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

In the Matter of the First Amended Accusation Against:	)	
CARLOS TINOCO DeCARVALHO, M.D.	)	**Case No. 8002014007952**
Physician's and Surgeon's Certificate No. A38504	)	**OAH No. 2017090679**
Respondent	)	

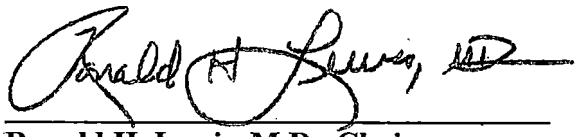
DECISION

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 December 7, 2018.

IT IS SO ORDERED: November 8, 2018.

MEDICAL BOARD OF CALIFORNIA



Ronald H. Lewis, M.D., Chair
Panel A

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

In the Matter of the Accusation Against: CARLOS TINOCO DeCARVALHO, M.D., Physician's and Surgeon's Certificate No. A 38504, Respondent.	Case No. 800-2014-007952 OAH No. 2017090679

PROPOSED DECISION

Debra D. Nye-Perkins, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter in San Diego, California, on September 6 through 7, and 10 through 13, 2018.

Jason J. Ahn, Deputy Attorney General, Department of Justice, Office of the Attorney General, State of California, represented complainant, Kimberly Kirchmeyer, Executive Director of the Medical Board of California (board).

David Rosenberg, Attorney at Law, Rosenberg, Shpall & Zeigen, represented respondent, Carlos Tinoco DeCarvalho, M.D., who was present throughout the hearing.

The matter was submitted on September 13, 2018.

PROTECTIVE SEALING ORDER

The names of the patients in this matter are subject to a protective sealing order. No court reporter or transcription service shall transcribe the actual names of a patient but shall instead refer to the patient by his or her corresponding assigned letter (Patients A through K) as set forth in a Confidential Names List received into evidence, placed under seal and used in this proposed decision. To protect privacy and confidential personal and medical information from inappropriate disclosure, a written Protective Order Sealing Confidential Records was issued. The order lists the exhibits ordered sealed and governs the release of documents to the public. A reviewing court, parties to this matter, their attorneys, and a

government agency decision maker or designee under Government Code section 11517 may review the documents subject to the order, provided that such documents are protected from release to the public.

SUMMARY

Complainant alleged that respondent was grossly negligent in his care of patients A and B; committed repeated negligent acts in his care of Patents A, B, C, E, F, G, H, I, J, and K; was incompetent in his care of Patients C and D; failed to maintain adequate and accurate records for Patients A, B, C, E, F, H, I, J, and K; and committed general unprofessional conduct by inappropriately touching the breast of a woman in October 2010 and inappropriately touching the breast of another woman on January 16, 2014.

Clear and convincing evidence established that respondent was grossly negligent in his care of Patients A and B; repeatedly negligent in his care of Patients A, B, C, E, F, G, H, I, J, and K; incompetent in his care of Patients C and D; and he failed to maintain adequate and accurate records for Patients A, B, C, E, F, H, I, J, and K. In addition, respondent committed general unprofessional conduct by inappropriately touching the breasts of two women without their consent.

Respondent requires further training and oversight. The public will be adequately protected if respondent's license is placed on probation with appropriate terms and conditions of probation consistent with the board's disciplinary guidelines.

FACTUAL FINDINGS

Background and License History

1. On June 14, 1982, the board issued Physician's and Surgeon's Certificate No. A 38504 to respondent, Carlos Tinoco DeCarvalho, M.D. The license will expire on December 31, 2019, unless it is renewed or revoked.

2. On February 7, 2018, complainant filed the first amended accusation, No. 800-2014-007952, against respondent. The first amended accusation alleged five causes for discipline of respondent's license:

First Cause for Discipline. Gross negligence in his care of Patients A and B as follows: With regard to Patient A, the accusation alleged that respondent noted in Patient A's records that Patient A understood his condition and had capacity to make medical decisions, which was contrary to other evidence in Patient A's medical record, and respondent failed to assess Patient A's foot, and failed to document a complete admission history and physical for Patient A and failed to include assessments and plan of treatment in two progress notes for Patient A. With regard to Patient B, the accusation alleged that

respondent failed to document an increased white blood cell count and failed to sign progress notes in a timely manner.

Second Cause for Discipline. Repeated negligent acts in respondent's care and treatment of Patients A through K as follows: With regard to Patient A, respondent noted in Patient A's records that Patient A understood his condition and had capacity to make medical decisions, which was contrary to other evidence in Patient A's medical record, and he failed to assess Patient A's foot, and failed to document a complete admission history and physical for Patient A and failed to include assessments and plan of treatment in two progress notes for Patient A. Additionally, with regard to Patient A, respondent failed to visit Patient A within 72 hours of Patient A's admission to the skilled nursing facility. With regard to Patient B, he failed to document an increase white blood cell count for Patient B and failed to sign progress notes in a timely manner. With regard to Patient C respondent failed to adequately reassess or fully document his reassessment of Patient C as Patient C was showing signs of clinical deterioration, and he failed to adequately document Patient C's medical care. With regard to Patient E, respondent failed to sign progress notes until after Patient E died. With regard to Patient F, respondent failed to timely complete progress notes and failed to communicate or document communication with Patient F's family. With regard to Patient G, respondent transferred Patient G to nuclear medicine for a HIDA[1] scan prior to sufficiently stabilizing Patient G. With regard to Patients H through K, respondent failed to timely dictate a history and physical for those patients.

Third Cause for Discipline. Incompetence in respondent's care of Patients C and D, including ordering Ativan for Patient C as a premedication for an MRI, despite that it was contraindicated for a patient with declining neurological function, and respondent's lack of knowledge in his management and diagnosis of Patient D's DKA.[2]

Fourth Cause for Discipline. Failed to maintain adequate and accurate records relating to his care and treatment of Patients A, B, C, E, F, G, H, I, J.

Fifth Cause for Discipline. Respondent engaged in generally unprofessional conduct by inappropriately touching the breasts of two women without their consent.

3. Respondent filed a notice of defense, and this hearing followed.

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[1] HIDA scan refers to nuclear cholecystography or hepatobiliary imaging with the use of a radiopharmaceutical that is secreted by hepatocytes (liver cells) into the biliary tree and normally into the gallbladder to rule out acute cholecystitis. This imaging procedure requires intravenous injection of the radiopharmaceutical with sequential imaging taken over the first hour and visualization of the gallbladder in a normal study within 30 minutes after injection. Delayed images are possible over a number of hours up to 24 hours.

[2] DKA means diabetic ketoacidosis, which is a serious complication of diabetes that occurs when a person's body produces high levels of blood acids called ketones as a result of the body not producing sufficient amounts of insulin.

