

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

In the Matter of the Accusation Against:)
)
)

DARRYL MATTHEW SEE, M.D.)
)
)

File No. 04-2004-161179

Physician's and Surgeon's)
Certificate No. G 61569)
)
)

Respondent.)
_____)

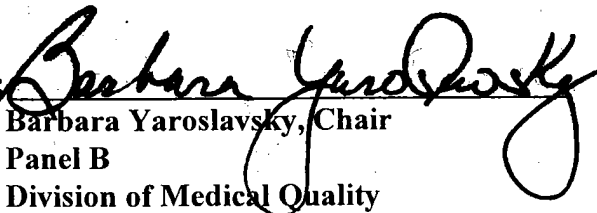
DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on October 30, 2007.

IT IS SO ORDERED October 23, 2007.

MEDICAL BOARD OF CALIFORNIA

By: 
Barbara Yaroslavsky, Chair
Panel B
Division of Medical Quality

1 EDMUND G. BROWN JR., Attorney General
of the State of California
2 STEVEN V. ADLER
Supervising Deputy Attorney General
3 RICHARD D. HENDLIN, State Bar No. 76742
Deputy Attorney General
4 California Department of Justice
110 West "A" Street, Suite 1100
5 San Diego, CA 92101
6 P.O. Box 85266
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8
9 Attorneys for Complainant

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

12 In the Matter of the Accusation Against:

13 **DARRYL MATTHEW SEE, M.D.**

14 6971 Faculty Circle #D
15 Buena Park, CA 90621

16 Physician's and Surgeon's Certificate
17 No. G 61569

18 Respondent.

Case No. 04-2004-161179

OAH No. L-2007050442

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

19
20 IT IS HEREBY STIPULATED AND AGREED by and between the parties in this
21 proceeding that the following matters are true:

22 **PARTIES**

23 1. Barbara Johnston (Complainant) is the Executive Director of the Medical
24 Board of California, appears solely in her official capacity and is represented in this matter by
25 Edmund G. Brown Jr., Attorney General of the State of California, by Richard D. Hendlin,
26 Deputy Attorney General.

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1 2. DARRYL MATTHEW SEE, M.D. (Respondent) is represented in this
2 proceeding by attorney Kevin Gallagher, Esq., whose address is 680 Newport Center Drive, Suite
3 100 Newport Beach, CA 92660, and whose telephone number is (714) 757-8607.

4 3. On or about October 13, 1987, the Medical Board of California issued
5 Physician's and Surgeon's Certificate No. G61569 to DARRYL MATTHEW SEE, M.D. The
6 Certificate was in full force and effect at all times relevant to the charges brought in Accusation
7 No. 04-2004-161179 and will expire on May 31, 2009, unless renewed.

8 **JURISDICTION**

9 4. Accusation No. 04-2004-161179 was filed before the Division of Medical
10 Quality (Division) for the Medical Board of California, Department of Consumer Affairs, and is
11 currently pending against Respondent. A true and correct copy of the Accusation and all other
12 statutorily required documents were properly served on Respondent on November 20, 2006.
13 Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct
14 copy of Accusation No. 04-2004-161179 is attached as Exhibit A and incorporated herein by
15 reference.

16 **ADVISEMENT AND WAIVERS**

17 5. Respondent has carefully read, discussed with counsel, and fully
18 understands the charges and allegations in Accusation No. 04-2004-161179. Respondent also
19 has carefully read, discussed with counsel, and fully understands the effects of this Stipulated
20 Surrender of License and Order.

21 6. Respondent is fully aware of his legal rights in this matter, including the
22 right to a hearing on the charges and allegations in the Accusation; the right to confront and
23 cross-examine the witnesses against him; the right to present evidence and to testify on his own
24 behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the
25 production of documents; the right to reconsideration and court review of an adverse decision;
26 and all other rights accorded by the California Administrative Procedure Act and other applicable
27 laws.

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1 **ORDER**

2 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate
3 No. G61569, issued to Respondent DARRYL MATTHEW SEE, M.D. is surrendered and
4 accepted by the Division of Medical Quality.

5 13. The surrender of Respondent's Physician's and Surgeon's Certificate
6 No. G61569 and the acceptance of the surrendered license by the Division shall constitute the
7 imposition of discipline against Respondent. This stipulation constitutes a record of the
8 discipline and shall become a part of Respondent's license history with the Division.

