medical Board of California decided that Dr. John Edward Massey had a consensual affair with a patient in 2013 and voted in 2018 to revoke his medical license. Dr. Massey seeks a stay of revocation while he challenges the Board's order by writ. Massey and the Board agree that a stay is proper if (1) "the public interest will not suffer" and (2) the Board "is unlikely to prevail ultimately on the merits." (See CCP §1094.5(h)(1).)

Public Interest. Dr. Massey, an expert in pain management, declares that some 1,000 patients rely on him for care and medication refills, and his clinic cannot serve those patients without him. Massey also declares that, in more than 20 years' practice, no patient beyond the two[1] in this case has accused him of inappropriate behavior. Further, Massey says the patient who claimed a sexual affair (which he denies) was someone he knew independently of their professional relationship, and the public interest is not implicated.

[1] The Board found that the second patient's claim of impropriety was not supported by the evidence.

The Board's opposition to Dr. Massey's stay request largely does not attempt to rebut his public interest evidence. It says nothing about his 1,000 patients and does not dispute that he has never been disciplined. Instead, the Board criticizes Massey for not agreeing with the accusation of a sexual relationship with the patient.

Merits. Dr. Massey says – and again the Board's opposition does not dispute – that to warrant a stay he need only demonstrate a likelihood of prevailing on one of his writ petition's bases. That basis: license revocation is "an unduly harsh result" for a physician with no prior history of complaints and no disciplinary record. Massey quotes a statute providing that the Board "shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee." (See Bus. & Prof. Code §2229(b); *Borden v. Division of Medical Quality* (1994) 30 Cal.App.4th 874.)

Again, the Board's opposition does little to try to rebut Dr. Massey's points. It instead invokes the powers of a government agency and again criticizes Massey for not conceding a sexual relationship. For present purposes, it suffices to note that powers of government officials are not unbounded.

Dr. Massey's motion for a stay of license revocation during writ proceedings is GRANTED.

Dated: May 3, 2018

Richard B. Ulmer Jr.
Judge of the Superior Court

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

In the Matter of the Accusation Against:	
JOHN EDWARD MASSEY, M.D.	Case No. 800-2014-005108
Physician's and Surgeon's Certificate No. G76734	OAH No. 2017060281
Respondent	

DECISION

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

This Decision shall become effective at 5:00 p.m. on May 9, 2018.

IT IS SO ORDERED April 9, 2018.

MEDICAL BOARD OF CALIFORNIA

By: Kristina Lawson

Kristina Lawson, JD, Chair
Panel B

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

In the Matter of the Accusation Against: JOHN EDWARD MASSEY, M.D. Physician's and Surgeon's Certificate No. G76734, Respondent.	Case No. 800-2014-005108 OAH No. 2017060281

PROPOSED DECISION

Administrative Law Judge Diane Schneider, State of California, Office of Administrative Hearings, heard this matter on February 12-16 and 20-21, 2018, in Oakland, California.

Deputy Attorneys General Carolyne Evans and Alice W. Wong represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California.

Cyrus A. Tabari, Attorney at Law, Sheuerman, Martini, Tabari, Zenere & Garvin, represented respondent John Edward Massey, M.D.

The record closed and the matter was submitted for decision on February 21, 2018.

FACTUAL FINDINGS

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

2. On June 7, 1993, the Board issued Physician's and Surgeon's Certificate (Certificate) No. G76734 to John Edward Massey, M.D. (respondent). Respondent's Certificate was in full force and effect at the times of the acts set forth below and will expire on December 31, 2018, unless renewed.

3. The first amended accusation alleges that respondent committed unprofessional conduct (sexual misconduct, gross negligence, repeated acts of negligence, incompetence, and failure to maintain adequate and accurate medical records) in connection with two of his patients, who received pain management treatment from respondent through their workers' compensation carriers. The patients are referred to as Patients A and B.[1] Respondent denies the charges. He filed a notice of defense and this hearing followed.

Expert testimony at hearing

4. Charles S. Szabo, M.D., Ph.D., has practiced medicine for over 35 years. He has held a Board-certification in anesthesia since 1986, and in pain medicine since 1994. Dr. Szabo previously worked as the Medical Director of the Pain Treatment Center at Kentfield Rehabilitation Hospital. He recently closed his private practice in pain management. Dr. Szabo is currently a utilization review specialist in workers' compensation matters and a medical reviewer for the Board. Dr. Szabo offered expert testimony on behalf of complainant. His expert opinion was persuasive and unrebutted.

Respondent's background

5. Respondent completed his medical degree, his residency in anesthesiology, and a fellowship in pain management at Stanford University. He has practiced medicine for 24 years and is Board-certified in anesthesiology and pain management. He has practiced in the field of pain management with his partner, Peter Abaci, M.D., since 1999.

6. In 2005, Dr. Abaci and respondent opened the Bay Area Pain & Wellness Center (clinic) in Los Gatos. Their clinic includes a Functional Restoration Program (FRP).[2] In opening the clinic, respondent's goal was to help patients transition from pain medications. The clinic was sold to Prospira, a private equity group, in 2012, and then sold again to Integrative Pain Management (IPM) Medical Group, Inc., in 2017. Since selling their practice in 2012, respondent and Dr. Abaci have remained working at the clinic as employees.

7. Respondent testified that as a physician, it is important to him to find out his patients' goals; to listen to them, to act as their advocate, and to treat them with compassion. Nurse practitioners and physician's assistants see clinic patients on many of their visits, but respondent is available for consultations as needed.

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[1] The patients are referred to by letters to protect their privacy.

[2] The FRP employs an integrative medicine model, which includes a team of practitioners, such as acupuncturists, physical therapists, personal trainers, psychologists, art therapists, and yoga instructors.

8. Respondent is married and has two grown children who are pursuing professional degrees. His wife also practices medicine. This is respondent's first disciplinary proceeding before the Board.

Allegations involving Patient A

COMPLAINANT'S EVIDENCE

9. Patient A began receiving pain management treatment from respondent at the clinic in 2008, when she was 45 years old, following industrial orthopedic injuries. Patient A was employed at Applied Materials until January 15, 2008, after she developed repetitive stress injuries and cumulative trauma. Patient A has not worked since 2008. Patient A's diagnoses have included: cervical degenerative disc disease; upper extremity radiculopathy and cumulative trauma disorder; complex regional pain syndrome (CRPS) with sleep and mood (anxiety and depression) disorders related to chronic pain; regional myofascial pain; and carpal tunnel syndrome. Patient A was deemed 100 percent disabled and unemployable as a result of her various conditions. Patient A participated in the clinic's FRP, which is a six-week program designed to help patients manage pain.[3] Patient A received treatment at the clinic until she left in December 2013, as a result of the events that are the subject of this hearing.

10. During her treatment, Patient A experienced depression, sadness, and anxiety about issues in her life and the constant level of her chronic pain. Respondent prescribed medications to treat her depression and anxiety. According to respondent's November 19, 2008, chart note, Patient A "has no pre-industrial psychological history"; respondent opined that Patient A's psychological and psychiatric issues were secondary to her industrial injuries.

11. Patient A expressed intermittent suicidal ideations, without an active plan, to clinic staff[4] in November and December, 2012, and January 4, 2013, about five months before respondent and Patient A commenced their sexual relationship. During a visit in November 2012, Patient A shared with clinic staff that she had been in pain for 10 years and was having trouble coping. She promised not to harm herself, and was instructed by staff to call 911 or proceed to the emergency room if her symptoms became more acute. Patient A's psychological difficulties were exacerbated in December 2012, because she was extremely concerned about her daughter's welfare and their relationship was rocky. After the note on January 4, 2013, the records at the clinic do not contain any notes that Patient A had suicidal ideations in 2013. Patient A has never been hospitalized for psychiatric reasons.

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[3] Patient A's medical records state that she graduated from the FRP on May 2, 2008.

[4] Patient A's providers were: nurse practitioner Linda Joshua on November 8, 2012; respondent on December 4, 2012, and nurse practitioner Risa Bernasconi on January 4, 2013.