Respondent's Background

4. Respondent is 67 years old and was born and raised in Brazil. He moved to the United States after he finished high school in Brazil. He completed his pre-med coursework at Riverside City College, Loma Linda University, and the University of California, Riverside. Respondent attended medical school at Guadalajara Medical School and graduated with his Doctorate of Medicine degree in 1976. Respondent explained that in Mexico, all medical school graduates must complete a year of "pre-licensing internship" and another year of "social service to the community." Respondent completed his pre-licensing internship in North Carolina in 1977, and he completed his social service commitment in 1978 in Guadalajara, Mexico. Thereafter, he completed a residency in Internal Medicine in Dearborn, Michigan in 1982.

5. In 1982, after he became licensed to practice medicine in California, respondent joined a private practice in Chula Vista, California. Soon thereafter respondent received hospital privileges at three different hospitals located in the South Bay, including Scripps Mercy Hospital Chula Vista, and Sharp Hospital Chula Vista. Respondent held the title of Chair of the Department of Medicine from 1998 to 1999 at one of the hospitals where he had privileges, and from 2009 to 2013 he held the position of Co-chair of the Department of Medicine at Scripps Mercy Hospital Chula Vista. His duties as Chair and Co-chair required him to ensure that the quality of care for the hospital was being met by physicians in his department. Respondent's privileges at Scripps Mercy Chula Vista have recently been suspended. Respondent also has affiliations with seven different skilled nursing facilities. He has been the medical director of three of those skilled nursing facilities. For the last eight or nine months he has been the medical director of a skilled nursing facility named Windsor Gardens of Golden Hill.

Complainant's Evidence

TESTIMONY OF DR. RUSSELL EVAN HOXIE, JR. REGARDING PATIENT A

6. Dr. Russell Evan Hoxie has been licensed to practice medicine in California since July 1, 1989 and has practiced medicine for over 25 years. He received his Bachelor of Science degree in Psychobiology in 1982 from Loma Linda University and his Doctorate of Medicine degree in 1988 from Loma Linda University School of Medicine. He completed his internship at Loma Linda University in 1989. Dr. Hoxie completed his residency in Internal Medicine in 1991 at Loma Linda University. Dr. Hoxie also completed a fellowship in Geriatric Medicine in 1993 at the University of California, Los Angeles. Dr. Hoxie is currently on the faculty at Loma Linda University School of Medicine as an Associate Professor of Medicine, a position he has held since December 2002. From July 1993 to December 2002, Dr. Hoxie was an Assistant Professor of Medicine at Loma Linda University. He is board certified in Internal Medicine from the American Board of Internal Medicine and has been since 1991. Dr. Hoxie is also board certified in Geriatric Medicine from the American Board of Internal Medicine and has been since 1994. Additionally, Dr.

Hoxie is board certified in Hospice and Palliative Medicine from the American Board of Internal Medicine and has been since 2008.

In 1993, Dr. Hoxie began working as a Staff Physician at the Veterans Affairs Loma Linda Healthcare System (VA Loma Linda) where he worked for one year in the General Internal Medicine Clinic and in the Long-Term Care Nursing Center. In 1994, he became the Medical Director of the Community Living Center and Section Chief of Geriatric Medicine at the VA Loma Linda, a position he currently holds. Dr. Hoxie testified that this position requires him to oversee all care provided for veterans in the skilled nursing center for geriatric patients, as well as to oversee the hospice unit, which provides care to terminally ill patients. In addition to his positions as the Medical Director and Section Chief, Dr. Hoxie continues to work as a Staff Physician at the VA Loma Linda. Dr. Hoxie began working as an expert reviewer for the Medical Board of California in 2003, and continues to do so. In 2006 he began working as a consultant for the Central Complaint Unit of the Medical Board of California and continues to do so.

7. Dr. Hoxie testified that, to provide an expert opinion concerning respondent's care and treatment of Patient A, he reviewed Patient A's medical records, transcripts of interviews of respondent, and the investigative report of the Medical Board of California. Dr. Hoxie formed an opinion regarding respondent's treatment and care of Patient A and summarized his opinions in his expert report.

8. Dr. Hoxie testified that he is familiar with the standard of care in the medical community in California during the time period Patient A received treatment from respondent. He defined "standard of care" as the level of knowledge, skill and care in the diagnosis and treatment of a patient possessed and exercised by other reasonably prudent physicians in the same or similar circumstances at the time in question. Dr. Hoxie stated that there are varying degrees of departure from the standard of care that range from simple departures to extreme departures. Dr. Hoxie described a simple departure from the standard of care, also known as a negligent act, as the failure to use the knowledge, skill and care in the diagnosis and treatment possessed and exercised by other reasonably prudent physicians in the same or similar circumstances at the time in question. He described an extreme departure from the standard of care, also known as gross negligence, as the failure to provide even a scant level of care to the patient. Dr. Hoxie is familiar with the standard of care applicable to the care rendered to Patient A based on his 25 years of experience practicing as a physician in California working in long term care facilities. He also participates in the VA Loma Linda medical center peer review process which requires him to review medical records of his peers to determine if the standard of care has been met. He has participated in the peer review process since 1993.

9. From his review of the records, Dr. Hoxie learned that Patient A was an 88-year-old man who was taken to Scripps Mercy Chula Vista Hospital on March 23, 2015, because he had an infection in his left foot. Dr. Gordon Beh dictated the History and Physical (H & P) for Patient A upon his admission to the hospital and noted that Patient A "is deaf and severely demented." Dr. Beh wrote, "I am unable to obtain an accurate family

history . . . I am unable to obtain an accurate review of systems given the patient's mental status." The medical record from Dr. Beh indicated that Patient A's left toe had dry gangrene,[3] and Patient A had osteomyelitis[4] of his left foot requiring hospital admission and treatment with intravenous antibiotics. On March 28, 2015, at about 8:00 p.m., Patient A was transferred to Castle Manor Nursing & Rehabilitative Center (Castle Manor) so that he could continue to receive intravenous antibiotics for the treatment of the osteomyelitis of his left foot. Respondent was assigned as the physician for Patient A at Castle Manor.

