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

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| In the Matter of the Accusation Against: | |
| **DONALD WOO LEE, M.D.** | Case No. 17-2007-183005 |
| Physician and Surgeon's Certificate No. A 56294 | OAH No. 2010011001 |
| Respondent. | |

# DECISION AFTER SUPERIOR COURT REMAND

This matter was heard by Julie Cabos-Owen, Administrative Law Judge (ALJ) with the Office of Administrative Hearings (OAH), on January 24, 25, 26, 27 and 31, and February 1 and 2, 2011, in Los Angeles, California. Complainant was represented by E.A. Jones III, Deputy Attorney General. Donald Woo Lee, M.D. (Respondent) was present and represented by Paul Spackman of Iungerich & Spackman.

On the fourth day of hearing, Complainant amended the Accusation at page 13, by adding a paragraph numbered 8QQ, which stated, "Respondent was negligent in his care and treatment of patient J.M. in that he failed to follow up with Patient J.M. from his September 29, 2006 discharge until his readmission to the hospital on October 17, 2006." Respondent objected to the amendment, arguing that there was insufficient notice of the additional negligence allegation. Respondent's due process objection was sustained since Respondent was not afforded a reasonable opportunity to prepare his defense to the new allegation. Although, pursuant to Government Code section 11507, the Accusation was amended to include the additional allegation, no evidence regarding the additional negligence allegation was admitted nor was the additional allegation considered as grounds for discipline.

Oral and documentary evidence was received, and argument was heard. The record closed, and the matter was submitted for decision on February 2, 2011.

On April 11, 2011, Panel A of the Medical Board of California (Board) adopted the proposed decision issued by ALJ Cabos-Owen. Thereafter, Respondent petitioned for a writ of administrative mandamus in Sacramento County Superior Court. In August 2012, the Superior Court granted the petition and issued a writ directing the Board to re-determine the penalty in light of the Court's ruling. Specifically, the Superior Court found that several adverse finds of the Board were not supported by the weight of the evidence and therefore cannot be sustained. The remaining causes for discipline are limited to repeated negligent acts with one patient and inadequate medical records.

Following the Court's ruling, the Board issued a Notice of Hearing for Oral Argument on September 25, 2012, and set oral argument for October 25, 2012. At the October 25, 2012, meeting of the Board, Panel A heard oral argument, with Deputy Attorney General E.A. Jones representing Complainant and Paul Spackman representing Respondent, who was not present.

Board members Yaroslavsky, Salomonson, Bishop, Diego, and Serrano Sewell were present, and at oral argument, pursuant to section 11515 of the Government Code, the Panel took official notice that Respondent entered into a stipulated settlement for discipline on a separate matter. Having heard oral argument and read the written argument submitted by both parties, the Board, in light of the Court's ruling, enters the following as its decision in this matter.

## FACTUAL FINDINGS

1. On January 5, 2010, Complainant Barbara Johnston filed the Accusation while acting in her official capacity as the Executive Director of the Board.

2. On August 21, 1996, the Board issued Physician and Surgeon's Certificate Number A 56294 to Respondent. Respondent's certificate was in full force and effect at all relevant times and will expire on August 31, 2012, unless renewed.

3. Respondent obtained his medical degree in 1994 at St. George's University in the West Indies.[1] He completed an Internal Medicine residency at University of California, Los Angeles (UCLA) School of Medicine / Wadsworth Veteran's Affairs (VA) Medical Center in 1997. He was certified by the American Board of Internal Medicine in 1997; however, that certification has expired, and although he is eligible for recertification, he has

[1] This was not listed on his Curriculum Vitae. Instead, his CV read:

> UCLA School of Medicine/Wadsworth V.A. Medical Center
> Department of Medicine, West Los Angeles, CA
> July 1995-June 1997 PGY 3 Internal Medicine Residency
> Medical Degree

not been recertified. Since 1998, Respondent has operated a private primary care practice providing inpatient and outpatient care. He currently has offices in Temecula (operating for 13 years) and in Mira Loma (opened approximately four months ago within a senior community). In order to provide better access for patients, Respondent added an urgent care component to his practice, which is staffed by physician assistants. However, if patients insist on seeing him, his staff will "squeeze them in between [his scheduled] appointments." The majority of his patients are geriatric patients, with Medi-Care coverage and supplemental coverage through various senior health plans which are typically health maintenance organizations (HMOs). Consequently, referrals from his primary practice typically require approval from the medical group which holds the contract with the health plan. When Respondent is out of town or unavailable, his physician assistants cover his outpatients, and colleagues at the hospital cover his inpatients.

***The Experts***

4(a). Complainant offered the testimony of Jofel M. Yan, M.D., F.A.C.P., to establish the standard of care in this case. Dr. Yan is a hospitalist with HealthCare Partners Medical Group, in Torrance, California, and an Associate Professor of Medicine at the UCLA School of Medicine. Dr. Yan received his medical degree from University of California, Davis in 1990, and completed an Internal Medicine residency in 1993 at St. Mary Medical Center in Long Beach, California. He is certified by the American Board of Internal Medicine (original certification 1993; recertification 2003). From 1994 through 2004, he practiced in an academic setting, at the St. Mary Medical Center Internal Medicine Residency Program as a full-time faculty member and then as the Associate Program Director, and also at the UCLA School of Medicine as an Assistant Professor of Medicine (July 1994 through June 2001) and as an Associate Professor of Medicine (July 2001 through June 2004). While at St. Mary, his practice included geriatric patients. In 2004, he "decided to take care of more patients," and moved to a hospital-based private practice, where he sees patients in acute and sub-acute settings, with a large geriatric population. Since 2004, his practice has not included outpatients.

4(b). Complainant also offered the testimony of Benjamin F. Yasharel, M.D., to establish the standard of care in this case. Dr. Yasharel obtained his medical degree from Tufts University School of Medicine, in Boston, Massachusetts, in 1999. He completed an Internal Medicine residency in 2002 at the UCLA, West Los Angeles Veterans Administration Medical Center. He is certified by the American Board of Internal Medicine. Since 2003, he has been in private practice in West Hills, California. His current practice is comprised of 90 percent outpatient and 10 percent inpatient. He sees a primarily older population, between ages 60 and 100.

4(c). Respondent offered the testimony of Suraj Achar, M.D., F.A.A.F.P., to establish the standard of care for the treatment of both patients. Dr. Achar received his medical degree from State University of New York at Buffalo School of Medicine in 1993. He is certified by the American Board of Family Medicine (certified 1996; recertified 2003). Dr. Achar is an Associate Clinical Professor at the University of California, San

Diego School of Medicine (UCSD) in the Department of Family and Preventative Medicine, training residents in family practice. He is also the Medical Director for UCSD La Jolla Family and Sports Medicine. Dr. Achar has worked for several years as an expert medical reviewer for the Board. As part of his preparation for this case, Dr. Achar visited Respondent's medical practice for a day; he observed Respondent's examination of several patients, spoke to his staff, and reviewed his patient records.

4(d). All of the experts were qualified to testify as experts on the standard of care in this case. However, since Dr. Yan has been in a hospital-based practice for seven years, his opinions regarding the standard of care in an outpatient setting were given less weight than those of Drs. Yasharel and Achar. Apart from the foregoing, any additional weight given to one expert's testimony over the others' was based on the content of their testimonies and the bases for their opinions.

4(e). Dr. Achar's testimony often took on the tenor of an advocate, rather than an impartial expert. Several times on cross examination, he avoided answering questions directly, instead presenting arguments in Respondent's favor. His tenacious defense of Respondent's actions, particularly his attempt to rationalize Respondent's falsification of records (set forth more fully below), diminished his credibility.

***Facts Re: Patient L.W.***[2]

5. On April 1, 2004, Patient L.W., a 79-year old woman met with Respondent to discuss transferring her care from another primary care physician. They discussed her history, and Respondent noted her drug allergies (penicillin, Keflex and Demerol), her primary medical issues and medications taken. On the progress record, Respondent noted the patient's hypertension, for which she had been taking Propanol; her thyroid problems, for which she had been taking Synthroid; her gastroesophageal reflux disease (GERD), for which she was taking Aciphex; her arthritis/low back pain, for which she was taking Vicodin and Bextra; her hyperlipidemia for which she was taking Zocor; and her restless leg syndrome, for which she was taking Clonazepam (generic for Klonopin). Her prior prescription for Premarin and Hydrochlorothiazide (HCTZ), a diuretic, was also noted. Respondent believed the patient was asymptomatic at that time and did not recommend any change of medications, all of which appeared appropriate. Respondent provided L.W. with a Health Questionnaire to complete and also requested her medical records from her prior primary care physician. Thereafter, Respondent saw L.W. approximately 25 times in his practice.

6. On May 19, 2004, Patient L.W. saw Respondent again. She provided him with the completed Health Questionnaire and attached a one-page summary wherein she reported a lengthy medical history which included: restless leg syndrome; hypertension;

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[2] Patients' and family members' initials are used in lieu of their full names in order to protect their privacy.

GERD; arthritis; thyroid problems; hyperlipidemia; an appendectomy in 1954; surgery to an ovary in 1956; a complete hysterectomy in 1959; a laminectomy in 1965; a left breast biopsy (benign) in 1970; a hard palate carcinoma in 1988; a right breast biopsy (benign) in 1997; recurrent bladder cancer in 1996 (grade 1), 1997 (grade 2) and 2001 (grade 1); lower lip cancer in 1998 and 1999; and recurrent colon polyps in 1980, 1981 and 2001. L.W.'s one-page summary also listed her medications, which included: Propanol; Premarin; HCTZ; Synthroid; Zocor; Aciphex; Clonazepam/Klonopin; Hydrocodone/Vicodin; Bextra (which hurt her stomach); Extra Strength Tylenol; and Calcium + Vitamin D. It was noted that she was allergic to penicillin, Keflex and Demerol. A Physical Examination Form was filled out, indicating L.W.'s medications and drug allergies (penicillin, Keflex and Demerol). Her blood pressure was taken (112/70), but her pulse was not recorded. The Physical Examination Form omitted any other findings from examination. A urology referral was planned based on the history of bladder cancer. As was his custom and practice, since the patient was reportedly asymptomatic and there was no obvious overlap of medications which could cause her danger, Respondent continued six of the patient's previous medications: HCTZ; Synthroid; Zocor; Aciphex; Clonazepam; and Vicodin.

7(a). On May 19, 2004, laboratory blood and urine tests were conducted for L.W. which included a complete blood count (CBC), a basic metabolic panel, a lipid panel, and a thyroid assessment. Respondent ordered this lab work to monitor the medical issues reported by L.W. He noted that the patient's potassium level was slightly low (3.1 mEq/L, with a reference range of 3.5-5.5). He decided to change the patient's diet and observe her to see if they could bring her potassium to the correct level. Respondent also noted that the patient's calcium level was slightly elevated (10.9 mg/dL, with a reference range of 9.5-10.6). Since the patient was taking a diuretic, he was not concerned with this reading, but believed that he still needed to follow up. All other readings were within an acceptable range, including liver function, thyroid and cholesterol.

7(b). On April 4, 2005, Respondent ordered, and L.W. underwent, similar blood tests as part of her annual examination. Regarding the 2005 lab results, Respondent noted that the patient's potassium was still low (3.1), so he prescribed a potassium supplement on April 15, 2005. Additionally, since L.W.'s calcium was more elevated (11.3), he ordered a decrease in her calcium supplement. All other readings, including liver function and cholesterol, were within normal ranges

7(c). On October 23, 2006, Respondent ordered, and L.W. underwent blood tests which indicated that her calcium and potassium levels were within the acceptable ranges.

8. After referring L.W. to a urologist in 2004, Respondent continued to refer her to a urologist for yearly bladder cancer screening.

9. After Respondent obtained L.W.'s prior medical records, he noted that she had undergone mammography on September 2, 2003, with normal results. Respondent ordered a screening mammogram in 2005. On May 23, 2005, L.W. underwent a mammogram which was unremarkable. Follow-up in one year was recommended.

10(a). L.W.'s last colonoscopy ordered by her prior physician took place in 2001.

10(b). In October 2005, Respondent referred L.W. to the Inland Valley Digestive Diseases Associates, after she complained of rectal bleeding. On November 21, 2005, a colonoscopy with polypectomy was performed.

10(c). In April 2006, a colonoscopy with hemmoroidectomy and polypectomy was performed on L.W.

11(a). On November 29, 2004, patient L.W. had a lumbar spine x-ray for back pain after a fall. No fracture was noted, but it was noted that "bones are osteopenic."

11(b). On November 28, 2005, an x-ray of L.W.'s right wrist after a fall showed a non-displaced fracture of the distal radius. It was noted that "bones are osteopenic."

11(c). There was no specific documentation in the patient chart indicating that Respondent followed up on the issue of osteopenia. However, in his testimony, Respondent pointed out that L.W. was already taking Premarin for her menopausal symptoms, and that medication was also used to treat osteoporosis. According to Respondent, this patient did not have osteoporosis, only osteopenia, but Premarin would benefit her in the event she did develop osteoporosis. He noted that she was also taking calcium and vitamin D supplements, and thus was on maximum therapy anyway. Therefore, even assuming she developed osteoporosis, Respondent would not have changed her treatment.

12(a). In November 28, 2005, L.W. underwent a chest x-ray after her fall (see Factual Finding 11(b)). Her fall apparently occurred at some point after her November 21, 2005 colonoscopy and polypectomy (see Factual Finding 10(b)). The chest x-ray indicated abnormal findings in the right upper lobe consistent with pneumonia. Continued follow-up was recommended "to exclude the possibility for underlying pathology such as a mass."

12(b). On December 6, 2005, Respondent saw L.W. in his office. His assessment included wrist fracture and pneumonia. The plan included follow up with an orthopedist and repeat chest x-ray the following week.

12(c). On December 10, 2005, L.W. was admitted to Ranch Springs Medical Center complaining of generalized weakness, shortness of breath and a cough. Her blood pressure was 90/60 and her heart rate was 80. She was diagnosed with: pneumonia; dehydration; rib pain and fracture to right radius subsequent to fall; hypertension, currently hypotension and dehydrated; hypothyroidism; hypokalemia secondary to hydrochlorothiazide; constipation with weight loss, should be ruled out for colon cancer; history of restless leg syndrome. L.W. was given IV fluids and her HCTZ was held.

12(d). On December 30, 2005, L.W. was seen by a physician assistant in Respondent's urgent care clinic, complaining of confusion, lethargy, memory loss, mild

nausea and vomiting, and lack of appetite since her fall. The plan written by the physician assistant was not entirely legible.

13. On January 6, 2006, L.W. came to Respondent's office and reported that she had stopped taking all of her medications approximately two weeks prior without seeking Respondent's approval. Respondent was concerned about this discontinuation of medication, since she could have rebound tachycardia from the lack of Propanol and HCTZ, and/or she could have withdrawal symptoms (including heart palpitation, anxiety and sweating) from sudden discontinuation of the Clonazepam. Respondent's note of a heart exam is illegible. Under allergies was listed "no known drug allergies," which was incorrect. L.W.'s blood pressure was measured at 110/62. Her pulse was documented at 56 beats per minute (bpm), which appeared to be incorrect given the findings of the EKG taken at that visit. An EKG revealed a heart rate of 113 bpm, sinus tachycardia, with premature atrial contractions. Respondent's impression included fatigue and atrial fibrillation /sinus tachycardia. The plan included starting a long acting beta blocker and following up in one week to see if the patient was responding to the medication. Although he added atrial fibrillation as a possible concern, he did not think L.M. was experiencing atrial fibrillation. Nevertheless, he decided to monitor the patient "just to be sure."

14. On January 13, 2006, Patient L.W. saw Respondent in follow-up. A long-acting beta blocker (Toprolol) and an oral opiate (Vicodin) were listed as medications. Under allergies was listed "no known drug allergies," which was incorrect. The patient's heart rate was documented at 56 bpm. No physical exam or repeat EKG was recorded. The assessment and plan included "normal sinus rhythm . atrial fibrillation" and the beta blocker was continued. A urology referral was also noted.

15. On February 3, 2006, L.W. saw Respondent for follow-up. No known allergies were listed. The patient's pulse was 72 bpm, and her blood pressure was 128/80. Under allergies was listed "no known drug allergies." Respondent's assessment was "hypertension / atrial fibrillation . normal sinus rhythm." The beta blocker was continued.

16. On March 3, 2006, Patient L.W. saw Respondent again in follow-up. Her heart rate was 58 bpm, and her blood pressure was 150/80. Medications were listed as: Toprolol, Aciphex, Vicodin and Hydrocortisone cream. Under allergies was listed "no known drug allergies." No physical exam was noted. An EKG that day showed her heart rate at 57-59 bpm. The assessment and plan included "atrial fibrillation . normal sinus rhythm," and the beta blocker was continued. The rest of the assessment / plan was illegible. Since L.W. was not having palpitations after resuming the beta blocker, Respondent did not believe he needed further follow-up on the issue of atrial fibrillation.

17. On the night of November 20, 2006, while seated at her dining room table, Patient L.W. fell asleep, slipped off her chair onto the floor and injured her right hip. She did not immediately seek medical attention because she had to leave town to attend a funeral. However, during the trip she experienced pain and had to use a walker to ambulate, which she had not required prior to the fall.

18. On November 24, 2006, patient L.W. was seen by a physician assistant in the urgent care division of Respondent's office. The physician assistant documented that L.W. complained of pain from her hips to her knees. Her current medications were listed as Vicodin, Toprol, Aciphex, Requip and Clonazepam. No pulse was recorded. Physical examination revealed abnormalities in her gait (able to walk slow with slight limp), pain in her back on lifting her right knee, and point tenderness in her back. X-rays of her lumbar spine and bilateral hips were ordered. The assessment was "hip/back pain from fall," and the plan was to "rest/avoid walking until x-ray results known." Respondent co-signed the chart.

19(a). On November 24, 2006, x-ray films of L.W.'s lumbar spine and bilateral hips were taken. According to the radiologist, the x-rays revealed "mild dextroconvex scoliotic curvature" and "5 mm anterior subluxation of L4 on L5." There was no fracture noted.

19(b). At the administrative hearing, both Complainant's experts and Respondent's expert viewed the November 24, 2006 x-rays and confirmed that no fractures were visible on the films.

20(a). On December 26, 2006, Respondent saw Patient L.W., who complained of lower back pain and bilateral hip and leg pain. Her blood pressure was documented at 160/90, but no pulse was recorded. The list of current medications included Clonazepam, Requip, Celebrex, Metoprolol, Vicodin and Aciphex.

20(b). At the December 26, 2006 visit, Respondent wrote a progress note, documenting a back examination and noting tenderness at the right lumbar spine. His assessment was "lower back pain," with a treatment plan of Kenalog (steroid) injection as well as a Lidoderm patch (topical antesthetic).

21. On January 8, 2007, L.W. was seen by a physician assistant at Respondent's office. L.W. continued to complain of worsening pain in her lower back, hip, leg and groin. The physician assistant noted that L.W. stated she was in "severe and excruciating pain" in her right hip, radiating into her back, despite taking four Vicodin tablets at a time. An examination revealed pain and tenderness in her lower back, radiating to her right hip, with very limited range of motion. L.W. was using as walker and was having difficulty getting up and down from the examination table. According to the physician assistant, L.W. needed "immediate relief from pain as her hope appears to be deteriorating and her pain is increasing." The assessment was "acute or chronic severe lower back pain." Respondent cosigned the note. No diagnostic tests were ordered, but a referral was made for a pain management consultation.

22(a). On January 24, 2007, L.W. was seen at the Temecula Pain Management Group (TPMG), by physician assistant J. Lauerman, whose report was co-signed by Jack Druit, M.D. At that visit, L.W. complained of pain in her right hip and lower back. She

reported that she recently started taking one tablet of Percocet per day, and that the pain was getting better. On the prior day, she was able to walk without a walker for the first time in two months.

22(b). On examination, tenderness was noted at the right greater trochanter bursa, with some mild tenderness in the parasacral area. Gait, motor and neurological examinations were noted to be normal. L.W. was diagnosed with trochanteric bursitis. The following recommendations were made: right trochanteric bursa injection of steroids; decrease Percocet; increase Celebrex (an anti-inflammatory medication) to 200 mg twice per day for pain relief. No diagnostic tests were recommended.

23. On January 25, 2007, patient L.W. was seen by Respondent, who noted that she still complained of back and hip pain, but that she was "overall improved." Respondent had been provided with the TPMG findings and recommendations. As recommended by the TPMG, Respondent increased L.W.'s Celebrex prescription and discontinued the Percocet, but also prescribed Vicodin. Respondent's assessment was "lower back pain / bilateral hip pain." At that point, due to the improvement, Respondent did not contemplate further diagnostic testing.

24. On February 13, 2007, L.W. returned to Respondent with complaints of severe pain from her waist radiating down her legs and difficulty walking. At this visit, the patient was observed by her husband to be crawling on the floor in pain. After examination, Respondent's assessment was "acute sciatica." He prescribed Torodol injections (an anti-inflammatory to control the pain) and he added a notation to "find out authorization for follow up pain clinic."

25(a). On or after February 13, 2007, Respondent added notations to his December 26, 2006 progress note (see Factual Finding 20). He added a notation indicating that the patient had an x-ray with no fracture, and that her pain had improved. Respondent also added a notation documenting the performance of a hip examination, and noting pain at the greater trochanter area and limited range of motion due to pain. He also added an assessment which included bilateral hip pain. The change in the medical record was not dated by Respondent to show when the document was amended.

25(b). Respondent testified that he altered the December 26, 2006 progress in order to provide evidence that the patient was having hip problems in December and therefore obtain approval from the medical group for re-referral to TPMG for hip injections. Respondent stated that he believed if he sent progress notes without any data regarding a hip examination, it was likely that the medical group would deny approval for the referral for hip injections.

25(c). The evidence did not establish that Respondent conducted a hip examination on December 26, 2006. Therefore, even if Respondent altered the progress note in order to obtain approval for a referral (rather than to insert exculpatory documentation prior to

sending L.W.'s medical record to the Board), this alteration was still done with a fraudulent intent and constitutes dishonesty.

26. Although L.W. obtained approval for the referral on February 16, 2007, TPMG could not give her an appointment for injections until March 1, 2007.

27. On February 20, 2007, L.W. came to Respondent's office after calling to request a cortisone injection. At that visit, she complained of worsening pain in her right hip, stating that she was unable to walk or bear weight. Respondent's assessment was "degenerative joint disease of the right hip." Respondent administered a Kenalog injection to her right hip and ordered a stat MRI of her right hip to "rule out [a] tear or other etiology."

28. On February 22, 2007, L.W. returned to Respondent's office to receive another Kenalog injection. Respondent's assessment was "hip bursitis." Respondent noted "call pain clinic," and ordered an MRI of her lumbar spine and right hip.

29(a). On February 23, 2007, an MRI of L.W.'s lumbar spine was performed at Temecula Valley Advanced Imaging. The findings included a fracture of the right upper sacrum, with a maximum gap of 3mm at the fracture site. The entire extent of the fracture was not visible on the MRI. The findings also included a possible non-displaced left mid-sacral fracture vs. an MRI imaging artifact, not optimally visualized on the MRI. There were no vertebral fractures.

29(b). An MRI of L.W.'s right hip was performed on February 24, 2007. The MRI showed a "right femoral neck fracture, superior to the intertrochanteric area, with adjacent bone marrow edema. Maximum displacement [was] about 1.5 cm."

29(c). The findings of the February 23 and 24 MRIs were discussed with Respondent by phone on the afternoon of February 26, 2007.

30. On February 27, 2007, L.W. was admitted to Rancho Springs Medical Center and underwent a right hip replacement surgery. The post operative diagnosis of the orthopedic surgeon, Jack E. Ellis, M.D., was "right femoral neck chronic fracture." During the surgery, Dr. Ellis noted that the fracture had "shown no significant healing." The patient tolerated the procedure well and was later discharged.

***Standard of Care re: Patient L.W.***

Alleged Repeated Negligent Acts:

*Failure "to perform/document a complete initial history & physical" and*
*Failure to "perform/document screening tests or surveillance of health issues"*

31(a). Dr. Yan stated that the standard of care requires a primary care internal medicine physician to conduct a comprehensive initial evaluation and to conduct a medication reconciliation to determine if it was necessary to continue prior medications. Dr. Yan admitted that, if the patient appears to be doing well, there is no reason to stop the patient's current regimen and start a new one, and it would be unwise to make such changes all at one time. Dr. Yan opined that Respondent's May 19, 2004 initial evaluation was incomplete, was not comprehensive and therefore, fell below the standard of care. According to Dr. Yan, Respondent conducted no medication reconciliation of the patient's prior regimen and the medications prescribed by Respondent; there was no documentation of the patient's chronic conditions that were being addressed; and the patient's allergies were not well documented. However, these factual bases for his opinion were not borne out by the evidence, which indicated instead that L.W. had provided Respondent with a list of her medications and prior procedures; that Respondent had already noted these medications and the conditions for which they were prescribed in his April 1, 2004 progress note; and that the patient's allergies were noted in the May 19, 2004 progress note and on the Physical Examination Form.