9 14. Respondent shall lose all rights and privileges as a Physician and Surgeon
10 in California as of the effective date of the Division's Decision and Order.

11 15. Respondent shall cause to be delivered to the Division both his wall
12 certificate and pocket license certificate on or before the effective date of the Decision and Order.

13 16. Respondent fully understands and agrees that if he ever files an application
14 for licensure or a petition for reinstatement in the State of California, the Division shall treat it as
15 a petition for reinstatement. Respondent must comply with all the laws, regulations and
16 procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all
17 of the charges and allegations contained in Accusation No. 04-2004-161179 shall be deemed to
18 be true, correct and admitted by Respondent when the Division determines whether to grant or
19 deny the petition.

20 17. Should Respondent ever apply or reapply for a new license or certification,
21 or petition for reinstatement of a license, by any other health care licensing agency in the State of
22 California, all of the charges and allegations contained in Accusation, No. 04-2004-161179 shall
23 be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of
24 Issues or any other proceeding seeking to deny or restrict licensure.

25 18. The Division hereby finds good cause has been shown within the meaning
26 of Business and Professions Code section 2307, subdivision (a), to permit Respondent to file a
27 petition for reinstatement after two years from the effective date of this Order.


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ACCEPTANCE

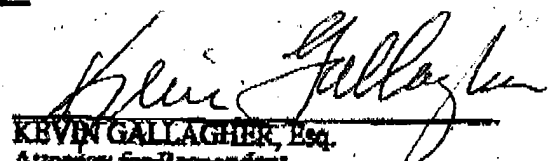
I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, Kevin Gallagher, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. 061569. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Division of Medical Quality, Medical Board of California.

DATED: 8/29/07


DARRYL MATTHEW SEE, M.D.
Respondent

I have read and fully discussed with Respondent DARRYL MATTHEW SEE, M.D., the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 8/30/07


KEVIN GALLAGHER, Esq.
Attorney for Respondent

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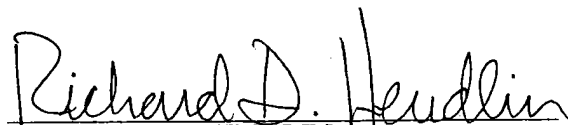
ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Division of Medical Quality, Medical Board of California of the Department of Consumer Affairs.

DATED: August 30th 2007

EDMUND G. BROWN JR., Attorney General
of the State of California

STEVEN V. ADLER
Supervising Deputy Attorney General


RICHARD D. HENDLIN
Deputy Attorney General

Attorneys for Complainant

DOJ Matter ID: SD2005701751
30320184.wpd

Exhibit A

**In the Matter of the Accusation Against:
DARRYL MATTHEW SEE, M.D.**

Accusation No. 04-2004-161179

1 BILL LOCKYER, Attorney General
of the State of California
2 THOMAS LAZAR
Supervising Deputy Attorney General
3 RICHARD D. HENDLIN, State Bar No. 76742
Deputy Attorney General
4 California Department of Justice
110 West "A" Street, Suite 1100
5 San Diego, CA 92101
6 P.O. Box 85266
San Diego, CA 92186-5266
7 Telephone: (619) 645-2071
Facsimile: (619) 645-2061
8
9 Attorneys for Complainant

10 **BEFORE THE**
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
11 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA
12

13 In the Matter of the Accusation Against:
14 **DARRYL MATTHEW SEE, M.D.**
2701 Snapdragon
15 Bozeman, MT 59718
16 Physician's and Surgeon's
Certificate No. G 61569
17
18 Respondent.

Case No. 04-2004-161179
OAH No.
A C C U S A T I O N

19 Complainant alleges:

20 PARTIES

- 21 1. David T. Thornton (Complainant) brings this Accusation solely in his
22 official capacity as the Executive Director of the Medical Board of California, Department of
23 Consumer Affairs.
24 2. On or about October 13, 1987, the Medical Board of California issued
25 Physician's and Surgeon's Certificate No. G 61569 to DARRYL MATTHEW SEE, M.D.
26 (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times
27 relevant to the charges brought herein and will expire on May 31, 2007, unless renewed.

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JURISDICTION

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3. This Accusation is brought before the Division of Medical Quality (Division) for the Medical Board of California, Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 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 Division deems proper.