10. Dr. Hoxie noted that the first documentation by respondent regarding Patient A occurred on March 31, 2015. The "Admission and Physical Examination" form for Patient A's admission to Castle Manor was signed by respondent and, the only information written on the document was "See Hosp. H & P." Additionally, respondent put a check mark beside the "yes" answer box for each of the questions: "patient informed of condition," "patient understands condition," and "resident has capacity to make decisions." The first progress note entered in Patient A's medical record that references respondent was written on March 31, 2015, at 11:00 p.m., which is about 75 hours after Patient A was admitted to Castle Manor. The progress note stated "seen by Dr. DeCarvalho no new order." However, Dr. Hoxie admitted that he does not know what time respondent saw Patient A on March 31, 2015, because the medical record only shows that respondent saw the patient some time on March 31, 2015. Dr. Hoxie opined that the standard of care requires an internal medicine doctor admitting a patient to a nursing home facility to visit the patient within 72 hours of the patient's admission to the nursing home facility. He stated that this standard of care is also corroborated by the joint commission that accredits nursing homes, which has a similar requirement. Dr. Hoxie also noted that during respondent's interview by the Medical Board of California, respondent admitted that Castle Manor had a requirement that the treating physician see newly admitted patients within 72 hours of admission to the facility. Dr. Hoxie opined that, based on the medical records, which are the only indication of when respondent visited Patient A, respondent did not visit Patient A within 72 hours of his admission to Castle Manor, and instead did so about 75 hours after Patient A was admitted. Dr. Hoxie opined that this constituted a simple departure from the standard of care based upon the fact that respondent did visit the patient but it appeared he was about three hours outside of the required timeframe.

11. Dr. Hoxie also testified that respondent provided no information in the medical records to explain why he concluded that Patient A had the capacity to make decisions or understand his condition in light of other information in Patient A's medical record from his admission to the hospital stating that Patient A was deaf and severely demented. These conditions would negate Patient A's ability to hear or understand any communication to him

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[3] Gangrene tissue is tissue that has died as a result of inadequate blood flow to the area.

[4] Osteomyelitis is a bacterial infection causing destruction of bone. Osteomyelitis of the left foot would mean that the bone in the left foot had been damages by a bacterial infection.

regarding his condition and would negate his capacity to make decisions. Respondent acknowledged the H & P from Scripps Mercy Chula Vista Hospital created by Dr. Beh by incorporating them into his Castle Manor admission notes. Dr. Beh's H & P notes also state, "The patient is DNR/DNI. His daughter is his surrogate medical decision maker." Dr. Hoxie testified that this notation in the hospital H & P would be overridden by respondent's later notation using check marks on the "yes" box to indicate that Patient A had capacity to make his own medical decisions and understood his condition. Dr. Hoxie further stated that respondent failed to provide any explanation for the change in Patient A's ability to make medical decisions and failed to provide a sufficient physical examination to establish that Patient A's status had changed from "deaf and severely demented." Dr. Hoxie opined that the standard of care required that respondent properly assess Patient A's decision-making capacity and document such assessment. He stated that the assessment must include questions requiring verbal answers beyond simply "yes" or "no" or nods. Dr. Hoxie stated that respondent failed to document any such assessment of Patient A, and respondent's cursory conclusion that Patient A had such decision-making capacity was in direct contradiction to extensive information in the hospital H & P. Dr. Hoxie stated that respondent's failure to properly assess and document his assessment of Patient A's decision-making capacity was an extreme departure from the standard of care.

12. Dr. Hoxie also stated that Patient A's medical records from Castle Manor A include only two progress notes from respondent regarding Patient A's condition and plan of treatment. Specifically, the records show that on March 31, 2015, respondent provided a progress note that states as follows:

(1) Chronic systolic CHF –LVEF[5] 10-15% - Lasix

(2) CAD-NTG-PRN/HTN[6]-Coreg.

(3) Hypertension-Lipitor/PAD-Plavix

(4) CKD[7]- Follow BUN & Creat.

(5) CVD[8]-Plavix/Gout-Albupurinol

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[5] CHF-LVEF means "congestive heart failure with a left ventricular ejection fraction" of 10 to 15 percent. The Lasix notation means that the patient would be treated for this condition with the drug Lasix.

[6] The second notation indicated that Patient A had cardiac disease and hypertension and included notes for management of that condition.

[7] CKD indicates that Patient A had chronic kidney disease and this note stated that his blood should be monitored for certain indicators related to the chronic kidney disease.

(6) AF[9]- rate control.

Dr. Hoxie stated that nothing in this March 31, 2015, progress notes indicated that respondent ever conducted a physical examination of Patient A's left foot. The note failed to mention Patient A's osteomyelitis of his left foot or any treatment plan for it and failed to mention gangrene of the left toe or any treatment plan for it. Dr. Hoxie testified that respondent's failure to perform such an assessment when the left foot osteomyelitis and left toe gangrene was the primary reason Patient A was admitted to Castle Manor was an extreme departure from the standard of care.

The only other progress note in the Castle Manor records for Patient A was dated April 6, 2015, and provided a list similar to that of March 31, 2015. This progress note also made no mention of any physical examination conducted by respondent of Patient A's left foot or toe, and provided no mention of an assessment or plan of treatment for the osteomyelitis of the left foot or gangrene of the left toe.

Dr. Hoxie testified that the medical records indicate that on April 15, 2015, Patient A was transferred from Castle Manor to Sharp Hospital Chula Vista because the infection of his left foot and the gangrene on his left toe had worsened. On April 22, 2015, Patient A underwent a left leg amputation above the knee in order to prevent any further spread of the infection from his left foot. On May 2, 2015, Patient A died from his illnesses.

Dr. Hoxie opined that the standard of care for an Internal Medicine doctor who is treating a patient admitted to a nursing home for the treatment of an infected foot is to perform a physical examination of the foot and document the findings and anticipated plan for treatment. Respondent failed to do this and, his failure to do so was an extreme departure from the standard of care. Dr. Hoxie noted that respondent's failure to properly perform a physical examination of Patient A's foot and document his findings and plan of treatment resulted in Patient A's foot infection progressing, requiring amputation of his left leg above the knee.

On cross-examination Dr. Hoxie acknowledged that Patient A's medical records indicated that on March 28, 2015, at 11:00 p.m. respondent made orders for the treatment of Patient A's left foot, including orders for the nursing staff to clean the foot and paint the left toe with betadine, as well as to administer intravenous antibiotics for treatment of the left foot infection. Dr. Hoxie acknowledged that these were appropriate treatments for the left foot and toe infection. However, Dr. Hoxie clarified that these orders were written upon Patient A's initial admission to Castle Manor, and it is incumbent upon respondent to reassess Patient A's condition after admission to adjust the treatment accordingly. Dr. Hoxie

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[8] CVD indicates that Patient A had cardio-vascular disease and this note indicated the drugs to be used for treatment of that condition.

[9] AF means atrial fibrillation, which is a heart disorder affecting the heart rate. This note indicated that "rate control" should be utilized for treatment.

explained that an infection of the foot can change very quickly and respondent failed to reassess the foot on his subsequent two visits on March 31, 2015, and April 6, 2015. Accordingly, Dr. Hoxie stood by his opinion that respondent's failure to assess Patient A's left foot and toe and document his findings and treatment plan constituted an extreme departure from the standard of care.