31(b). Dr. Yan also opined that screening and preventative measures should have been pursued at the initial visit and subsequent visits. According to Dr. Yan, although lab tests were done in 2004, the medical record did not document continued surveillance for thyroid, cholesterol and other conditions by way of follow-up lab work. However, this factual basis for his opinion was not borne out by the evidence. Dr. Yan admitted later in his testimony that he did not notice the 2005 follow-up lab work, and that Respondent did obtain lab tests after 2004 to follow up on abnormal chemistries (low potassium and elevated calcium). In light of the follow up lab work, Dr. Yan instead opined that Respondent should not have waited a year to check the potassium level, but should have followed up with lab work in two weeks. Additionally, Dr. Yan asserted that since the medications "causing the abnormal results" were continued, "managing the abnormalities was below the standard of care." Dr. Yan did not explain the bases for his assertion that the medications were the proven cause of the abnormal results, nor whether he believed immediate discontinuation of medications, despite their necessity to manage chronic conditions, was warranted. He did not adequately address why Respondent's approach of making less drastic changes to the patient's diet and calcium supplement was inappropriate, particularly given the normal levels that were eventually reached. Dr. Yan admitted that the 2005 mammogram and colonoscopy were appropriate surveillance/screening for L.W. He also admitted that Respondent's referral to a urologist was appropriate.

31(c). Dr. Achar testified that the standard of care for a new patient requires taking the patient's past medical history, past surgical history, allergies, social history, family history and the history of their present illness, if they have one. The physician should conduct a physical examination, make an assessment and set up a plan. The physician should also try to obtain the records from the patient's prior treating physician(s). The standard of care also requires a physician to assess the patient's previously prescribed medications to determine if they are appropriate and, if so, to continue the prescription. The Health Questionnaire which L.W. completed, along with her attached list of medications

and medical history/procedures, was a complete and comprehensive history. Respondent's assessment and plan from the April 1, 2004 visit was also appropriate. The lab tests on May 19, 2004, provided information for assessing L.W.'s hypothyroidism, hypertension, liver function and cholesterol. Thereafter, the patient's thyroid function, liver function, cholesterol level, potassium level, calcium level and other blood counts were monitored. Although her potassium level was slightly low in 2004, Respondent followed up in 2005 and added a potassium supplement to L.W.'s medication regime, which brought her potassium levels to a normal level in 2006. Additionally, although the patient's calcium level was mildly elevated in 2004 and in 2005, Respondent decreased L.W.'s calcium supplement, which brought her calcium to a normal level in 2006. All of Respondent's follow up on abnormal readings was within the standard of care. Furthermore, Respondent's ordering mammography in 2005 and referrals to a urologist for bladder cancer screening and to a gastroenterologist for colonoscopy were all within the standard of care. Dr. Achar opined that Respondent met the standard of care in "perform[ing] and document[ing] interval screening tests, preventative measures or surveillance of the patient's ongoing health issues, including, but not limited to, mammography."

31(d). Regarding whether Respondent engaged in negligent acts in his care of L.W. by failure "to perform and /or document a complete initial history and physical of patient L.W" or by failure to "otherwise perform and/or document interval screening tests, preventative measures or surveillance of the patient's ongoing health issues, including, but not limited to, mammography," the opinions of Dr. Yan were less persuasive than those of Dr. Achar. Therefore, the opinions of Dr. Achar, set forth in Factual Finding 31(c), are adopted as facts herein.

*Failure to properly evaluate / follow up on evidence of osteopenia*

32(a). Dr. Yan testified that osteopenia could be a warning sign of a patient progressing toward osteoporosis, which can, in turn, lead to fracture. He opined that, ideally, a physician should obtain bone densitometry to help determine what treatment to recommend, and that a physician should also discuss with his patient treatments for osteopenia, the risks of taking hormone replacements and alternative treatment options such as bisphosphonates (e.g. Fosamax). Dr. Yan acknowledged that L.W. was taking Premarin (estrogen replacement) for menopausal symptoms. He admitted that L.W. did not have osteoporosis, that Premarin would be one of the treatment options for osteoporosis, and that a physician should have tried "not to give a patient both" Premarin and Fosamax in 2006. He also acknowledged that Premarin and Fosamax were not typically used for treating osteopenia. Dr. Yan agreed that Premarin may have been a more cost-effective medication, but insisted that, while patient preference is important, the physician must have the discussion of the options with the patient. Dr. Yan opined that Respondent fell below the standard of care in failing to discuss screening or other treatment options with the patient. He did not address the contraindication of the patient's GERD to prescribing Fosamax, which was the only alternative treatment to which he alluded, and whether there was still a need for patient discussion in light of this contraindication.

32(b). Dr. Yasharel opined that the standard of care for addressing a finding of osteopenia is to order a bone density scan to see if treatment is necessary. Dr. Yasharel further opined that Respondent committed a simple departure from the standard of care in failing to follow up on the finding of osteopenia. He admitted that Premarin does provide some protection for osteopenia, but noted that even patients who are on a treatment regimen have the potential for not responding to the medication. Therefore, analysis is still needed, and the results of a bone density study could potentially warrant a change in medication. Based on his clinical experience, Dr. Yasharel opined that Fosamax was a more effective than Premarin and that both medications can be taken at the same time. However, he admitted that GERD could be a contraindication to prescribing Fosamax.

32(c). Dr. Achar opined that a bone density scan should be used if it will make a difference in the treatment of the patient. L.W. was already taking Premarin for another medical condition, so the Premarin was addressing osteoporosis prevention as well. Although Fosamax is a "stronger" medication, L.W.'s GERD (for which she was taking Aciphex) was a relative contraindication to Fosamax, which can cause esophagitis. Therefore, further imaging of bone density would not have changed her therapy, and thus would not have been helpful. Dr. Achar opined that Respondent's refraining from ordering the test was not below the standard of care.

32(d). Regarding whether Respondent engaged in negligent acts in his care of L.W. by failure "to properly evaluate and follow up on evidence of osteopenia," the opinions of Drs. Yan and Yasharel were less persuasive than those of Dr. Achar. Therefore, the opinions of Dr. Achar, set forth in Factual Finding 32(c), are adopted as facts herein.

*Failure to properly evaluate / follow up on the suspicion of atrial fibrillation*

33(a). Dr. Yan testified that the EKGs taken January 6, 2006, and March 3, 2006, contained no evidence of atrial fibrillation. Nevertheless, it was appropriate for Respondent to order repeat EKGs if he was concerned about possible atrial fibrillation. However, Dr. Yan opined that, if Respondent suspected atrial fibrillation, the standard of care also required him to work up that potential diagnosis with a more detailed cardiac history (including prior heart palpitations, exercise tolerance, dizziness and chest pain). One option was a Holter monitor to capture rhythms for 24 to 72 hours; other options would be diagnostic tests such as an echocardiogram to confirm or rule out structural abnormalities, or referral to a cardiologist. According to Dr. Yan, Respondent's workup was not a comprehensive workup of atrial fibrillation and was, therefore, below the standard of care.

33(b). Dr. Yasharel agreed that the EKGs taken January 6, 2006, and March 3, 2006, contained no evidence of atrial fibrillation. However, if Respondent suspected atrial fibrillation, it was appropriate for him to order repeat EKGs. According to Dr. Yasharel, "if there was atrial fibrillation, which I did not see, then an echocardiogram would have been approp, but was not done." Dr. Yasharel did not specify at what point in time, the echocardiogram should have been ordered. Dr. Yasharel opined that it was a departure

from the standard of care not to follow up with an echocardiogram on suspicion of atrial fibrillation.

33(c). It was unclear why Drs. Yan and Yasharel would find that the standard of care required follow up on a condition which they both opined was not evidenced in the initial EKG. Addtionally, given that Drs.Yan and Yasharel found the repeat EKG in March appropriate, it was unclear at what point they believed an echocardiogram (and according to Dr. Yan, a Holter monitor or cardiology referral) should have been ordered. Since Respondent had discounted atrial fibrillation as a possible diagnosis by March 3, 2006, it could not have been necessary thereafter. However, Drs. Yan and Yasharel did not specify that the echocardiogram, Holter monitor or cardiology referral should have been ordered prior to March 3, 2006, or that the repeat EKG should have occurred earlier.

33(d). Dr. Achar opined that Respondent appropriately followed up on his suspicion of atrial fibrillation. Dr. Achar testified that, given the patient's discontinuation of all medications, it was reasonable for Respondent to become concerned and it was appropriate to order an EKG. According to Dr. Achar, the patient's heart rate of 113 and the irregularity in rhythm were reasons for Respondent to consider atrial fibrillation, and resuming the patient's beta-blocker was appropriate and within the standard of care. It was also appropriate for him to order a repeat EKG.

33(e). Regarding whether Respondent engaged in negligent acts in his care of L.W. by failure to "properly evaluate and follow up on the suspicion and/or diagnosis of atrial fibrillation," the opinions of Drs. Yan and Yasharel were less persuasive than the opinions of Dr. Achar. Therefore, the opinions of Dr. Achar, set forth in Factual Finding 33(d), are adopted as facts herein.

34. Complainant did not establish by clear and convincing evidence that Respondent engaged in negligent acts in his care of L.W. by any of the following: (1) failure "to perform and /or document a complete initial history and physical of patient L.W." (Accusation, para. 8Q); (2) failure to "otherwise perform and/or document interval screening tests, preventative measures or surveillance of the patient's ongoing health issues, including, but not limited to, mammography" (Accusation, para. 8R); (3) failure "to properly evaluate and follow up on evidence of osteopenia" (Accusation, para. 8S); (4) failure "to properly evaluate and follow up on the suspicion and/or diagnosis of atrial fibrillation" (Accusation, para. 8T).

*Failure to properly evaluate/follow up on hip injury and continuing pain*

35(a)(1). Dr. Yan opined that, in 2006, to address complaints of persistent pain in an elderly person after a fall, the standard of care required an internist to evaluate the patient for a fracture. Patient L.W. had a number of risk factors for fracture, including: a trauma/fall; evidence of low bone mass/osteopenia on prior x-rays; and a prior fall from which she had sustained a fracture. Given the high index of suspicion for fracture in this patient, the standard of care required Respondent to pursue a fracture diagnosis more

aggressively, even if the initial imaging did not show a fracture. According to Dr. Yan, the standard of care required the completion of a history and physical after the trauma and ordering plain film x-rays, which Respondent did. It was reasonable, at that point, for Respondent to rely on that x-ray reading, which Dr. Yan confirmed showed no evidence of a fracture. However, the x-ray is just one piece of information used to manage the patient. The entire clinical picture must be considered as well. Dr. Yan admitted that a patient could experience radiculopathy from a disc pressing on nerves and could experience hip pain from a cartilage injury after trauma. However, he maintained that nothing in the clinical picture pointed toward cartilage injury. In this case, L.W. had a higher risk for fracture and had continuing complaints of pain and difficulty walking, despite use of oral opiates, anti-inflammatory medication and bursa injections. According to Dr. Yan, in this clinical situation, the standard of care required Respondent to obtain further diagnostic testing which could include a repeat x-ray or a more sensitive test such as an MRI. Dr. Yan also noted that an MRI could have confirmed or ruled out the spinal stenosis, cartilage injury or trochanter bursitis. The risks to a patient from an undiagnosed hip fracture include displacement of the fracture; this, in turn, can lead to risks including long term pain and debility, bleeding, neurological symptoms, avascular necrosis and death.

35(a)(2). Dr. Yan noted that, by January 8, 2007, L.W. was experiencing persistent, worsening pain in her low back, hip and groin; was taking four Vicodin at a time, without a decrease in pain; and was using a walker. Although a pain management consultation was ordered, there was no plan for change of management/treatment. He acknowledged that the pain management consultation several weeks later described L.W. as being able to walk and in no acute distress. Therefore, it was reasonable for Respondent to discount a hip fracture at that time, since she appeared to be improving clinically with time and with a combination of therapies. Nevertheless, by February 13, 2007, the patient was suffering from severe pain from her waist down and was having difficulty walking again. Respondent's assessment was "acute sciatica." A week later, Respondent ordered MRIs of her lumbar spine and her hip, to "rule out a tear or other etiology." Respondent has several opportunities to pursue the diagnosis of fracture over several months. Dr. Yan opined that Respondent's repeated failure to consider a diagnosis of fracture in a fall-risk patient whose pain and symptoms originated from a fall/trauma and progressed despite treatment, was an extreme departure from the standard of care. Dr. Yan also opined that Respondent's failure to investigate this possible diagnosis with further diagnostic modalities, including x-ray or MRI, was an extreme departure from the standard of care.

35(b). Dr. Yasharel agreed that the x-rays ordered by Respondent showed no evidence of a fracture and that it was appropriate for Respondent to consider diagnoses other than fracture at that time. However, after a month of patient complaints of pain and inability to walk, Respondent should have reconsidered fracture as a diagnosis. With an elderly patient who returns for several visits with the same complaints of pain, is not responding to medications and is unable to walk, the standard of care required further imaging such as an MRI. According to Dr. Yasharel, it was a simple departure from the standard of care for Respondent to fail to obtain further radiologic studies at an earlier point in time.

35(c). Dr. Achar testified that, with a patient complaining of pain after a fall, the standard of care requires an appropriate history, focused examination on the part causing pain and appropriate testing, which was an x-ray, and appropriate treatment. There are two types of fractures; one is caused by trauma (e.g. a fall), and the other is a stress fracture, caused by overload. X-rays are used to diagnose trauma-induced fractures, and MRI is used to diagnose overload or stress fractures only. According to Dr. Achar, MRI is not used to diagnose trauma fractures. Dr. Achar opined that Respondent ordered the test dictated by the standard of care (x-ray) and then continued with his care of the patient, prescribing medication, referring to a specialist, performing specialized treatment (injections) and ultimately ordering special testing which led to the discovery of the missed fracture. Given the findings from TPMG at the end of January, Dr. Achar maintained that it was appropriate for Respondent to continue believing that the patient's pain was caused by some condition other than fracture and therefore, not order further imaging. Respondent later ordered the MRI to look for other causes of the patient's hip pain, not fracture. According to Dr. Achar, it was appropriate to order the MRI on February 20, 2007, and not sooner, because L.W. was then unable to walk.

He did not explain why L.W.'s prior difficulties walking, or her crawling across the floor in pain on February 13, 2007, did not warrant ordering an MRI at those points in time. Dr. Achar opined that Respondent's course of treatment following L.W.'s fall was timely and was within the standard of care.

35(d). Regarding whether Respondent engaged in negligent acts in his care of L.W. by failure to "properly evaluate and follow up on the patient's hip injury in the face of continuing patient complaints of pain and the ineffectiveness of his treatment modalities," the opinions of Drs. Yan and Yasharel were more persuasive than the opinions of Dr. Achar. Therefore, the opinions of Drs. Yan and Yasharel, set forth in Factual Findings 35(a) and 35(b), are adopted as facts herein, except as follows: Although Dr. Yan opined that Respondent's failure constituted an extreme departure from the standard of care, Dr. Yasharel, who has a outpatient practice similar to Respondent's, opined that it constituted a simple departure from the standard of care. Consequently, Dr. Yasharel's finding of simple negligence is adopted as the appropriate finding.

35(e). Respondent did not consider fracture as a possible diagnosis after the initial x-ray came back negative, despite the patient's risk factors and subsequent increase in pain and difficulty walking. On December 26, 2007, his assessment was "lower back pain." (He did not add the information regarding the patient's hip problems until on or after February 13, 2007.) At the January 8, 2007 visit, when L.W. was in "severe and excruciating pain" in her right hip, radiating into her back, despite taking four Vicodin tablets at a time, Respondent should have reconsidered a possible hip fracture diagnosis. He did not, and the assessment remained "acute or chronic severe lower back pain." A month-long subsidence in symptoms, aided by an increase in anti-inflammatory medication, intervened. This understandably waylaid any consideration of a fracture diagnosis. However, by February 13, 2007, L.W. again had complaints of severe pain from her waist radiating down her legs

and difficulty walking. At this visit, the patient was observed by her husband to be crawling on the floor in pain. Nevertheless, Respondent's assessment remained "acute sciatica," and he did not consider fracture as a possibility. No further diagnostic testing was ordered at that visit. Even when he ordered the MRI a week later, he was considering a tear, not a fracture, as a possibility. This failure to consider a diagnosis of fracture in a fall-risk patient whose pain and symptoms originated from a fall/trauma and progressed despite treatment constituted a simple departure from the standard of care.

*Negligent failure to maintain adequate and accurate records*

36(a)(1). Dr.Yan opined that for physician documentation in a patient chart the standard of care required accurate and complete documentation. Documentation of office visits must be complete, with notation regarding physical exam, vital signs and a consistent listing of allergies. In Respondent's records, several progress notes were incomplete and/or illegible, and the patient's allergies were incorrectly listed numerous times as "no known drug allergies." Dr. Yan opined that Respondent's recordkeeping constituted a simple departure from the standard of care

36(a)(2). Dr. Yan further opined that in making changes to a medical record, the standard of care requires the physician to identify the change and include the date and time of the amendment, and sign the amendment. Respondent's alteration of the December 26, 2006 progress note after the fact, without indicating the date and time of the amendment and signing the amendment was an extreme departure from the standard of care and constituted unprofessional conduct.

36(b)(1). Dr. Yasharel opined the standard of care requires a medical record to be readable and understandable to a subsequent care provider. There were several illegible chart entries made by Respondent in his office chart. Dr. Yasharel opined that the illegibility was a departure from the standard of care.

36(b)(2). Dr. Yasharel opined that, in making changes to a medical record, the standard of care requires the physician to date and initial the addendum, which was not done in this case. This constituted an extreme departure from the standard of care.

36(c)(1). With regard to Respondent's recordkeeping, Dr. Achar opined that the standard of care did not require a pulse to be documented at each visit. Dr. Achar did not address whether incorrectly listing "no known drug allergies" on numerous progress records fell below the standard of care.

36(c)(2). Dr. Achar harnessed his greatest powers of advocacy, and evasion, during his testimony on the issue of Respondent's alteration of the December 26, 2006 progress note. He agreed that, when placing addendums in a medical record, physicians are expected to include their name and date and the reason for the addendum. However, Dr. Achar pointed out that he has reviewed numerous patient charts and "it happens all the time that additional information is added or lined out and the physician has not signed and dated

it." He went on to state that "how we define the standard of care is different from how we train physicians, and we train physicians [to sign and date addendums]." According to Dr. Achar, the standard of care is what a prudent physician would do in the same or similar circumstances, and "many prudent physicians would [include addendums] without dating and signing." He further pointed out that Respondent's alteration was necessary to obtain approval for a referral, and that "one reason the standard of care was met was that the additions made were factually accurate" and made with the intent to help a patient. He argued that Business and Professions Code section 2262 "says that physicians are not allowed to record information in a medical record that is false," but that there was no evidence that any of Respondent's added information was false. He also argued that Section 2262 "says that physicians cannot add anything in a medical record with fraudulent intent to deceive," and in this case there was no fraudulent intent when adding information to obtain a needed consultation for a patient. Dr. Achar made this argument on the assumption that the range of hip motion testing added by Respondent had indeed been performed. On cross examination, Dr. Achar stalwartly held fast to this assumption, refusing to admit that there was no hip examination or range of motion testing on December 26, 2006. Instead, he insisted that, "the fact that [Respondent] did not document it on the original note does not mean that he did not perform [the examination and testing. Dr. Achar was asked on cross examination: Assuming that no such hip examination or range of motion testing had been done on December 26, 2006, but documentation of such was added later without an examination or testing being done, is that a falsification of records? At first, Dr. Achar refused to assume the hypothetical presented. However, after being instructed to assume the facts of the hypothetical, he admitted that such actions would be falsification of records and below the standard of care.

36(d). Regarding whether Respondent engaged in negligent acts in his care of L.W. by failure to "maintain adequate and accurate records of the care and treatment of patient L.W.," the opinions of Drs. Yan and Yasharel were more persuasive than the opinions of Dr. Achar. Therefore, the opinions of Drs. Yan and Yasharel, set forth in Factual Findings 36(a) and 36(b), are adopted as facts herein.

37. Complainant established by clear and convincing evidence that Respondent engaged in negligent acts in his care of L.W. when he: (1) "failed to properly evaluate and follow up on the patient's hip injury in the face of continuing patient complaints of pain and the ineffectiveness of his treatment modalities" (Accusation, para 8U); and (2) failed to maintain adequate and accurate records of the care and treatment of patient L.W. (Accusation, para. 8V).

Altering Medical Records and Dishonesty:

38. Complainant established by clear and convincing evidence that Respondent altered the medical records of patient L.W. for the office visit of December 26, 2006, without dating and signing the amendment, and that this alteration was still done with a fraudulent intent and constitutes dishonesty. (Accusation, paras. 9B and 10A..) (See Factual Findings 25 and 36.)

Gross Negligence:

39. Complainant did not establish by clear and convincing evidence that Respondent "was grossly negligent in the care and treatment of patient LW when he failed to properly evaluate and follow up on the patient's hip injury in the face of continuing patient complaints of pain and the ineffectiveness of his treatment modalities." (Accusation, para. 11 B.) (See Factual Finding 35.)

40. Complainant established by clear and convincing evidence that Respondent "was grossly negligent when he altered the medial records of patient L.W. for the office visit of December 26, 2006." (Accusation, para. 11C.) (See Factual Finding 36.)

Failure to Maintain Adequate and Accurate Records:

41. Complainant established by clear and convincing evidence that Respondent failed to maintain adequate and accurate records of the care and treatment of patient L.W. (Accusation, para. 12B.) (See Factual Finding 36.)

***Facts Re: Patient J.M.***

42. On January 18, 2006, a 77-year-old male patient, J.M., was seen by Respondent in his office. J.M. had been seen previously by Respondent. At the January 18, 2006 visit, Respondent documented J.M.'s history of lung cancer in 1996, and his osteoporosis. The patient's blood pressure was documented, but not his pulse. Respondent ordered a chest x-ray and prescribed Fosamax for the osteoporosis.

43. The chest x-ray, taken on January 18, 2006, with no prior x-rays for comparison, resulted in an abnormal finding of "volume loss with pleural thickening or effusion" in the right lung. The left lung was clear. Respondent ordered a CT, with contrast, of the patient's chest.

44. On February 6, 2006, the CT was performed, with no prior CT for comparison. It showed a moderate-sized hiatal hernia and volume loss in the right lung with small pleural effusion. In the left upper lobe, the CT showed a "3cm x 1 cm linear density suggestive of scarring. Neoplastic process less likely, although not entirely excluded," and in the left lower lobe, it showed a "2 cm x 1 cm linear scarring more likely than mass." Due to the abnormalities in the left upper lung, a three-month follow-up chest CT in May 2006 was recommended.

45(a). On June 13, 2006, Respondent faxed a request for a follow up chest CT scan.

45(b). On July 24, 2006, the follow up chest CT was performed with the February 6, 2006 CT for comparison. The impression was "Stable CT Chest, with findings as described." The findings included:

2 cm irregular density in the left upper lobe anteriorly in the apex is stable suggesting scarring. Similarly, a linear opacity in the left lower lobe posteriorly is stable suggesting scarring. The right pleural fluid collection approximately 3 cm thick is stable, as is consolidative changes of the medial aspect of the right lower lobe along the mediastinum. Again noted is moderately enlarged hiatal hernia. There is no evidence of adrenal mass. The few tiny aortopulmonary lymph nodes are not considered enlarged by CT size criteria and measure no more than 7 mm in diameter. There is irregularity of the posterior aspects of the right eighth and ninth ribs and right T9 transverse process, not appearing significantly changed.

46. There were no further follow up CT scans.

*September 21 – 22, 2006 hospitalization*

47. On September 20 2006, J.M. fell over his walker, striking the left side of his chest.

48. On September 21, 2006, he went to the Ranch Springs Medical Center (Ranch Springs) Emergency Room (ER), suffering from left chest pain and shortness of breath. The ER physician noted J.M.'s history of lung cancer and hypertension. A chest x-ray showed apparent congestive heart failure (CHF) and a left rib fracture, with no pneumothorax. An arterial blood gas (ABG) test revealed hypoxia, and some of his laboratory values were abnormal, including a high white blood count and mildly elevated BNP. While in the ER, J.M. required supplemental oxygen to maintain adequate saturation. The ER physician noted that at one point while J.M. was on four liters of oxygen, had a pulse oxymeter reading of 84 percent; when oxygen was removed, his pulse oxymetry readings dropped into the 70s. Thereafter, he was placed on a nonrebreather mask, and his oxygen saturation climbed to the mid to upper 90s. He was started on intravenous (IV) fluids, and a diuretic was given for the CHF. A CT scan of the chest was ordered to rule out pulmonary embolus. The ER physician's impression was "acute hypoxia." His differential diagnoses were: pulmonary contusion versus CHF, rule out pulmonary embolus; and left rib fracture.

49. The patient was admitted to the hospital in "fair and stable" condition, under the care of Respondent.

50. A chest CT scan on September 22, 2006, confirmed the rib fracture. The findings also included "no gross pulmonary arterial filling defect to suggest pulmonary embolism," and a "small, less than 5%, left pneumothorax."

51(a). On September 22, 2006, Respondent placed a handwritten admission note in the progress notes. He noted "history and physical – see dictated note." Under assessment

and plan, several lines were illegible. However, he noted J.M.'s rib fracture and hypoxia, and his plan included: "admit for hypoxia/pain management," rib brace, "physical therapy evaluation (remainder illegible), "discharge home (remainder illegible)", and "if not return to normal then will arrange for home oxygen."