5. Section 2234 provides:

"The Division of Medical Quality 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 [Chapter 5, the Medical Practice Act].

"(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.

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

6 "(d) Incompetence.

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

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

10 "..."

11 6. Section 2236 of the Code states:

12 "(a) The conviction of any offense substantially related to the qualifications,
13 functions, or duties of a physician and surgeon constitutes unprofessional conduct within
14 the meaning of this chapter [Chapter 5, the Medical Practice Act]. The record of
15 conviction shall be conclusive evidence only of the fact that the conviction occurred.

16 "(b) The district attorney, city attorney, or other prosecuting agency shall notify
17 the Division of Medical Quality of the pendency of an action against a licensee charging a
18 felony or misdemeanor immediately upon obtaining information that the defendant is a
19 licensee. The notice shall identify the licensee and describe the crimes charged and the
20 facts alleged. The prosecuting agency shall also notify the clerk of the court in which the
21 action is pending that the defendant is a licensee, and the clerk shall record prominently
22 in the file that the defendant holds a license as a physician and surgeon.

23 "(c) The clerk of the court in which a licensee is convicted of a crime shall,
24 within 48 hours after the conviction, transmit a certified copy of the record of conviction
25 to the board. The division may inquire into the circumstances surrounding the
26 commission of a crime in order to fix the degree of discipline or to determine if the
27 conviction is of an offense substantially related to the qualifications, functions, or duties
28 of a physician and surgeon.

1 "(d) A plea or verdict of guilty or a conviction after a plea of nolo contendere is
2 deemed to be a conviction within the meaning of this section and Section 2236.1. The
3 record of conviction shall be conclusive evidence of the fact that the conviction
4 occurred."

5 7. Section 2239 of the Code states:

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

15 "(b) A plea or verdict of guilty or a conviction following a plea of nolo
16 contendere is deemed to be a conviction within the meaning of this section. The Division
17 of Medical Quality may order discipline of the licensee in accordance with Section 2227
18 or the Division of Licensing may order the denial of the license when the time for appeal
19 has elapsed or the judgment of conviction has been affirmed on appeal or when an order
20 granting probation is made suspending imposition of sentence, irrespective of a
21 subsequent order under the provisions of Section 1203.4 of the Penal Code allowing such
22 person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting
23 aside the verdict of guilty, or dismissing the accusation, complaint, information, or
24 indictment."

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

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1 FIRST CAUSE FOR DISCIPLINE

2 (Gross Negligence)

3 9. Respondent is subject to disciplinary action under sections 2227 and 2234,
4 as defined by section 2234, subdivision (b), of the Code, in that he was grossly negligent in his
5 care and treatment of patients V.D., R.S., J.G., A.E. and D.F. The circumstances are as follows:

6 10. Respondent's practice included substantial research. Respondent claimed
7 he had developed an artificial intelligence system for the management of AIDS. He also claimed
8 to have other accomplishments, including helping to develop the concept of immune system
9 reconstitution in many diseases, establish models of viral-induced diabetes and heart disease,
10 developing an oral system for vaccine delivery, validating the use of bioassays in the study of
11 natural products and determined conditions under which neuronal regeneration is possible. He
12 was in private practice. At the times in question, respondent claimed to be the co-chair of the
13 Research Division, American Neutraceutical Association and the Director of the Orange County
14 Institute of Longevity Medicine.

15 Patient V.D.

16 11. On or about September 12, 2003, patient V.D. went to respondent's office.
17 V.D., then a 38-year old man, related his complaints to respondent. Respondent failed to obtain a
18 complete history and perform and/or chart a physical examination. Respondent prescribed
19 Xanax and another drug, the name of which is illegible.

20 12. On or about September 19, 2003, V.D. returned to respondent's office.
21 V.D. requested an AIDS blood test. V.D. complained of chronic fatigue syndrome. Respondent
22 ordered the blood test V.D. requested.

23 13. V.D. returned on or about October 3, 2003, complaining of fatigue,
24 headache and low grade fevers. Respondent diagnosed a chronic viral infection. Respondent
25 neither ordered nor reviewed lab tests when making this diagnosis and/or failed to record such
26 order and/or review in the chart. There is no consent from V.D. for release of medical records,
27 including records relating to his prior medical treatment, in respondent's chart for V.D.