12. For the first three years that Patient A was treated by respondent, he treated Patient A appropriately. Patient A had monthly visits with respondent or a nurse practitioner. During the FRP, she had weekly check-in visits with either respondent or a nurse practitioner. Patient A enjoyed participating in the FRP and was motivated to use the techniques offered by clinic staff to ameliorate her symptoms. After she completed the FRP she continued to avail herself of services, such as wellness counseling, at the clinic.

13. Respondent and Patient A occasionally saw each other at high school volley ball games where both of their daughters played.[5] Starting in the end of 2011, respondent started to behave differently towards her. He shared details regarding his daughter's fitting for her wedding dress; he described the wedding planning; he asked her about her daughter; he also asked Patient A if she was involved in a sexual relationship. These comments made Patient A uncomfortable. In 2012, respondent's side hugs advanced to frontal hugs, and then intimate hugs, with her breasts pressed into his chest. Patient A was taken off guard. Respondent also made comments to the effect that Patient A's body "looked hot" and he wanted to "do" her. Patient A understood these comments to mean that he wanted to have sex with her.

14. Respondent continued to increase his physical contact with Patient A at the clinic. He would take her into an exam room when she was at the clinic for other appointments, and he would kiss her. Patient A was embarrassed and initially said no to his sexual advances, but she later acceded to them. On one occasion, respondent stated that he was "excited" and showed Patient A his erection, which was visible from his pants. He also made comments to Patient A regarding her breast size. On another occasion, Patient A was having a hard time getting comfortable on her stomach, as she prepared to receive a cortisone injection from respondent. Respondent commented that the size of Patient A's breasts made it hard for her to comfortably lie on her stomach.

15. Beginning on May 21, 2013, continuing to November 9, 2013, respondent made 54 calls from his cell phone to Patient A's landline at her residence. (Patient A did not have a cell phone during this time period.) Prior to May 21, 2013, respondent had never called Patient A at her home. A lot of the calls were "hang ups." Patient A got caller identification because she wanted to know who kept calling her and hanging up, and discovered that it was respondent. Patient A returned a few calls to respondent during this period.

16. Phone logs show that the calls were made from respondent's cell phone to Patient A's landline on the following dates in 2013:[6] May 21, 22, 23, 24, 25, 29; June 3, 4, 5, 12, 13, 17, 21, 24; July 3, 8, 10, 12, 14, 18, 31; August 4, 5, 11, 13, 14, 29; September 4, 5,

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[5] Respondent's daughters graduated from high school in 2008 and 2010; Patient A's daughter graduated in 2012.

[6] Sometimes respondent made multiple calls on the same day.

18, 19, 20, 25; October 1, 4, 10, 11; and November 9. While 35 of the calls lasted under a minute, and many lasted under five minutes, other calls lasted longer. For example, lengthier calls occurred on May 25 (eight minutes), May 29 (13 minutes), June 21 (25 minutes), August 4 (18 minutes), August 2 (17 minutes), and October 1 (six minutes).[7] The remainder of the calls were under five minutes.

17. Respondent's phone calls related to his sexual and personal relationship with Patient A. None of the calls from respondent were made in connection with her medical care or treatment. Although Patient A made a number of calls to the clinic during this time period, these calls were about clinic business, such as appointments, and were not made to speak with respondent. Respondent never expressed concerns to Patient A regarding her mental health, and she never expressed suicidal ideations to him during any of their calls.

18. Between May 22, 2013, and June 25, 2013, respondent visited Patient A's house five times and they had sexual intercourse. Between July and October 2013, respondent visited Patient A at her home at least four times; and while it appears that they had some physical contact during his visits between July and October, they did not engage in sexual intercourse.

19. None of respondent's visits to Patient A's house were made in connection with her medical care or treatment. During his visits to Patient A's home, respondent never dropped off any forms for long term or social security disability to Patient A. If there were forms to complete, Patient A picked them up and dropped them off during her frequent visits to the clinic. Respondent never expressed concerns to Patient A regarding her mental health, and she never expressed suicidal ideations to him during any of his visits.

20. Patient A documented the dates of her sexual encounters with respondent on her monthly calendar with notations such as "John sex," "JM sex," and "Massey sex." Because they did not use birth control and Patient A was concerned about becoming pregnant, she kept track of when they had sex and when she had her menstrual cycle.[8]

21. Between May and November 2013, when Patient A and respondent were engaged in a sexual or personal relationship, respondent continued to treat Patient A in the clinic, and during some of the clinic visits Patient A and respondent had sexualized encounters (but not intercourse). During the time that respondent was engaged in a sexual relationship with Patient A, respondent prescribed psychoactive drugs, including morphine, Xanax, Dilaudid, Lyrica, Lunesta, and Prozac, to treat her pain and her psychological

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[7] Respondent also made two requests to Patient A to be "Facebook friends." The date of the first request was not established by the record. The second request was made on September 9, 2013.

[8] Patient A also had herself tested for SDT's and HIV on August 30, 2013. Patient A handed respondent the bill and asked him to "take care" of it. Respondent put the bill in his pocket.

conditions.[9] Patient A also continued to receive treatment from other staff at the clinic, such as nurse practitioners, counselors, and other health professionals.

22. Their sexual relationship commenced on May 22, 2013. Respondent called Patient A shortly before 9:30 a.m., and asked if he could come over. Patient A's home was a 10- to 15-minute drive from respondent's office, and a five to seven minute drive from respondent's residence. Shortly thereafter respondent arrived, he told her that he was attracted to her and said "I really want to fuck you." Patient A expressed reluctance about becoming involved with him because he was married. Respondent was persuasive. He explained to her that "things with his wife aren't what they seem to be." They went into the bedroom and had sexual intercourse. He stayed there for about 90 minutes. While they were having sex, respondent's phone kept buzzing. He told Patient A that Dr. Abaci was waiting for him, as they were flying to San Diego in the afternoon to attend the funeral of their colleague and friend, Sam Maywood, M.D. Respondent was running late, so he rushed to get dressed and left without showering. Upon leaving he commented to Patient A that he would be "wearing her" all day. After respondent left, Patient A was shocked and confused because everything had happened so fast.

23. Respondent came over the following day, May 23, and they had sexual intercourse again. He stayed longer, for two to three hours, and was more caring. Several days later, Patient A spoke to respondent on the telephone. (Phone logs reveal that the two spoke on the phone on May 25 for eight minutes.) She cried because she was upset that she had sexual relations with a married man. He replied, "we'll give it some time."

24. Respondent and Patient A had another sexual encounter on June 3, 2013. Phone logs establish that respondent called Patient A at around 11:34 a.m. Respondent came over to Patient A's house during the afternoon of June 3, and they had sexual intercourse. He stayed for about an hour and a half. On June 12, 2013, respondent came over again and had sexual relations with Patient A. During their last tryst, on June 25, 2013, Patient A described respondent as acting angry and rough during their sexual encounter. Respondent held Patient A's head down to perform fellatio. He also placed his penis and fingers inside of Patient A's vagina, which hurt her. This caused her to bleed; respondent noticed the blood on his penis and asked her if she was okay.

25. Patient A was extremely conflicted about her affair with respondent because he was married, and her actions were morally and ethically contrary to her Christian faith. (Patient A is a devoted Christian who is active in her church.) She also felt uncomfortable with their sexual relationship because he was her doctor. When Patient A expressed a reluctance to continue their relationship, respondent told her that he was going through marital difficulties. Respondent shared that things were not how they appeared in his

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[9] After workers' compensation had stopped covering treatment for Patient A's psychiatric conditions, respondent wrote prescriptions to treat her anxiety and depression; and he also tried to get workers' compensation to provide her with coverage for her psychiatric conditions.

marriage: his wife was an alcoholic and had been in a rehabilitation program, and later, Alcoholics Anonymous. Respondent also told Patient A how much he enjoyed being with her and that he had thought about her a lot. Patient A felt better hearing that respondent cared for her.