51(b). Respondent did not dictate the admission history and physical (H&P) until December 13, 2006. In the dictated H&P, Respondent noted, "In the emergency room the patient was evaluated and found to have some rib fractures and also given the patient's condition and history with a little bit of hypoxia, so we decided to admit the patient." Respondent listed laboratory data as "essentially all normal." His assessment was "status post fall with rib fracture." His assessment and plan mirrored that of his handwritten note.

52. On September 22, 2006, at 10:23 a.m., Respondent ordered a rib brace, physical therapy evaluation, pulse oxymetry, and "ABG on room air. Call me with results."

53. On September 22, 2006, between 8:00 am and 4:00 p.m., J.M.'s oxygen level was at 97 percent on a non-rebreather mask, fell to 76 percent on room air, and returned to 97 percent when the non-rebreather mask was replaced.

54(a). On September 22, 2006, at 2:15 p.m., Respondent issued a telephone order, stating "discharge home with oxygen." However, the patient remained in the hospital, and according to Respondent, Dr. Carrasco took over the patient's care. However, there was no order or other documentation specifying the transfer of care.

54(b). According to a nursing note, at 4:00 p.m., J.M's oxygen saturation was 85 percent, so the patient received four liters of oxygen via nasal cannula per Dr. Carrasco's order. J.M.'s oxygen saturation then improved to between 90 to 92 percent with the supplemental oxygen. There was no documentation in the medical record indicating that Dr. Carrasco examined the patient prior to issuing the order for oxygen.

55. On September 22, 2006, at 6:30 p.m., J.M. was discharged home with oxygen. At that point, his oxygen saturation was 89 percent with four liters of oxygen via nasal cannula. His pulse was 107, and his blood pressure was 131/75.

56. Respondent's final progress note for J.M.'s September 21-22, 2006 hospitalization was not written until November 4, 2006. His final diagnosis was "left rib fracture, pain management, and hypoxia – Chronic Obstructive Pulmonary Disease (COPD)." The patient's condition on discharge was listed as "fair," and instructions were to "follow up with primary care physician." His admission H&P for the September 21-22, 2006 hospitalization was not dictated until November 14, 2006.

57. At the administrative hearing, Respondent explained that "discharge to home" means the start of discharge planning, which involves preparation for discharge and arranging ancillary services, including oxygen. According to Respondent, many times patients are not yet ready to go home when the discharge order is made, but a physician

needs to plan for the discharge, especially on Friday, when the on-call physician takes over coverage of inpatients until Monday morning. Respondent admitted that he did not specify the oxygen level for discharge. He also admitted that at the time of the discharge order, he was on a nonrebreather mask so he would not have sent the patient home at that time. According to Respondent, the physician who discharges the patient ultimately decides the level of oxygen to order for home use. However, Respondent insisted that he signed the patient over to the on-call physician, Dr. Carrasco, for further care and to determine if the patient was stable to go home, and that it was Dr. Carrasco's responsibility for discharge of the patient. Respondent also agreed that the patient should not have been discharged home with a respiratory rate of 107.

*September 27 – 29, 2006 hospitalization*

58. On September 26, 2006, J.M. saw Respondent in follow up. The patient complained of inability to eat, abdominal pain and nausea. No vital signs were recorded. The findings on lung and abdominal examinations were abnormal. Respondent's assessment was "right upper quadrant tender / mild jaundice." He ordered stat liver function tests and a right upper quadrant ultrasound to rule out cholelithiasis (gallstones). He did not instruct the patient to go to the ER because it was not an emergent situation.

59. On September 27, 2006, an ultrasound of J.M.'s abdomen revealed moderate bilateral hydronephrosis with a dilated bladder but no gallstone. The patient was instructed to go to the ER, and Respondent was contacted.

60. On September 27, 2006, J.M. went to the Inland Valley Medical Center (Inland Valley) ER where he was found to have respiratory insufficiency, urinary retention, dehydration, malnutrition, electrolyte abnormalities, low platelets and difficulty swallowing liquids. He was admitted under Respondent's care, with a diagnosis of respiratory insufficiency, dysphagia (difficulty swallowing) and urinary retention.

61. On September 28, 2006, Respondent performed a H&P on J.M. at Inland Valley. His progress note stated, "H /P – see dictated note." His assessment was "urinary incontinence, dysphagia, consolidation of the lung and rib fracture." His plan included observation, placement of a Foley catheter, supplemental oxygen, antibiotics, breathing treatment, and a swallow evaluation.

62. On September 28, 2006, J.M. underwent a swallow evaluation. At 2:40 p.m., Respondent was paged, and at 4:40 p.m., he was informed of the results from the swallow evaluation. At 4:50 p.m. Respondent ordered a modified barium swallow evaluation.

63. On September 28, 2006, after speaking to the nurse at 9:00 p.m., Respondent turned over the care of J.M. to Dr. Carrasco.

64. On September 29, 2006, J.M. underwent a modified barium swallow evaluation. Respondent was not notified of the findings, which included a recommendation for a pulmonology consultation.

65. On September 29, 2006, at 3:33 p.m., Dr. Carraso ordered the patient discharged to home, with a visiting nurse for Foley catheter care, home physical therapy, home oxygen, and follow up with Respondent in one week. Respondent was not involved in the discharge of J.M.

66. On October 26, 2006, Respondent wrote a discharge summary, indicating that the patient had been discharged in "fair" condition with final diagnoses of "pneumonia; dysphagia [and] urinary incontinence."

*October 16-25, 2006 hospitalization*

67. On October 16, 2006, Patient J.M. was taken by ambulance to the Rancho Springs ER, suffering from shortness of breath. He was admitted with sepsis, secondary to pneumonia and urinary tract infection, CHF, acute on chronic respiratory failure and multiple decubitis ulcers. Respondent performed a H&P. Consultations with various specialists were obtained. Cultures revealed methicillin-resistant staphylococcus aureus (MRSA), drug resistant organisms, in the lungs and urine. The patient was provided with broad spectrum antibiotics, system steroids, respiratory therapy, noninvasive ventilation, wound care, feedings via nasogastric tube (NGT) and daily physical therapy. There was little change in the patient's severe dysphagia.

68. Nutrition was one of greatest concerns during the October hospitalization. Since there was no access for proper feedings, they had to rely on NGT feedings, which involves the risk of aspiration. A gastroenterologist was consulted and determined that percutaneous endoscopic gastronomy (PEG) tube placement was not feasible due to the placement of J.M.'s stomach below his rib cage. A surgeon was also consulted for possible placement of a jejunostomy tube (J-tube) in the small intestine, but the surgeon determined that J.M. would not be able to tolerate surgery. The only option left was NGT feeding.

69(a). Respondent discussed with J.M.'s wife and daughter the possible placement of J.M. in long term care after discharge. However, J.M.'s family rejected that option because he had previously asked not to be placed in a nursing home after a prior negative experience in such a facility. They insisted on his discharge home, and Respondent wanted to honor J.M.'s and his family's wishes.

69(b). Respondent knew that J.M.'s wife had several decades of experience caring for a quadriplegic son. J.M.'s wife, with help from family members had taken care of her son's decubitis ulcers, Foley catheter, peripherally inserted central catheter (PICC) lines, and feeding through a gastric tube. Consequently, she and Respondent felt that she was capable, along with family support and extra help from home health agencies and visiting nurses, to care for her husband on discharge to their home.

69(c). Nursing notes indicated J.M.'s family had been instructed about NGT feeding (management, complications and risks) and about wound care.

70(a). One of the specialists consulted was Munif Salek, M.D., a pulmonologist, who saw J.M. almost every day of his October hospitalization. Dr. Salek was involved in ordering diagnostic modalities (e.g. x-ray and bronchoscopy), prescribing treatment and managing J.M.'s oxygen.

70(b). Respondent last saw the patient on October 24, 2006. On October 25, 2006, Dr. Salek examined J.M. Dr. Salek believed that, from a pulmonology standpoint, J.M. appeared to be improving, and that it was appropriate to discharge the patient home with vancomycin, breathing treatment and oxygen. In his October 25, 2006 progress note, Dr. Salek indicated "discharge home with vancomycin . . ."

71. On October 25, 2006, J.M. was discharged home with IV antibiotics, NGT feedings, home oxygen, Foley catheter and multiple pressure ulcers requiring care. There was no documentation of post-discharge medications or a follow-up plan.

*November 1 – 19, 2006 hospitalization*

72. On November 1, 2006, J.M. went to Rancho Springs ER with respiratory distress. His experienced oxygen desaturation to about 82 percent with three or four liters of oxygen via nasal cannula. A nonrebreather mask was placed and his oxygen saturation increased to 87 percent. He was then intubated, placed on mechanical ventilation and admitted to the intensive care unit (ICU) in critical condition.

73. On November 1, 2006, Abayomi A. Odubela, M.D. conducted an H&P. His impression included was acute respiratory failure, bilateral pneumonia, CHF and mild anemia. The treatment plan included bronchodilator nebulized treatments, IV antibiotics, and IV steroids.

74. On November 2, 2006, Dr. Salek conducted pulmonary consultation. His impression included: acute on chronic respiratory failure with right lung pneumonia, recurrent; history of MRSA pneumonia; rule out pulmonary embolus on this patient; COPD; history of lung cancer; history of urinary tract infection; cachexia, malnutrition and dysphagia, on tube feedings; and anemia. Dr. Salek later (Nov. 10) performed a bronchoscopy which revealed mild tracheobronchitis.

75. During his this hospitalization, J.M. was treated with anticoagulation (for pulmonary embolism), steroids, bronchodilators, antibiotics, NGT feedings and wound care.

76. On November 6, 2006, J.M. was transferred to Respondent's care at Rancho Springs. This was documented on a physician's order on November 6, 2006, at approximately 8:30 p.m.

77. Subspecialists continued to follow the patient. J.M. was on mechanical ventilation from November 1 through November 10, 2006. He was transferred out of ICU on November 15, 2006.

78. On November 17, 2006, J.M. experienced difficulty with the NGT feedings and was switched by Respondent to total parenteral nutrition (TPN). A left arm PICC line was placed on November 18, 2006, for that purpose. When it failed later that day, the PICC line was switched to the right upper extremity.

79. On November 17, 2006, at 1:40 p.m., Respondent issued a telephone order for the "possible discharge on November 18, 2006, with home [TPN], home health and physical therapy."

80. Toward the end of the hospitalization, J.M's wife spoke to one of the nurses about the option of hospice care. J.M.'s family ultimately decided against hospice because it requires a do not resuscitate order.

81. On November 18, 2006, a new 20 to 30 percent left pneumothorax was seen on serial chest x-rays (by the same radiologist each time), at 5:10 a.m., 1:45 p.m., 2:00 p.m. and 7:25 p.m. The first three x-ray reports indicated, "Dr. Salek immediately made aware of the findings."

82. On November 18, 2006, at 2:20 p.m., Dr. Salek issued a telephone order discontinuing the discharge home. This discontinuation of the discharge was also documented in the nursing notes at 2:50 p.m.[3] At 3:30 p.m., Dr. Salek spoke with J.M.'s wife, explaining pneumothorax.

83. On November 19, 2006, another chest x-ray was taken and read by a different radiologist than the prior day. No pneumothorax was mentioned in the findings. However, the x-ray report also noted that the November 19, 2006 x-ray had been "with 11-18-06," and that "findings [were] essentially unchanged from 11-18-06."

84. On November 19, 2006, both Respondent and Dr. Salek examined J.M. Both noted that there was no pneumothorax. From a pulmonology standpoint, Dr. Salek felt it was appropriate to discharge the patient. At that time, he found J.M.'s vital signs stable with 96 percent oxygen saturation with supplemental oxygen via nasal cannula. Respondent and Dr. Salek agreed that it was appropriate to discharge the patient.

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[3] Although Dr. Salek's telephone order in the medical record has a handwritten date of "11/17/06," the totality of the evidence indicates that date is wrong, for the following reasons: (1) Dr. Salek's order appears on the same page as another physician's order dated 11/18/06; (2) the nurse who wrote the telephone order also wrote the more extensive nursing notes on 11/18/06 describing Dr. Salek's discontinuation of the discharge; and (3) the nurse who wrote both the telephone order and the nursing notes did not appear to be on duty on 11/17/06, since another nurse made the entries in the nursing notes on that date.

85. On November 19, 2006, at 9:00 a.m., Respondent ordered the patient discharged home. At that time, J.M.'s oxygen saturation was 95 percent on six liters of oxygen via nasal cannula. The patient was discharged to home that day with IV nutrition (TPN) NG feedings and six liters of supplemental oxygen.

86. On December 13, 2006, Respondent's dictated a discharge summary for the November hospitalization. The discharge summary included the diagnoses of sepsis, secondary to pneumonia and urinary tract infections, dysphagia and CHF. There was no mention of pulmonary embolism, the PICC line, or the condition of the patient at discharge.

*November 20, 2006 hospital admission*

87. On November 20, 2006, J.M. was taken by ambulance to the Hemet Valley Medical Center ER in respiratory distress. X-rays taken on that date showed no pneumothorax. The patient was admitted with diagnoses of sepsis syndrome, pneumonia, urinary tract infection, CHF, acute on chronic respiratory failure and multiple stage II pressure ulcers. Respondent was not involved in J.M's care during this hospitalization.

***Standard of Care re: Patient J.M.***

Repeated Negligent Acts:

Failure to follow up on chest imaging abnormalities

88(a). Dr. Yan opined that, for a patient with a history of lung cancer, the standard of care requires close and careful surveillance to detect recurrence of the primary lung cancer or redevelopment of new tumors. A surveillance program would include comparison to prior chest imaging studies, pulmonary function tests to assess lung capacity, bone scan or referral to a pulmonologist. Dr. Yan opined that Respondent failed to provide adequate follow up on the patient's abnormal chest x-ray and CT findings. While the CT findings could be related to the patient's prior treatment, they could also represent recurrence of cancer or progression of COPD. According to Dr. Yan, further investigation such as referral to a specialist or pulmonary function tests was warranted. Since these measures were not taken, Respondent departed from the standard of care. Dr. Yan pointed out that, while the radiologist recommended a repeat CT in three months, the repeat CT was done five months later. According to Dr. Yan, if there was a clinical progression in symptoms or interval change prompting the follow up, the delay would be a departure from the standard of care. Dr. Yan did not specify whether he considered the February 2006 CT as showing a "clinical progression of symptoms" for which a delay in follow up would be a departure from the standard of care.

88(b). Dr. Yasharel opined that, for a patient with a history of lung cancer, the standard of care requires surveillance with once-per-year CT scans or x-rays. In this case, abnormalities were noted and a three month follow up was recommended. However, Dr.

Yasharel admitted that follow up between "three to five months is still within the standard of care."

88(c). Dr. Achar did not provide any opinions regarding this issue.

88(d). Regarding whether Respondent engaged in negligent acts in his care of J.M. by failure to "properly and timely follow up on chest imaging abnormalities," the opinion of Dr. Yan was less persuasive than that of Dr. Yasharel, who has a similar outpatient practice as Respondent. Therefore, the opinions of Dr. Yasharel, set forth in Factual Finding 88(b), are adopted as facts herein.

*September 22, 2006 Discharge*

89(a). Dr. Yan noted that J.M. had prior lung cancer, and underlying lung disease, had sustained a traumatic rib fracture, and was now using supplemental oxygen. During the hospitalization, he had CHF and hypoxia, with critically low saturation levels when taken off the supplemental oxygen. Dr. Yan opined that Respondent failed to meet the standard of care in the evaluation and management of J.M. by his early discharge of a patient with significant hypoxia. Respondent's discharge order was below the standard of care because J.M. needed continued inpatient management and further evaluation of his hypoxia given the low degree of the oxygen saturation and less than ideal response to initial management. Dr. Carrasco's subsequent order for four liters of oxygen did not change Dr. Yan's opinion since Respondent had issued the discharge order and Dr. Carrasco had only issued an order for oxygen. Although another physician was involved later, there was no documentation of the transfer of care, as the standard of care requires, and Respondent was still responsible for his discharge order. Additionally, Dr. Yan pointed out that the discharge order is interpreted to indicate "discharge home with oxygen now," meaning that the patient was ready to be discharged at that time. The discharge order did not indicate that discharge planning would begin or that the patient would be discharged only if he was stable or if his oxygen level was at a specific level. The clinical data up until the time of the discharge order indicated that the patient was not stable for discharge; in fact, the patient was not stable for discharge at 6:30 p.m. either.

89(b). Dr. Yasharel opined that Respondent committed a simple departure from the standard of care in ordering the patient's discharge on November 22, 2006. Dr. Yasharel opined that J.M. was not sufficiently stable for discharge on September 22, 2006. He pointed out that Respondent's discharge order was a telephone order, and that nothing in the record indicated that Respondent had seen the patient just prior to the discharge order. The discharging physician is responsible for evaluating the patient to determine if he is stable for discharge at the time of the order. He further opined that Respondent's discharge order was not proper because, at the time of the discharge order, the patient required a non-rebreather mask to maintain a high level of oxygen concentration, which may not be deliverable via the oxygen tank and nasal cannula provided for home use. On cross-examination, Dr. Yasharel agreed that, assuming Dr. Carrasco actually evaluated the patient prior to the patient's discharge, that would have placed responsibility on Dr. Carrasco to

ensure the patient was stable for discharge and to notify Respondent if the patient was not stable for discharge. However, Dr. Yasharel also correctly pointed out that there was no documentation in the medical record indicating that Dr. Carrasco was the last physician to evaluate J.M. According to Dr. Yasharel, the fact that Dr. Carrasco ordered treatment after the discharge order does not change Respondent's responsibility for issuing the earlier discharge order.

89(c). Dr. Achar opined that Respondent did not commit any departures from the standard of care with respect to the September 21 – 22, 2006 hospitalization. According to Dr. Achar, Respondent had signed out his patients to Dr. Carrasco, and no express hand off needed to be documented in the chart. Dr. Achar opined that patient responsibility transferred fully to the physician to whom the patients were signed out, and that if a patient needed further treatment and "further decision for discharge," that would "fall under the realm" of the other physician if the patient "actually goes home." Therefore, Dr. Achar opined that after Respondent signed out his patient, the responsibility for J.M. lay with Dr. Carrasco.

89(d). Dr. Achar's testimony on the issue of the September 22, 2006 discharge was not convincing. Even assuming that Dr. Carrasco was the covering physician after Respondent "signed out," Respondent had already written the improper discharge order. Additionally, the order stated "discharge to home," and did not contain specifications that discharge was only "likely" or dependent on whether the subsequent covering physician's evaluation of the patient to ensure he was stable for the ordered discharge. If Respondent had evaluated J.M. at the time of the telephone discharge order, he would have discovered that the patient was not stable for discharge at that time. Therefore, even if Dr. Carrasco should have notified Respondent to inform him that the patient was not stable at 4:00 p.m., that does not vitiate Respondent's prior improper discharge order at a time when his oxygen saturation was so low.

89(e). Regarding whether Respondent engaged in negligent acts in his care of J.M. by way of his September 22, 2006 discharge order, the opinions of Drs. Yan and Yasharel were more persuasive than those of Dr. Achar. Therefore, the opinions of Drs. Yan and Yasharel, set forth in Factual Finding 89(a) and 89(b), are adopted as facts herein.

*September 29, 2006 Discharge*

90(a). Dr. Yan testified that Respondent met the standard of care for the time he cared for J.M. during his September 27 through 29, 2006 hospitalization. Additionally, Dr. Yan opined that since the discharge order was issued by a covering physician, Respondent committed no departure from the standard of care regarding the discharge order.

90(b). Dr. Yasharel testified that, assuming Dr. Carrasco signed the discharge home order, Dr. Carrasco would be responsible for the discharge of the patient.

90(c). Dr. Achar opined that Respondent committed no departure from the standard of care for the September 27 through 29, 2006 hospitalization.

90(d). Complainant did not establish by clear and convincing evidence that Respondent committed any departure from the standard of care in his treatment of J.M. during the September 27 through 29, 2006 hospitalization.

*October 25, 2006 Discharge*

91(a). Dr. Yan noted that, during the October 2006 hospitalization, Respondent and the consultants documented clinical improvement, but that the patient remained quite debilitated during this stay. As he described it, the patient was "in a spiral and quality of life was getting worse." Dr. Yan opined that, in light of repeat hospitalization of a declining patient with increasing needs, the standard of care required a primary care physician to determine whether the family was able to continue providing the requisite level of care at home; if they could not, other options such as additional care givers, skilled nursing facilities or board and care should be explored. Dr. Yan acknowledged that Respondent discussed with J.M.'s wife the option of placing him in a nursing home due to high needs (including wound care, respiratory therapy and NGT feedings) and that she wanted to care for J.M. at home. Dr. Yan acknowledged that there was documentation of this discussion. However, Dr. Yan pointed out that there was no documentation in the medical records regarding the capacity of J.M.'s family to provide the required care at home. According to Dr. Yan, the standard of care also required a discussion of end of life matters and providing support for that. He saw no documentation of discussion of end of life options or hospice, even though the patient was declining. Dr. Yan opined that Respondent committed a simple departure from the standard of care "in terms of hospital care and post discharge planning in assessing the family's capacity to care for [J.M.] at home."

91(b). Dr. Yasharel opined that Respondent committed a simple departure from the standard of care in discharging J.M. on October 25, 2006. According to Dr. Yasharel, there was no documentation that Respondent saw the patient on the date of discharge. Dr. Yasharel maintained that the standard of care required the primary care physician to examine the patient for discharge and that, in this case, the patient was not stable for discharge. Dr. Yasharel held this view, even though Dr. Salek, a pulmonologist who followed the patient almost daily, had examined the patient and found him stable for discharge. Dr. Yasharel agreed that, if J.M.'s only problem was pulmonary, then there would be no problem with the discharge order. However, he pointed out that the patient also had urinary tract infection and dysphagia. Nevertheless, he also acknowledged that J.M. was on antibiotics and that he had been seen by several specialists and a NGT was the only way to feed the patient at that point. Dr. Yasharel acknowledged that Respondent had discussed a nursing home as a discharge option.

91(c)(1). Dr. Achar opined that J.M. received appropriate care during the October hospitalization, which including Respondent's care and the input and treatment provided by consultants. According to Dr. Achar, the role of the primary care physician is to seek

appropriate consultations, to coordinate the patient's care with all specialists and follow up on testing and nursing notes. Dr. Achar opined that all appropriate medical consultations were obtained. A pulmonologist was consulted and saw the patient at least once per day; a gastroenterologist and a surgeon were consulted in attempts to address the patient's nutritional needs; and a wound care specialist was consulted for care of the patient's decubitis ulcers. The primary and most life-threatening condition was the patient's aspiration pneumonia, and the pulmonology specialist was instrumental in deciding how to manage the patient and ultimately when to send the patient home. On October 25, 2006, Dr. Selak, the primary specialist, felt it was safe to send the patient home; typically the primary care physician will follow the recommendations of the specialists since they have greater training in their areas of expertise.

91(c)(2). Dr. Achar additionally opined that all preparations were in place at the October 25, 2006 discharge. He pointed out that the family had stated their wish to take the patient home and had verbalized their understanding of the risks and complications involved with home care. The patient's wife confirmed that she knew how to give the feedings and understood the aspiration risk. Given the patient's wife's 25 years of caring for a quadriplegic son, the physician could assume that she was likely very capable handling the mental and physical stress of caring for her husband at home.

91(c)(3). Dr. Achar noted that the family had insisted the patient's discharge home and not to a nursing facility. Although it is a shared decision regarding the benefits and risks of discharge to home, the family and the patient have the ultimate say. Based on his experience and research, he has learned that patients do not want to die at the hospital, but would rather spend their final days at home with their families.

91(d). Regarding whether Respondent engaged in negligent acts in his care of J.M. by way of the October 2006 discharge, the opinions of Drs. Yan and Yasharel were less persuasive than those of Dr. Achar. Therefore, the opinions of Dr. Achar, set forth in Factual Findings 91(c)(1), 91(c)(2), and 91(c)(3), are adopted as facts herein.

*November 19, 2006 Discharge*

92(a). Dr. Yan noted that, with the November re-hospitalization, J.M. was requiring much more care with increasing debility. Dr. Yan opined that a physician must ascertain whether it is safe to discharge a patient back to the home environment. According to Dr. Yan, it is a departure from the standard of care to send a patient back to an environment without determining the capacity of his caregivers to provide care (including wound care, administering IV antibiotics, care of a PICC line and Foley catheter, and NGT feeding). Options should have been discussed with family, including board and care, skilled nursing facilities, sub-acute facilities or hiring more home health care workers. He did not see any documentation of this in the medical record for this hospitalization. According to Dr. Yan, if such a discussion took place and the physician felt it was unsafe to discharge to home, the physician could: make recommendations for a safer placement; discharge to home with a recommendation for additional caregivers; or recommend placing the patient on hospice

and not returning to the hospital if the patient deteriorates further. Dr. Yan stated that, if the family insists on home discharge, the physician can document the discharge "against medical advice." Dr. Yan opined that it was a departure from the standard of care to fail to address post-hospital care with close follow up. Dr. Yan also opined that it was a departure from the standard of care to fail to address end of life care in a patient so clearly deteriorating. During this hospitalization, there was no formal hospice consultation or meeting documented.