13. Dr. Hoxie further testified that proper medical record keeping is an essential element of patient care necessary to ensure continuity of care of a patient for any medical professional who picks up the medical records. Dr. Hoxie opined that the standard of care requires that respondent provide medical records that are up to date, accurate and legible so that they can be used to remind respondent of the care he has already provided to the patient and to communicate that information to the patient's interdisciplinary healthcare team. Dr. Hoxie stated that respondent's multiple documentation failures, including failure to complete an admission history and physical examination of Patient A or any assessment of Patient A's mental status, a complete lack of documentation of respondent's examination of Patient A's left foot and toe, and a lack of documentation of any treatment plan for Patient A's left foot and toe constituted an extreme departure from the standard of care. Dr. Hoxie stressed that there was less than scant evidence that respondent provided any assessment and treatment plan for Patient A's left foot and toe, which was the primary reason he was admitted to Castle Manor.

TESTIMONY OF DR. RACHEL CANNING

14. Dr. Rachel Canning has been licensed to practice medicine in California since 1999. She received her Bachelor of Arts degree in Molecular, Cellular, and Developmental Biology in 1993 from Haverford College. She received her Doctorate of Medicine degree in 1998 from New York University School of Medicine. She completed her Internal Medicine residency in 2001 at the University of California, Los Angeles Medical Center. From 2001 to 2003, Dr. Canning worked as a clinical instructor at the University of California, Los Angles Medical Center in the Department of Medicine. Her position as a clinical instructor required that she supervise and instruct medical residents and students in patient care while she worked in the hospital as a Hospitalist. In 2003, she began working in her current position as a clinical instructor at The Kaiser Permanente Medical Group (Kaiser Hospital) in Oakland, California. As a clinical instructor she is a faculty hospitalist providing direct patient care and supervising and instructing medical residents and students. Dr. Canning is board certified in Internal Medicine from the American Board of Internal Medicine and has been since 2001.

Dr. Canning testified she reviewed various documents, including the medical records regarding respondent's treatment and care for Patients B, C, D, E, and F, transcripts of interviews of respondent regarding the care of Patients B, C, D, E, and F, as well as the board's investigative report regarding respondent's care of Patients B, C, D, E, and F. Dr. Canning formed an opinion regarding respondent's treatment and care of those five patients and summarized her opinions in her expert report. Dr. Canning testified that she is familiar with the standard of care in California for an Internal Medicine physician during the time

respondent cared for these five patients. Dr. Canning defined the standard of care as the level of knowledge, skill and care in the diagnosis and treatment possessed and exercised by other reasonably prudent physicians in the same or similar circumstances at the time in question. Dr. Canning stated that there are varying degrees of departure from the standard of care that range from simple departures to extreme departures. She described a simple departure from the standard of care, also known as a negligent act, as failure to use the knowledge, skill and care in the diagnosis and treatment possessed and exercised by other reasonably prudent physicians in the same or similar circumstances at the time in question. She described an extreme departure from the standard of care as the failure to provide even scant care to the patient, also known as gross negligence. She explained that the degree of the departure from the standard of care determines if the departure is simple or extreme. Dr. Canning is familiar with the standard of care in this case based upon her many years of experience practicing as a physician in California, courses she has taken, articles and literature she read, interaction with other physicians, and her work over the past 15 years performing weekly peer reviews for the Department of Medicine consisting of 60 physicians. She stated that each week she reviews about two cases for the peer review process.

Treatment and Documentation for Patient B

15. Dr. Canning testified Patient B was admitted to Sharp Hospital Chula Vista on August 3, 2015, with peritonitis, an infection of the abdominal cavity. Patient B had a multitude of complex medical conditions, including heart disease, high blood pressure, kidney disease, and was on dialysis. At the time of her admission to the hospital, Patient B had already had a CT scan that showed she likely had a perforated colon and sepsis. During the course of her stay in the hospital, she required surgery, and her recovery was complicated by an abdominal abscess formation. Dr. Canning stated that Patient B's medical records show daily progress notes written by respondent on August 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13, 2015, in the electronic medical record system (EMR). However, each of those 10 daily progress notes was signed on August 14, 2015, within the time period of 2:29 p.m. to 3:19 p.m. Accordingly, all of those notes were signed by respondent days after the note was made. Dr. Canning explained that daily progress notes written by the physician are a crucial part of the medical record that allows all medical professionals to know what is happening with the patient in a timely manner. She stated that if an electronic progress note is not signed, it remains a draft and is visible only to the person who drafted it. Accordingly, the progress notes drafted by respondent were not visible to others on Patient B's medical team or a part of Patient B's medical record until respondent signed them. Dr. Canning opined that the standard of care regarding the time to complete medical documentation, such as signing progress notes, is that the documentation should be completed within 24 hours after the patient assessment. She stated that hospitals also typically have their own rules and requirements for when the documentation must be completed. Dr. Canning stated that respondent's failure to complete over a week's worth of his progress notes for Patient B until up to 10 days after the patient was assessed deprived Patient B's other health providers of important medical information about Patient B and was an extreme departure from the standard of care. Given the number of days and the number of progress notes at issue, Dr.

Canning opined that respondent's documentation failure for Patient B was an extreme departure from the standard of care.

Additionally, Dr. Canning opined that Patient B's medical records showed that her white blood cell count (WBC) was 15,500 on August 6, 2015, and increased to 17,800 by August 7, 2015, and to 27,700 by August 8, 2015. Dr. Canning explained that the most common reason for an increase in WBC is an infection. However, Dr. Canning stated respondent never documented the WBC increase and also never documented a treatment plan to deal with the increase WBC for Patient B.[10] Dr. Canning opined that respondent's failure to document his assessment and treatment plan for Patient B's increase in WBC was an extreme departure from the standard of care requiring prompt and accurate documentation.

Treatment and Documentation for Patient C

16. Dr. Canning testified Patient C was admitted to Sharp Hospital Chula Vista on September 7, 2015, for high blood pressure with nausea, vomiting and dizziness. Respondent was assigned to provide care for Patient C. Patient C had a history of a previous stroke with left sided weakness. Within 24 hours after Patient C's admission to the hospital, she began to have difficulty swallowing and in the middle of the night had a significant clinical change with difficulty breathing. As a result of Patient C's significant clinical change, the rapid response team was called to assess her. The rapid response team is a team of hospital personnel who are called for immediate consultation for any patient with a significant clinical change that is short of cardiac or respiratory arrest. Dr. Canning stated that the medical records for Patient C indicated that a physician from the rapid response team communicated with respondent regarding Patient C's worsening condition and, as a result, respondent ordered respiratory breathing treatments around the clock. Dr. Canning stated these facts indicated that Patient C's medical condition was deteriorating. Dr. Cannon stated that when a patient is seen by a rapid response team because of a deteriorating medical status, the standard of care requires that the treating physician reassess the patient, document this or her assessment, and document their plan of treatment for the patient. In this case, respondent failed to document in Patient C's medical records any information about Patient C's deteriorating medical condition or any treatment plan to deal with that deteriorating medical condition. Dr. Cannon noted that Patient C's medical records had no documentation from respondent regarding any reassessment of Patient C after she had been assessed by the rapid response team and her medical status had clearly deteriorated. Dr. Cannon stated that respondent's failure to do so was a simple departure from the standard of care in this case because he did not reassess Patient C the day after her decline. Respondent did not reassess

[10] On the fifth day of hearing in this matter after Dr. Canning's testimony, the parties stipulated that the daily progress notes for Patient B, as shown in Exhibit L, documented a daily WBC count for Patient B in each daily entry.