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1 Respondent failed to review patient V.D.'s medical records at any time during respondent's care
2 and treatment of V.D.

3 14. V.D. returned to see respondent on or about October 17, 2003.

4 Respondent related that the HIV test was negative. Although respondent charted an order for
5 antivirals, there are no prescription forms in the record and none were specified in the medical
6 record. V.D. returned on or about October 22, 2003, complaining of abdominal pain and fatigue.
7 Respondent again charted his impression of chronic fatigue syndrome and viral infection.
8 Respondent ordered "IV Mg", "GF" and supplements.

9 15. V.D. returned to see respondent on or about October 29, 2003.

10 Respondent noted that the visit was to follow up chronic viral and mycoplasma infection.
11 Respondent ordered indium, "IV cocktail" and supplements. V.D. visited respondent's office
12 again on or about October 31, 2003, for follow-up. Respondent repeated the order for indium,
13 "IV cocktail" and "D supplements." V.D.'s last recorded visit to respondent was on or about
14 November 5, 2003. Respondent charted his impressions: chronic viral infections - mycoplasma
15 and parvo.

16 16. V.D. paid respondent a \$2,500.00 advance for tests for other viruses or
17 pathogenic bacteria to establish a cause for V.D.'s fatigue.

18 17. V.D. did not agree to participate in a research study or program. V.D. did
19 not sign a consent for such participation, and none appears in the medical records for V.D.
20 maintained by respondent.

21 18. On an unspecified date, respondent gave V.D. 22 unlabeled vials and
22 instructed V.D. to take the contents of each vial on an empty stomach. Respondent told V.D. that
23 the vials contained indium. V.D. had the contents of one or more vials tested and learned that
24 the vials tested contained indium.

25 19. V.D. decided to have independent lab tests to learn whether he had parvo
26 virus and/or mycoplasma fermentans. A lab report on blood drawn on November 4 and printed
27 on November 7, 2003, showed that V.D. had high levels of toxoplasma gondii, negligible levels

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1 of parvovirus IgG and IgM and was negative for mycoplasma penetrans, mycoplasma
2 pneumoniae, mycoplasma fermentans and mycoplasma hominis.

3 Respondent committed gross negligence in his care and treatment of patient V.D.
4 which included, but was not limited to, the following:

5 20. Respondent supplied unlabeled medication vials to V.D.

6 21. Respondent provided unlabeled vials containing indium, lead, copper, zinc
7 which were also highly acidic, to V.D. and instructed V.D. to take the vials. Respondent did not
8 provide any information to V.D. concerning potential ill effects of the vials.

9 22. Respondent failed to take and/or chart a complete and detailed history.

10 23. Respondent failed to order and/or perform and/or chart orders and/or
11 results for blood tests to rule out common causes of fatigue. Respondent failed to order and/or
12 chart orders for tests including but not limited to a complete blood count, a thyroid test, a liver
13 function test and a kidney function test.

14 24. In the event that V.D. was participating in a research study, respondent
15 failed to obtain and/or chart an informed consent from V.D.

16 25. Respondent's medical records for V.D. were incomplete to the extent that
17 they constitute an extreme departure from the standard of care.

18 Patient R.S.

19 26. In or about April 2004 patient R.S. learned of respondent via respondent's
20 website. R.S. went to see respondent for treatment of diabetes and fluid in the stomach. When
21 R.S. met respondent, R.S. recounted that he had been diagnosed by Kaiser with hepatitis and
22 pulmonary hypertension. Respondent stated that R.S. was suffering from a clogged liver and that
23 respondent could help R.S. Respondent provided R.S. with "growth factor." On or about May 5,
24 2004, R.S. gave respondent a check for \$4,500.00 to cover the cost of the substances respondent
25 would provide to R..S.

26 27. Respondent did not make and/or maintain and/or retain any medical
27 records for R.S.

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1 28. R.S. paid \$478.00 to Atrium Biotech for "Natcell - pancreas porcine" and
2 "Natcell - Liver (8) porcine."

3 29. R.S. received an undated letter from respondent in which respondent
4 claimed to be in Europe and stated that he would no longer be able to treat his patients.
5 Respondent recommended other physicians. The note from respondent was enclosed with a
6 "Dear Patient" letter from a representative of the supplier for the "growth factors" respondent had
7 been ordering for patients.