26. Patient A reached out to her neighbor, Karen Wilson, for help with her extreme emotional upset regarding her relationship with respondent. Wilson testified at hearing to the following facts: Patient A was focused on raising her daughter and did not have a lot of visitors. On a date not established by the record, after respondent and Patient A had engaged in sex, Wilson received a hysterical phone call from Patient A. Wilson came to Patient A's house and found her on the floor, crying uncontrollably. It took Wilson an hour to calm her down. Patient A shared with Wilson that earlier that day, respondent had showed up at her house; they had sex; this was the first time that she had engaged in sexual intercourse in her home; and after he left, Patient A began to feel remorseful. Patient A also shared that she had sexualized encounters with respondent at the clinic. Patient A talked about stopping Bible studies. Wilson discouraged her from doing so and suggested that Patient A seek "wiser counsel" than herself to work through her feelings. Patient A agreed to do so, and sought counsel about her affair with respondent from her pastor, and a woman at her church who is involved with the women's ministry.

27. On Sunday, July 14, 2013, respondent came to Patient A's residence about 2:00 p.m. He was wearing flip-flops and shorts. He shared with Patient A pictures from his high school class reunion and other events in his life. Patient A documented this visit in her calendar and journal, as well as three other visits between August and October 2013.

28. At the time she was having the affair with respondent, Patient A participated in stress management counseling with Karlee Holden, a wellness counselor at respondent's clinic. In her interview with the Board, Holden reported that during a counseling session, Patient A confided that she was involved with someone, but that it was "complicated" because he was married. Holden recounted that Patient A was excited about the love and connection she found in her new relationship, but she also realized that the relationship had limitations because the man was married. Holden also reported that through their sessions, in spite of Patient A's feelings for this married man, she realized that she needed to end the relationship.

29. Patient A later told Holden that the man with whom she was having an affair was respondent. Patient A asked Holden to keep her affair with respondent confidential because she was embarrassed and ashamed and did not want anyone to know about it. Holden, however, reported this to her supervisors. In an email to Holden dated August 4, 2013, Patient A expressed how upset she was that Holden disclosed her affair with respondent to Holden's supervisor:

> I trusted you with what I shared with you was Confidential. I even asked you if what I shared would be shared with anyone in the clinic and you assured me that it would not. After talking

with you last night I find out that you have spoken to another employee at the clinic, without my consent.

. . . . At this time I don't want to get the clinic involved with my private life. It has become complicated and unsettling to me. I do not want this experience; of me reaching out for help, to become a traumatic experience. And it feels like it is becoming that.

30. After Holden reported the incident to the clinic, Prospira launched an investigation. Respondent repeatedly called Patient A and asked her to meet with him in a coffee shop to discuss the investigation relating to their sexual relationship. Patient A did not want to be seen with respondent in public. He persisted, and she finally agreed to meet him.

31. Patient A met respondent at a restaurant for 20 to 30 minutes, on a date not established by the record. Respondent told Patient A that clinic management had questioned him about their affair. He told Patient A that he denied that they were involved in a sexual relationship. He told Patient A that management would be questioning her too. Respondent asked Patient A to deny their affair and report that "nothing had happened." Respondent expressed concerns that if Patient A disclosed their relationship to management that he could "lose his job"; and if he lost his job, he would no longer be her doctor, prescribe her medications, or complete her forms. Patient A was scared by respondent's statements as to the potential repercussions of revealing their affair. In spite of her fear, she told respondent that if asked, she could not lie about it.

32. Patient A told respondent that she did not want to continue their relationship. She asked him to stop contacting her. But he persisted and continued to call and come to her house. Patient A thought that if she told respondent's wife and daughter about their affair, he would stop contacting her. In October 2013, Patient A left a note on what she believed was the car owned by respondent's wife; and she also sent a Facebook message to respondent's daughter to the effect that respondent is a liar and is having an inappropriate relationship. Respondent was upset that Patient A had reached out to his wife and daughter.

33. Prospira contacted Patient A on a number of occasions to interview her regarding her relationship with respondent. For reasons that were not made clear by the record, Patient A was not interviewed by Prospira. Respondent continued his employment at the clinic. Patient A left respondent's practice on December 12, 2013, and transferred her care to Melinda Brown, M.D.

34. Patient A experienced an increase in her anxiety and depression as a result of her affair with respondent. She experienced panic attacks, insomnia, nightmares, and felt unsafe in her home. Paul D. Michaels, M.D., a psychiatrist, performed a qualified medical examination of Patient A on November 1, 2013, to evaluate her psychiatric conditions in

connection with her workers' compensation case.[10] During this evaluation, Patient A told Dr. Michaels that she felt "manipulated or seduced by [respondent] and was not able to say no to his advances that went on between May 2013 up until October 2013."

35. Patient A was reluctant to tell her general practitioner, Tiffany Davies, M.D., about her affair with respondent; Patient A was concerned that Dr. Davies might know respondent or his wife, who is also a physician. In November, 2013, however, Patient A disclosed to Dr. Davies that respondent had abused her.

36. Dr. Michaels encouraged Patient A to report respondent to the police and the Board. She did so. In May 2014, Patient A filed a police report with the San Jose Police Department in which she relayed her consensual sexual encounters with respondent. In July 2014, Patient A was interviewed by the Board, and outlined in detail, her sexual encounters with respondent.

37. Patient A has a difficult time discussing her sexual relationship with respondent, as it is private and embarrassing to do so. Patient A has not sued respondent or Prospira for respondent's sexual misconduct. Her experience with respondent harmed her and changed her. She now only wants to see female doctors.

RESPONDENT'S EVIDENCE

38. Respondent denies that he had a sexual relationship with Patient A. He denies taking her to an exam room to kiss her; or pressing himself into her breasts; or having an erection while Patient A was in the examination room. He also denies making comments about Patient A's breast size because it is "not in his character" and is inappropriate. He maintains that if he made such comments nurses could hear him and would lodge a complaint against him. Respondent maintains that he hugged Patient A about six times, in the context of responding to her emotional pain about her life in general and her relationship with her daughter.

39. Respondent was "incredulous" when he heard that Patient A told Holden that they were involved in a sexual relationship. He claims that when he called Patient A regarding her statement to Holden, that Patient A said that it was a "mistake" and that Holden had "lied."

40. Respondent stated that he does not remember making any of the 54 calls to Patient A between May 21 and November 9, 2013. He further testified that at the time he made the calls, he did not document them because he did not realize that such documentation

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[10] Dr. Michaels diagnosed claimant with major depression, and in his report, concluded that this condition "is a compensable consequence of industrial physical injuries of November 27, 2001 and May 1, 2005."

was necessary. Respondent testified that he shared his cell phone number with his patients, and it was not unusual for them to call him.

41. Respondent admits going to Patient A's residence two times, on two unspecified days, during the spring or summer of 2013. Respondent claims that he visited Patient A's home for the purpose of dropping off forms for long term disability and social security disability. Patient A's medical records do not contain any documentation of his visits to her house, or that he provided her with disability forms.

42. Respondent claims that he called Patient A for the following reasons: He was concerned about her suicidal ideations, how she was feeling about her relationship with her daughter, and on other occasions, he was returning Patient A's calls to the clinic. Respondent's claims are unsupported by Patient A's clinic records: During the time period in question (May to November 2013) there was no documentation in Patient A's file that she had expressed suicidal ideations or that respondent had concerns regarding Patient A's suicidal ideations, or that he had referred for an urgent psychiatric evaluation, or that he advised her to call 911. Respondent stated that he did not document Patient A's suicidal ideations "because at some point, it becomes redundant." (During the time period in which Patient A's clinic records do reflect that she was having suicidal ideations, between November 2012 and January 2013, respondent did not call her.) There was also no documentation in Patient A's medical records that she had called to talk to him, or that he had returned her phone calls.

43. On May 22, 2013, respondent traveled with Dr. Abaci and William George[11] to San Diego to attend Dr. Maywood's funeral,[12] which began at 4:00 p.m. Respondent testified that on the morning of May 22, 2013, he was in the clinic seeing patients; he also talked with Dr. Abaci about out how to support Dr. Maywood's family. Respondent further testified that he had lunch with George and then went to the airport to catch an afternoon flight that left around 1:30 p.m. George testified that he spoke with respondent and Dr. Abaci around 10:00 a.m. on May 22, 2013; he met respondent for lunch at about 11:30 a.m., and then headed to the airport to catch a flight to San Diego that left around 1:15 p.m.