92(b). As with his testimony regarding the October hospitalization, Dr. Achar noted that the family had insisted on the patient's discharge home and not to a nursing facility. Although it became clearer with each admission that nothing more medically could be done for the patient and that hospice was the best option, the family was not willing to give up. J.M.'s wife would not sign a "do not resuscitate order" and was not ready to accept hospice care. A physician cannot force a family to accept hospice or to agree to a "do not resuscitate order." Given the situation, Respondent had done what he could to fulfill his responsibility regarding the discussion of end of life issues. Dr. Achar also opined that documenting a "discharge against medical advance" (AMA) is unethical and below the standard of care. If a physician signs out a patient AMA, the insurance company may not pay for supplemental oxygen, medication or NGT feeding. The physician needs put the patient and families first and use a collaborative effort to "do the next best therapy" at home.

92(c). Regarding whether Respondent engaged in negligent acts in his care of J.M. by way of the November 19, 2006 discharge, the opinions of Dr. Yan were less persuasive than those of Dr. Achar. Therefore, the opinions of Dr. Achar, set forth in Factual Findings 92(b), are adopted as facts herein.

*Negligent failure to maintain adequate and accurate records*

93(a)(1). Dr. Yan testified that the transition of care is important since those providing post-hospitalization care often rely on information from the recent hospitalization as a basis of patient care. An outpatient physician must be aware of key events. The standard of care requires comprehensive records; therefore, an inpatient physician must dictate a comprehensive discharge summary providing a complete picture of the hospitalization. The standard of care also requires that medical records be completed in a timely manner, especially in the transition of care from hospitalization to document acute events. In this case, the patient was gravely ill and discharged home with a number of therapies, so the discharge summaries needed to be dictated in timely manner.

93(a)(2). Dr. Yan opined that Respondent failed to meet the standard of care in that he failed to complete documentation in timely manner. He noted that Respondent failed to dictate the September 22, 2006 H&P until December 13, 2006, which was untimely. Dr. Yan also opined that Respondent did not meet that standard of care for complete and comprehensive records. He pointed out that the November 19, 2006 discharge summary (not dictated until December 13, 2006), was incomplete and lacking several key

components from the hospitalization (e.g. failure to mention pulmonary embolism; failure to mention follow-up instructions for post-hospitalization; failure to mention patient's condition at discharge. Consequently, Respondent's discharge summary constituted a departure from the standard of care.

93(a)(3). Dr. Yan additionally opined that the standard of care requires that medical records be legible. Many of Respondent's notes were illegible, which is a departure from the standard of care.

93(b). Dr. Yasharel testified that, although it is typically determined by hospital rules, generally, a discharge summary is dictated within a week after discharge. The patient was discharged on November 19, 2006, but the discharge summary was not dictated until December 13, 2006. This failure to timely dictate a discharge summary does not meet the community standard, and is therefore a simple departure from the standard of care. Dr. Yasharel agreed with Dr. Yan that Respondent failed to dictate an accurate discharge note for November 19, 2006, since he failed document the patient's condition or a follow up plan. Dr. Yan also noted various instances of Respondent's illegible chart entries for J.M. Given the foregoing, Dr. Yan opined that Respondent engaged in a departure from the standard of care in terms of recordkeeping.

93(c). Dr. Achar insisted that, as a whole, Respondent's medical record keeping was neat and legible, followed the standard templates and was within the standard of care.

93(d). Regarding whether Respondent engaged in negligent acts in his care of J.M. by way of his failure to maintain adequate and accurate records, the opinions of Drs. Yan and Yasharel were more persuasive than those of Dr. Achar. Therefore, the opinions of Drs. Yan and Yasharel, set forth in Factual Findings 93(a)(1), 93(a)(2), 93(a)(3) and 93(b), are adopted as facts herein.

94. Complainant did not establish by clear and convincing evidence that Respondent engaged in negligent acts in his care of J.M. by any of the following: (1) failure "to properly and timely follow up on chest imaging abnormalities" (Accusation, para. 8KK.); (2) failure "to assure proper evaluation of the patient for discharge to his home environment" on September 29, 2006 (Accusation, para. 8MM.); (3) failure "to properly evaluate the patient for discharge, including whether the patient was stable . . . and evaluating whether the family was capable of providing the required level of care" (Accusation, para. 8NN); and (4) failure "to properly evaluate the patient for discharge including plans for follow up with the patient after discharge home and plans for end of life care" (Accusation, para. 8OO).

95. Complainant established by clear and convincing evidence that Respondent engaged in negligent acts in his care of J.M. when he: (1) ordered J.M. discharged on September 22, 2006, "notwithstanding the patient's abnormal vital signs. . ." (Accusation, para. 8LL.); and (2) failed to "maintain adequate and accurate records" (Accusation, para. 8PP).

Failure to Maintain Adequate and Accurate Records:

96. Complainant established by clear and convincing evidence that Respondent failed to maintain adequate and accurate records of the care and treatment of patient J.M. when he: (1) failed to timely dictate the September 22, 2006 H&P until December 13, 2006 (Accusation, para. 9B); (2) failed to timely dictate the November 19, 2006 discharge summary and failed to note the follow up plan (Accusation, para. 9E); and (3) failed to legibly document in the patient's chart (Accusation, para. 9F). (See Factual Finding 93.)

97. Complainant did not establish by clear and convincing evidence that Respondent failed to maintain adequate and accurate records of the care and treatment of patient J.M. by way of the following: (1) failure to chart assessment of a swallow evaluation or dictate discharge summary following September 29, 2006 discharge (Accusation, para. 9C); and (2) failure to adequately document evaluation of J.M. for discharge (Accusation, para. 9D).

***Respondent Rehabilitation***

98. At the administrative hearing, Respondent assured the Board that, in the future, if he needed to add late information to a progress note, he will "definitely add the dates and his initials and the reason [for the late amendment]."

99(a). For purposes of this case, Dr. Achar visited Respondent's practice for one full day at the beginning of January 2011, to assess how Respondent was treating patients, to look at patient medical records and to talk to Respondent's staff. Dr. Achar was present in the examination room while Respondent saw four or five patients. Dr. Achar's general impression of Respondent's quality of care was favorable. According to Dr. Achar, Respondent employed the "Four E's" that are taught in medical school: he engaged with the patients; empathized with patients; educated the patients about their diagnosis and treatment plans (he did this in English and Korean); and he enlisted the patients in their treatment plans by asking them to follow up and arranging for follow up.

99(b). Regarding his medical records, Dr. Achar observed that Respondent used the S.O.A.P. (subjective, objective, assessment, plan) format, and his notes were very easy to read. Respondent wrote the notes while in the examination room and included salient points in the history of the illness. According to Dr. Achar, Respondent's records were more legible than 80 percent of other physicians' charts he has reviewed.

99(c). Dr. Achar concluded that Respondent ran a well-organized office and that his present practice was operating within the standard of care.

100. Several employees, colleagues and patients testified on Respondent's behalf and characterized him as a caring physician who is very attentive to patient problems. According to his character witnesses, Respondent's patients are very well cared for.

101. For the past 10 years, Respondent has gone on medical missions overseas once or twice a year, providing free medical care to those in need.

## LEGAL CONCLUSIONS

*First Cause for Discipline – Repeated Negligent Acts*

1(a). Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), in that Respondent committed repeated negligent acts in his care of patients L.W. and J.M. when he: (1) "failed to properly evaluate and follow up on [L.M.'s] hip injury in the face of continuing patient complaints of pain and the ineffectiveness of his treatment modalities" (Accusation, para. 8U); (2) failed to maintain adequate and accurate records of the care and treatment of patient L.W. (Accusation, para. 8V); (3) ordering J.M. discharged on September 22, 2006, "notwithstanding the patient's abnormal vital signs. . ." (Accusation, para. 8LL.); and (4) failed "maintain adequate and accurate records" (Accusation, para. 8PP), as set forth in Factual Findings 5 through 30, 35, 36, 37, 42 through 87, 89, 93, and 95.

The Superior Court determined that only the adverse finding of repeated negligent acts related to Respondent's discharge of patient J.M. was supported by the weight of the evidence.

1(b). Cause does not exist to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), for repeated negligent acts in the care of patients L.W. and J.M. for the following grounds, which were not established by clear and convincing evidence: (1) failure "to perform and /or document a complete initial history and physical of patient L.W." (Accusation, para. 8Q); (2) failure "otherwise perform and/or document interval screening tests, preventative measures or surveillance of the patient's ongoing health issues, including, but not limited to, mammography" for L.W. (Accusation, para. 8R); (3) failure "to properly evaluate and follow up on evidence of osteopenia" in L.W. (Accusation, para. 8S); (4) failure "to properly evaluate and follow up on the suspicion and/or diagnosis of atrial fibrillation" for L.W. (Accusation, para. 8T); (5) failure "to properly and timely follow up on chest imaging abnormalities" for J.M. (Accusation, para. 8KK.); (6) failure "to assure proper evaluation of the patient [J.M.] for discharge to his home environment" on September 29, 2006 (Accusation, para. 8MM.); (7) failure "to properly evaluate the patient [J.M.] for discharge, including whether the patient was stable . . . and evaluating whether the family was capable of providing the required level of care" (Accusation, para. 8NN); and (8) failure "to properly evaluate the patient [J.M.] for discharge including plans for follow up with the patient after discharge home and plans for end of life care" (Accusation, para. 8OO), as set forth in Factual Findings 5 through 30, 31, 32, 33, 34, 42 through 87, 88, 90, 91, 92, and 94.

*Second Cause for Discipline -Altering Medical Records*

2. Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2262, in that Respondent altered a medical record of a patient with fraudulent intent, as set forth in Factual Findings 25, 36 and 38.

The Superior Court determined that this adverse finding was not supported by the weight of the evidence.

*Third Cause for Discipline – Dishonesty*

3. Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (e), in that Respondent engaged in dishonest conduct by altering a medical record of a patient, as set forth in Factual Findings 25, 36 and 38.

The Superior Court determined that this adverse finding was not supported by the weight of the evidence.

*Fourth Cause for Discipline – Gross Negligence*

4(a). Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (b), in that Respondent committed gross negligence in his care of patient L.W. when he altered her medical records, as set forth in Factual Findings 25, 36, 38 and 40.

The Superior Court determined that this adverse finding was not supported by the weight of the evidence.

4(b). Cause does not exist to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (b), on the grounds of gross negligence for failure "to properly evaluate and follow up on the patient's hip injury in the face of continuing patient complaints of pain and the ineffectiveness of his treatment modalities," since it was not established by clear and convincing evidence that this departure from the standard of care rose to the level of gross negligence, as set forth in Factual Findings 5 through 35, 37, and 39.

*Fifth Cause for Discipline-Failure to Maintain Adequate and Accurate Records*

5(a). Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2266, in that Respondent failed to maintain adequate and accurate records for patients L.W. and J.M., as set forth in Factual Findings 5 through 30, 36 and 37, 42 through 87, 93, 95 and 96.

5(b). Cause does not exist to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2266, for failure to maintain adequate and accurate records on the following grounds, which were not established by clear and convincing evidence: (1) failure to chart assessment of a swallow evaluation or dictate discharge summary following J.M.'s September 29, 2006 discharge (Accusation, para. 9C), and (2) failure to adequately document evaluation of J.M. for discharge (Accusation, para. 9D), as set forth in Factual Findings 42 through 87, 93, 95 and 97.

*Sixth Cause for Discipline – Unprofessional Conduct*

6. Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, in that Respondent engaged in unprofessional conduct, as set forth in Factual Findings 5 through 96. 7(a).

## THE SUPERIOR COURT'S RULING

7. In its ruling, the Superior Court found that several causes for discipline with respect to patient L.W. were not supported by the evidence, as follows: 1) gross negligence, 2) alteration of a medical record with fraudulent intent ; 3) unprofessional conduct in Respondent's documentation of additional medical information; and 4) illegible medical records. The Court found that the findings of negligence with respect to patient J.M.'s discharge from the hospital and inadequate and inaccurate medical records for both patients were supported by the weight of the evidence and therefore were sustained.

## THE MEASURE OF DISCIPLINE

8. In this case, Respondent has been licensed for over 14 years, without prior discipline. He appears to have made an effort to operate his current practice within the standard of care, and he has indicated his intent to change his method of amending medical records in order to comply with the standard of care. Respondent has the support of colleagues, patients and employees who characterize him as a caring physician. His value to the community is also demonstrated by his 10-year participation in medical missions through which he has used his medical knowledge to provide for those in need.

Complainant did not establish that the public would be endangered, absent revocation of Respondent's license, and therefore, revocation would be unduly harsh discipline. In this case, Respondent's violations involved a record-keeping violation, and repeated negligent acts. The Board believes that Respondent could remedy the areas of violation if placed on probation. This probation would involve prohibition of supervision of physician assistants who comprise a significant part of his practice. However, given the lapses involved in this case, such a prohibition is necessary to provide adequate public protection.

9. The Proposed Decision initially adopted by the Board placed Respondent on probation for five years with standard terms and conditions and required the completion of certain remedial and rehabilitative courses, including an ethics class and an educational program. In light of the Court's ruling, the Board finds that a shorter probationary term is warranted, and as the allegation of dishonesty was not sustained, there is no rational basis to require an ethics class. The Board notes that the three-year probationary term ordered here is a deviation from the Model Disciplinary Guidelines (2011) but is of the opinion that such a deviation is warranted because of the Court's ruling that several of the most serious allegations were not supported by the evidence. Additionally, Respondent has commenced efforts to change his practice, as Respondent's counsel testified he has taken record keeping and educational classes. As to the former class, record keeping, upon Respondent's submission of documents evidencing successful completion of that class, condition 12 of his probation will be deemed satisfied.

## ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Physician's and Surgeon's Certificate No. A56294, issued to Respondent Donald Woo Lee, M.D., is revoked. However, the revocation is stayed, and Respondent is placed on probation for three years upon the following terms and conditions.

### 1. Notification

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

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

### 2. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

### 3. Obey All Laws

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

### 4. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

### 5. Probation Unit Compliance

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

Respondent shall not engage in the practice of medicine in Respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

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

### 6. Interview with the Board or Its Designee

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

### 7. Residing or Practicing Out-of-State

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the

exception of this condition and the following terms and conditions of probation: Obey All Laws and Probation Unit Compliance.

Respondent's license shall be automatically cancelled if Respondent's periods of temporary or permanent residence or practice outside California totals two years. However, Respondent's license shall not be cancelled as long as Respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

### 8. Failure to Practice Medicine -California Resident

In the event Respondent resides in the State of California and, for any reason, Respondent stops practicing medicine in California, Respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve Respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if Respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

### 9. Violation of Probation

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

## 10. License Surrender

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

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

## 11. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

## 12. Medical Record Keeping Course

Within 60 calendar days of the effective date of this decision, Respondent shall enroll in a course in medical record keeping, at Respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first six months of probation is a violation of probation.

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

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

**13. Completion of Probation**

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

This Decision shall become effective on **December 7, 2012**.

IT IS SO ORDERED this **9th** day of **November**, 2012.

Barbara Yaroslavsky
Chair, Panel A

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

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| In the Matter of the Accusation Against: | ) | |
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| | ) | |
| DONALD WOO LEE, M.D. | ) | Case No. 17-2007-183005 |
| | ) | |
| Physician's and Surgeon's Certificate No. A-56294 | ) | |
| | ) | |
| | ) | |
| 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 11, 2011.

IT IS SO ORDERED April 11, 2011.

MEDICAL BOARD OF CALIFORNIA

By: Shelton Duruisseau
Shelton Duruisseau, Ph.D., Chair
Panel A

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

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| **In the Matter of the Accusation Against:** | **Case No. 17-2007-183005** |
| **DONALD WOO LEE, M.D.**<br>**Physician and Surgeon's Certificate No. A 56294,** | **OAH No. 2010011001** |
| **Respondent.** | |

# PROPOSED DECISION

This matter was heard by Julie Cabos-Owen, Administrative Law Judge (ALJ) with the Office of Administrative Hearings (OAH), on January 24, 25, 26, 27 and 31, and February 1 and 2, 2011, in Los Angeles, California. Complainant was represented by E.A. Jones III, Deputy Attorney General. Donald Woo Lee, M.D. (Respondent) was present and represented by Paul Spackman of Iungerich & Spackman.

On the fourth day of hearing, Complainant amended the Accusation at page 13, by adding a paragraph numbered 8QQ, which stated, "Respondent was negligent in his care and treatment of patient J.M. in that he failed to follow up with Patient J.M. from his September 29, 2006 discharge until his readmission to the hospital on October 17, 2006." Respondent objected to the amendment, arguing that there was insufficient notice of the additional negligence allegation. Respondent's due process objection was sustained since Respondent was not afforded a reasonable opportunity to prepare his defense to the new allegation. Although, pursuant to Government Code section 11507, the Accusation was amended to include the additional allegation, no evidence regarding the additional negligence allegation was admitted nor was the additional allegation considered as grounds for discipline.

Oral and documentary evidence was received, and argument was heard. The record closed, and the matter was submitted for decision on February 2, 2011.

## FACTUAL FINDINGS

1. On January 5, 2010, Complainant Barbara Johnston filed the Accusation while acting in her official capacity as the Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

2. On August 21, 1996, the Board issued Physician and Surgeon's Certificate Number A 56294 to Respondent. Respondent's certificate was in full force and effect at all relevant times and will expire on August 31, 2012, unless renewed.

3. Respondent obtained his medical degree in 1994 at St. George's University in the West Indies.[1] He completed an Internal Medicine residency at University of California, Los Angeles (UCLA) School of Medicine / Wadsworth Veteran's Affairs (VA) Medical Center in 1997. He was certified by the American Board of Internal Medicine in 1997; however, that certification has expired, and although he is eligible for recertification, he has not been recertified. Since 1998, Respondent has operated a private primary care practice providing inpatient and outpatient care. He currently has offices in Temecula (operating for 13 years) and in Mira Loma (opened approximately four months ago within a senior community). In order to provide better access for patients, Respondent added an urgent care component to his practice, which is staffed by physician assistants. However, if patients insist on seeing him, his staff will "squeeze them in between [his scheduled] appointments." The majority of his patients are geriatric patients, with Medi-Care coverage and supplemental coverage through various senior health plans which are typically health maintenance organizations (HMOs). Consequently, referrals from his primary practice typically require approval from the medical group which holds the contract with the health plan. When Respondent is out of town or unavailable, his physician assistants cover his outpatients, and colleagues at the hospital cover his inpatients.

***The Experts***

4(a). Complainant offered the testimony of Jofel M. Yan, M.D., F.A.C.P., to establish the standard of care in this case. Dr. Yan is a hospitalist with HealthCare Partners Medical Group, in Torrance, California, and an Associate Professor of Medicine at the UCLA School of Medicine. Dr. Yan received his medical degree from University of California, Davis in 1990, and completed an Internal Medicine residency in 1993 at St. Mary Medical Center in Long Beach, California. He is certified by the American Board of Internal Medicine (original certification 1993; recertification 2003). From 1994 through 2004, he practiced in an academic setting, at the St. Mary Medical Center Internal Medicine Residency Program as a full-time faculty member and then as the Associate Program Director, and also at the UCLA School of Medicine as an Assistant Professor of Medicine (July 1994 through June 2001) and as an Associate Professor of Medicine (July 2001 through June 2004). While at St. Mary, his practice included geriatric patients. In 2004, he "decided to take care of more patients," and moved to a hospital-based private practice, where he sees patients in acute and

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[1] This was not listed on his Curriculum Vitae. Instead, his CV read:

> UCLA School of Medicine/Wadsworth V.A. Medical Center
> Department of Medicine, West Los Angeles, CA
> July 1995-June 1997 PGY 3 Internal Medicine Residency
> Medical Degree

sub-acute settings, with a large geriatric population. Since 2004, his practice has not included outpatients.

4(b). Complainant also offered the testimony of Benjamin F. Yasharel, M.D., to establish the standard of care in this case. Dr. Yasharel obtained his medical degree from Tufts University School of Medicine, in Boston, Massachusetts, in 1999. He completed an Internal Medicine residency in 2002 at the UCLA, West Los Angeles Veterans Administration Medical Center. He is certified by the American Board of Internal Medicine. Since 2003, he has been in private practice in West Hills, California. His current practice is comprised of 90 percent outpatient and 10 percent inpatient. He sees a primarily older population, between ages 60 and 100.

4(c). Respondent offered the testimony of Suraj Achar, M.D., F.A.A.F.P., to establish the standard of care for the treatment of both patients. Dr. Achar received his medical degree from State University of New York at Buffalo School of Medicine in 1993. He is certified by the American Board of Family Medicine (certified 1996; recertified 2003). Dr. Achar is an Associate Clinical Professor at the University of California, San Diego School of Medicine (UCSD) in the Department of Family and Preventative Medicine, training residents in family practice. He is also the Medical Director for UCSD La Jolla Family and Sports Medicine. Dr. Achar has worked for several years as an expert medical reviewer for the Board. As part of his preparation for this case, Dr. Achar visited Respondent's medical practice for a day; he observed Respondent's examination of several patients, spoke to his staff, and reviewed his patient records.

4(d). All of the experts were qualified to testify as experts on the standard of care in this case. However, since Dr. Yan has been in a hospital-based practice for seven years, his opinions regarding the standard of care in an outpatient setting were given less weight than those of Drs. Yasharel and Achar. Apart from the foregoing, any additional weight given to one expert's testimony over the others' was based on the content of their testimonies and the bases for their opinions.

4(e). Dr. Achar's testimony often took on the tenor of an advocate, rather than an impartial expert. Several times on cross examination, he avoided answering questions directly, instead presenting arguments in Respondent's favor. His tenacious defense of Respondent's actions, particularly his attempt to rationalize Respondent's falsification of records (set forth more fully below), diminished his credibility.

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*Facts Re: Patient L.W.*[2]

5. On April 1, 2004, Patient L.W., a 79-year old woman met with Respondent to discuss transferring her care from another primary care physician. They discussed her history, and Respondent noted her drug allergies (penicillin, Keflex and Demerol), her primary medical issues and medications taken. On the progress record, Respondent noted the patient's hypertension, for which she had been taking Propanol; her thyroid problems, for which she had been taking Synthroid; her gastroesophageal reflux disease (GERD), for which she was taking Aciphex; her arthritis/low back pain, for which she was taking Vicodin and Bextra; her hyperlipidemia for which she was taking Zocor; and her restless leg syndrome, for which she was taking Clonazepam (generic for Klonopin). Her prior prescription for Premarin and Hydrochlorothiazide (HCTZ), a diuretic, was also noted. Respondent believed the patient was asymptomatic at that time and did not recommend any change of medications, all of which appeared appropriate. Respondent provided L.W. with a Health Questionnaire to complete and also requested her medical records from her prior primary care physician. Thereafter, Respondent saw L.W. approximately 25 times in his practice.

6. On May 19, 2004, Patient L.W. saw Respondent again. She provided him with the completed Health Questionnaire and attached a one-page summary wherein she reported a lengthy medical history which included: restless leg syndrome; hypertension; GERD; arthritis; thyroid problems; hyperlipidemia; an appendectomy in 1954; surgery to an ovary in 1956; a complete hysterectomy in 1959; a laminectomy in 1965; a left breast biopsy (benign) in 1970; a hard palate carcinoma in 1988; a right breast biopsy (benign) in 1997; recurrent bladder cancer in 1996 (grade 1), 1997 (grade 2) and 2001 (grade 1); lower lip cancer in 1998 and 1999; and recurrent colon polyps in 1980, 1981 and 2001. L.W.'s one-page summary also listed her medications, which included: Propanol; Premarin; HCTZ; Synthroid; Zocor; Aciphex; Clonazepam/Klonopin; Hydrocodone/Vicodin; Bextra (which hurt her stomach); Extra Strength Tylenol; and Calcium + Vitamin D. It was noted that she was allergic to penicillin, Keflex and Demerol. A Physical Examination Form was filled out, indicating L.W.'s medications and drug allergies (penicillin, Keflex and Demerol). Her blood pressure was taken (112/70), but her pulse was not recorded. The Physical Examination Form omitted any other findings from examination. A urology referral was planned based on the history of bladder cancer. As was his custom and practice, since the patient was reportedly asymptomatic and there was no obvious overlap of medications which could cause her danger, Respondent continued six of the patient's previous medications: HCTZ; Synthroid; Zocor; Aciphex; Clonazepam; and Vicodin.

7(a). On May 19, 2004, laboratory blood and urine tests were conducted for L.W. which included a complete blood count (CBC), a basic metabolic panel, a lipid panel, and a

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[2] Patients' and family members' initials are used in lieu of their full names in order to protect their privacy.

thyroid assessment. Respondent ordered this lab work to monitor the medical issues reported by L.W. He noted that the patient's potassium level was slightly low (3.1 mEq/L, with a reference range of 3.5-5.5). He decided to change the patient's diet and observe her to see if they could bring her potassium to the correct level. Respondent also noted that the patient's calcium level was slightly elevated (10.9 mg/dL, with a reference range of 9.5-10.6). Since the patient was taking a diuretic, he was not concerned with this reading, but believed that he still needed to follow up. All other readings were within an acceptable range, including liver function, thyroid and cholesterol.

7(b). On April 4, 2005, Respondent ordered, and L.W. underwent, similar blood tests as part of her annual examination. Regarding the 2005 lab results, Respondent noted that the patient's potassium was still low (3.1), so he prescribed a potassium supplement on April 15, 2005. Additionally, since L.W.'s calcium was more elevated (11.3), he ordered a decrease in her calcium supplement. All other readings, including liver function and cholesterol, were within normal ranges

7(c). On October 23, 2006, Respondent ordered, and L.W. underwent blood tests which indicated that her calcium and potassium levels were within the acceptable ranges.

8. After referring L.W. to a urologist in 2004, Respondent continued to refer her to a urologist for yearly bladder cancer screening.