Patient C until she was already in the Intensive Care Unit (ICU) after she had gone into respiratory arrest and a "code blue"[11] had been called.

Dr. Canning also opined that respondent's medical record keeping for Patient C was a departure from the standard of care with regard to two daily progress notes. Specifically, the medical records showed that respondent wrote a progress note for Patient C on September 9, 2015, but that progress note was not signed by respondent until September 12, 2015. If the progress note is not signed it is not final, not part of the patient's record, and not visible to other hospital staff. Also, respondent wrote a progress note for Patient C on September 10, 2015, but that progress note was not signed by respondent until September 12, 2015. Dr. Canning opined that the standard of care for medical record keeping requires that daily progress notes be signed by the physician within 24 hours of the physician's assessment of the patient. Also, Dr. Canning noted that the progress note dated September 9, 2015, contained discrepancies and inaccurate medical information because the note stated that Patient C was "OXT&P" meaning "oriented to time and place;" however, at the time of that assessment Patient C was in the ICU, intubated, on a ventilator, and. sedated. Dr. Canning stated that, as a result, the September 9, 2015, progress note contained conflicting and inaccurate information. She stated this is a common problem with the pre-population of electronic medical records, but respondent still had an obligation to make sure the record was correct and that inaccurate information was not "carried over" from previous entries. Dr. Canning opined that respondent's failure to timely sign the two progress notes, as well as his failure to ensure the correctness of the September 9, 2015, progress note, constituted a simple departure from the standard of care. She stated it was a simple departure because his failures were limited on the number of progress notes, and his signature was only two to three days late.

Dr. Canning also testified that medical records showed that Patient C was having significant difficulty managing her secretions, with difficulty swallowing, and breathing as a result. This information was documented in the medical records for Patient C prior to September 9, 2015. On September 9, 2015, respondent ordered an MRI scan for Patient C in order to determine whether or not she had had another stroke. On September 9, 2015, respondent ordered that Patient C receive Ativan, a drug related to valium used as a sedative and anti-anxiety medication, before getting the MRI. Respondent put a note in Patient C's medical records that the Ativan was given to Patient C to help her tolerate laying down for the MRI. However, Dr. Canning also noted that respondent failed to document anywhere in Patient C's medical records that Patient C was anxious or agitated. Dr. Canning noted that medical records indicated that Patient C could not lay flat because she could not breathe as a result of her inability to control her secretions. Dr. Canning stated that giving Patient C a sedative, such as Ativan, when she was already having breathing problems because of her inability to swallow and deal with her secretions was contraindicated. She stated that giving Ativan to a patient with breathing problems because of secretions would likely make the problem worse because the patient would be unable to swallow and clear the secretions when

[11] "Code blue" means a hospital emergency response team is called to respond immediately when a patient goes into respiratory and/or cardiac arrest.

she was sedated, and her secretions would likely end up in her lungs. Dr. Canning noted that in this clinical situation where Patient C's respiratory status was unstable, giving her Ativan before the MRI was not safe. Dr. Canning testified that the medical records showed that, in fact, Patient C received the Ativan prior to the MRI scan, was then lying down in the MRI machine and suffered a respiratory arrest while in the MRI machine. Thereafter, a "code blue" was called for Patient C and she was sent to ICU. Dr. Canning opined that the standard of care required that a physician make a determination of whether the medication prescribed was appropriate for the patient at the particular time it was prescribed. She testified that given the scant medical documentation on the patient's status, including no documentation regarding whether Patient C was anxious, there appeared to be no indication for giving Patient C Ativan, particularly given the high risk to this patient in light of her difficulty breathing. Dr. Canning opined that respondent did not necessarily depart from the standard of care by giving Patient C Ativan, but he demonstrated a lack of knowledge on the premedication of Patient C with Ativan.

Treatment and Documentation of Patient D

17. Dr. Canning testified that her review of medical records showed that Patient D was admitted to Sharp Hospital Chula Vista on September 18, 2015. Patient D was an insulin dependent type 1 diabetic with multiple complications including end stage renal disease and heart failure. Dr. Canning stated that at the time Patient D was admitted to the hospital, her blood-glucose level was measured at 252 with an anion gap[12] of 28. However, the next day, on September 19, 2015, her blood-glucose was measured at 648 and later the same day it was 915 with an anion gap of 33. Dr. Canning opined that these numbers indicated that Patient D had diabetic ketoacidosis (DKA). However, Dr. Canning stated that there is no indication in Patient D's medical record that respondent noted that the patient had DKA or explained his treatment for it. Dr. Canning stated that respondent failed to document Patient D's metabolic abnormalities or his treatment for it.

Dr. Canning noted that the medical records for Patient D showed that upon her admission to the hospital from the emergency room on September 18, 2015, respondent ordered Patient D to get insulin named Lantis, which is a long acting insulin. However, for some unknown reason, the nurses at the hospital failed to give this drug to the patient. The next morning on September 19, 2015, respondent ordered that Patient D receive insulin Aspart, a short acting insulin given under the skin. Dr. Canning explained that the short acting insulin is part of a "sliding scale" of insulin treatment for insulin dependent diabetics admitted to a hospital. She stated that these patients require multifactorial considerations for their treatment for this complex metabolic abnormality, but respondent's poor documentation makes it unclear whether he simply did not recognize the issue of DKA appropriately, or if he simply did not treat Patient D appropriately for the DKA. She opined that respondent's H

[12] An anion gap is a calculation utilizing measurements of electrolytes to provide information regarding a build-up of acid in the body, a condition associated with diabetes. An anion gap of less than 14 is normal, and any anion gap over 14 indicates acidosis or too much acid in the bloodstream.

& P for this patient failed to comment on the DKA issue at all. As a result, Dr. Canning concluded that respondent lacked knowledge in Patient D's management and diagnosis of DKA. However, she declined to opine that he deviated from the standard of care, which requires the correct diagnosis of DKA and timely management with insulin, fluids and electrolytes.