44. Respondent submitted his work schedules on May 22 and 23, and June 3, 12 and 25, 2013, which list his appointments, including cancellations and missed appointments. He claims these schedules provide him with an alibi because, in his view, the various schedules precluded him from leaving his office to have sex with Patient A. Respondent's schedules, however, only set forth his schedule, rather than his actual whereabouts on any

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[11] George is the former CEO of Prospira, a business consultant for the clinic, and a childhood friend of respondent's.

[12] Dr. Maywood was an anesthesiologist and pain management physician who practiced in San Diego. He was a colleague, friend and business associate of respondent's and Dr. Abaci's. Respondent and Dr. Abaci were in the process of helping him develop a FRP in San Diego. Dr. Maywood passed away suddenly.

given day. As such, the schedules do not establish that respondent's work commitments precluded him from driving to Patient A's house and having sex with her on the above dates.

45. On the first day respondent testified at hearing, he stated that his wife was not an alcoholic and had never participated in an alcohol rehabilitation program. When his testimony continued the following day, respondent admitted that he had lied during his previous testimony. He then acknowledged that his wife is an alcoholic and that she had been to alcohol rehabilitation. Respondent maintained, however, that he had never disclosed these facts to Patient A. He offered no plausible explanation as to how Patient A would have known these personal details if he had not told her about them.

46. In his interview with the Board, respondent claimed that Patient A had more than likely "friended" him on Facebook. But, when presented with his Facebook request to Patient A dated September 9, 2013, he admitted that he had initiated this contact. He testified that he often shares details about his life, such as his daughter's wedding pictures, with his patients, and that "about half of the people" on his Facebook page are his patients.

47. Respondent has not received previous complaints that he engaged in sexually inappropriate conduct with patients. Several employees of the clinic, as well as Dr. Abaci, testified at hearing regarding their positive views of respondent:

a. Dr. Abaci was particularly vocal about his beliefs regarding charges against respondent: he regards the allegations of sexual misconduct against respondent as "outlandish, crazy and wild." Dr. Abaci has never seen respondent act inappropriately with patients and it would be out of character for him to do so. Dr. Abaci's view of respondent will not change if he found out that respondent lied under oath.

b. Gelbert Rajo has worked at the clinic since 2007, performing a variety of duties, including resolving technology issues, responding to medical record requests, and checking in patients and "rooming" them. He describes respondent as "very charismatic" and someone who "goes above and beyond" for his patients. Rajo has never seen respondent act inappropriately with patients.

c. Jamie Tsai began working as a nurse practitioner at the clinic in 2011. She left in mid-June 2014 to work for the Palo Alto Medical Foundation in the field of sports medicine, which is her area of interest. She describes respondent as a "great mentor" and has not seen respondent act inappropriately with patients.

d. Chrystal Avila worked at the clinic office from 2006 to 2015. She describes respondent as a popular and honest doctor who was "booked months out." Avila would be shocked to learn that respondent acted inappropriately with patients and never heard anything negative about him.

e. Steven Feinberg, M.D., is a physiatrist and pain management physician. He has known respondent for 30 years. He has a very high opinion of respondent and would be

"very distressed" to find out that the allegations against him were true. In Dr. Feinberg's words, "it's just not him" to have a sexual relationship with his patient.

f. Candy Duenas has worked at the clinic for 18 years. She started working at the front desk and is now a medical assistant. She describes respondent as a "good doctor," "wonderful," and "straightforward." Duenas has not heard of any complaints that respondent engaged in inappropriate conduct towards his patients.

g. Michael Sullivan is a physical therapist and the Director of Rehabilitation Services at the clinic. He has worked at the clinic since 2011. Sullivan would be surprised to hear that engaged in sexual misconduct as respondent has always been appropriate and respectful to his patients and is highly regarded by them. Respondent has been a "good mentor" to Sullivan, and it is "beyond the scope of his imagination that respondent would cross boundaries" with his patients.

CREDIBILITY FINDINGS

48. The outcome of this case depends on the credibility of Patient A and respondent.

49. Patient A's testimony regarding her affair with respondent was corroborated over and over again, by multiple reliable sources: Patient A's phone logs confirm that respondent called her 54 times between May and November 2013. Patient A was aware of personal details regarding respondent's life that he shared with her, such as the fact that his wife was an alcoholic and had been in rehabilitation. Respondent confirmed these facts after initially lying about them at hearing. Patient A was also aware of details surrounding respondent's travel plans to San Diego on May 22, 2013, with Dr. Abaci, to attend Dr. Maywood's funeral.[13] The testimony of neighbor Wilson, Patient A's calendar, her email to Holden, the police report filed with the San Jose Police Department, and the records of Dr. Michaels and Dr. Davies also provided powerful corroboration of Patient A's testimony that she was engaged in a sexual relationship with respondent.

50. While there were a few minor inconsistencies in Patient A's testimony, and while her memory of some of the details of the affair was imprecise (such as the exact times that respondent arrived at her house), this did not detract from the credibility of her testimony, particularly in view of the abundant, credible, and persuasive evidence corroborating the existence of their affair.

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[13] Respondent's busy schedule on May 22, 2013, did not preclude his sexual encounter with Patient A. In fact, Patient A's testimony is made even more believable by her knowledge that she was aware of the buzzing of respondent's phone, and the fact that he was pressed for time to leave for his trip, so much so, that he did not have time to take a shower after they had sex.

51. Respondent continues to deny that his affair with Patient A ever occurred. Instead, he claims that his calls were made in response to her calls or to check up on her mental health, and his visits were made in connection with dropping off disability forms at her house. Respondent's testimony was not supported by Patient A's clinic records. Moreover, respondent offered no plausible explanation for his 54 calls to Patient A; or why Patient A would be aware of his wife's alcoholism and participation in rehabilitation, if he did not tell her about it. Respondent relies heavily on his clinic schedules to establish that he could not have been available to drive over to Patient A's house to have sexual relations with her. Respondent's schedules, however, have limited evidentiary value in that they only set forth his schedule and do not establish respondent's actual whereabouts on the dates at issue.

52. Respondent's denial of his affair with Patient A, and the various explanations he proffered to support his denial, lacked credibility and candor in light of the profuse and trustworthy evidence demonstrating otherwise. The fact that respondent testified untruthfully at hearing regarding his wife's alcoholism and participation in rehabilitation raised additional doubts regarding his veracity, particularly because these facts, known by Patient A, provided powerful corroboration of his affair with her.

EXPERT OPINION REGARDING RESPONDENT'S MISCONDUCT INVOLVING PATIENT A

RESPONDENT'S SEXUAL RELATIONSHIP WITH PATIENT A

53. Dr. Szabo's testimony established the facts set forth in Factual Findings 55 through 57. In medical school, residency, and continuing education, physicians are taught that it is an extreme departure from the standard of care to enter into a sexual relationship with a patient. The standard of care requires the physician to preserve the boundaries of the physician-patient relationship. Sexual relationships between physicians and patients are strictly forbidden for a number of reasons: sexual relations between doctors and patients constitutes a "boundary violation"; there is a disparity of power in that the physician is satisfying his own needs without regard to the patient, who is "basically powerless"; and, such conduct could cause the patient to lose trust and confidence in her physician.

54. These risks are especially present in workers' compensation cases involving chronic pain: these patients are particularly vulnerable since they are dependent on the physician for assistance with completing workers' compensation forms and obtaining pain medication.