9. After Respondent obtained L.W.'s prior medical records, he noted that she had undergone mammography on September 2, 2003, with normal results. Respondent ordered a screening mammogram in 2005. On May 23, 2005, L.W. underwent a mammogram which was unremarkable. Follow-up in one year was recommended.

10(a). L.W.'s last colonoscopy ordered by her prior physician took place in 2001.

10(b). In October 2005, Respondent referred L.W. to the Inland Valley Digestive Diseases Associates, after she complained of rectal bleeding. On November 21, 2005, a colonoscopy with polypectomy was performed.

10(c). In April 2006, a colonoscopy with hemmoroidectomy and polypectomy was performed on L.W.

11(a). On November 29, 2004, patient L.W. had a lumbar spine x-ray for back pain after a fall. No fracture was noted, but it was noted that "bones are osteopenic."

11(b). On November 28, 2005, an x-ray of L.W.'s right wrist after a fall showed a non-displaced fracture of the distal radius. It was noted that "bones are osteopenic."

11(c). There was no specific documentation in the patient chart indicating that Respondent followed up on the issue of osteopenia. However, in his testimony, Respondent pointed out that L.W. was already taking Premarin for her menopausal symptoms, and that medication was also used to treat osteoporosis. According to Respondent, this patient did not have osteoporosis, only osteopenia, but Premarin would benefit her in the event she did develop osteoporosis. He noted that she was also taking calcium and vitamin D supplements, and thus was on maximum therapy anyway. Therefore, even assuming she developed osteoporosis, Respondent would not have changed her treatment.

12(a). In November 28, 2005, L.W. underwent a chest x-ray after her fall (see Factual Finding 11(b)). Her fall apparently occurred at some point after her November 21, 2005 colonoscopy and polypectomy (see Factual Finding 10(b)). The chest x-ray indicated abnormal findings in the right upper lobe consistent with pneumonia. Continued follow-up was recommended "to exclude the possibility for underlying pathology such as a mass."

12(b). On December 6, 2005, Respondent saw L.W. in his office. His assessment included wrist fracture and pneumonia. The plan included follow up with an orthopedist and repeat chest x-ray the following week.

12(c). On December 10, 2005, L.W. was admitted to Ranch Springs Medical Center complaining of generalized weakness, shortness of breath and a cough. Her blood pressure was 90/60 and her heart rate was 80. She was diagnosed with: pneumonia; dehydration; rib pain and fracture to right radius subsequent to fall; hypertension, currently hypotension and dehydrated; hypothyroidism; hypokalemia secondary to hydrochlorothiazide; constipation with weight loss, should be ruled out for colon cancer; history of restless leg syndrome. L.W. was given IV fluids and her HCTZ was held.

12(d). On December 30, 2005, L.W. was seen by a physician assistant in Respondent's urgent care clinic, complaining of confusion, lethargy, memory loss, mild nausea and vomiting, and lack of appetite since her fall. The plan written by the physician assistant was not entirely legible.

13. On January 6, 2006, L.W. came to Respondent's office and reported that she had stopped taking all of her medications approximately two weeks prior without seeking Respondent's approval. Respondent was concerned about this discontinuation of medication, since she could have rebound tachycardia from the lack of Propanol and HCTZ, and/or she could have withdrawal symptoms (including heart palpitation, anxiety and sweating) from sudden discontinuation of the Clonazepam. Respondent's note of a heart exam is illegible. Under allergies was listed "no known drug allergies," which was incorrect. L.W.'s blood pressure was measured at 110/62. Her pulse was documented at 56 beats per minute (bpm), which appeared to be incorrect given the findings of the EKG taken at that visit. An EKG revealed a heart rate of 113 bpm, sinus tachycardia, with premature atrial contractions.

Respondent's impression included fatigue and atrial fibrillation /sinus tachycardia. The plan included starting a long acting beta blocker and following up in one week to see if the patient was responding to the medication. Although he added atrial fibrillation as a possible concern, he did not think L.M. was experiencing atrial fibrillation. Nevertheless, he decided to monitor the patient "just to be sure."

14. On January 13, 2006, Patient L.W. saw Respondent in follow-up. A long-acting beta blocker (Toprolol) and an oral opiate (Vicodin) were listed as medications. Under allergies was listed "no known drug allergies," which was incorrect. The patient's heart rate was documented at 56 bpm. No physical exam or repeat EKG was recorded. The assessment and plan included "normal sinus rhythm ← atrial fibrillation" and the beta blocker was continued. A urology referral was also noted.

15. On February 3, 2006, L.W. saw Respondent for follow-up. No known allergies were listed. The patient's pulse was 72 bpm, and her blood pressure was 128/80. Under allergies was listed "no known drug allergies." Respondent's assessment was "hypertension / atrial fibrillation → normal sinus rhythm." The beta blocker was continued.

16. On March 3, 2006, Patient L.W. saw Respondent again in follow-up. Her heart rate was 58 bpm, and her blood pressure was 150/80. Medications were listed as: Toprolol, Aciphex, Vicodin and Hydrocortisone cream. Under allergies was listed "no known drug allergies." No physical exam was noted. An EKG that day showed her heart rate at 57-59 bpm. The assessment and plan included "atrial fibrillation → normal sinus rhythm," and the beta blocker was continued. The rest of the assessment / plan was illegible. Since L.W. was not having palpitations after resuming the beta blocker, Respondent did not believe he needed further follow-up on the issue of atrial fibrillation.

17. On the night of November 20, 2006, while seated at her dining room table, Patient L.W. fell asleep, slipped off her chair onto the floor and injured her right hip. She did not immediately seek medical attention because she had to leave town to attend a funeral. However, during the trip she experienced pain and had to use a walker to ambulate, which she had not required prior to the fall.

18. On November 24, 2006, patient L.W. was seen by a physician assistant in the urgent care division of Respondent's office. The physician assistant documented that L.W. complained of pain from her hips to her knees. Her current medications were listed as Vicodin, Toprol, Aciphex, Requip and Clonazepam. No pulse was recorded. Physical examination revealed abnormalities in her gait (able to walk slow with slight limp), pain in her back on lifting her right knee, and point tenderness in her back. X-rays of her lumbar spine and bilateral hips were ordered. The assessment was "hip/back pain from fall," and the plan was to "rest/avoid walking until x-ray results known." Respondent co-signed the chart.

19(a). On November 24, 2006, x-ray films of L.W.'s lumbar spine and bilateral hips were taken. According to the radiologist, the x-rays revealed "mild dextroconvex scoliotic curvature" and "5 mm anterior subluxation of L4 on L5." There was no fracture noted.

19(b). At the administrative hearing, both Complainant's experts and Respondent's expert viewed the November 24, 2006 x-rays and confirmed that no fractures were visible on the films.

20(a). On December 26, 2006, Respondent saw Patient L.W., who complained of lower back pain and bilateral hip and leg pain. Her blood pressure was documented at 160/90, but no pulse was recorded. The list of current medications included Clonazepam, Requip, Celebrex, Metoprolol, Vicodin and Aciphex.

20(b). At the December 26, 2006 visit, Respondent wrote a progress note, documenting a back examination and noting tenderness at the right lumbar spine. His assessment was "lower back pain," with a treatment plan of Kenalog (steroid) injection as well as a Lidoderm patch (topical antesthetic).

21. On January 8, 2007, L.W. was seen by a physician assistant at Respondent's office. L.W. continued to complain of worsening pain in her lower back, hip, leg and groin. The physician assistant noted that L.W. stated she was in "severe and excruciating pain" in her right hip, radiating into her back, despite taking four Vicodin tablets at a time. An examination revealed pain and tenderness in her lower back, radiating to her right hip, with very limited range of motion. L.W. was using as walker and was having difficulty getting up and down from the examination table. According to the physician assistant, L.W. needed "immediate relief from pain as her hope appears to be deteriorating and her pain is increasing." The assessment was "acute or chronic severe lower back pain." Respondent co-signed the note. No diagnostic tests were ordered, but a referral was made for a pain management consultation.

22(a). On January 24, 2007, L.W. was seen at the Temecula Pain Management Group (TPMG), by physician assistant J. Lauerman, whose report was co-signed by Jack Druit, M.D. At that visit, L.W. complained of pain in her right hip and lower back. She reported that she recently started taking one tablet of Percocet per day, and that the pain was getting better. On the prior day, she was able to walk without a walker for the first time in two months.

22(b). On examination, tenderness was noted at the right greater trochanter bursa, with some mild tenderness in the parasacral area. Gait, motor and neurological examinations were noted to be normal. L.W. was diagnosed with trochanteric bursitis. The following recommendations were made: right trochanteric bursa injection of steroids; decrease Percocet; increase Celebrex (an anti-inflammatory medication) to 200 mg twice per day for

pain relief. No diagnostic tests were recommended.

23. On January 25, 2007, patient L.W. was seen by Respondent, who noted that she still complained of back and hip pain, but that she was "overall improved." Respondent had been provided with the TPMG findings and recommendations. As recommended by the TPMG, Respondent increased L.W.'s Celebrex prescription and discontinued the Percocet, but also prescribed Vicodin. Respondent's assessment was "lower back pain / bilateral hip pain." At that point, due to the improvement, Respondent did not contemplate further diagnostic testing.

24. On February 13, 2007, L.W. returned to Respondent with complaints of severe pain from her waist radiating down her legs and difficulty walking. At this visit, the patient was observed by her husband to be crawling on the floor in pain. After examination, Respondent's assessment was "acute sciatica." He prescribed Torodol injections (an anti-inflammatory to control the pain) and he added a notation to "find out authorization for follow up pain clinic."

25(a). On or after February 13, 2007, Respondent added notations to his December 26, 2006 progress note (see Factual Finding 20). He added a notation indicating that the patient had an x-ray with no fracture, and that her pain had improved. Respondent also added a notation documenting the performance of a hip examination, and noting pain at the greater trochanter area and limited range of motion due to pain. He also added an assessment which included bilateral hip pain. The change in the medical record was not dated by Respondent to show when the document was amended.

25(b). Respondent testified that he altered the December 26, 2006 progress in order to provide evidence that the patient was having hip problems in December and therefore obtain approval from the medical group for re-referral to TPMG for hip injections. Respondent stated that he believed if he sent progress notes without any data regarding a hip examination, it was likely that the medical group would deny approval for the referral for hip injections.

25(c). The evidence did not establish that Respondent conducted a hip examination on December 26, 2006. Therefore, even if Respondent altered the progress note in order to obtain approval for a referral (rather than to insert exculpatory documentation prior to sending L.W.'s medical record to the Board), this alteration was still done with a fraudulent intent and constitutes dishonesty.

26. Although L.W. obtained approval for the referral on February 16, 2007, TPMG could not give her an appointment for injections until March 1, 2007.

27. On February 20, 2007, L.W. came to Respondent's office after calling to request a cortisone injection. At that visit, she complained of worsening pain in her right hip,

stating that she was unable to walk or bear weight. Respondent's assessment was "degenerative joint disease of the right hip." Respondent administered a Kenalog injection to her right hip and ordered a stat MRI of her right hip to "rule out [a] tear or other etiology."

28. On February 22, 2007, L.W. returned to Respondent's office to receive another Kenalog injection. Respondent's assessment was "hip bursitis." Respondent noted "call pain clinic," and ordered an MRI of her lumbar spine and right hip.

29(a). On February 23, 2007, an MRI of L.W.'s lumbar spine was performed at Temecula Valley Advanced Imaging. The findings included a fracture of the right upper sacrum, with a maximum gap of 3mm at the fracture site. The entire extent of the fracture was not visible on the MRI. The findings also included a possible non-displaced left mid-sacral fracture vs. an MRI imaging artifact, not optimally visualized on the MRI. There were no vertebral fractures.

29(b). An MRI of L.W.'s right hip was performed on February 24, 2007. The MRI showed a "right femoral neck fracture, superior to the intertrochanteric area, with adjacent bone marrow edema. Maximum displacement [was] about 1.5 cm."

29(c). The findings of the February 23 and 24 MRIs were discussed with Respondent by phone on the afternoon of February 26, 2007.

30. On February 27, 2007, L.W. was admitted to Rancho Springs Medical Center and underwent a right hip replacement surgery. The post operative diagnosis of the orthopedic surgeon, Jack E. Ellis, M.D., was "right femoral neck chronic fracture." During the surgery, Dr. Ellis noted that the fracture had "shown no significant healing." The patient tolerated the procedure well and was later discharged.

***Standard of Care re: Patient L.W.***

Alleged Repeated Negligent Acts:

*Failure "to perform/document a complete initial history & physical" and*
*Failure to "perform/document screening tests or surveillance of health issues"*

31(a). Dr. Yan stated that the standard of care requires a primary care internal medicine physician to conduct a comprehensive initial evaluation and to conduct a medication reconciliation to determine if it was necessary to continue prior medications. Dr. Yan admitted that, if the patient appears to be doing well, there is no reason to stop the patient's current regimen and start a new one, and it would be unwise to make such changes all at one time. Dr. Yan opined that Respondent's May 19, 2004 initial evaluation was

incomplete, was not comprehensive and therefore, fell below the standard of care. According to Dr. Yan, Respondent conducted no medication reconciliation of the patient's prior regimen and the medications prescribed by Respondent; there was no documentation of the patient's chronic conditions that were being addressed; and the patient's allergies were not well documented. However, these factual bases for his opinion were not borne out by the evidence, which indicated instead that L.W. had provided Respondent with a list of her medications and prior procedures; that Respondent had already noted these medications and the conditions for which they were prescribed in his April 1, 2004 progress note; and that the patient's allergies were noted in the May 19, 2004 progress note and on the Physical Examination Form.

31(b). Dr. Yan also opined that screening and preventative measures should have been pursued at the initial visit and subsequent visits. According to Dr. Yan, although lab tests were done in 2004, the medical record did not document continued surveillance for thyroid, cholesterol and other conditions by way of follow-up lab work. However, this factual basis for his opinion was not borne out by the evidence. Dr. Yan admitted later in his testimony that he did not notice the 2005 follow-up lab work, and that Respondent did obtain lab tests after 2004 to follow up on abnormal chemistries (low potassium and elevated calcium). In light of the follow up lab work, Dr. Yan instead opined that Respondent should not have waited a year to check the potassium level, but should have followed up with lab work in two weeks. Additionally, Dr. Yan asserted that since the medications "causing the abnormal results" were continued, "managing the abnormalities was below the standard of care." Dr. Yan did not explain the bases for his assertion that the medications were the proven cause of the abnormal results, nor whether he believed immediate discontinuation of medications, despite their necessity to manage chronic conditions, was warranted. He did not adequately address why Respondent's approach of making less drastic changes to the patient's diet and calcium supplement was inappropriate, particularly given the normal levels that were eventually reached. Dr. Yan admitted that the 2005 mammogram and colonoscopy were appropriate surveillance/screening for L.W. He also admitted that Respondent's referral to a urologist was appropriate.

31(c). Dr. Achar testified that the standard of care for a new patient requires taking the patient's past medical history, past surgical history, allergies, social history, family history and the history of their present illness, if they have one. The physician should conduct a physical examination, make an assessment and set up a plan. The physician should also try to obtain the records from the patient's prior treating physician(s). The standard of care also requires a physician to assess the patient's previously prescribed medications to determine if they are appropriate and, if so, to continue the prescription. The Health Questionnaire which L.W. completed, along with her attached list of medications and medical history/procedures, was a complete and comprehensive history. Respondent's assessment and plan from the April 1, 2004 visit was also appropriate. The lab tests on May 19, 2004, provided information for assessing L.W.'s hypothyroidism, hypertension, liver

function and cholesterol. Thereafter, the patient's thyroid function, liver function, cholesterol level, potassium level, calcium level and other blood counts were monitored. Although her potassium level was slightly low in 2004, Respondent followed up in 2005 and added a potassium supplement to L.W.'s medication regime, which brought her potassium levels to a normal level in 2006. Additionally, although the patient's calcium level was mildly elevated in 2004 and in 2005, Respondent decreased L.W.'s calcium supplement, which brought her calcium to a normal level in 2006. All of Respondent's follow up on abnormal readings was within the standard of care. Furthermore, Respondent's ordering mammography in 2005 and referrals to a urologist for bladder cancer screening and to a gastroenterologist for colonoscopy were all within the standard of care. Dr. Achar opined that Respondent met the standard of care in "perform[ing] and document[ing] interval screening tests, preventative measures or surveillance of the patient's ongoing health issues, including, but not limited to, mammography."

31(d). Regarding whether Respondent engaged in negligent acts in his care of L.W. by failure "to perform and /or document a complete initial history and physical of patient L.W" or by failure to "otherwise perform and/or document interval screening tests, preventative measures or surveillance of the patient's ongoing health issues, including, but not limited to, mammography," the opinions of Dr. Yan were less persuasive than those of Dr. Achar. Therefore, the opinions of Dr. Achar, set forth in Factual Finding 31(c), are adopted as facts herein.

*Failure to properly evaluate / follow up on evidence of osteopenia*

32(a). Dr. Yan testified that osteopenia could be a warning sign of a patient progressing toward osteoporosis, which can, in turn, lead to fracture. He opined that, ideally, a physician should obtain bone densitometry to help determine what treatment to recommend, and that a physician should also discuss with his patient treatments for osteopenia, the risks of taking hormone replacements and alternative treatment options such as bisphosphonates (e.g. Fosamax). Dr. Yan acknowledged that L.W. was taking Premarin (estrogen replacement) for menopausal symptoms. He admitted that L.W. did not have osteoporosis, that Premarin would be one of the treatment options for osteoporosis, and that a physician should have tried "not to give a patient both" Premarin and Fosamax in 2006. He also acknowledged that Premarin and Fosamax were not typically used for treating osteopenia. Dr. Yan agreed that Premarin may have been a more cost-effective medication, but insisted that, while patient preference is important, the physician must have the discussion of the options with the patient. Dr. Yan opined that Respondent fell below the standard of care in failing to discuss screening or other treatment options with the patient. He did not address the contraindication of the patient's GERD to prescribing Fosamax, which was the only alternative treatment to which he alluded, and whether there was still a need for patient discussion in light of this contraindication.

32(b). Dr. Yasharel opined that the standard of care for addressing a finding of osteopenia is to order a bone density scan to see if treatment is necessary. Dr. Yasharel further opined that Respondent committed a simple departure from the standard of care in failing to follow up on the finding of osteopenia. He admitted that Premarin does provide some protection for osteopenia, but noted that even patients who are on a treatment regimen have the potential for not responding to the medication. Therefore, analysis is still needed, and the results of a bone density study could potentially warrant a change in medication. Based on his clinical experience, Dr. Yasharel opined that Fosamax was a more effective than Premarin and that both medications can be taken at the same time. However, he admitted that GERD could be a contraindication to prescribing Fosamax.

32(c). Dr. Achar opined that a bone density scan should be used if it will make a difference in the treatment of the patient. L.W. was already taking Premarin for another medical condition, so the Premarin was addressing osteoporosis prevention as well. Although Fosamax is a "stronger" medication, L.W.'s GERD (for which she was taking Aciphex) was a relative contraindication to Fosamax, which can cause esophagitis. Therefore, further imaging of bone density would not have changed her therapy, and thus would not have been helpful. Dr. Achar opined that Respondent's refraining from ordering the test was not below the standard of care.

32(d). Regarding whether Respondent engaged in negligent acts in his care of L.W. by failure "to properly evaluate and follow up on evidence of osteopenia," the opinions of Drs. Yan and Yasharel were less persuasive than those of Dr. Achar. Therefore, the opinions of Dr. Achar, set forth in Factual Finding 32(c), are adopted as facts herein.

*Failure to properly evaluate / follow up on the suspicion of atrial fibrillation*

33(a). Dr. Yan testified that the EKGs taken January 6, 2006, and March 3, 2006, contained no evidence of atrial fibrillation. Nevertheless, it was appropriate for Respondent to order repeat EKGs if he was concerned about possible atrial fibrillation. However, Dr. Yan opined that, if Respondent suspected atrial fibrillation, the standard of care also required him to work up that potential diagnosis with a more detailed cardiac history (including prior heart palpitations, exercise tolerance, dizziness and chest pain). One option was a Holter monitor to capture rhythms for 24 to 72 hours; other options would be diagnostic tests such as an echocardiogram to confirm or rule out structural abnormalities, or referral to a cardiologist. According to Dr. Yan, Respondent's workup was not a comprehensive workup of atrial fibrillation and was, therefore, below the standard of care.

33(b). Dr. Yasharel agreed that the EKGs taken January 6, 2006, and March 3, 2006, contained no evidence of atrial fibrillation. However, if Respondent suspected atrial fibrillation, it was appropriate for him to order repeat EKGs. According to Dr. Yasharel, "if there was atrial fibrillation, which I did not see, then an echocardiogram would have been

approp, but was not done." Dr. Yasharel did not specify at what point in time, the echocardiogram should have been ordered. Dr. Yasharel opined that it was a departure from the standard of care not to follow up with an echocardiogram on suspicion of atrial fibrillation.

33(c). It was unclear why Drs. Yan and Yasharel would find that the standard of care required follow up on a condition which they both opined was not evidenced in the initial EKG. Addtionally, given that Drs.Yan and Yasharel found the repeat EKG in March appropriate, it was unclear at what point they believed an echocardiogram (and according to Dr. Yan, a Holter monitor or cardiology referral) should have been ordered. Since Respondent had discounted atrial fibrillation as a possible diagnosis by March 3, 2006, it could not have been necessary thereafter. However, Drs. Yan and Yasharel did not specify that the echocardiogram, Holter monitor or cardiology referral should have been ordered prior to March 3, 2006, or that the repeat EKG should have occurred earlier.

33(d). Dr. Achar opined that Respondent appropriately followed up on his suspicion of atrial fibrillation. Dr. Achar testified that, given the patient's discontinuation of all medications, it was reasonable for Respondent to become concerned and it was appropriate to order an EKG. According to Dr. Achar, the patient's heart rate of 113 and the irregularity in rhythm were reasons for Respondent to consider atrial fibrillation, and resuming the patient's beta-blocker was appropriate and within the standard of care. It was also appropriate for him to order a repeat EKG.

33(e). Regarding whether Respondent engaged in negligent acts in his care of L.W. by failure to "properly evaluate and follow up on the suspicion and/or diagnosis of atrial fibrillation," the opinions of Drs. Yan and Yasharel were less persuasive than the opinions of Dr. Achar. Therefore, the opinions of Dr. Achar, set forth in Factual Finding 33(d), are adopted as facts herein.

34. Complainant did not establish by clear and convincing evidence that Respondent engaged in negligent acts in his care of L.W. by any of the following: (1) failure "to perform and /or document a complete initial history and physical of patient L.W." (Accusation, para. 8Q); (2) failure to "otherwise perform and/or document interval screening tests, preventative measures or surveillance of the patient's ongoing health issues, including, but not limited to, mammography" (Accusation, para. 8R); (3) failure "to properly evaluate and follow up on evidence of osteopenia" (Accusation, para. 8S); (4) failure "to properly evaluate and follow up on the suspicion and/or diagnosis of atrial fibrillation" (Accusation, para. 8T).

*Failure to properly evaluate/follow up on hip injury and continuing pain*

35(a)(1). Dr. Yan opined that, in 2006, to address complaints of persistent pain in an

elderly person after a fall, the standard of care required an internist to evaluate the patient for a fracture. Patient L.W. had a number of risk factors for fracture, including: a trauma/fall; evidence of low bone mass/osteopenia on prior x-rays; and a prior fall from which she had sustained a fracture. Given the high index of suspicion for fracture in this patient, the standard of care required Respondent to pursue a fracture diagnosis more aggressively, even if the initial imaging did not show a fracture. According to Dr. Yan, the standard of care required the completion of a history and physical after the trauma and ordering plain film x-rays, which Respondent did. It was reasonable, at that point, for Respondent to rely on that x-ray reading, which Dr. Yan confirmed showed no evidence of a fracture. However, the x-ray is just one piece of information used to manage the patient. The entire clinical picture must be considered as well. Dr. Yan admitted that a patient could experience radiculopathy from a disc pressing on nerves and could experience hip pain from a cartilage injury after trauma. However, he maintained that nothing in the clinical picture pointed toward cartilage injury. In this case, L.W. had a higher risk for fracture and had continuing complaints of pain and difficulty walking, despite use of oral opiates, anti-inflammatory medication and bursa injections. According to Dr. Yan, in this clinical situation, the standard of care required Respondent to obtain further diagnostic testing which could include a repeat x-ray or a more sensitive test such as an MRI. Dr. Yan also noted that an MRI could have confirmed or ruled out the spinal stenosis, cartilage injury or trochanter bursitis. The risks to a patient from an undiagnosed hip fracture include displacement of the fracture; this, in turn, can lead to risks including long term pain and debility, bleeding, neurological symptoms, avascular necrosis and death.