8 30. In a written explanation respondent provided to a Board investigator,
9 respondent noted that R.S. suffered from severe arthritis of the knees and was seeking treatment
10 for that ailment. Respondent also recommended that his patients could be followed by
11 respondent's mentor, one Arnold Takemoto, who is not a licensed physician.

12 Respondent committed gross negligence in his care and treatment of patient R.S.
13 which included, but was not limited to, the following:

14 31. Respondent injected porcine pancreas and porcine liver extracts into R.S.

15 32. Porcine pancreas and porcine liver extract treatment lack FDA approval.

16 33. Respondent abandoned patient R.S.

17 Patients R.G. and L.G.

18 34. Patient R.G. is a quadriplegic who was being treated by respondent with
19 stem cells apparently as part of a research project being conducted by respondent. Respondent
20 represented that after one year of treatment, R.G. would be "normal" from the waist up and that it
21 would take longer to restore full bowel, bladder and other functions below the waist. R.G.'s
22 parents paid respondent \$12,000.00 for the treatments.

23 35. Respondent also treated R.G.'s mother, L.G., who was suffering from
24 rheumatoid arthritis of the knees. Respondent was paid \$3,500.00 for these treatments. The
25 treatment appeared to work at first, but then L.G.'s condition worsened.

26 36. In June, 2004, respondent left his patients and went to Europe and never
27 returned. Respondent failed to respond to phone messages and e-mails.

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1 37. Respondent claimed to have maintained medical records for R.G. and
2 L.G., including complete and executed research consents and protocols. However, respondent
3 claimed that the records were lost when his family cleaned out his apartment while respondent
4 was in Europe.

5 38. In a letter to a Medical Board investigator from respondent dated February
6 23, 2005, respondent recommended that care and treatment of his patients could be provided by
7 one Arnold Takemoto who is not a licensed physician and resides in Arizona.

8 39. During respondent's care and treatment of R.G., respondent did not order
9 and/or chart an order for x-rays and/or lab tests. Respondent failed to perform a complete
10 physical examination and to take a detailed history on either R.G. or L.G.

11 40. Respondent failed to provide adequate follow-up care for either R.G. or
12 L.G.

13 Respondent committed gross negligence in his care and treatment of patients R.G.
14 and L.G. which included, but was not limited to, the following:

15 41. Respondent failed to create and/or maintain medical records relating to his
16 care and treatment of the patients R.G. and L.G.

17 42. Respondent failed to obtain and retain an adequate informed consent for
18 the experimental drug research he conducted on patients R.G. and L.G.

19 43. Respondent conducted a study of an investigational drug or substance
20 without obtaining appropriate and required approvals and reviews.

21 44. Respondent falsely and without medical basis represented that patient R.G.
22 would experience an 80% return in function above the knees within eight months.

23 45. Respondent abandoned patients R.G. and L.G.

24 46. In response to a query from a Medical Board investigator, respondent
25 suggested that Arnold Takemoto, who is not a licensed physician and who resides in Arizona,
26 could provide excellent care for respondent's patients in place of respondent.

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1 Patient A.E.

2 47. On or about May 12, 2004, patient A.E. went to respondent's office on a
3 friend's recommendation. A.E. was apparently suffering from pain in his neck and back.
4 Respondent performed a brief physical examination and got some information about A.E.'s
5 history. Respondent failed to create and/or maintain any medical record for this and all
6 respondent's care of patient A.E. Respondent told patient A.E. that respondent could rejuvenate
7 the ligaments in patient A.E.'s back and neck by injecting a stem cell product. Respondent
8 requested payment for the stem cell product in advance, and patient A.E. gave respondent a
9 check for \$2,500.00. A.E.'s visits to respondent were billed to Medicare, but Medicare did not
10 cover the cost of the stem cell substance respondent wished to inject into patient A.E.

11 48. Patient A.E. visited respondent's office on several occasions from May
12 2004 to July 2004. On some or all of these occasions, respondent injected a clear substance into
13 patient A.E.'s neck and/or buttocks. Respondent came to patient A.E.'s home on one occasion to
14 give an injection.