55. Gross negligence is an extreme departure from the standard of care that occurs when a physician delivers care that no reasonably prudent physician would deliver. Complainant alleges, Dr. Szabo opined, and it is found, that respondent's acts of engaging in a sexual relationship with Patient A, constitute sexual misconduct, unprofessional conduct, and gross negligence.[14]

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[14] Complainant also alleges that respondent's sexual misconduct constitutes incompetence and repeated acts of negligence. While Dr. Szabo testified that respondent's

FAILURE TO DOCUMENT CALLS, VISITS, AND REFER PATIENT A FOR PSYCHIATRIC CARE

56. Complainant alleges, and Dr. Szabo opined, that respondent committed unprofessional conduct and gross negligence, and did not maintain adequate records, by failing to document his calls to Patient A between May and November 2013, including any alleged concerns that Patient A was suicidal in her file; for failing to contact Patient A's other treating physicians to inform them of his concerns regarding Patient A's mental health; for failing to refer Patient A for an urgent psychiatric evaluation; and, for failing to document that he visited Patient A's home two times for the purpose of dropping off disability forms.[15]

57. According to Dr. Szabo, it was crucial for respondent to document his calls to Patient A since respondent claimed that Patient A had expressed suicidal ideations, which is a potentially life threatening situation. In light of respondent's professed concerns regarding Patient A's suicidal ideations, Dr. Szabo also opined that it was unprofessional conduct and an extreme departure from the standard of care for respondent, who is not a psychiatrist, to have failed to refer Patient A for an urgent psychological evaluation to determine if she posed a risk of harm to herself. Dr. Szabo concluded that respondent's omissions, described above, constituted gross negligence and a failure to maintain adequate and accurate records.

58. Dr. Szabo's testimony regarding the standard of care was persuasive. The allegations of unprofessional conduct, gross negligence and failure to maintain adequate records, however, were not substantiated by the evidence for the simple reason that respondent's testimony that his visits and calls to Patient A were connected to her medical treatment is incredible. The reasons for respondent's visits and calls were related to his sexual relationship with Patient A and not for any legitimate medical reason. And, while respondent's sexual relationship with Patient A constitutes egregious misconduct, his failure to document the calls and visits in Patient A's records that occurred in the context of their affair cannot be deemed unprofessional since they were wholly unrelated to her medical treatment.

Allegations involving Patient B

59. At hearing, complainant amended the first amended accusation as follows: In paragraph 22, line 10, "In August 2011" is replaced by "On May 19, 2014"; in paragraph 23,

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conduct was unprofessional, he did not testify that it constituted incompetence or repeated acts of negligence. As no evidence was presented to support these allegations, no finding can be made that respondent was incompetent and committed repeated acts of negligence when he engaged in a sexual relationship with Patient A.

[15] Dr. Szabo also opined that if respondent visited Patient A's house to drop off social security and long term disability forms, he should have made copies of these forms and placed them in another chart created for this purpose.

line 23, "During one of these visits" is replaced by "After the FRP, during an office visit"; in paragraph 24, line 13, "On two other visits during the FRP" is deleted.

60. While working as a bakery manager at a large supermarket in 2006, Patient B suffered an injury to her right upper extremity. Patient B underwent five surgeries, the last of which was in 2010. Patient B saw respondent for an initial consultation on June 21, 2011, and underwent a multidisciplinary evaluation at the clinic on March 20, 2012, when she was 37 years old.

61. Respondent's diagnoses of Patient B included: right upper extremity CRPS I, right sided hand-shoulder syndrome; diffuse regional myofascial pain; chronic pain syndrome with both sleep and mood disorder, and opioid dependency. When respondent evaluated Patient B in March 2012, respondent noted that she was anxious and depressed, and had what respondent termed "a non-functional right upper extremity." According to her chart notes, Patient B had no history of substance abuse and no psychological history prior to her industrial injury.

62. Respondent believed that Patient B would greatly benefit from participating in the FRP. Patient B commenced the FRP on June 11, 2012, and graduated six weeks later, on July 20, 2012. She attended the program six hours each day for six weeks. At the time of her multidisciplinary evaluation in March 2012, Patient B was three months pregnant, with a September due date. She stood out because at the time, she was the only pregnant participant in the FRP.[16] Patient B's last visit to the clinic was on June 23, 2014, when she saw Antoinette Morley, LMFT. Patient B was discharged from the clinic in a letter dated June 24, 2014. At the time she was discharged from respondent's practice respondent was Patient B's primary treating physician for workers' compensation.

INAPPROPRIATE TOUCHING

63. Patient B testified that on two occasions, once in 2012, when she was pregnant, and once in 2014, respondent touched the sides of her breasts with his hands while she was wearing an examination gown, was unclothed from the waist up, with no chaperone present in the examination room. Patient B also testified that respondent made inappropriate and crude references to Patient B regarding the size of her breasts and her sexual desirability, and that respondent made an inappropriate comment to her husband to the effect that her husband must like young females since he met Patient B when she was 16 years old.

64. Patient B's tearful and emotional demeanor while testifying about these events was consistent with someone who is telling the truth, and there was no motive for Patient B to fabricate these events. However, Patient B's testimony regarding the dates of these

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[16] Patient B's son was born on September 4, 2012. The delivery was difficult, and Patient B was hospitalized for 18 days thereafter. Patient B's complications stemming from the birth lasted one year.

incidents, which happened between four and six years ago, as well as the nature of the incidents, when viewed in conjunction with other evidence at hearing, lacked sufficient certainty, specificity and consistency to meet the clear and convincing evidence standard. This standard requires that the evidence be "sufficiently strong to command the unhesitating assent of every reasonable mind." (*In re Angelia P.* (1981) 28 Cal.3d 908, 919, citing *Sheehan v Sullivan* (1899) 126 Cal. 189, 193.) Thus, while Patient B's testimony that respondent inappropriately touched her breasts and made inappropriate comments to her is believable and probably occurred, it is found that the evidence presented to support these allegations do not, as a matter of law, rise to the level of clear and convincing evidence.

65. As a result of Patient B's experiences with respondent, she no longer trusts male doctors; and when she must see a male doctor, she always takes someone with her to the appointments. It took until November 2012, but Patient B eventually found a female pain management doctor, Dr. Brown. Patient B told Dr. Brown that there were "some inappropriate things that made her uncomfortable" about respondent. Dr. Brown gave her the business card of Board investigator Ralph Hughes, and Patient B contacted him.

66. Respondent testified that he would never inappropriately touch a patient's breast or make inappropriate comments to a patient. Respondent also maintained that he did not remember Patient B, and her presence at the hearing did not jog his memory. As Dr. Szabo astutely noted, respondent's assertion that he did not remember Patient B is "not easily comprehended," given the length of time respondent treated her and the fact that Patient B stood out due to her pregnancy. Additionally, when discussing his decision to discharge Patient B, respondent testified, with emotion in his voice, that he deemed Patient B "unsalvageable" because she was abusing opioids.[17] This testimony is inconsistent with respondent's assertion that he had no memory of Patient B. While from a legal perspective this point is academic, since it has already been found that the allegations were not proven as a matter of law, respondent's testimony, again, raises serious concerns about his veracity.

DISCHARGE FROM CLINIC

67. The letter discharging Patient B from the clinic, dated June 24, 2014, states:

> This letter is to inform you that I will no longer be your physician and will stop providing medical care to you. I will continue to provide routine and emergency medical care to you over the next 30 days while you seek another physician.

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[17] Respondent did not document these concerns in Patient B's chart. In fact, at Patient B's last medical visit to the clinic on June 12, 2014, she was prescribed eight tabs of Norco per day, which was deemed "medically necessary to relieve the effects of the industrial injury."

I suggest you consult the local physician referral service, your county medical society or the yellow pages of your local telephone book as soon as possible so that you may find another physician who will assume responsibility for your care. I will be pleased to assist the physician of your choice by sending him or her a copy of your medical records. Your written authorization is required. Please see staff for this form.

68. A chart note on June 24, 2014, stated that Patient B would be discharged from the practice.

COMPLAINANT'S EVIDENCE

69. Patient B received the discharge letter by certified mail, and called the clinic to speak with respondent. He never returned her call. Patient B asked clinic staff to explain why she was discharged and was unable to obtain an explanation.[18] Patient B also contacted the clinic, by mail and telephone, to obtain copies of her medical records.

70. Respondent did not refer Patient B to another physician; he did not inform the workers' compensation insurance carrier that he would no longer be Patient B's doctor, and a new treating physician was required; and, he did not respond to Patient B's requests for medical records.

71. Patient B was particularly distressed because her psychotherapy appointments at the clinic were cancelled, and she needed them, as they helped her address her pain. She was also upset because the clinic did not help her find another doctor; and she asked for, but was not provided with, a copy of her medical records. Patient B sought assistance from her regular doctor to ensure the continuity of her prescriptions.