35(a)(2). Dr. Yan noted that, by January 8, 2007, L.W. was experiencing persistent, worsening pain in her low back, hip and groin; was taking four Vicodin at a time, without a decrease in pain; and was using a walker. Although a pain management consultation was ordered, there was no plan for change of management/treatment. He acknowledged that the pain management consultation several weeks later described L.W. as being able to walk and in no acute distress. Therefore, it was reasonable for Respondent to discount a hip fracture at that time, since she appeared to be improving clinically with time and with a combination of therapies. Nevertheless, by February 13, 2007, the patient was suffering from severe pain from her waist down and was having difficulty walking again. Respondent's assessment was "acute sciatica." A week later, Respondent ordered MRIs of her lumbar spine and her hip, to "rule out a tear or other etiology." Respondent has several opportunities to pursue the diagnosis of fracture over several months. Dr. Yan opined that Respondent's repeated failure to consider a diagnosis of fracture in a fall-risk patient whose pain and symptoms originated from a fall/trauma and progressed despite treatment, was an extreme departure from the standard of care. Dr. Yan also opined that Respondent's failure to investigate this possible diagnosis with further diagnostic modalities, including x-ray or MRI, was an extreme departure from the standard of care.

35(b). Dr. Yasharel agreed that the x-rays ordered by Respondent showed no

evidence of a fracture and that it was appropriate for Respondent to consider diagnoses other than fracture at that time. However, after a month of patient complaints of pain and inability to walk, Respondent should have reconsidered fracture as a diagnosis. With an elderly patient who returns for several visits with the same complaints of pain, is not responding to medications and is unable to walk, the standard of care required further imaging such as an MRI. According to Dr. Yasharel, it was a simple departure from the standard of care for Respondent to fail to obtain further radiologic studies at an earlier point in time.

35(c). Dr. Achar testified that, with a patient complaining of pain after a fall, the standard of care requires an appropriate history, focused examination on the part causing pain and appropriate testing, which was an x-ray, and appropriate treatment. There are two types of fractures; one is caused by trauma (e.g. a fall), and the other is a stress fracture, caused by overload. X-rays are used to diagnose trauma-induced fractures, and MRI is used to diagnose overload or stress fractures only. According to Dr. Achar, MRI is not used to diagnose trauma fractures. Dr. Achar opined that Respondent ordered the test dictated by the standard of care (x-ray) and then continued with his care of the patient, prescribing medication, referring to a specialist, performing specialized treatment (injections) and ultimately ordering special testing which led to the discovery of the missed fracture. Given the findings from TPMG at the end of January, Dr. Achar maintained that it was appropriate for Respondent to continue believing that the patient's pain was caused by some condition other than fracture and therefore, not order further imaging. Respondent later ordered the MRI to look for other causes of the patient's hip pain, not fracture. According to Dr. Achar, it was appropriate to order the MRI on February 20, 2007, and not sooner, because L.W. was then unable to walk. He did not explain why L.W.'s prior difficulties walking, or her crawling across the floor in pain on February 13, 2007, did not warrant ordering an MRI at those points in time. Dr. Achar opined that Respondent's course of treatment following L.W.'s fall was timely and was within the standard of care.

35(d). Regarding whether Respondent engaged in negligent acts in his care of L.W. by failure to "properly evaluate and follow up on the patient's hip injury in the face of continuing patient complaints of pain and the ineffectiveness of his treatment modalities," the opinions of Drs. Yan and Yasharel were more persuasive than the opinions of Dr. Achar. Therefore, the opinions of Drs. Yan and Yasharel, set forth in Factual Findings 35(a) and 35(b), are adopted as facts herein, except as follows: Although Dr. Yan opined that Respondent's failure constituted an extreme departure from the standard of care, Dr. Yasharel, who has a outpatient practice similar to Respondent's, opined that it constituted a simple departure from the standard of care. Consequently, Dr. Yasharel's finding of simple negligence is adopted as the appropriate finding.

35(e). Respondent did not consider fracture as a possible diagnosis after the initial x-ray came back negative, despite the patient's risk factors and subsequent increase in pain and difficulty walking. On December 26, 2007, his assessment was "lower back pain." (He did

not add the information regarding the patient's hip problems until on or after February 13, 2007.) At the January 8, 2007 visit, when L.W. was in "severe and excruciating pain" in her right hip, radiating into her back, despite taking four Vicodin tablets at a time, Respondent should have reconsidered a possible hip fracture diagnosis. He did not, and the assessment remained "acute or chronic severe lower back pain." A month-long subsidence in symptoms, aided by an increase in anti-inflammatory medication, intervened. This understandably waylaid any consideration of a fracture diagnosis. However, by February 13, 2007, L.W. again had complaints of severe pain from her waist radiating down her legs and difficulty walking. At this visit, the patient was observed by her husband to be crawling on the floor in pain. Nevertheless, Respondent's assessment remained "acute sciatica," and he did not consider fracture as a possibility. No further diagnostic testing was ordered at that visit. Even when he ordered the MRI a week later, he was considering a tear, not a fracture, as a possibility. This failure to consider a diagnosis of fracture in a fall-risk patient whose pain and symptoms originated from a fall/trauma and progressed despite treatment constituted a simple departure from the standard of care.

*Negligent failure to maintain adequate and accurate records*

36(a)(1). Dr.Yan opined that for physician documentation in a patient chart the standard of care required accurate and complete documentation. Documentation of office visits must be complete, with notation regarding physical exam, vital signs and a consistent listing of allergies. In Respondent's records, several progress notes were incomplete and/or illegible, and the patient's allergies were incorrectly listed numerous times as "no known drug allergies." Dr. Yan opined that Respondent's recordkeeping constituted a simple departure from the standard of care

36(a)(2). Dr. Yan further opined that in making changes to a medical record, the standard of care requires the physician to identify the change and include the date and time of the amendment, and sign the amendment. Respondent's alteration of the December 26, 2006 progress note after the fact, without indicating the date and time of the amendment and signing the amendment was an extreme departure from the standard of care and constituted unprofessional conduct.

36(b)(1). Dr. Yasharel opined the standard of care requires a medical record to be readable and understandable to a subsequent care provider. There were several illegible chart entries made by Respondent in his office chart. Dr. Yasharel opined that the illegibility was a departure from the standard of care.

36(b)(2). Dr. Yasharel opined that, in making changes to a medical record, the standard of care requires the physician to date and initial the addendum, which was not done in this case. This constituted an extreme departure from the standard of care.

36(c)(1). With regard to Respondent's recordkeeping, Dr. Achar opined that the standard of care did not require a pulse to be documented at each visit. Dr. Achar did not address whether incorrectly listing "no known drug allergies" on numerous progress records fell below the standard of care.

36(c)(2).Dr. Achar harnessed his greatest powers of advocacy, and evasion, during his testimony on the issue of Respondent's alteration of the December 26, 2006 progress note. He agreed that, when placing addendums in a medical record, physicians are expected to include their name and date and the reason for the addendum. However, Dr. Achar pointed out that he has reviewed numerous patient charts and "it happens all the time that additional information is added or lined out and the physician has not signed and dated it." He went on to state that "how we define the standard of care is different from how we train physicians, and we train physicians [to sign and date addendums]." According to Dr. Achar, the standard of care is what a prudent physician would do in the same or similar circumstances, and "many prudent physicians would [include addendums] without dating and signing." He further pointed out that Respondent's alteration was necessary to obtain approval for a referral, and that "one reason the standard of care was met was that the additions made were factually accurate" and made with the intent to help a patient. He argued that Business and Professions Code section 2262 "says that physicians are not allowed to record information in a medical record that is false," but that there was no evidence that any of Respondent's added information was false. He also argued that Section 2262 "says that physicians cannot add anything in a medical record with fraudulent intent to deceive," and in this case there was no fraudulent intent when adding information to obtain a needed consultation for a patient. Dr. Achar made this argument on the assumption that the range of hip motion testing added by Respondent had indeed been performed. On cross examination, Dr. Achar stalwartly held fast to this assumption, refusing to admit that there was no hip examination or range of motion testing on December 26, 2006. Instead, he insisted that, "the fact that [Respondent] did not document it on the original note does not mean that he did not perform [the examination and testing. Dr. Achar was asked on cross examination: Assuming that no such hip examination or range of motion testing had been done on December 26, 2006, but documentation of such was added later without an examination or testing being done, is that a falsification of records? At first, Dr. Achar refused to assume the hypothetical presented. However, after being instructed to assume the facts of the hypothetical, he admitted that such actions would be falsification of records and below the standard of care.

36(d). Regarding whether Respondent engaged in negligent acts in his care of L.W. by failure to "maintain adequate and accurate records of the care and treatment of patient L.W.," the opinions of Drs. Yan and Yasharel were more persuasive than the opinions of Dr. Achar. Therefore, the opinions of Drs. Yan and Yasharel, set forth in Factual Findings 36(a) and 36(b), are adopted as facts herein.

37. Complainant established by clear and convincing evidence that Respondent

engaged in negligent acts in his care of L.W. when he: (1) "failed to properly evaluate and follow up on the patient's hip injury in the face of continuing patient complaints of pain and the ineffectiveness of his treatment modalities" (Accusation, para 8U); and (2) failed to maintain adequate and accurate records of the care and treatment of patient L.W. (Accusation, para. 8V).

Altering Medical Records and Dishonesty:

38. Complainant established by clear and convincing evidence that Respondent altered the medical records of patient L.W. for the office visit of December 26, 2006, without dating and signing the amendment, and that this alteration was still done with a fraudulent intent and constitutes dishonesty. (Accusation, paras. 9B and 10A..) (See Factual Findings 25 and 36.)

Gross Negligence:

39. Complainant did not establish by clear and convincing evidence that Respondent "was grossly negligent in the care and treatment of patient LW when he failed to properly evaluate and follow up on the patient's hip injury in the face of continuing patient complaints of pain and the ineffectiveness of his treatment modalities." (Accusation, para. 11 B.) (See Factual Finding 35.)

40. Complainant established by clear and convincing evidence that Respondent "was grossly negligent when he altered the medial records of patient L.W. for the office visit of December 26, 2006." (Accusation, para. 11C.) (See Factual Finding 36.)

Failure to Maintain Adequate and Accurate Records:

41. Complainant established by clear and convincing evidence that Respondent failed to maintain adequate and accurate records of the care and treatment of patient L.W. (Accusation, para. 12B.) (See Factual Finding 36.)

***Facts Re: Patient J.M.***

42. On January 18, 2006, a 77-year-old male patient, J.M., was seen by Respondent in his office. J.M. had been seen previously by Respondent. At the January 18, 2006 visit, Respondent documented J.M.'s history of lung cancer in 1996, and his osteoporosis. The patient's blood pressure was documented, but not his pulse. Respondent ordered a chest x-ray and prescribed Fosamax for the osteoporosis.

43. The chest x-ray, taken on January 18, 2006, with no prior x-rays for comparison, resulted in an abnormal finding of "volume loss with pleural thickening or

effusion" in the right lung. The left lung was clear. Respondent ordered a CT, with contrast, of the patient's chest.

44. On February 6, 2006, the CT was performed, with no prior CT for comparison. It showed a moderate-sized hiatal hernia and volume loss in the right lung with small pleural effusion. In the left upper lobe, the CT showed a "3cm x 1 cm linear density suggestive of scarring. Neoplastic process less likely, although not entirely excluded," and in the left lower lobe, it showed a "2 cm x 1 cm linear scarring more likely than mass." Due to the abnormalities in the left upper lung, a three-month follow-up chest CT in May 2006 was recommended.

45(b). On June 13, 2006, Respondent faxed a request for a follow up chest CT scan.

45(b). On July 24, 2006, the follow up chest CT was performed with the February 6, 2006 CT for comparison. The impression was "Stable CT Chest, with findings as described." The findings included:

> 2 cm irregular density in the left upper lobe anteriorly in the apex is stable suggesting scarring. Similarly, a linear opacity in the left lower lobe posteriorly is stable suggesting scarring. The right pleural fluid collection approximately 3 cm thick is stable, as is consolidative changes of the medial aspect of the right lower lobe along the mediastinum. Again noted is moderately enlarged hiatal hernia. There is no evidence of adrenal mass. The few tiny aortopulmonary lymph nodes are not considered enlarged by CT size criteria and measure no more than 7 mm in diameter. There is irregularity of the posterior aspects of the right eighth and ninth ribs and right T9 transverse process, not appearing significantly changed.

46. There were no further follow up CT scans.

*September 21 – 22, 2006 hospitalization*

47. On September 20 2006, J.M. fell over his walker, striking the left side of his chest.

48. On September 21, 2006, he went to the Ranch Springs Medical Center (Ranch Springs) Emergency Room (ER), suffering from left chest pain and shortness of breath. The ER physician noted J.M.'s history of lung cancer and hypertension. A chest x-ray showed apparent congestive heart failure (CHF) and a left rib fracture, with no pneumothorax. An arterial blood gas (ABG) test revealed hypoxia, and some of his laboratory values were abnormal, including a high white blood count and mildly elevated BNP. While in the ER,

J.M. required supplemental oxygen to maintain adequate saturation. The ER physician noted that at one point while J.M. was on four liters of oxygen, had a pulse oxymeter reading of 84 percent; when oxygen was removed, his pulse oxymetry readings dropped into the 70s. Thereafter, he was placed on a nonrebreather mask, and his oxygen saturation climbed to the mid to upper 90s. He was started on intravenous (IV) fluids, and a diuretic was given for the CHF. A CT scan of the chest was ordered to rule out pulmonary embolus. The ER physician's impression was "acute hypoxia." His differential diagnoses were: pulmonary contusion versus CHF, rule out pulmonary embolus; and left rib fracture.

49. The patient was admitted to the hospital in "fair and stable" condition, under the care of Respondent.

50. A chest CT scan on September 22, 2006, confirmed the rib fracture. The findings also included "no gross pulmonary arterial filling defect to suggest pulmonary embolism," and a "small, less than 5%, left pneumothorax."

51(a). On September 22, 2006, Respondent placed a handwritten admission note in the progress notes. He noted "history and physical – see dictated note." Under assessment and plan, several lines were illegible. However, he noted J.M.'s rib fracture and hypoxia, and his plan included: "admit for hypoxia/pain management," rib brace, "physical therapy evaluation (remainder illegible), "discharge home (remainder illegible)", and "if not return to normal then will arrange for home oxygen."

51(b). Respondent did not dictate the admission history and physical (H&P) until December 13, 2006. In the dictated H&P, Respondent noted, "In the emergency room the patient was evaluated and found to have some rib fractures and also given the patient's condition and history with a little bit of hypoxia, so we decided to admit the patient." Respondent listed laboratory data as "essentially all normal." His assessment was "status post fall with rib fracture." His assessment and plan mirrored that of his handwritten note.

52. On September 22, 2006, at 10:23 a.m., Respondent ordered a rib brace, physical therapy evaluation, pulse oxymetry, and "ABG on room air. Call me with results."

53. On September 22, 2006, between 8:00 am and 4:00 p.m., J.M.'s oxygen level was at 97 percent on a non-rebreather mask, fell to 76 percent on room air, and returned to 97 percent when the non-rebreather mask was replaced.

54(a). On September 22, 2006, at 2:15 p.m., Respondent issued a telephone order, stating "discharge home with oxygen." However, the patient remained in the hospital, and according to Respondent, Dr. Carrasco took over the patient's care. However, there was no order or other documentation specifying the transfer of care.

54(b). According to a nursing note, at 4:00 p.m., J.M's oxygen saturation was 85 percent, so the patient received four liters of oxygen via nasal cannula per Dr. Carrasco's order. J.M.'s oxygen saturation then improved to between 90 to 92 percent with the supplemental oxygen. There was no documentation in the medical record indicating that Dr. Carrasco examined the patient prior to issuing the order for oxygen.

55. On September 22, 2006, at 6:30 p.m., J.M. was discharged home with oxygen. At that point, his oxygen saturation was 89 percent with four liters of oxygen via nasal cannula. His pulse was 107, and his blood pressure was 131/75.

56. Respondent's final progress note for J.M.'s September 21-22, 2006 hospitalization was not written until November 4, 2006. His final diagnosis was "left rib fracture, pain management, and hypoxia – Chronic Obstructive Pulmonary Disease (COPD)." The patient's condition on discharge was listed as "fair," and instructions were to "follow up with primary care physician." His admission H&P for the September 21-22, 2006 hospitalization was not dictated until November 14, 2006.

57. At the administrative hearing, Respondent explained that "discharge to home" means the start of discharge planning, which involves preparation for discharge and arranging ancillary services, including oxygen. According to Respondent, many times patients are not yet ready to go home when the discharge order is made, but a physician needs to plan for the discharge, especially on Friday, when the on-call physician takes over coverage of inpatients until Monday morning. Respondent admitted that he did not specify the oxygen level for discharge. He also admitted that at the time of the discharge order, he was on a nonrebreather mask so he would not have sent the patient home at that time. According to Respondent, the physician who discharges the patient ultimately decides the level of oxygen to order for home use. However, Respondent insisted that he signed the patient over to the on-call physician, Dr. Carrasco, for further care and to determine if the patient was stable to go home, and that it was Dr. Carrasco's responsibility for discharge of the patient. Respondent also agreed that the patient should not have been discharged home with a respiratory rate of 107.

*September 27 – 29, 2006 hospitalization*

58. On September 26, 2006, J.M. saw Respondent in follow up. The patient complained of inability to eat, abdominal pain and nausea. No vital signs were recorded. The findings on lung and abdominal examinations were abnormal. Respondent's assessment was "right upper quadrant tender / mild jaundice." He ordered stat liver function tests and a right upper quadrant ultrasound to rule out cholelithiasis (gallstones). He did not instruct the patient to go to the ER because it was not an emergent situation.

59. On September 27, 2006, an ultrasound of J.M.'s abdomen revealed moderate bilateral hydronephrosis with a dilated bladder but no gallstone. The patient was instructed

to go to the ER, and Respondent was contacted.

60. On September 27, 2006, J.M. went to the Inland Valley Medical Center (Inland Valley) ER where he was found to have respiratory insufficiency, urinary retention, dehydration, malnutrition, electrolyte abnormalities, low platelets and difficulty swallowing liquids. He was admitted under Respondent's care, with a diagnosis of respiratory insufficiency, dysphagia (difficulty swallowing) and urinary retention.

61. On September 28, 2006, Respondent performed a H&P on J.M. at Inland Valley. His progress note stated, "H /P – see dictated note." His assessment was "urinary incontinence, dysphagia, consolidation of the lung and rib fracture." His plan included observation, placement of a Foley catheter, supplemental oxygen, antibiotics, breathing treatment, and a swallow evaluation.

62. On September 28, 2006, J.M. underwent a swallow evaluation. At 2:40 p.m., Respondent was paged, and at 4:40 p.m., he was informed of the results from the swallow evaluation. At 4:50 p.m. Respondent ordered a modified barium swallow evaluation.

63. On September 28, 2006, after speaking to the nurse at 9:00 p.m., Respondent turned over the care of J.M. to Dr. Carrasco.

64. On September 29, 2006, J.M. underwent a modified barium swallow evaluation. Respondent was not notified of the findings, which included a recommendation for a pulmonology consultation.

65. On September 29, 2006, at 3:33 p.m., Dr. Carraso ordered the patient discharged to home, with a visiting nurse for Foley catheter care, home physical therapy, home oxygen, and follow up with Respondent in one week. Respondent was not involved in the discharge of J.M.

66. On October 26, 2006, Respondent wrote a discharge summary, indicating that the patient had been discharged in "fair" condition with final diagnoses of "pneumonia; dysphagia [and] urinary incontinence."

*October 16-25, 2006 hospitalization*

67. On October 16, 2006, Patient J.M. was taken by ambulance to the Rancho Springs ER, suffering from shortness of breath. He was admitted with sepsis, secondary to pneumonia and urinary tract infection, CHF, acute on chronic respiratory failure and multiple decubitis ulcers. Respondent performed a H&P. Consultations with various specialists were obtained. Cultures revealed methicillin-resistant staphylococcus aureus (MRSA), drug resistant organisms, in the lungs and urine. The patient was provided with broad spectrum

antibiotics, system steroids, respiratory therapy, noninvasive ventilation, wound care, feedings via nasogastric tube (NGT) and daily physical therapy. There was little change in the patient's severe dysphagia.

68. Nutrition was one of greatest concerns during the October hospitalization. Since there was no access for proper feedings, they had to rely on NGT feedings, which involves the risk of aspiration. A gastroenterologist was consulted and determined that percutaneous endoscopic gastronomy (PEG) tube placement was not feasible due to the placement of J.M.'s stomach below his rib cage. A surgeon was also consulted for possible placement of a jejunostomy tube (J-tube) in the small intestine, but the surgeon determined that J.M. would not be able to tolerate surgery. The only option left was NGT feeding.

69(a). Respondent discussed with J.M.'s wife and daughter the possible placement of J.M. in long term care after discharge. However, J.M.'s family rejected that option because he had previously asked not to be placed in a nursing home after a prior negative experience in such a facility. They insisted on his discharge home, and Respondent wanted to honor J.M.'s and his family's wishes.

69(b). Respondent knew that J.M.'s wife had several decades of experience caring for a quadriplegic son. J.M.'s wife, with help from family members had taken care of her son's decubitis ulcers, Foley catheter, peripherally inserted central catheter (PICC) lines, and feeding through a gastric tube. Consequently, she and Respondent felt that she was capable, along with family support and extra help from home health agencies and visiting nurses, to care for her husband on discharge to their home.

69(c). Nursing notes indicated J.M.'s family had been instructed about NGT feeding (management, complications and risks) and about wound care.

70(a). One of the specialists consulted was Munif Salek, M.D., a pulmonologist, who saw J.M. almost every day of his October hospitalization. Dr. Salek was involved in ordering diagnostic modalities (e.g. x-ray and bronchoscopy), prescribing treatment and managing J.M.'s oxygen.

70(b). Respondent last saw the patient on October 24, 2006. On October 25, 2006, Dr. Salek examined J.M. Dr. Salek believed that, from a pulmonology standpoint, J.M. appeared to be improving, and that it was appropriate to discharge the patient home with vancomycin, breathing treatment and oxygen. In his October 25, 2006 progress note, Dr. Salek indicated "discharge home with vancomycin . . ."

71. On October 25, 2006, J.M. was discharged home with IV antibiotics, NGT feedings, home oxygen, Foley catheter and multiple pressure ulcers requiring care. There was no documentation of post-discharge medications or a follow-up plan.

*November 1 – 19, 2006 hospitalization*

72. On November 1, 2006, J.M. went to Rancho Springs ER with respiratory distress. His experienced oxygen desaturation to about 82 percent with three or four liters of oxygen via nasal cannula. A nonrebreather mask was placed and his oxygen saturation increased to 87 percent. He was then intubated, placed on mechanical ventilation and admitted to the intensive care unit (ICU) in critical condition.

73. On November 1, 2006, Abayomi A. Odubela, M.D. conducted an H&P. His impression included was acute respiratory failure, bilateral pneumonia, CHF and mild anemia. The treatment plan included bronchodilator nebulized treatments, IV antibiotics, and IV steroids.

74. On November 2, 2006, Dr. Salek conducted pulmonary consultation. His impression included: acute on chronic respiratory failure with right lung pneumonia, recurrent; history of MRSA pneumonia; rule out pulmonary embolus on this patient; COPD; history of lung cancer; history of urinary tract infection; cachexia, malnutrition and dysphagia, on tube feedings; and anemia. Dr. Salek later (Nov. 10) performed a bronchoscopy which revealed mild tracheobronchitis.

75. During his this hospitalization, J.M. was treated with anticoagulation (for pulmonary embolism), steroids, bronchodilators, antibiotics, NGT feedings and wound care.

76. On November 6, 2006, J.M. was transferred to Respondent's care at Rancho Springs. This was documented on a physician's order on November 6, 2006, at approximately 8:30 p.m.

77. Subspecialists continued to follow the patient. J.M. was on mechanical ventilation from November 1 through November 10, 2006. He was transferred out of ICU on November 15, 2006.

78. On November 17, 2006, J.M. experienced difficulty with the NGT feedings and was switched by Respondent to total parenteral nutrition (TPN). A left arm PICC line was placed on November 18, 2006, for that purpose. When it failed later that day, the PICC line was switched to the right upper extremity.

79. On November 17, 2006, at 1:40 p.m., Respondent issued a telephone order for the "possible discharge on November 18, 2006, with home [TPN], home health and physical therapy."

80. Toward the end of the hospitalization, J.M's wife spoke to one of the nurses about the option of hospice care. J.M.'s family ultimately decided against hospice because it

requires a do not resuscitate order.

81. On November 18, 2006, a new 20 to 30 percent left pneumothorax was seen on serial chest x-rays (by the same radiologist each time), at 5:10 a.m., 1:45 p.m., 2:00 p.m. and 7:25 p.m. The first three x-ray reports indicated, "Dr. Salek immediately made aware of the findings."

82. On November 18, 2006, at 2:20 p.m., Dr. Salek issued a telephone order discontinuing the discharge home. This discontinuation of the discharge was also documented in the nursing notes at 2:50 p.m.[3] At 3:30 p.m., Dr. Salek spoke with J.M.'s wife, explaining pneumothorax.

83. On November 19, 2006, another chest x-ray was taken and read by a different radiologist than the prior day. No pneumothorax was mentioned in the findings. However, the x-ray report also noted that the November 19, 2006 x-ray had been "with 11-18-06," and that "findings [were] essentially unchanged from 11-18-06."

84. On November 19, 2006, both Respondent and Dr. Salek examined J.M. Both noted that there was no pneumothorax. From a pulmonology standpoint, Dr. Salek felt it was appropriate to discharge the patient. At that time, he found J.M.'s vital signs stable with 96 percent oxygen saturation with supplemental oxygen via nasal cannula. Respondent and Dr. Salek agreed that it was appropriate to discharge the patient.