Treatment and Documentation of Patient E

18. Dr. Canning testified that her review of medical records showed that Patient E was admitted to Sharp Hospital Chula Vista on June 19, 2015, for a hip fracture. Patient E had a complex medical history with multiple issues including multiple myeloma, coronary artery disease, cardiomyopathy, peripheral vascular disease, diabetes, and atrial fibrillation. Patient E was taken to the operating room for hip surgery on June 21, 2015. Her post-operative course was complicated and she suffered a "code blue" arrest on June 25, 2015. She was admitted to the ICU where she died approximately 24 hours later.

Dr. Canning testified that respondent drafted a progress note for Patient E on June 25, 2015, but did not sign that progress note until two days later on June 27, 2015, after Patient E had already died. Dr. Canning again stressed that the standard of care requires that progress notes be completed and signed by the physician within 24 hours of patient assessment. Accordingly, Dr. Canning opined that respondent deviated from the standard of care for medical documentation for Patient E because he did not sign the progress note for two days after it was written. She stated that this was a simple departure from the standard of care because it was only one progress note and the delay was only one day.

Treatment and Documentation of Patient F

19. Dr. Canning testified that her review of medical records showed that Patient F was admitted to the Sharp hospital on May 14, 2015, because she was scheduled to have a biliary stent removed on an outpatient basis by a gastroenterologist, but she was sent to the emergency room instead because she was sick with fever and diarrhea. Patient F had a complex medical history of kidney disease, stroke, hypertension, diabetes, and biliary stent, and was on dialysis.

Dr. Canning testified that the medical records show respondent wrote a progress note for Patient F on May 15, 2017, but did not sign that progress note until two days later on May 17, 2015. She stated that respondent's failure to sign this progress note within the required 24-hour period after his assessment was a simple departure from the standard of care. Additionally, Dr. Canning stated that nursing notes from the medical record show that Patient F's daughter was frustrated and upset because respondent had not arranged for a consultation from the gastroenterologist for Patient F while she was in the hospital. The medical records included a nursing note indicating that respondent had been made aware of Patient F's daughter's concerns and that respondent would be in later to discuss the issues with the daughter. However, Dr. Canning noted there was no documentation in Patient F's medical records of respondent having any communication with Patient F's daughter. Dr.

Canning opined that the standard of care for an Internal Medicine physician under the same circumstances requires daily communication with patients (and their families, especially if the patient can't speak for themselves) with documentation of that communication in the medical record. Dr. Canning opined that respondent's failure to document any communications with Patient F's daughter in light of the medical records indicating that the daughter was very upset and that respondent would speak to her was a simple departure from the standard of care.

TESTIMONY OF DR. ROGER ACHEATEL

20. Dr. Roger Acheatel has been licensed to practice medicine in California since 1981. He is also licensed to practice law in California, but his license is on inactive status. He received his undergraduate degree in Political Science and American History from the University of California Los Angeles. He received his Doctorate of Medicine degree in 1980 from University of California, Los Angeles School of Medicine. He completed his internship at Cedars Sinai Hospital in 1981. He completed his Internal Medicine residency in 1983 at Cedars Sinai Hospital. He also completed a fellowship in Cardiology in 1986 at Cedars Sinai Hospital. Dr. Acheatel is board certified in Internal Medicine and has been since 1981. He is also board certified in Cardiology and has been since 1987. Dr. Acheatel began his medical practice in Escondido in 1986, practicing Cardiology and Interventional Cardiology. He continues in this same practice currently and has hospital privileges at Palomar Medical Center and Pomerado Hospital. Dr. Acheatel has had both of those hospital privileges since 1986.

21. Dr. Acheatel testified he reviewed various documents, including the medical records regarding respondent's treatment and care for Patients G, H, I, J, and K, transcripts of interviews of respondent, as well as the board's investigative report. Dr. Acheatel formed an opinion regarding respondent's treatment and care of those five patients and summarized his opinions in his expert report. Dr. Acheatel testified that he is familiar with the standard of care in California for an Internal Medicine physician during the time respondent cared for these five patients. Dr. Acheatel defined the standard of care as the level of knowledge, skill and care in the diagnosis and treatment possessed and exercised by other reasonably prudent physicians in the same or similar circumstances at the time in question. Dr. Acheatel stated that there are varying degrees of departure from the standard of care ranging from simple departures to extreme departures. He described a simple departure from the standard of care, also known as a negligent act, as failure to use the knowledge, skill and care in the diagnosis and treatment possessed and exercised by other reasonably prudent physicians in the same or similar circumstances at the time in question. He described an extreme departure from the standard of care as the failure to provide even scant care to the patient, also known as gross negligence. He explained that the degree of the departure from the standard of care determines if the departure is simple or extreme. Dr. Acheatel is familiar with the standard of care applicable to the care provided to Patients G, H, I, J, and K based upon his many years of experience practicing as a physician in California, his work teaching health care law at Michigan State University, and his work as Chairman of the peer review committee at a

hospital for three years where he was instrumental in the creation of the peer review process for the hospital.

Treatment and Documentation of Patient G

22. Dr. Acheatel testified that medical records showed Patient G was admitted to Scripps Hospital Chula Vista on October 18, 2011, at 6:30 a.m. through the emergency room where he was complaining of weakness, abdominal and chest discomfort, and fainting. Patient G was diagnosed with sepsis, a severe infection of bacteria in the bloodstream, and possible cholecystitis, an inflammation of the gallbladder. Patient G was admitted to the ICU on October 18, 2011. Respondent saw Patient G in the ICU and ordered a HIDA scan to rule out cholecystitis. At approximately 3:30 p.m. a nurse in the ICU made a note in Patient G's medical record reflecting her concern that Patient G's vital signs, including blood pressure and rapid breathing, suggested that he was not stable and that sending him out of ICU for a HIDA scan would be dangerous for him under those circumstances. Despite the nurse's concerns, respondent sent Patient G to nuclear medicine to have the HIDA scan. When the patient arrived at the nuclear medicine department at approximately 3:40 p.m. his heartrate went down dramatically and a "code blue" was called. Patient G was resuscitated and returned to ICU where he again went into cardiac arrest and required cardio-pulmonary resuscitation (CPR) and, despite all efforts, Patient G died at 8:58 p.m. on October 18, 2011. Dr. Acheatel noted that prior to Patient G being sent to get the HIDA scan, respondent had consulted with Dr. Hernandez, a surgeon, who saw Patient G at 2:38 p.m. Dr. Hernandez was aware that Patient G was being sent to nuclear medicine for a HIDA scan and gave no objection to doing so. Additionally, respondent had consulted with an infectious disease specialist who saw Patient G after he returned from the HIDA scan and was back in ICU. Accordingly, Dr. Acheatel noted that the infectious disease specialist was not able to provide an opinion on whether or not Patient G should have been sent for a HIDA scan.