RESPONDENT'S EVIDENCE

72. During her last medical appointment with physician's assistant Heather Elledge on June 12, 2014, Patient B was given a 30-day supply of her prescriptions.

73. Respondent was not involved with the process of providing patients with copies of their records, and he did not prepare letters terminating patients from the clinic. At the time that Patient B was discharged from the clinic, Rajo was in charge of creating discharge letters. His practice is to prepare such letters after he receives a note from the provider. Rajo then creates the discharge letter and sends it to the patient. The physician

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[18] Patient B was eventually told that she was dropped from the practice because she surreptitiously recorded an appointment when she was seen by Tsai and because respondent was concerned that Patient B was abusing opioids. These points were not proven, and are also not germane to whether respondent provided her with appropriate information at the time she was discharged.

does not review the discharge letter Rajo sends to the patient. Rajo remembers generating the discharge letter, dated June 24, 2014, to Patient B, placing respondent's electronic signature on it, and sending it to her.

74. The Board's website contains the following statement regarding terminating/severing the physician/patient relationship:

> Although a physician is allowed to sever or terminate the patient/physician relationship, in order to avoid allegations of patient abandonment (unprofessional conduct), a physician should notify patients of the following in writing when the physician wishes to discontinue care:
>
> > The last day the physician will be available to render medical care, assuring the Patient has been provided with at least 15 days of emergency treatment and prescriptions before discontinuing the physician's availability.
> >
> > Alternative sources of medical care, i.e., refer patient to other physicians, by name, or to the local medical society's referral service.
> >
> > The information necessary to obtain the medical records compiled during the patient's care (whom to contact, how and where).

75. The discharge letter to Patient B meets the Board's guidelines to the extent that respondent stated that he would continue to provide Patient B with routine and emergency care; he stated that he would assist Patient B's future doctor by providing him or her with Patient B's medical records upon receipt of Patient B's written authorization; and, he suggested that Patient B call the local medical society's referral service in order to obtain another doctor. Patient B had been prescribed a month's worth of medications on her last visit with Elledge on June 12, 2014; and the discharge letter stated that respondent would provide her with routine care for 30 days.

EXPERT OPINION REGARDING DISCHARGE[19] OF PATIENT B

76. The letter discharging Patient B from respondent's care, dated June 24, 2014, was inadvertently left out of the clinic's initial production of documents to the Board, and was therefore not reviewed by Dr. Szabo when he initially evaluated whether respondent's termination of Patient B deviated from the standard of care.

77. Dr. Szabo was the only expert to testify at hearing; thus, his testimony regarding the standard of care, set forth below, stands unrebutted. According to Dr. Szabo, the discharge letter sent to Patient B, and respondent's termination of her as a patient, was deficient in a number of respects: First, because respondent failed to provide Patient B with an explanation as to why she was being discharged, Patient B did not have an opportunity to talk to respondent to see if treatment could be continued. Second, the standard of care in workers' compensation cases is that physicians treating workers' compensation patients must inform the workers' compensation insurance carrier that he or she will no longer be the treating physician; without this information, the patient could not seek other treatment. Third, respondent failed to provide Patient B with a copy of her medical records. While Dr. Szabo acknowledged that respondent's termination letter dated June 24, 2014, did comply with the standard of care in some respects, it did not change his opinion that the deficiencies outlined above in connection with respondent's termination from the clinic, constituted an extreme departure from the standard of care.

LEGAL CONCLUSIONS

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

2. Unprofessional conduct is grounds for discipline of a physician's certificate pursuant to Business and Professions Code section 2234. Unprofessional conduct includes gross negligence (Bus. & Prof. Code, § 2234, subd. (b)), repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)), incompetence (Bus. & Prof. Code, § 2234, subd. (d)), engaging in sexual misconduct or having sexual relations with a patient (Bus. & Prof. Code, § 726, subd. (a)), and the failure to maintain adequate and accurate patient records (Bus. & Prof. Code, § 2266).

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[19] Inasmuch as the charges that respondent engaged in inappropriate touching and made sexually inappropriate comments to Patient B were not sustained, it is unnecessary to discuss Dr. Szabo's analysis as to whether these comments, if made, deviated from the standard of care.

First cause for discipline (unprofessional conduct, sexual misconduct, gross negligence, repeated negligent acts, or incompetence)

3. By reason of the matters set forth in Factual Findings 13-36, and 49-55, the evidence established that with respect to his sexual relationship with Patient A, respondent committed sexual misconduct, gross negligence, and unprofessional conduct. Accordingly, cause for license discipline exists pursuant to Business and Professions Code sections 726 (sexual misconduct), 2234 (unprofessional conduct), and 2234, subdivision (b) (gross negligence).

4. By reason of the matters set forth in Factual Finding 55, the evidence established that with respect to his sexual relationship with Patient A, cause for discipline does not exist for violations of section 2234, subdivisions (c) (repeated negligent acts), or (d) (incompetence).

5. By reason of the matters set forth in Factual Findings 56 and 58, the evidence did not establish that respondent's failure to document his calls and visits with Patient A, including any concerns about her mental health, and his failure to refer Patient A for an urgent psychiatric evaluation constituted unprofessional conduct. Accordingly, cause for license discipline does not exist for this alleged misconduct pursuant to Business and Professions Code section 2234 (unprofessional conduct), section 2234, subdivision (b) (gross negligence), section 2234, subdivisions (c) (repeated negligent acts), or section 2234, subdivision (d) (incompetence).

Second cause for discipline (unprofessional conduct, sexual misconduct, gross negligence, repeated negligent acts, or incompetence)

6. By reason of the matters set forth in Factual Finding 64, the evidence did not establish that with respect to Patient B, respondent committed sexual misconduct, gross negligence, repeated negligent acts, or that he failed to act competently or professionally. Accordingly, cause for discipline does not exist for this alleged misconduct pursuant to Business and Professions Code sections 726, 2234 (unprofessional conduct), and 2234, subdivisions (b) (gross negligence), (c) (repeated negligent acts), or (d) (incompetence).

7. By reason of the matters set forth in Factual Finding 77, respondent's termination of Patient B from his practice was unprofessional and grossly negligent. Accordingly, cause for discipline exists pursuant to Business and Professions Code section 2234 (unprofessional conduct), and 2234, subdivision (b) (gross negligence).

Third cause for discipline (failure to maintain adequate and accurate patient records)

8. The evidence did not establish that respondent failed to maintain adequate and accurate records for Patients A or B. With respect to Patient A, the allegations were not established because the instances of calls and contacts made by respondent were not for medical reasons, but were part and parcel of respondent's affair with Patient A. (Factual Finding 58.) With respect to Patient B, the first amended accusation alleges that respondent's records are deficient in that they failed to include a letter of discharge in Patient B's file, and because

respondent failed to document the physical examinations on Patient A that were alleged to have occurred. These allegations were not proven. (Factual Findings 63-64, 67.) Accordingly, cause for license discipline for this alleged misconduct does not exist pursuant to Business and Professions Code section 2266, in conjunction with Business and Professions Code section 2234, subdivision (a).

Disciplinary determination

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

In determining whether or not a licensee is sufficiently rehabilitated to justify continued licensure, it must be kept in mind that, in exercising its licensing functions, protection of the public is the highest priority of the Board. The Board seeks to ensure that licensees will, among other things, be completely candid and worthy of the responsibilities they bear by reason of their licensure. The outcome of this case, therefore, turns on whether respondent has taken responsibility for his misconduct and taken steps to rehabilitate himself to the extent that he can be trusted to practice medicine in a manner consistent with public safety.

At the outset of this analysis, it is noted that respondent has earned the respect of his colleagues and employees, and he has not been previously disciplined by the Board. Respondent's misconduct in the instant case, however, is particularly egregious, and is further exacerbated by a host of aggravating factors. Under these circumstances, in order to remain licensed, respondent must make a particularly strong showing of rehabilitation.