85. On November 19, 2006, at 9:00 a.m., Respondent ordered the patient discharged home. At that time, J.M.'s oxygen saturation was 95 percent on six liters of oxygen via nasal cannula. The patient was discharged to home that day with IV nutrition (TPN) NG feedings and six liters of supplemental oxygen.

86. On December 13, 2006, Respondent's dictated a discharge summary for the November hospitalization. The discharge summary included the diagnoses of sepsis, secondary to pneumonia and urinary tract infections, dysphagia and CHF. There was no mention of pulmonary embolism, the PICC line, or the condition of the patient at discharge.

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[3] Although Dr. Salek's telephone order in the medical record has a handwritten date of "11/17/06," the totality of the evidence indicates that date is wrong, for the following reasons: (1) Dr. Salek's order appears on the same page as another physician's order dated 11/18/06; (2) the nurse who wrote the telephone order also wrote the more extensive nursing notes on 11/18/06 describing Dr. Salek's discontinuation of the discharge; and (3) the nurse who wrote both the telephone order and the nursing notes did not appear to be on duty on 11/17/06, since another nurse made the entries in the nursing notes on that date.

*November 20, 2006 hospital admission*

87. On November 20, 2006, J.M. was taken by ambulance to the Hemet Valley Medical Center ER in respiratory distress. X-rays taken on that date showed no pneumothorax. The patient was admitted with diagnoses of sepsis syndrome, pneumonia, urinary tract infection, CHF, acute on chronic respiratory failure and multiple stage II pressure ulcers. Respondent was not involved in J.M's care during this hospitalization.

***Standard of Care re: Patient J.M.***

Repeated Negligent Acts:

*Failure to follow up on chest imaging abnormalities*

88(a). Dr. Yan opined that, for a patient with a history of lung cancer, the standard of care requires close and careful surveillance to detect recurrence of the primary lung cancer or redevelopment of new tumors. A surveillance program would include comparison to prior chest imaging studies, pulmonary function tests to assess lung capacity, bone scan or referral to a pulmonologist. Dr. Yan opined that Respondent failed to provide adequate follow up on the patient's abnormal chest x-ray and CT findings. While the CT findings could be related to the patient's prior treatment, they could also represent recurrence of cancer or progression of COPD. According to Dr. Yan, further investigation such as referral to a specialist or pulmonary function tests was warranted. Since these measures were not taken, Respondent departed from the standard of care. Dr. Yan pointed out that, while the radiologist recommended a repeat CT in three months, the repeat CT was done five months later. According to Dr. Yan, if there was a clinical progression in symptoms or interval change prompting the follow up, the delay would be a departure from the standard of care. Dr. Yan did not specify whether he considered the February 2006 CT as showing a "clinical progression of symptoms" for which a delay in follow up would be a departure from the standard of care.

88(b). Dr. Yasharel opined that, for a patient with a history of lung cancer, the standard of care requires surveillance with once-per-year CT scans or x-rays. In this case, abnormalities were noted and a three month follow up was recommended. However, Dr. Yasharel admitted that follow up between "three to five months is still within the standard of care."

88(c). Dr. Achar did not provide any opinions regarding this issue.

88(d). Regarding whether Respondent engaged in negligent acts in his care of J.M. by failure to "properly and timely follow up on chest imaging abnormalities," the opinion of Dr. Yan was less persuasive than that of Dr. Yasharel, who has a similar outpatient practice as

Respondent. Therefore, the opinions of Dr. Yasharel, set forth in Factual Finding 88(b), are adopted as facts herein.

*September 22, 2006 Discharge*

89(a). Dr. Yan noted that J.M. had prior lung cancer, and underlying lung disease, had sustained a traumatic rib fracture, and was now using supplemental oxygen. During the hospitalization, he had CHF and hypoxia, with critically low saturation levels when taken off the supplemental oxygen. Dr. Yan opined that Respondent failed to meet the standard of care in the evaluation and management of J.M. by his early discharge of a patient with significant hypoxia. Respondent's discharge order was below the standard of care because J.M. needed continued inpatient management and further evaluation of his hypoxia given the low degree of the oxygen saturation and less than ideal response to initial management. Dr. Carrasco's subsequent order for four liters of oxygen did not change Dr. Yan's opinion since Respondent had issued the discharge order and Dr. Carrasco had only issued an order for oxygen. Although another physician was involved later, there was no documentation of the transfer of care, as the standard of care requires, and Respondent was still responsible for his discharge order. Additionally, Dr. Yan pointed out that the discharge order is interpreted to indicate "discharge home with oxygen now," meaning that the patient was ready to be discharged at that time. The discharge order did not indicate that discharge planning would begin or that the patient would be discharged only if he was stable or if his oxygen level was at a specific level. The clinical data up until the time of the discharge order indicated that the patient was not stable for discharge; in fact, the patient was not stable for discharge at 6:30 p.m. either.

89(b). Dr. Yasharel opined that Respondent committed a simple departure from the standard of care in ordering the patient's discharge on November 22, 2006. Dr. Yasharel opined that J.M. was not sufficiently stable for discharge on September 22, 2006. He pointed out that Respondent's discharge order was a telephone order, and that nothing in the record indicated that Respondent had seen the patient just prior to the discharge order. The discharging physician is responsible for evaluating the patient to determine if he is stable for discharge at the time of the order. He further opined that Respondent's discharge order was not proper because, at the time of the discharge order, the patient required a non-rebreather mask to maintain a high level of oxygen concentration, which may not be deliverable via the oxygen tank and nasal cannula provided for home use. On cross-examination, Dr. Yasharel agreed that, assuming Dr. Carrasco actually evaluated the patient prior to the patient's discharge, that would have placed responsibility on Dr. Carrasco to ensure the patient was stable for discharge and to notify Respondent if the patient was not stable for discharge. However, Dr. Yasharel also correctly pointed out that there was no documentation in the medical record indicating that Dr. Carrasco was the last physician to evaluate J.M. According to Dr. Yasharel, the fact that Dr. Carrasco ordered treatment after the discharge order does not change Respondent's responsibility for issuing the earlier discharge order.

order does not change Respondent's responsibility for issuing the earlier discharge order.

89(c). Dr. Achar opined that Respondent did not commit any departures from the standard of care with respect to the September 21 – 22, 2006 hospitalization. According to Dr. Achar, Respondent had signed out his patients to Dr. Carrasco, and no express hand off needed to be documented in the chart. Dr. Achar opined that patient responsibility transferred fully to the physician to whom the patients were signed out, and that if a patient needed further treatment and "further decision for discharge," that would "fall under the realm" of the other physician if the patient "actually goes home." Therefore, Dr. Achar opined that after Respondent signed out his patient, the responsibility for J.M. lay with Dr. Carrasco.

89(d). Dr. Achar's testimony on the issue of the September 22, 2006 discharge was not convincing. Even assuming that Dr. Carrasco was the covering physician after Respondent "signed out," Respondent had already written the improper discharge order. Additionally, the order stated "discharge to home," and did not contain specifications that discharge was only "likely" or dependent on whether the subsequent covering physician's evaluation of the patient to ensure he was stable for the ordered discharge. If Respondent had evaluated J.M. at the time of the telephone discharge order, he would have discovered that the patient was not stable for discharge at that time. Therefore, even if Dr. Carrasco should have notified Respondent to inform him that the patient was not stable at 4:00 p.m., that does not vitiate Respondent's prior improper discharge order at a time when his oxygen saturation was so low.

89(e). Regarding whether Respondent engaged in negligent acts in his care of J.M. by way of his September 22, 2006 discharge order, the opinions of Drs. Yan and Yasharel were more persuasive than those of Dr. Achar. Therefore, the opinions of Drs. Yan and Yasharel, set forth in Factual Finding 89(a) and 89(b), are adopted as facts herein.

*September 29, 2006 Discharge*

90(a). Dr. Yan testified that Respondent met the standard of care for the time he cared for J.M. during his September 27 through 29, 2006 hospitalization. Additionally, Dr. Yan opined that since the discharge order was issued by a covering physician, Respondent committed no departure from the standard of care regarding the discharge order.

90(b). Dr. Yasharel testified that, assuming Dr. Carrasco signed the discharge home order, Dr. Carrasco would be responsible for the discharge of the patient.

90(c). Dr. Achar opined that Respondent committed no departure from the standard of care for the September 27 through 29, 2006 hospitalization.

90(d). Complainant did not establish by clear and convincing evidence that

Respondent committed any departure from the standard of care in his treatment of J.M. during the September 27 through 29, 2006 hospitalization.

*October 25, 2006 Discharge*

91(a). Dr. Yan noted that, during the October 2006 hospitalization, Respondent and the consultants documented clinical improvement, but that the patient remained quite debilitated during this stay. As he described it, the patient was "in a spiral and quality of life was getting worse." Dr. Yan opined that, in light of repeat hospitalization of a declining patient with increasing needs, the standard of care required a primary care physician to determine whether the family was able to continue providing the requisite level of care at home; if they could not, other options such as additional care givers, skilled nursing facilities or board and care should be explored. Dr. Yan acknowledged that Respondent discussed with J.M.'s wife the option of placing him in a nursing home due to high needs (including wound care, respiratory therapy and NGT feedings) and that she wanted to care for J.M. at home. Dr. Yan acknowledged that there was documentation of this discussion. However, Dr. Yan pointed out that there was no documentation in the medical records regarding the capacity of J.M.'s family to provide the required care at home. According to Dr. Yan, the standard of care also required a discussion of end of life matters and providing support for that. He saw no documentation of discussion of end of life options or hospice, even though the patient was declining. Dr. Yan opined that Respondent committed a simple departure from the standard of care "in terms of hospital care and post discharge planning in assessing the family's capacity to care for [J.M.] at home."

91(b). Dr. Yasharel opined that Respondent committed a simple departure from the standard of care in discharging J.M. on October 25, 2006. According to Dr. Yasharel, there was no documentation that Respondent saw the patient on the date of discharge. Dr. Yasharel maintained that the standard of care required the primary care physician to examine the patient for discharge and that, in this case, the patient was not stable for discharge. Dr. Yasharel held this view, even though Dr. Salek, a pulmonologist who followed the patient almost daily, had examined the patient and found him stable for discharge. Dr. Yasharel agreed that, if J.M.'s only problem was pulmonary, then there would be no problem with the discharge order. However, he pointed out that the patient also had urinary tract infection and dysphagia. Nevertheless, he also acknowledged that J.M. was on antibiotics and that he had been seen by several specialists and a NGT was the only way to feed the patient at that point. Dr. Yasharel acknowledged that Respondent had discussed a nursing home as a discharge option.

91(c)(1). Dr. Achar opined that J.M. received appropriate care during the October hospitalization, which including Respondent's care and the input and treatment provided by consultants. According to Dr. Achar, the role of the primary care physician is to seek appropriate consultations, to coordinate the patient's care with all specialists and follow up

on testing and nursing notes. Dr. Achar opined that all appropriate medical consultations were obtained. A pulmonologist was consulted and saw the patient at least once per day; a gastroenterologist and a surgeon were consulted in attempts to address the patient's nutritional needs; and a wound care specialist was consulted for care of the patient's decubitis ulcers. The primary and most life-threatening condition was the patient's aspiration pneumonia, and the pulmonology specialist was instrumental in deciding how to manage the patient and ultimately when to send the patient home. On October 25, 2006, Dr. Selak, the primary specialist, felt it was safe to send the patient home; typically the primary care physician will follow the recommendations of the specialists since they have greater training in their areas of expertise.

91(c)(2). Dr. Achar additionally opined that all preparations were in place at the October 25, 2006 discharge. He pointed out that the family had stated their wish to take the patient home and had verbalized their understanding of the risks and complications involved with home care. The patient's wife confirmed that she knew how to give the feedings and understood the aspiration risk. Given the patient's wife's 25 years of caring for a quadriplegic son, the physician could assume that she was likely very capable handling the mental and physical stress of caring for her husband at home.

91(c)(3). Dr. Achar noted that the family had insisted the patient's discharge home and not to a nursing facility. Although it is a shared decision regarding the benefits and risks of discharge to home, the family and the patient have the ultimate say. Based on his experience and research, he has learned that patients do not want to die at the hospital, but would rather spend their final days at home with their families.

91(d). Regarding whether Respondent engaged in negligent acts in his care of J.M. by way of the October 2006 discharge, the opinions of Drs. Yan and Yasharel were less persuasive than those of Dr. Achar. Therefore, the opinions of Dr. Achar, set forth in Factual Findings 91(c)(1), 91(c)(2), and 91(c)(3), are adopted as facts herein.

*November 19, 2006 Discharge*

92(a). Dr. Yan noted that, with the November re-hospitalization, J.M. was requiring much more care with increasing debility. Dr. Yan opined that a physician must ascertain whether it is safe to discharge a patient back to the home environment. According to Dr. Yan, it is a departure from the standard of care to send a patient back to an environment without determining the capacity of his caregivers to provide care (including wound care, administering IV antibiotics, care of a PICC line and Foley catheter, and NGT feeding). Options should have been discussed with family, including board and care, skilled nursing facilities, sub-acute facilities or hiring more home health care workers. He did not see any documentation of this in the medical record for this hospitalization. According to Dr. Yan, if such a discussion took place and the physician felt it was unsafe to discharge to home, the

physician could: make recommendations for a safer placement; discharge to home with a recommendation for additional caregivers; or recommend placing the patient on hospice and not returning to the hospital if the patient deteriorates further. Dr. Yan stated that, if the family insists on home discharge, the physician can document the discharge "against medical advice." Dr. Yan opined that it was a departure from the standard of care to fail to address post-hospital care with close follow up. Dr. Yan also opined that it was a departure from the standard of care to fail to address end of life care in a patient so clearly deteriorating. During this hospitalization, there was no formal hospice consultation or meeting documented.

92(b). As with his testimony regarding the October hospitalization, Dr. Achar noted that the family had insisted on the patient's discharge home and not to a nursing facility. Although it became clearer with each admission that nothing more medically could be done for the patient and that hospice was the best option, the family was not willing to give up. J.M.'s wife would not sign a "do not resuscitate order" and was not ready to accept hospice care. A physician cannot force a family to accept hospice or to agree to a "do not resuscitate order." Given the situation, Respondent had done what he could to fulfill his responsibility regarding the discussion of end of life issues. Dr. Achar also opined that documenting a "discharge against medical advance" (AMA) is unethical and below the standard of care. If a physician signs out a patient AMA, the insurance company may not pay for supplemental oxygen, medication or NGT feeding. The physician needs put the patient and families first and use a collaborative effort to "do the next best therapy" at home.

92(c). Regarding whether Respondent engaged in negligent acts in his care of J.M. by way of the November 19, 2006 discharge, the opinions of Dr. Yan were less persuasive than those of Dr. Achar. Therefore, the opinions of Dr. Achar, set forth in Factual Findings 92(b), are adopted as facts herein.

*Negligent failure to maintain adequate and accurate records*

93(a)(1). Dr. Yan testified that the transition of care is important since those providing post-hospitalization care often rely on information from the recent hospitalization as a basis of patient care. An outpatient physician must be aware of key events. The standard of care requires comprehensive records; therefore, an inpatient physician must dictate a comprehensive discharge summary providing a complete picture of the hospitalization. The standard of care also requires that medical records be completed in a timely manner, especially in the transition of care from hospitalization to document acute events. In this case, the patient was gravely ill and discharged home with a number of therapies, so the discharge summaries needed to be dictated in timely manner.

93(a)(2). Dr. Yan opined that Respondent failed to meet the standard of care in that he failed to complete documentation in timely manner. He noted that Respondent failed to dictate the September 22, 2006 H&P until December 13, 2006, which was untimely. Dr.

Yan also opined that Respondent did not meet that standard of care for complete and comprehensive records. He pointed out that the November 19, 2006 discharge summary (not dictated until December 13, 2006), was incomplete and lacking several key components from the hospitalization (e.g. failure to mention pulmonary embolism; failure to mention follow-up instructions for post-hospitalization; failure to mention patient's condition at discharge. Consequently, Respondent's discharge summary constituted a departure from the standard of care.

93(a)(3). Dr. Yan additionally opined that the standard of care requires that medical records be legible. Many of Respondent's notes were illegible, which is a departure from the standard of care.

93(b). Dr. Yasharel testified that, although it is typically determined by hospital rules, generally, a discharge summary is dictated within a week after discharge. The patient was discharged on November 19, 2006, but the discharge summary was not dictated until December 13, 2006. This failure to timely dictate a discharge summary does not meet the community standard, and is therefore a simple departure from the standard of care. Dr. Yasharel agreed with Dr. Yan that Respondent failed to dictate an accurate discharge note for November 19, 2006, since he failed document the patient's condition or a follow up plan. Dr. Yan also noted various instances of Respondent's illegible chart entries for J.M. Given the foregoing, Dr. Yan opined that Respondent engaged in a departure from the standard of care in terms of recordkeeping.

93(c). Dr. Achar insisted that, as a whole, Respondent's medical record keeping was neat and legible, followed the standard templates and was within the standard of care.

93(d). Regarding whether Respondent engaged in negligent acts in his care of J.M. by way of his failure to maintain adequate and accurate records, the opinions of Drs. Yan and Yasharel were more persuasive than those of Dr. Achar. Therefore, the opinions of Drs. Yan and Yasharel, set forth in Factual Findings 93(a)(1), 93(a)(2), 93(a)(3) and 93(b), are adopted as facts herein.

94. Complainant did not establish by clear and convincing evidence that Respondent engaged in negligent acts in his care of J.M. by any of the following: (1) failure "to properly and timely follow up on chest imaging abnormalities" (Accusation, para. 8KK.); (2) failure "to assure proper evaluation of the patient for discharge to his home environment" on September 29, 2006 (Accusation, para. 8MM.); (3) failure "to properly evaluate the patient for discharge, including whether the patient was stable . . . and evaluating whether the family was capable of providing the required level of care" (Accusation, para. 8NN); and (4) failure "to properly evaluate the patient for discharge including plans for follow up with the patient after discharge home and plans for end of life care" (Accusation, para. 8OO).

95. Complainant established by clear and convincing evidence that Respondent engaged in negligent acts in his care of J.M. when he: (1) ordered J.M. discharged on September 22, 2006, "notwithstanding the patient's abnormal vital signs. . ." (Accusation, para. 8LL.); and (2) failed to "maintain adequate and accurate records" (Accusation, para. 8PP).

Failure to Maintain Adequate and Accurate Records:

96. Complainant established by clear and convincing evidence that Respondent failed to maintain adequate and accurate records of the care and treatment of patient J.M. when he: (1) failed to timely dictate the September 22, 2006 H&P until December 13, 2006 (Accusation, para. 9B); (2) failed to timely dictate the November 19, 2006 discharge summary and failed to note the follow up plan (Accusation, para. 9E); and (3) failed to legibly document in the patient's chart (Accusation, para. 9F). (See Factual Finding 93.)

97. Complainant did not establish by clear and convincing evidence that Respondent failed to maintain adequate and accurate records of the care and treatment of patient J.M. by way of the following: (1) failure to chart assessment of a swallow evaluation or dictate discharge summary following September 29, 2006 discharge (Accusation, para. 9C); and (2) failure to adequately document evaluation of J.M. for discharge (Accusation, para. 9D).

***Respondent Rehabilitation***

98. At the administrative hearing, Respondent assured the Board that, in the future, if he needed to add late information to a progress note, he will "definitely add the dates and his initials and the reason [for the late amendment]."

99(a). For purposes of this case, Dr. Achar visited Respondent's practice for one full day at the beginning of January 2011, to assess how Respondent was treating patients, to look at patient medical records and to talk to Respondent's staff. Dr. Achar was present in the examination room while Respondent saw four or five patients. Dr. Achar's general impression of Respondent's quality of care was favorable. According to Dr. Achar, Respondent employed the "Four E's" that are taught in medical school: he engaged with the patients; empathized with patients; educated the patients about their diagnosis and treatment plans (he did this in English and Korean); and he enlisted the patients in their treatment plans by asking them to follow up and arranging for follow up.

99(b). Regarding his medical records, Dr. Achar observed that Respondent used the S.O.A.P. (subjective, objective, assessment, plan) format, and his notes were very easy to read. Respondent wrote the notes while in the examination room and included salient points

in the history of the illness. According to Dr. Achar, Respondent's records were more legible than 80 percent of other physicians' charts he has reviewed.

99(c). Dr. Achar concluded that Respondent ran a well-organized office and that his present practice was operating within the standard of care.

100. Several employees, colleagues and patients testified on Respondent's behalf and characterized him as a caring physician who is very attentive to patient problems. According to his character witnesses, Respondent's patients are very well cared for.

101. For the past 10 years, Respondent has gone on medical missions overseas once or twice a year, providing free medical care to those in need.

## LEGAL CONCLUSIONS

*First Cause for Discipline – Repeated Negligent Acts*

1(a). Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), in that Respondent committed repeated negligent acts in his care of patients L.W. and J.M. when he: (1) "failed to properly evaluate and follow up on [L.M.'s] hip injury in the face of continuing patient complaints of pain and the ineffectiveness of his treatment modalities" (Accusation, para. 8U); (2) failed to maintain adequate and accurate records of the care and treatment of patient L.W. (Accusation, para. 8V); (3) ordering J.M. discharged on September 22, 2006, "notwithstanding the patient's abnormal vital signs. . ." (Accusation, para. 8LL.); and (4) failed "maintain adequate and accurate records" (Accusation, para. 8PP), as set forth in Factual Findings 5 through 30, 35, 36, 37, 42 through 87, 89, 93, and 95.

1(b). Cause does not exist to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), for repeated negligent acts in the care of patients L.W. and J.M. for the following grounds, which were not established by clear and convincing evidence: (1) failure "to perform and /or document a complete initial history and physical of patient L.W." (Accusation, para. 8Q); (2) failure "otherwise perform and/or document interval screening tests, preventative measures or surveillance of the patient's ongoing health issues, including, but not limited to, mammography" for L.W. (Accusation, para. 8R); (3) failure "to properly evaluate and follow up on evidence of osteopenia" in L.W. (Accusation, para. 8S); (4) failure "to properly evaluate and follow up on the suspicion and/or diagnosis of atrial fibrillation" for L.W. (Accusation, para. 8T); (5) failure "to properly and timely follow up on chest imaging abnormalities" for J.M. (Accusation, para. 8KK.); (6) failure "to assure proper evaluation of the patient [J.M.] for discharge to his home environment" on September 29, 2006 (Accusation, para. 8MM.); (7) failure "to properly evaluate the patient [J.M.] for

discharge, including whether the patient was stable . . . and evaluating whether the family was capable of providing the required level of care" (Accusation, para. 8NN); and (8) failure "to properly evaluate the patient [J.M.] for discharge including plans for follow up with the patient after discharge home and plans for end of life care" (Accusation, para. 8OO), as set forth in Factual Findings 5 through 30, 31, 32, 33, 34, 42 through 87, 88, 90, 91, 92, and 94.

*Second Cause for Discipline - Altering Medical Records*

2. Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2262, in that Respondent altered a medical record of a patient with fraudulent intent, as set forth in Factual Findings 25, 36 and 38.

*Third Cause for Discipline – Dishonesty*

3. Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (e), in that Respondent engaged in dishonest conduct by altering a medical record of a patient, as set forth in Factual Findings 25, 36 and 38.

*Fourth Cause for Discipline – Gross Negligence*

4(a). Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (b), in that Respondent committed gross negligence in his care of patient L.W. when he altered her medical records, as set forth in Factual Findings 25, 36, 38 and 40.

4(b). Cause does not exist to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (b), on the grounds of gross negligence for failure "to properly evaluate and follow up on the patient's hip injury in the face of continuing patient complaints of pain and the ineffectiveness of his treatment modalities," since it was not established by clear and convincing evidence that this departure from the standard of care rose to the level of gross negligence, as set forth in Factual Findings 5 through 35, 37, and 39.

*Fifth Cause for Discipline - Failure to Maintain Adequate and Accurate Records*

5(a). Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2266, in that Respondent failed to maintain adequate and accurate records for patients L.W. and J.M., as set forth in Factual Findings 5 through 30, 36 and 37, 42 through 87, 93, 95 and 96.

5(b). Cause does not exist to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2266, for failure to maintain adequate and accurate records on the following grounds, which were not established by clear and convincing evidence: (1) failure to chart assessment of a swallow evaluation or dictate discharge summary following J.M.'s September 29, 2006 discharge (Accusation, para. 9C), and (2) failure to adequately document evaluation of J.M. for discharge (Accusation, para. 9D), as set forth in Factual Findings 42 through 87, 93, 95 and 97.

*Sixth Cause for Discipline – Unprofessional Conduct*

6. Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, in that Respondent engaged in unprofessional conduct, as set forth in Factual Findings 5 through 96.

7(a). In this case, Respondent has been licensed for over 14 years, without prior discipline. He appears to have made an effort to operate his current practice within the standard of care, and he has indicated his intent to change his method of amending medical records in order to comply with the standard of care. Respondent has the support of colleagues, patients and employees who characterize him as a caring physician. His value to the community is also demonstrated by his 10-year participation in medical missions through which he has used his medical knowledge to provide for those in need.

7(b). Complainant did not establish that the public would be endangered, absent revocation of Respondent's license, and therefore, revocation would be unduly harsh discipline. In this case, the majority of Respondent's violations are record-keeping violations, although one of these record-keeping violations involves dishonesty, which is of great concern. The remaining violations appear to involve lapses of focus on patient treatment (failure to pursue a fracture diagnosis for L.W. and premature hospital discharge of J.M.), which must be remedied by way of education. However, it appears that Respondent could remedy the areas of violation if placed on probation. This probation would involve prohibition of supervision of physician assistants who comprise a significant part of his practice. However, given the lapses involved in this case, such a prohibition is necessary to provide adequate public protection.