23. Dr. Acheatel opined that the standard of care in this situation required that all attempts should have been made to stabilize Patient G before he was moved outside of the ICU for any reason, including any diagnostic tests, because it is not safe to send such a patient outside of the ICU in an unstable condition. Dr. Acheatel testified that efforts to stabilize Patient G's breathing, heart rate, blood pressure etc. should be performed before transferring Patient G to the HIDA scan. He stressed that in order to stabilize Patient G's breathing, Patient G should have been intubated before sending him to the HIDA scan. Dr. Acheatel opined that respondent's failure to stabilize Patient G prior to taking him out of the ICU was a simple departure from the standard of care. He explained that it was a simple departure because, while it is true that the HIDA scan results would have been extremely helpful for developing a treatment plan to determine whether the source of Patient G's issues was cholecystitis, the patient was still too unstable to be transferred. Dr. Acheatel stated that this was an error in judgment on respondent's part and, accordingly, it is a simple departure from the standard of care. Dr. Acheatel noted that the only other health care provider who agreed with respondent's decision to send Patient G out of the ICU for the HIDA scan was Dr. Hernandez. He stressed that no other physicians or health care providers approved respondent's decision. Dr. Acheatel stated that he also believed that Dr. Hernandez was in

error for failing to make sure Patient G was stabilized before agreeing with his transfer to the nuclear medicine department.

Documentation for Patients H, I, J, and K.

24. Dr. Acheatel also testified that with regard to medical documentation, such as an H & P, the standard of care required that the H & P be dictated and completed within 24 hours of a patient's admission to the hospital. He stated that the hospital by-laws of Scripps Hospital Chula Vista also require that the H & P be dictated and completed within 24 hours of a patient's admission to the hospital. Dr. Acheatel testified that respondent failed to dictate and complete an H & P for Patient H, Patient I, Patient J, and Patient K within 24 hours after each of those patients was admitted to the hospital. Dr. Acheatel opined that respondent's failure to timely complete the H & P for each of those four patients constituted a simple departure from the standard of care for each patient. Dr. Acheatel stressed that the admission H & P is an extremely important document for patient care and if it is not completed in a timely manner, potential harm could result to the patient.

25. At the hearing, respondent stipulated to the truth and accuracy of the allegations contained in paragraphs 30, 31, 32, and 33 of the First Amended Accusation. As alleged in those paragraphs, respondent admitted he failed to dictate an admission H & P within the required 24 hours after admission for each Patient H, Patient I, Patient J, and Patient K.

TESTIMONY OF MADELYN HOROWITZ

26. Madelyn Horowitz currently works as a telemetry technician for Scripps Hospital Chula Vista in the telemetry unit on the Cardiac floor. Her job requires her to observe cardiac rhythms of patients on the Cardiac floor of the hospital and report her findings to physicians. Ms. Horowitz has a certification in electro-cardiogram (EKG) rhythm analysis. She began working in her current position in 2009, immediately upon completion of her certification as a telemetry technician. Ms. Horowitz has known respondent since she began working at Scripps Hospital Chula Vista and worked with him on the Cardiac floor. Ms. Horowitz testified that in late October 2010 while she was working in the telemetry unit, respondent was sitting at the doctor's computer located inside the telemetry unit. Ms. Horowitz stated that respondent then got up from the computer, walked near her, and asked her about a particular patient's heart rhythm. Ms. Horowitz stopped what she was doing and leaned forward while standing to look at the monitor. As Ms. Horowitz leaned forward, respondent "reached around [her] and grabbed [her] right breast." Ms. Horowitz pushed her elbow back towards respondent to stop him while she said "no." Thereafter, Ms. Horowitz completed the task of getting the rhythm information respondent requested and provided it to him. Ms. Horowitz stated respondent then went back to his computer and was acting very awkward and nervous. Ms. Horowitz stated she was alone with respondent when this incident happened. She also stated she never gave him permission to touch her right breast for any reason. Ms. Horowitz was only 19 or 20 years old at the time of this incident and had been working at the hospital for only one year. Ms. Horowitz said she did not report the

incident at the time because she was worried about how the incident may impact her career because of a physician, such as respondent, was in a position of power. Ms. Horowitz was afraid of losing her job "if [she] approached this in the wrong way." She said she also did not report it because she had no witnesses and felt that the hospital would "weigh [her] word against [respondent's]" and she would "have no ground to stand on." She was particularly concerned that the hospital would not take any action because there had been a previous incident with a male co-worker who would text and call multiple women from the telemetry unit. In that instance a group of women, including Ms. Horowitz, reported the incidents to the hospital, but the hospital took no action against the perpetrator. Accordingly, Ms. Horowitz had a negative impression of how the hospital would handle a complaint against respondent. Ms. Horowitz stressed that she is "100 percent certain" that respondent touched her right breast that day. On December 5, 2010, Ms. Horowitz finally reported the incident regarding respondent to the hospital human resources (HR) department after her parents urged her to do so. Ms. Horowitz stated she recalled the day she reported the incident to the Human Resources (HR) Department because on that day she notified her co-worker she had an appointment with HR and was going to file a complaint. After returning from HR, Ms. Horowitz stated her co-worker "punched [her] in the face" for being gone from the telemetry unit for so long. Ms. Horowitz left work and filed a police report against the co-worker who hit her. Ms. Horowitz testified that before the October 2010 incident when respondent touched her breast, respondent had never previously inappropriately touched her. She stated that after the October 2010 incident respondent made sure he was not alone with respondent in the telemetry unit.

TESTIMONY OF CHELSEA MILLER

27. Chelsea Miller is currently a registered nurse and has been one for seven years. In January 2014, she worked as an R.N. at Scripps Hospital Chula Vista. She knows respondent through her work at Scripps Hospital Chula Vista where they worked together for about one year prior to January 16, 2014. Ms. Miller no longer works at Scripps Hospital Chula Vista and is working as a nurse at a different location. Ms. Miller testified that on January 16, 2014, respondent came into the unit where she worked. Ms. Miller had not seen respondent for several weeks as he had been in training. Ms. Miller said she was at the fourth floor nursing station when she saw respondent and she told him "hi" and they hugged. Ms. Miller stated that when they hugged respondent reached around and touched her left breast. She described the hug as she came in for a "side hug" and respondent came in for a "front hug." She stated that when this happened respondent's right arm reached around and touched her left breast. Ms. Miller did not say anything to respondent after the "hug" and walked away quickly to take care of patients. When he touched her breast, respondent did not say anything to Ms. Miller. Ms. Miller also testified that the nurses' station was very well lit as the time of the incident. After Ms. Miller returned to the nursing station after taking care of her patients, she made eye contact with Eleanor Coleman, her supervisor. Ms. Coleman walked up to Ms. Miller and said "did that just happen?" and Ms. Miller said "yes." Ms. Coleman told Ms. Miller that she must report the incident to HR, and, within 15 minutes of it happening, both women went to HR and reported the incident. When she reported the incident to HR, Ms. Miller was questioned with her manager, supervisor and another HR

representative present. Ms. Miller testified that she is "100 percent confident" that respondent touched her breast without her consent that day. Ms. Miller testified that on one occasion prior to the January 16, 2014, incident respondent had touched her abdomen and it made her uncomfortable. Although she felt it was inappropriate, Ms. Miller never reported that incident. Ms. Miller testified that she has never had a dating or romantic relationship with respondent at any time.