Respondent coaxed Patient A into having a sexual relationship in spite of her reluctance. After the affair was brought to the attention of clinic management, respondent asked Patient A to lie about it. At hearing, he used Patient A's prior history of suicidal ideations as justifications for his calls. Respondent's misconduct and his testimony at hearing reflect an egregious betrayal of the trust Patient A placed in him. Patient A suffered significant emotional distress as a result of respondent's misconduct, and she was particularly vulnerable, given her chronic pain, mood disorders, and dependency on respondent as her workers' compensation physician. Respondent's misconduct is further aggravated by his pattern of dishonesty, in that he lied under oath during his Board interview and at hearing regarding the existence of the affair. His false testimony regarding his wife's alcoholism and treatment is also particularly troubling, because these facts, known by Patient A, provided powerful corroboration of his affair with her.

At hearing, complainant argued that revocation of respondent's Certificate is necessary to protect the public. Respondent contended that the first amended accusation should be dismissed; this contention is inapposite to the instant discussion in light of the findings of extremely serious misconduct, and is therefore not addressed. As a backup position, respondent requests that if it is found that he committed misconduct, placing his Certificate on probation is sufficient to protect the public. Had respondent testified truthfully at hearing, taken responsibility for his extremely serious misconduct, and taken substantial steps to rehabilitate himself, his suggestion that a lengthy term of probation would be sufficient to protect the public might be persuasive. Not one of these factors, however, exist in the instant case.

As the California Supreme Court has observed, "Fully acknowledging the wrongfulness of [one's] actions is an essential step towards rehabilitation." (*Seide v. Committee of Bar Examiners* (1989) 49 Cal.3d 933, 940.) In the instant case, respondent's repeated denials of his misconduct reflect that he has not taken an essential first step towards his rehabilitation. Because the record is devoid of any evidence of rehabilitation, and in light of respondent's lack of candor with the Board and at hearing, the Board lacks assurances that respondent can be trusted to perform licensed activities in a manner consistent with public safety. Against this background, protection of the public requires revocation of respondent's Certificate.

ORDER

Physician's and Surgeon's Certificate No. G76734, issued to respondent John Edward Massey, M.D., is revoked pursuant to Legal Conclusions 3 and 7, jointly and individually.

DATED: March 23, 2018

DocuSigned by:
Diane Schneider
B77EF67ORA7A431

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Administrative Law Judge
Office of Administrative Hearings

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

In the Matter of the First Amended Accusation Against: **John Edward Massey, M.D.** **15047 Los Gatos Blvd, #200** **Los Gatos, CA 95032** **Physician's and Surgeon's Certificate No. G76734,** Respondent.	Case No. 800-2014-005108 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

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[1] The term "Board" means the Medical Board of California. "Division of Medical Quality or "Division" shall also be deemed to refer to the Board (Bus & Prof. Code Section 2002).

2. On or about June 7, 1993, the Board issued Physician's and Surgeon's Certificate Number G76734 to John Edward Massey, M.D. (Respondent). Respondent's certificate is renewed and current with an expiration date of December 31, 2018.

JURISDICTION

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

4. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

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

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

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

6. Section 726 of the Code states:

(a) "The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under thisor under any initiative act referred to in this division."

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

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

PERTINENT DRUGS

8. The following controlled substances and/or dangerous drugs are involved in this proceeding:

A. **Dilaudid**, is a trade name for hydromorphone hydrochloride, whose primary therapeutic use is relief of pain. Dilaudid is a hydrogenated ketone of morphine and is a narcotic analgesic. It is a dangerous drug as defined in section 4022 and a schedule II controlled substance

as defined by section 11055, subdivision (d) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (d) of Title 21 of the Code of Federal Regulations. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, Dilaudid should be prescribed and administered with caution. Side effects include drowsiness, mental clouding, respiratory depression, and vomiting.

B. **Lunesta**, is a trade name for eszopiclone, which is a nonbenzodiazepine hypnotic agent that is indicated for the short term treatment of insomnia. It is a dangerous drug as defined in section 4022 and is a Schedule IV controlled substance as defined by Section 1308.14 (c) of Title 21 of the Code of Federal Regulations.

C. **Lyrica**, is a tradename for pregabalin that is indicated for neuropathic pain. It is a dangerous drug as defined in section 4022 and is a schedule V controlled substance as defined by Section 1308.14 (c) of Title 21 of the Code of Federal Regulations

D. **Morphine,** is for use in patients who require a potent opioid analgesic for relief of moderate to severe pain. Morphine is a dangerous drug as defined in section 4022, a schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations. Morphine can produce drug dependence and has a potential for being abused. Tolerance and psychological and physical dependence may develop upon repeated administration.

E. **Hydrocodone bitartrate with acetaminophen**, which is known by the trade names Norco or Vicodin, is a semi-synthetic opioid analgesic. It is a Schedule II controlled substance as defined by section 11055, subdivision (b) of the Health and Safety Code, and is a Schedule II controlled substance as defined by section 1308.13 (e) of Title 21 of the Code of Federal Regulations[2], and is a dangerous drug as defined in Business and Professions Code section 4022.

[2] Effective 10/06/2014, all hydrocodone combination products were re-scheduled from Schedule III to Schedule II controlled substances by the Federal Drug Enforcement Agency ("DEA"), section 1308.12 (b)(1)(vi) of Title 21 of the Code of Federal Regulations.

F. **Prozac,** a trade name for fluoxetine hydrochloride, is an antidepressant used to treat multiple conditions including major depressive disorder. Prozac is a dangerous drug as defined in section 4022.

G. **Xanax,** is a trade name for alprazolam tablets. Alprazolam is a psychotropic triazolo analogue of the 1,4 benzodiazepine class of central nervous system-active compounds. Xanax is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022, a schedule IV controlled substance and narcotic as defined by section 11057, subdivision (d) of the Health and Safety Code, and a Schedule IV controlled substance as defined by Section 1308.14 (c) of Title 21 of the Code of Federal Regulations. Xanax has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other CNS depressant drugs during treatment with Xanax.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct and/or Sexual Misconduct and/or Gross Negligence and/or Repeated Negligent Acts and/or Incompetence)

9. Respondent is subject to disciplinary action under sections 2234 for unprofessional conduct, 726 for sexual misconduct, 2234(b) for gross negligence, 2234(c) for repeated negligent acts, and 2234(d) for incompetence in his care and treatment of Patient A.[3] The circumstances are as follows:

PATIENT A

10. In 2008, Patient A (a 45 year old female), came under the care of Respondent, an anesthesiologist and pain management doctor. Patient A was referred to Respondent for pain management by her worker's compensation carrier after an industrial injury and remained under the continuous care of Respondent through December 2013. Patient A was diagnosed with cervical degenerative disc disease, upper extreme radiculopathy, upper extremity cumulative trauma, complex regional pain syndrome, and sleep and mood disorder.

[3] The patient will be identified as Patient A to protect her identity and privacy. The Respondent may learn the patient's information through the discovery process.

11. Between May 2013 and June 2013, Respondent engaged in a sexual relationship with Patient A. Respondent and Patient A had unprotected sexual intercourse approximately on five occasions at Patient's A's home. Patient A reported the sexual relationship to her other treating physicians.

12. Respondent visited Patient A at her home on multiple occasions between May and October of 2013. During his Medical Board interview on March 27, 2015, Respondent reported that he had been to Patient A's home on two occasions to drop off disability forms. Respondent failed to document in the patient's medical record that he had ever visited Patient A at her home or the reasons for any such visit.

13. Telephone records document that Respondent called Patient A's home numerous times between May 22, 2013 and November 9, 2013. During his Medical Board interview, Respondent stated that he had many telephone conversations with Patient A because he was worried that Patient A was suicidal and he did not want her to harm herself.

14. Respondent's medical records contain no indication that he believed that Patient A was suicidal or that he had spoken with her by telephone regarding concerns for her mental health. Respondent made no attempts to contact Patient A's other treating physicians to inform them of his concerns regarding Patient A's mental status, and he conceded in his Board interview that he did not know the name of Patient A's primary treating physician. Respondent failed to at any time refer Patient A for an urgent psychiatric consultation.