15 49. In July 2004, patient A.E. received an undated letter from respondent.
16 Respondent stated that his practice was moving and provided a new address. It also represented
17 that respondent would be in Europe between June 25, 2004, and July 19, 2004, getting re-
18 certified in regenerative medicine. Respondent stated that he would resume seeing patients after
19 July 20, 2004. When patient A.E. went to respondent's new office location for an appointment
20 on July 26, 2004, patient A.E. found that the office was vacant and had not had a tenant for about
21 two years. Patient A.E. did not hear from respondent again.

22 50. Respondent failed to create and/or maintain medical records regarding his
23 care and treatment of his patient, A.E.

24 51. In response to a query from a Medical Board investigator, respondent
25 suggested that Arnold Takemoto, who is not a licensed physician and who resides in Arizona,
26 could provide excellent care for respondent's patients in place of respondent.

27 Respondent committed gross negligence in his care and treatment of patient A.E.
28 which included, but was not limited to, the following:

1 52. Respondent abandoned patient A.E.

2 53. Respondent falsely and without medical basis represented to patient A.E.
3 that stem cell injections would help alleviate neck pain.

4 54. In the event that patient A.E. was a research subject, respondent failed to
5 obtain and/or maintain an appropriate informed consent. In addition, the study, if there was one,
6 was conducted without approvals and oversight required by law and/or proper research practices.

7 Patient D.F.

8 55. Patient D.F. went to see respondent based on the recommendation of a
9 friend. Patient D.F. lost the use of his legs after he suffered a ruptured aorta in July, 1998.

10 56. Respondent told patient D.F. that respondent could help patient D.F. by
11 injecting him with a stem cell derivative for a period of time. Respondent said that the
12 treatments would regenerate spinal nerves so the patient D.F. could walk again. Respondent
13 asked patient D.F. for \$9,000.00 to commence the treatment, to cover the cost of the substance
14 respondent would administer. Patient D.F. paid \$9,000.00 to respondent by check dated
15 October 1, 2003.

16 57. Patient D.F. saw respondent on about eleven occasions according to bills
17 submitted to Medicare by respondent.

18 58. Respondent gave patient D.F. a document entitled, "A 12 Month Study of
19 the Effects of Stem Cell Regeneration Factor on Spinal Cord Injury Patients." The cover of the
20 document identified it as an "IRB Study Proposal." The study was to be conducted by
21 "Dreamtech Research." Respondent was listed as the Principal Investigator. The document
22 lacked signatures and approvals. It recited that no serious side effects have been reported "for
23 any of the components." The drug to be studied was stem cell growth factor (SCGF), and the
24 objective was to determine if there is clinical response to SCGF and if it can cause nerve
25 regeneration. Patient D.F. signed a form entitled "Informed Consent" and dated it October 1,
26 2003, the same date as the check for \$9,000.00.

27 59. In e-mail communications from respondent to patient D.F., respondent
28 claimed that stem cells may help prevent seizures because some cells may stray to the brain and

1 heal damage there. As to side effects, respondent stated there would be "absolutely none."
2 Respondent also recommended reflexology, telling patient D.F. that it was optional but "evidence
3 shows it may work well."

4 60. Sometime in June, 2004, patient D.F. received an undated letter from
5 respondent which stated that respondent was going to be in Europe "getting recertified in
6 regenerative medicine." Respondent would be able to see patients after July 20, 2004, at a new
7 office location. D.F. had an appointment to see respondent in late July, 2004; the appointment
8 was canceled by respondent's office because respondent did not return.

9 61. Patient D.F. received an undated letter from a representative of "Herbal
10 Solutions" offering to order "growth factors" and enclosing a letter from respondent. In
11 respondent's undated letter, respondent stated that he had been in Europe for some time trying to
12 ensure that products will continue to come to the U.S. from France. Respondent states that he
13 was hospitalized and was ordered by a doctor to go on disability "for an extended period of
14 time." Respondent recommended three other providers.

15 Respondent committed gross negligence in his care and treatment of patient D.F.
16 which included, but was not limited to, the following:

17 62. Respondent used stem cells from a bovine source for an experimental
18 therapy without filing required paperwork regarding this investigational drug.

19 63. Respondent failed to obtain and/or record any approval from an
20 Independent Review Board (IRB) for his research protocol.

21 64. Respondent made misleading statements in the "Informed Consent."

22 65. Respondent abandoned patient D.F.

23 66. Respondent failed to make and/or retain medical records of his care and
24 treatment of patient D.F.

25 67. Respondent failed to take and/or chart an adequate history from patient
26 D.F.