7(c). In light of Respondent's potential for rehabilitation and the nature of his violations, the following order should provide adequate public protection without imposing overly-harsh discipline on Respondent.

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## ORDER

**WHEREFORE, THE FOLLOWING ORDER is hereby made:**

Physician's and Surgeon's Certificate No. A56294, issued to Respondent Donald Woo Lee, M.D., is revoked. However, the revocation is stayed, and Respondent is placed on probation for five years upon the following terms and conditions.

### 1. Notification

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

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

### 2. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

### 3. Obey All Laws

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

### 4. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

### 5. Probation Unit Compliance

Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses. Changes

of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Respondent shall not engage in the practice of medicine in Respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

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

**6. Interview with the Board or Its Designee**

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

**7. Residing or Practicing Out-of-State**

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws and Probation Unit Compliance.

Respondent's license shall be automatically cancelled if Respondent's periods of temporary or permanent residence or practice outside California totals two years. However, Respondent's license shall not be cancelled as long as Respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

### 8. Failure to Practice Medicine - California Resident

In the event Respondent resides in the State of California and, for any reason, Respondent stops practicing medicine in California, Respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve Respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if Respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

### 9. Violation of Probation

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

### 10. License Surrender

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

license shall be deemed disciplinary action.

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

### 11. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

### 12. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall annually provide proof of attendance for 65 hours of CME of which 40 hours are in satisfaction of this condition.

### 13. Medical Record Keeping Course

Within 60 calendar days of the effective date of this decision, Respondent shall enroll in a course in medical record keeping, at Respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first six months of probation is a violation of probation.

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

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

than 15 calendar days after the effective date of the Decision, whichever is later.

### 14. Ethics Course

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in ethics, at Respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation.

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

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

### 15. Completion of Probation

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

DATED: March 7, 2011

JULIE CABOS-OWEN
Administrative Law Judge
Office of Administrative Hearings

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

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>**DONALD WOO LEE, M.D.**<br><br>**41601 Laurel Valley Circle**<br>**Temecula, CA 92591**<br>**Physician's and Surgeon's Certificate**<br>**No. A56294**<br><br>Respondent. | Case No. 17-2007-183005<br><br>**ACCUSATION** |

Complainant alleges:

PARTIES

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

2. On or about August 21, 2009, the Medical Board of California issued Physician's and Surgeon's Certificate Number A56294 to Donald Woo Lee, M.D. (respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2010, unless renewed.

JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), 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 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[1] deems proper.

5. Section 2234 of the Code states:

"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.

"(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.

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[1] Pursuant to Business and Professions Code section 2002, "Division of Medical Quality" or "Division" shall be deemed to refer to the Medical Board of California.

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

6. 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."

7. Section 2262 of the Code states:

"Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

"In addition to any other disciplinary action, the Division of Medical Quality or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section."

**FIRST CAUSE FOR DISCIPLINE**

(Repeated Negligent Acts)

8. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that respondent engaged in repeated negligent acts. The circumstances are as follows:

Patient L.W. Factual Allegations

A. On or about May 19, 2004, patient L.W., a 79-year-old woman, first presented to respondent with a history of restless leg syndrome, hypertension, recurrent bladder cancer, lip cancer, hard palate cancer and recurrent colon polyps. She had a history of various surgeries, including left breast biopsy. A physical examination was performed but vital signs were incomplete. A urology referral was planned based on the history of bladder cancer. Six of twelve of the patient's previous medications were refilled; no medication reconciliation was documented. There was no documentation that the patient's chronic medical conditions were being addressed. There was no laboratory workup with respect to the previous medications which required lab monitoring. There was no documentation that age appropriate screening and preventive measures were pursued. Subsequent to the initial visit, there was no documentation to follow up on the planned urology referral.

Subsequent to the initial visit there is no documentation of an annual physical examination of patient L.W. and no documentation of interval screening tests, preventive measures or surveillance of the patient's ongoing health issues, including, but not limited to, mammography. On or about November 29, 2004, patient L.W. had a lumbar spine x-ray which disclosed evidence of osteopenia. There is no documentation in the patient chart of any follow up on this issue. Thereafter, on or about January 6, 2006, patient L.W. saw respondent, reporting that she had stopped all medications due to side-effects, including an episode of decreased mental status. Her pulse was 56 beats per minute (bpm). Respondent's note of a heart exam is illegible; there was no neurologic exam. Respondent's impression was fatigue and afib/sinus tachycardia. The plan included obtaining an EKG and starting a long acting beta-blocker. An EKG revealed sinus tachycardia with premature atrial contractions.

B. On or about January 13, 2006, patient L.W. saw respondent in follow up. A long acting beta blocker and an oral opiate were listed as medications. There were no indications listed for the opiate. The patient remained bradycardic at 56 bpm. No physical exam or repeat EKG was recorded. The beta-blocker was continued and a urology referral was noted.

C. On or about March 3, 2006, patient L.W. saw respondent in follow up. Her heart rate was 58 bpm. No physical exam was noted. An EKG that day showed sinus bradycardia at 59 bpm. The beta-blocker was continued.

D. On or about March 8, 2006, patient L.W. saw respondent for a surgery clearance for a hemmorroidectomy. No current lab tests were documented. Respondent noted on the preoperative form that the patient had no known drug allergies even though respondent's chart reflected that the patient had previously noted several such allergies. The last chest x-ray (CXR) of November 28, 2005, was abnormal revealing right upper lobe pneumonia with recommendations for close follow up to exclude underlying pathology such as a mass. No interval CXR was noted. Respondent assessed patient L.W. as a low risk for cardiac complications.

E. On or about May 23, 2006, patient L.W. was seen in urgent care complaining of bilateral leg pain. She was seen by a physician assistant; the chart was co-signed by respondent. Patient L.W. denied injury or trauma but reported a history of restless leg syndrome well managed by clonazepam until recently. No pulse was recorded. A physical exam revealed no swelling, ecchymosis or erythema in the extremities. No musculoskeletal, vascular or neurologic exam was noted. The diagnosis was restless leg syndrome and the plan called for a trial of Requip.

F. On or about June 8, 2006, the patient was seen by a physician assistant requesting a neurology consultation. The physician assistant increased the dosage of Requip.

G. On or about June 14, 2006, the patient had a neurology consultation with Raja Boutros, M.D. and Lama Al-Koury, M.D. The diagnosis of restless leg syndrome was confirmed but further metabolic work up was recommended as was tapering the patient off benzodiazepines.

H. On or about July 20, 2006, patient L.W. saw a physician assistant, who refilled the Requip. No pulse was recorded. There was no documentation regarding the neurologists' recommendations.

I. On or about November 20, 2006, patient L.W., while reportedly asleep seated at her dining room table, fell onto the floor injuring her right hip. She did not seek medical attention but flew out of town for a funeral. She reported experiencing terrible pain during the trip and having to use a walker to ambulate.

J. On or about November 24, 2006, patient L.W. was seen in urgent care at respondent's office by physician assistant; respondent co-signed the chart. The patient complained of pain from hips to knees. Her current mediations were listed as Vicodin, Toprol, Requip and Clonazepam. No pulse was recorded in the vital signs charted. Physical exam revealed abnormalities in her gait as well as point tenderness in her back. X-ray film of the lumbar spine and bilateral hips revealed mild to moderate degenerative joint disease in both hips as well as a 5 mm anterior subluxation of L4 on L5. There was no

fracture noted. The assessment was hip/back pain and plan for rest.

K. On or about December 26, 2006, patient L.W. was seen by respondent. No pulse was recorded. Celebrex was listed among the current medications. Respondent noted that there was no fracture on the initial x-ray; mild to moderate degenerative joint disease of bilateral hips was the radiologic impression. He noted tenderness at the right lumbar spine and treated the patient with a steroid/Marcaine (Kenalog) injection as well as a topical anesthetic (Lidoderm patch).

L. On or about January 8, 2007, the patient was seen by a physician assistant at respondent's office. Patient L.W. continued to complain of worsening pain despite treatment with oral narcotics, topical anesthetic and steroid injection. The physician assistant noted, "...severe LBP pt. needs immediate pain relief....needs immediate relief from pain as her hope appears to be deteriorating...." Respondent co-signed the note. The management plan remained unchanged; no diagnostic tests were ordered. A referral was made for pain management.

M. On or about January 24, 2007, the patient was seen by Temecula Pain Management (physician assistant J. Lauerman, co-signed by Jack Druit, M.D.). Point tenderness was noted at the right greater trochanter and parasacral area. Gait, motor and neurological examinations were noted to be normal. A diagnosis of trochanteric bursitis was made with recommendations to increase the anti-inflammatory medication in combination with a right trochanteric bursa steroid injection.

N. On or about January 25, 2007, and February 13 and 20, 2007, patient L.W. was seen by respondent with complaints of persistent pain and difficulty walking. Physical examinations revealed continued tenderness. Treatment continued with oral opiates, oral anti-inflammatory agents and soft tissue/bursa injections despite persistent pain. An MRI was scheduled on a February 22, 2007, visit to "rule out the possibility of cancer or a ligament tear."

O. On or about February 23, 2007, an MRI of the lumbar spine was performed at Temecula Valley Advanced Imaging, revealing a right upper sacral fracture as well as a

possible displaced left mid-sacral fracture. There were no vertebral fractures. A further MRI performed on or about February 24, 2007, of the right hip showed a right femoral neck fracture with ambulation. The findings were discussed with respondent by phone on February 26, 2007.

P. On or about February 27, 2007, patient L.W. was admitted to Rancho Springs Medical Center and underwent a right hip replacement surgery. The postoperative diagnosis from the orthopedic surgery was listed as right femoral neck chronic fracture. The patient had an unremarkable postoperative course with significant pain relief. Subsequently, the patient was admitted to a skilled nursing facility on March 1, 2007, for rehabilitation. She was discharged from the facility on March 9, 2007, able to ambulate 400 feet with a front wheel walker.

Patient L.W. Allegations of Negligence

Q. On or about May 19, 2004, and thereafter, respondent was negligent in the care and treatment of patient L.W. when he failed to perform and/or document a complete initial history and physical of patient L.W.

R. On or about May 19, 2004, and thereafter, respondent was negligent in the care and treatment of patient L.W. when he failed to perform and/or document an annual physical examination of patient L.W. and/or failed to otherwise perform and/or document interval screening tests, preventive measures or surveillance of the patient's ongoing health issues, including, but not limited to, mammography.

S. On or about November 29, 2004, and thereafter, respondent was negligent in the care and treatment of patient L.W. when he failed to properly evaluate and follow up on evidence of osteopenia.

T. On or about January 6, 2006, and thereafter, respondent was negligent in the care and treatment of patient L.W. when he failed to properly evaluate and follow up on the suspicion and/or diagnosis of atrial fibrillation.

U. Between on or about November 24, 2006, and February 23, 2007, respondent was negligent in the care and treatment of patient L.W. when he failed to properly evaluate

and follow up on the patient's hip injury in the face of continuing patient complaints of pain and the ineffectiveness of his treatment modalities.

V. On or about May 19, 2004, and thereafter, respondent was negligent in the care and treatment of patient L.W. when he failed to maintain adequate and accurate records of the care and treatment of patient L.W., including, but not limited to, failing to properly document an initial history and physical examination, failing to properly document annual physical examinations, failing to properly document interval screening tests, preventive measures or surveillance of the patient's ongoing health issues, including, but not limited to, mammography, failing to legibly annotate chart entries, failing to properly chart vital signs and failing to properly chart patient allergies.

Patient J.M. Factual Allegations

W. On or about January 18, 2006, 77-year-old patient J.M. was seen by respondent. The patient had been previously seen by respondent. Respondent noted a history of lung cancer in 1996 and osteoporosis. A CXR was ordered and treatment for the osteoporosis was initiated. The CXR demonstrated abnormalities in the right lung. A CT scan of the chest was ordered; it was performed on or about February 6, 2006. The scan revealed a number of abnormalities in both lungs including scarring, right volume loss suggesting prior surgery, right effusion and a moderately sized hiatal hernia. Clinical correlation, comparison to previous imaging and a short three month follow up were recommended. There is no documentation of follow up on these recommendations.

X. On or about July 24, 2006, a further CT scan of the chest was performed which revealed several persistent abnormalities including a 2 cm left upper lobe irregular density or scarring, persistent right pleural effusions, and right lower lobe consolidative changes. Abnormalities to the right ribs and thoracic vertebra were also noted. There is no documentation of follow up on these abnormalities.

Y. On or about September 19, 2006, patient J.M. fell over his walker, striking his chest. He presented to the Rancho Springs Medical Center emergency department on or about September 21, 2006, with left chest pain, shortness of breath and hypoxemia

requiring a high amount of oxygen to maintain saturation. The lung examination was abnormal; CXR revealed a left 7th rib fracture, bilateral infiltrates, cardiomegaly and congestive heart failure (CHF). Some lab values were abnormal, including a high white blood cell (WBC) count. An arterial blood gas (ABG) revealed significant hypoxia. The diagnosis was pulmonary contusion v. congestive heart failure, blunt trauma to the left chest and rib fracture. When the patient was taken off oxygen desaturation occurred. A CT scan of the chest was ordered which confirmed the rib fracture and showed a small left pneumothorax, biapical parenchymal scarring and mild to moderate right lower lung atelectasis and/or consolidation and a large hiatal hernia.

Z. The patient was admitted on September 22, 2006, under the care of respondent. Respondent performed a history and physical; his progress note references a dictation which was not performed until December 13, 2006. Respondent's assessment was status post fall with rib fracture, hypoxia. His plan included observation and pain management. He ordered a rib brace, a physical therapy (PT) evaluation, pulse oximetry and room air ABG with results to be called to him. The PT evaluation documented significant abnormalities in function, bed mobility, transfers and gait. Limiting factors of shortness of breath, strength and endurance were noted. The patient needed significant supplemental oxygen during the evaluation. Twice daily PT was recommended. The ABG performed showed significant hypoxia. By telephone order at 2:15 p.m., respondent ordered the patient discharged home on oxygen with bronchodilators, oral antibiotics and oral narcotics. A final progress note charted two months later on November 14, 2006, respondent noted that the patient's condition on discharge was fair with mild hypoxia secondary to chronic obstructive pulmonary disease (COPD), pain controlled via medication and a rib brace. Patient was discharged at 6:30 p.m. with an elevated pulse (113) and respirations (32). His oxygen saturation was 89% on 4 liters of oxygen, desaturating to 76% on room air.

AA. On or about September 26, 2006, patient J.M. saw respondent in follow up. The patient complained of not being able to eat, abdominal pain and nausea. No vital signs were recorded. Respondent documented lung and abdominal examinations as abnormal; his

assessment was right upper quadrant tender/mild jaundice. He ordered an ultrasound to rule out gallstones and a laboratory test to evaluate liver function. He did not document any discussion of medical issues from the hospitalization.

BB. On or about September 27, 2006, an ultrasound at Temecula Valley Advanced Imaging Center revealed moderate bilateral hydronephrosis with a dilated bladder but no gallstone. The patient was instructed to go to the emergency room and respondent was contacted.

CC. On or about September 27, 2006, patient J.M. presented to the Inland Valley Medical Center emergency department where he was found to have respiratory insufficiency, urinary retention, dehydration, malnutrition, electrolyte abnormalities and low platelets. Difficulty swallowing fluids was also noted. The patient was admitted under the care of respondent pursuant to respiratory insufficiency, dysphagia (difficulty swallowing) and urinary retention.

DD. On or about September 28, 2006, respondent performed a history and physical; his assessment was urinary incontinence, dysphagia and consolidation of the lung. His plan included observation, intravenous fluids, bladder catheterization, swallow evaluation, supplemental oxygen, respiratory therapy, systemic steroids and antimicrobial therapy.

EE. On or about September 29, 2006, the patient underwent a swallow evaluation which disclosed severe dysphagia with pulmonary compromise and a high aspiration risk; recommendations included swallowing precautions, a modified diet, daily speech therapy and a pulmonary consultation. Respondent was out of town this date; a covering physician ordered home discharge with a visiting nurse for Foley catheter care, home PT, home oxygen and follow up with respondent in one week. Respondent did not dictate a discharge summary nor chart any assessment of the swallowing evaluation.

FF. On or about October 6, 2006, the patient's wife called respondent's office to complain that the patient was not doing well and that his breathing was getting worse. There is no correlating documentation in the patient's chart. There is no documentation in the chart from September 29, 2006, to October 16, 2006.

GG. On or about October 16, 2006, patient J.M. presented by ambulance to the emergency department at Rancho Springs Medical Center with a complaint of shortness of breath. He was admitted with sepsis syndrome, pneumonia, complicated urinary tract infection, congestive heart failure, acute on chronic respiratory failure and multiple stage II pressure ulcers. Respondent performed a history and physical examination. Consultations were obtained. Cultures returned with drug resistant organisms in the lungs and urine; broad spectrum antibiotics, system steroids, respiratory therapy, noninvasive ventilation, wound care, feedings via nasogastric tube (NGT) and daily physical therapy were provided. Though some physical therapy goals were met, the patient remained quite debilitated. There was little change in the patient's severe dysphagia. Respondent discussed with the wife placing the patient in long term care but the family preferred home care. The patient was discharged home on October 25, 2006, with home intravenous antibiotics, NGT feedings, home oxygen, Foley catheter and multiple pressure ulcers requiring significant care. There is no documentation of post discharge medications or follow up plan. There is no documentation by respondent in the chart of post discharge care from October 25, 2006, to November 1, 2006.

HH. On or about November 1, 2006, patient J.M. presented to Rancho Springs Medical Center with respiratory distress requiring intubation and mechanical ventilation in the emergency department; he was thin, pale and poorly reactive. He was admitted to the intensive care unit (ICU). A pulmonary consultation was obtained. The patient was treated with anticoagulation, steroids, bronchodilators, antibiotics, NGT feedings and wound care.

II. On or about November 6, 2006, the patient was transferred to respondent's care at the hospital. Subspecialists continued to follow the patient. The patient was on mechanical ventilation from on or about November 1 through November 10, 2006. He was transferred out of the ICU on November 15, 2006. Thereafter, on or about November 17, 2006, the patient experienced difficulty with the NGT feedings and was switched by respondent to total parenteral (intravenous) nutrition (TPN). A left arm peripherally inserted central catheter (PICC) was placed on November 18, 2006, for that purpose; when

it failed later that day the catheter was switched to the right upper extremity. A new 20 to 30% left pneumothorax was seen by serial CXRs on November 18, 2006. On November 19, 2006, no pneumothorax was seen by CXR; respondent saw the patient that day and noted the patient was unchanged clinically and discharge was recommended. The patient was discharged with intravenous nutrition and 6 liters of supplemental oxygen. The nurse notes indicated that the patient's wife was contemplating hospice placement for the patient. Respondent's discharge summary dictated on December 13, 2009, does not address the issue of pulmonary embolism, the PICC line, the TPN treatment and the condition of the patient at discharge. The patient was discharged home on November 20, 2006. Many of respondent's notes on this admission were illegible.

JJ. On or about November 20, 2006, less than twenty-four hours after discharge, the patient presented to the Hemet Valley Medical Center emergency department with respiratory distress. He was found to have sepsis syndrome, pneumonia, complicated urinary tract infection, congestive heart failure, acute on chronic respiratory failure and multiple stage II pressure ulcers. He was admitted under the care of another physician. He required ICU care, vasopressors, prolonged mechanical ventilation with tracheotomy, systemic steroids, broad spectrum antimicrobial agents, respiratory therapy, wound care, left chest tube insertion for progressive left pneumothorax and transfusions. He was managed by multiple specialists. He was discharged to a sub-acute unit on December 21, 2006, and expired on December 24, 2006. Respondent was not involved in his care on this final hospitalization.

Patient J.M. Allegations of Negligence

KK. Between on or about January 18, 2006, and July 24, 2006, respondent was negligent in the care and treatment of patient J.M. when he failed to properly and timely follow up on chest imaging abnormalities in patient J.M., a post-lung cancer surgery patient.

LL. On or about September 22, 2006, respondent was negligent in the care and treatment of patient J.M. when ordered patient J.M. discharged notwithstanding the

patient's abnormal vital signs, abnormal laboratory tests, high oxygen requirements and lowered functional status.

MM. On or about September 29, 2006, respondent, as the primary care provider, was negligent in the care and treatment of patient J.M. when he failed to assure proper evaluation of the patient for discharge to his home environment in light of his ongoing need for oxygen and his dysphagia complicated nutrition needs.

NN. On or about October 25, 2006, respondent was negligent in the care and treatment of patient J.M. when he failed to properly evaluate the patient for discharge, including evaluating whether the patient was stable for discharge and evaluating whether the family was capable of providing the required level of care after the patient was discharged home.

OO. On or about November 19, 2006, respondent was negligent in the care and treatment of patient J.M. when he failed to properly evaluate the patient for discharge, including plans to follow up with the patient after discharge home and plans for end of life care.

PP. Between on or about September 22, 2006, and November 19, 2006, respondent was negligent in the care and treatment of patient J.M. when he failed to maintain adequate and accurate records of the care and treatment provided to patient J.M., including, but not limited to, his failure to legibly document progress notes and his failure to timely dictate admission and discharge notes.

**SECOND CAUSE FOR DISCIPLINE**

(Altering Medical Records)

9. Respondent is subject to disciplinary action under section 2262 in that respondent altered or modified a medical record of a patient with fraudulent intent. The circumstances are as follows:

Patient L.W.

A. The facts and circumstances alleged in paragraph 8 above are incorporated here as if fully set forth.

B. Between January 24, 2007, and January 29, 2008, respondent altered the medical record of patient L.W. for the office visit of December 26, 2006, to reflect the performance of a right hip examination. The change in the medical record was not dated and signed by respondent to show when the document was amended.

**THIRD CAUSE FOR DISCIPLINE**

(Dishonesty)

10. Respondent is subject to disciplinary action under section 2234, subdivision (e), in that respondent engaged in dishonest conduct in altering or modifying a medical record of a patient. The circumstances are as follows:

Patient L.W.

A. The facts and circumstances alleged in paragraph 9 above are incorporated here as if fully set forth.

**FOURTH CAUSE FOR DISCIPLINE**

(Gross Negligence)

11. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that respondent was grossly negligent. The circumstances are as follows:

Patient L.W.

A. The facts and circumstances alleged in paragraph 8 above are incorporated here as if fully set forth.

B. Between on or about November 24, 2006, and February 23, 2007, respondent was grossly negligent in the care and treatment of patient L.W. when he failed to properly evaluate and follow up on the patient's hip injury in the face of continuing patient complaints of pain and the ineffectiveness of his treatment modalities.

C. Between January 24, 2007, and January 29, 2008, respondent was grossly negligent when he altered the medical record of patient L.W. for the office visit of December 26, 2006, to reflect the performance of a right hip examination and failed to date and sign the medical record to show when the document was amended.

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## FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

12. Respondent is subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate and accurate records of medical services provided to patients. The circumstances are as follows:

Patient L.W.

A. The facts and circumstances alleged in paragraph 8 above are incorporated here as if fully set forth.

B. On or about May 19, 2004, and thereafter, respondent failed to maintain adequate and accurate records of the care and treatment of patient L.W., including, but not limited to, failing to properly document an initial history and physical examination, failing to properly document annual physical examinations, failing to properly document interval screening tests, preventive measures or surveillance of the patient's ongoing health issues, including, but not limited to, mammography, failing to legibly annotate chart entries, failing to properly chart vital signs and failing to properly chart patient allergies.

Patient J.M.

A. The facts and circumstances alleged in paragraph 8 above are incorporated here as if fully set forth.

B. On or after September 22, 2006, respondent failed to maintain adequate and accurate records by failing to timely dictate an admission note inasmuch as the admission note was not dictated until December 13, 2006.

C. On or about September 29, 2006, respondent failed to maintain adequate and accurate records when he failed to dictate a discharge summary and when he failed to chart any assessment of the swallowing evaluation.

D. On or about October 25, 2006, respondent failed to maintain adequate and accurate records by failing to adequately document evaluation of patient J.M. for discharge.

E. On or about November 19, 2006, respondent failed to maintain adequate and accurate records by failing to timely dictate a discharge note, and by failing to dictate an

accurate discharge note and by failing to notate appropriate follow up plans for the patient.

F. Between on or about September 21, 2006, and November 19, 2006, respondent failed to maintain adequate and accurate records by repeatedly failing to legibly document the patient's chart.

**SIXTH CAUSE FOR DISCIPLINE**

(Unprofessional Conduct)

13. Respondent is subject to disciplinary action under section 2234 in that engaged in unprofessional conduct. The circumstances are as follows:

A. The facts and circumstances alleged in paragraphs 8 through 12 above are incorporated here as if fully set forth.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A56294, issued to Donald Woo Lee, M.D.;

2. Revoking, suspending or denying approval of Donald Woo Lee, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Donald Woo Lee, M.D., if placed on probation, to pay the Medical Board of California the costs of probation monitoring;

4. Ordering Donald Woo Lee, M.D. to pay a civil penalty of five hundred dollars ($500) for any violation of section 2262 of the Business and Professions Code.

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

DATED: January 5, 2010.

BARBARA JOHNSTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*

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