15. During Respondent's sexual and personal relationship with Patient A, Respondent actively prescribed psychoactive drugs to Patient A, including Xanax, Dilaudid, Morphine, Lyrica, Lunesta, and Prozac. Respondent documented in Patient A's medical record on or about May 21, 2013, that management of Patient A's psychologic distress was outside the realm of his expertise as an anesthesiologist. Respondent, nevertheless prescribed medications to treat Patient A's psychological condition. Respondent failed to refer Patient A for treatment of her psychological distress.

16. Patient A reported her sexual relationship with Respondent to a counselor at the clinic where Respondent was treating Patient A. The counselor reported the sexual relationship to her

supervisors, who initiated an internal investigation. During this investigation, Respondent asked Patient A to say that nothing inappropriate had happened between them.

17. Respondent's conduct in engaging in a sexual relationship with Patient A, to whom he was prescribing numerous dangerous drugs and controlled substances for treatment of pain and mental health issues, and whom he knew to have serious mental health issues, constitutes unprofessional conduct and sexual misconduct with a patient, and is cause for discipline pursuant to sections 2234 and 726 of the Code.

18. Respondent's conduct in failing to properly manage professional boundaries and in entering into a sexual and personal relationship with Patient A, constitutes unprofessional conduct pursuant to section 2234. It also constitutes gross negligence within the meaning of section 2234(b), and/or incompetence within the meaning of section 2234(d).

19. Respondent's failure to document his alleged concerns regarding Patient A's mental health, failure to document his telephone contacts with the patient in this regard, and his failure to refer Patient A for an urgent psychiatric consultation and for treatment, constitutes unprofessional conduct pursuant to section 2234, gross negligence within the meaning of section 2234(b) and/or repeated negligent acts within the meaning of 2234(c) and/or incompetence within the meaning of 2234(d).

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct and/or Sexual Misconduct and/or Gross Negligence and/or Repeated Negligent Acts)

20. Respondent is subject to disciplinary action under sections 2234 for unprofessional conduct, 726 for sexual misconduct, 2234(b) for gross negligence, and 2234(c) for repeated negligent acts in his care and treatment of Patient B.[4] The circumstances are as follows:

PATIENT B

21. In 2011, Patient B (a thirty-seven year old female), came under the care of Respondent. Patient B was referred to Respondent by her worker's compensation carrier for pain

[4] The patient will be identified as Patient B to protect her identity and privacy. The Respondent may learn the patient's information through the discovery process.

management of a right wrist and arm industrial injury. She remained under the care of Respondent through approximately June 2014. Prior to being referred to Respondent, Patient B had undergone five surgical procedures on her right arm and wrist. Respondent diagnosed Patient B with complex regional pain syndrome type I involving the right upper extremity[5] (CRPS). He also diagnosed hand-shoulder syndrome, diffuse regional myofascial pain, left shoulder pain related to overuse of the right upper extremity, chronic pain syndrome with both sleep and mood disorder, and opioid dependency. Respondent felt that Patient B's condition was so complex that her treatment would require a multidisciplinary pain treatment through a functional restoration program at the pain clinic where Respondent practiced medicine ("pain clinic").

22. In August 2011, Respondent performed a stellate ganglion block to treat the patient's CRPS. Before performing the procedure, Respondent made an inappropriate comment that offended Patient B and her husband. Essentially, Respondent asked Patient B's husband how long he had been together with Patient B. Patient B's husband responded that he had known Patient B since she was 16 years of age. Respondent then made a comment about Patient B's husband "getting them while they were young." Patient B and her husband took the comment to mean that Patient B's husband liked young girls. Patient B and her husband appeared visibly shocked by the comment. Respondent's nurses noticed their reaction and explained to them that they should not be offended because Respondent is "just a big flirt."

23. On or about June 11, 2012, Patient B began the recommended six-week functional restoration program (FRP) at the pain clinic. During the program, Patient B was in her third trimester of pregnancy. In this program, Patient B was provided multidisciplinary treatment five days a week for approximately six hours a day. Respondent would see Patient B on a weekly basis for medical evaluations during the FRP. During one of these visits, Respondent examined Patient B in a way that made her feel uncomfortable. Initially, Patient B was asked by a nurse to remove all clothing from the waist up and put on an examination gown. Patient B put on the

[5] Complex Regional Pain Syndrome (CRPS) is a chronic pain condition that affects a person's arms, legs, hands, or feet. The condition usually occurs after some kind of injury or trauma to the area. CRPS is thought to be the result of damage or malfunction of central or peripheral nervous system. CRPS type 1 is also known as Reflex Sympathetic Dystrophy Syndrome (RSDS). CRPS can cause excessive or prolonged pain.

gown with the opening on the back as it is usually worn. Respondent, however, instructed the patient to move the gown so that the opening was in the front rather than the back. While she adjusted her gown to Respondent's specifications, Respondent did not leave the room but rather turned away from the patient and faced the opposite wall. Respondent then proceeded to examine the patient and ran his hand up and down the side of the patient's torso with her breasts exposed. Respondent touched the sides of Patient B's breasts. There was no chaperone in the room. Patient B had no complaints of pain or injury in the areas that Respondent touched and he did not explain why he was examining her in this manner. Given that Respondent did not explain to Patient B why he was examining her torso and breast area, she was not sure if the examination was for a legitimate medical reason. Respondent did not document this physical examination in the medical record nor did he indicate in the chart that there was a concern about a spread of CRPS to the torso.

24. On two other visits during the FRP, Respondent made inappropriate comments to Patient B while she was pregnant. On one occasion, Respondent glanced at Patient B's chest area and commented that her baby would be well fed. Patient B took Respondent's comment as a reference to the size of her breasts during her pregnancy. On a separate visit, Respondent also commented that when Patient B's child was older, she would be considered a MILF. Patient B understood MILF to mean "mother I would like to fuck." Approximately eight weeks after Patient B completed the FRP, she delivered her child.

25. In 2014, after the birth of her child, Respondent examined Patient B in a way that made her feel uncomfortable. Patient B was asked to put on an examination gown. Respondent asked her to wear the gown so that the opening was in the front. Respondent proceeded to place his hands underneath her gown, put his hands inside her armpits, and run his hands down the sides of her breasts. Patient B had no complains about breast pain. During this examination, unexpectedly, Respondent asked Patient B how breastfeeding was going. Patient B responded that she was unable to breastfeed. During this examination, there was no chaperone in the room. There was no record of this examination in the medical record nor was there any indication in the chart that there was a concern about a spread of CRPS to the torso.

26. After the June 2014 visit, Respondent improperly terminated Patient B as a patient. A letter of discharge was not present in the medical records and assurances of emergency care were not provided. It was not clearly documented in the medical record whether Patient B was provided with prescriptions for the treatment of her chronic and severe medical condition. Patient B was not provided with information on how to obtain her medical records, which is necessary for continued care. There was also no documentation in the medical records that Patient B's worker's compensation insurance carrier was notified that Respondent would no longer be the treating physician.

27. Respondent's failure in properly managing professional boundaries by making comments about Patient B's breast size, sexual desirability, and young age at which she met her husband, and performance of medically unnecessary physical examinations constitutes unprofessional conduct pursuant to section 2234, and/or gross negligence in violation of section 2234(b), and/or repeated negligent acts in violation of 2234(c), and sexual misconduct in violation of section 726.

28. Respondent's failure to properly terminate the patient/physician relationship with Patient B constitutes unprofessional conduct pursuant to section 2234, gross negligence within the meaning of section 2234(b), and/or repeated negligent acts within the meaning of 2234(c).

29. Respondent's failure to document the physical examinations that he performed on Patient B, and failure to document the termination of the patient/physician relationship constitutes unprofessional conduct pursuant to section 2234, gross negligence within the meaning of section 2234(b) and/or repeated negligent acts within the meaning of 2234 (c).

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Failure to Maintain Adequate and Accurate Medical Records)

30. The allegations of the First and Second Cause for Discipline are incorporated herein by reference.

31. Respondent is guilty of unprofessional conduct under sections 2234 and 2266 for failing to maintain adequate and accurate medical records with respect to Patients A and B.

PRAYER

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

1. Revoking or suspending Physician and Surgeon's Certificate Number G76734, issued to John Edward Massey, M.D.;

2. Revoking, suspending or denying approval of John Edward Massey, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering John Edward Massey, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: August 11, 2017

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