27 68. Respondent failed to perform and/or chart a physical examination of
28 patient D.F.

1 69. Respondent made statements to patient D.F. that would tend to mislead
2 patient D.F. about the benefits of respondent's treatment.

3 SECOND CAUSE FOR DISCIPLINE

4 (Repeated Negligent Acts)

5 70. Respondent is further subject to disciplinary action under sections 2227
6 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated
7 negligent acts in his care and treatment of patients V.D., R.S., J.G., A.E. and D.F. Paragraphs 10
8 through 69, inclusive, are incorporated by reference and are realleged as if fully set forth here.

9 THIRD CAUSE FOR DISCIPLINE

10 (Incompetence)

11 71. Respondent is further subject to disciplinary action under sections 2227
12 and 2234, as defined by 2234, subdivision (d), of the Code, in that he demonstrated
13 incompetence in his care and treatment of patient V.D. Paragraphs 10 through 25 inclusive, are
14 incorporated by reference and are realleged as if fully set forth here.

15 72. Respondent was incompetent in his care of patient V.D. in that respondent
16 failed to conduct a proper work-up of chronic fatigue syndrome so as to rule out other possible
17 causes of the symptoms reported by patient V.D.

18 FOURTH CAUSE FOR DISCIPLINE

19 (Conviction of Crime)

20 73. Respondent is further subject to disciplinary action under sections 2227
21 and 2234, as defined by section 2236, subdivision (a), of the Code, in that he was convicted of a
22 crime substantially related to the qualifications, functions or duties of a physician and surgeon.
23 The circumstances are as follows.

24 74. On or about September 5, 2003, respondent was involved in a traffic
25 accident at or near the intersection of Alicia and Pacific Island in Laguna Niguel. Respondent
26 rear-ended another car, and told sheriff's officers that he was very fatigued and was nodding off.
27 Before the collision, respondent's car was followed by an off-duty Deputy, who had been
28 watching respondent drive erratically for several miles before the accident.

1 75. Respondent had no measurable alcohol in his blood at or near the time of
2 the accident. However, respondent did have a measurable amount of barbiturates/phenobarbital
3 in his bloodstream.

4 76. On March 15, 2004, respondent pled guilty to a violation of Vehicle Code
5 section 23152, subdivision (a), driving a motor vehicle under the influence of drugs or alcohol in
6 the case of *People of the State of California v. Darryl Matthew See*, Orange County Superior
7 Court Case Number 04SM00572. Imposition of sentence was suspended and respondent was
8 placed on informal probation for three years on various terms and conditions, including a
9 requirement that he not take Ativan or have Ativan in his system while driving.

10 FIFTH CAUSE FOR DISCIPLINE

11 (Excessive Use of Drugs or Alcohol)

12 77. Respondent is further subject to disciplinary action under sections 2227
13 and 2234, as defined by section 2239, of the Code, in that he administered and/or used drugs to
14 the extent or in such a manner as to be dangerous or injurious to himself or others in that he was
15 involved in an accident while driving under the influence of drugs. Paragraphs 73 through 76,
16 inclusive are incorporated by reference and realleged as if set forth here in full.

17 SIXTH CAUSE FOR DISCIPLINE

18 (False Representations)

19 77. Respondent is further subject to disciplinary action under sections 2227
20 and 2234, as defined by section 2261, of the Code, in that he knowingly made or signed a
21 certificate or other document directly or indirectly related to the practice of medicine which
22 falsely represented the existence or nonexistence of a state of facts. Paragraphs 10 through 69,
23 inclusive, are incorporated by reference and realleged as if fully set forth here.

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SEVENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Accurate and Adequate Medical Records)

78. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate medical records of his care and treatment of patients V.D., R.S., J.G., A.E. and D.F. Paragraphs 10 through 69, inclusive, are incorporated by reference and are realleged as if fully set forth here.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G61569, issued to DARRYL MATTHEW SEE, M.D..
2. Revoking, suspending or denying approval of respondent's authority to supervise physician's assistants, pursuant to section 3527 of the Code;
3. If respondent is placed on probation, ordering Darryl Matthew See, M.D. to pay the Division of Medical Quality the costs of probation monitoring;
4. Taking such other and further action as deemed necessary and proper.

DATED: November 20, 2006


DAVID T. THORNTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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