28. At some time after the January 16, 2014, incident, Ms. Miller's hours at the hospital were cut, and she was looking for another nursing position. As a result, she reached out to respondent to ask if he knew about any open nursing positions at nursing homes because she knew that respondent worked at a number of nursing homes. Ms. Miller testified that respondent told her he could help her get work as a nurse at a nursing home and, they exchanged phone numbers. Ms. Miller stated she exchanged text messages with respondent before and after the January 16, 2014, incident, for a total of about 12 to 14 months. She also spoke with him on the telephone. Ms. Miller stated that there were times that her husband got upset that respondent was texting her. She stated she did respond to text messages from respondent outside of work, but she only had a professional relationship with him and sought his advice to get new jobs.

29. On March 14, 2014, while Ms. Miller was on vacation with her husband, respondent asked her to call him because he really needed to talk to her about the incident that occurred between them. During the text exchange, Ms. Miller wrote "Am I going to lose my job? . . . I am freaking out . . ." and "I told them I didn't want you to lose your job over it . . ." In response respondent wrote "My privileges may be suspended because of this." Ms. Miller then had a telephone conversation with respondent where respondent asked her to rescind her statement that he touched her breasts. Ms. Miller wrote in a subsequent text exchange, "I believe it was an accident . . . im [sic] sorry this shit is happening . . . neither of us need it at all . . . I will testify if need be . . ." Ms. Miller explained she engaged in this text exchange because she "was afraid and wanted this situation to go away" and "was speaking out of fear." She stated that she wished no ill-will on respondent and did not want to ruin his life. She admitted that when she texted respondent that she believed the incident was an accident she was lying, and she lied because she "wanted the whole thing to go away." However, she testified she does not actually believe that the breast touching incident was an accident. Ms. Miller testified that she had no issues with respondent professionally other than the touching incidents and that he asked her to rescind her statement.

TESTIMONY OF ELEANOR COLEMAN

30. Eleanor Coleman currently works as a registered nurse and patient care supervisor on the fourth floor at Scripps Hospital Chula Vista, where she has worked for 12 years. Ms. Coleman has been the patient care supervisor on the fourth floor for the past five years. As a patient care supervisor, Ms. Coleman supervises nurses and provides support for them, as well as deals with patient complaints. Ms. Coleman was Ms. Miller's direct supervisor in January 2014. Ms. Coleman also knew respondent as he worked at the hospital with them. On January 16, 2014, Ms. Coleman was on the phone and on hold at the nurses'

station on the fourth floor of the hospital when she saw respondent enter at the back of the nursing station while Ms. Miller was sitting at the station. Ms. Coleman observed Ms. Miller stand to greet respondent and observed them hug and then she saw respondent's hand move to Ms. Miller's breast and stay there for a few seconds. Ms. Coleman stated "it felt weird" and she "could not believe what [she] was seeing." Ms. Coleman stated she was certain that she saw respondent touch Ms. Miller's breast and that his hand stayed there for a few seconds. She did not believe respondent "brushed" her breast by mistake. After she witnessed the incident, Ms. Coleman went back to her phone call, and Ms. Miller walked away. Ms. Coleman observed Ms. Miller walk back to the nursing station after Ms. Coleman finished her phone call. Ms. Miller made eye contact with her. According to Ms. Coleman, Ms. Miller's face was red and her eyes were teary. Ms. Coleman asked Ms. Miller if she was ok, and Ms. Miller said "no." Ms. Coleman moved Ms. Miller to a private place and asked her if "she saw what she thought she saw." Ms. Miller said "yes." Ms. Coleman told Ms. Miller she (Ms. Coleman) had to report the incident, and Ms. Miller stated she understood Ms. Coleman had to report it and did not object to her doing so.

31. Ms. Coleman stated that she and Ms. Miller went to the HR department to report the incident. Ms. Coleman also gave a statement to HR about what she saw. Ms. Coleman stated that it was respondent's right hand that touched Ms. Miller's left breast. She reiterated that she did not believe that respondent accidentally touched Ms. Miller's breast because his hand stayed there for a few seconds.

Respondent's Evidence

TESTIMONY OF COREY MARCO, M.D.

32. Corey Marco, M.D. graduated from University of California, Los Angeles in 1964 with his bachelor's degree. He received his Doctorate of Medicine degree in 1967 from the University of California, Los Angeles School of Medicine. He also received his Juris Doctorate degree from Stanford University School of Law in 1975. Dr. Marco completed his Internship in 1968 at the U.S. Public Health Service on Staten Island, New York. Thereafter, from 1968 through 1970, Dr. Marco completed two years with the U.S. Public Health Service at the U.S.-Mexico border. Dr. Marco also completed a fellowship in Epidemiology in 1968 at the Center for Disease Control in Atlanta, Georgia. Dr. Marco was first licensed to practice medicine in California in 1967. He has been licensed to practice law in California since 1975. In 1975, Dr. Marco was board certified in family practice from the American Academy of Family Practice. He was recertified in 1985. He worked as the Medical Director of the Southern California Health Plan (H.M.O.) in San Diego, from 1977 to 1978. He had a private practice in Family Medicine from 1977 to 2017. Additionally, he had a private practice in Medical Law from 1977 to 2017. Dr. Marco practiced medicine for 40 years and retired from the practice of medicine in 2017. Dr. Marco's license to practice medicine in California was disciplined by the board on December 22, 2016. Respondent's license was publicly reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). The public reprimand provided as follows:

> On or about September 17, 2012, you failed to adequately evaluate and treat exertional chest pain, hypertension and hyperlipidemia, and you failed to keep adequate and accurate medical records, in your care and treatment of patient S.W., as more fully described in Accusation No. 800-2014-003232.

33. Dr. Marco testified he reviewed medical records for all of the patients at issue in this matter and the First Amended Accusation. He provided an expert opinion on behalf of respondent and summarized his findings in his expert report, which is one and one-half pages in length. Dr. Marco admitted during his testimony that he drafted his expert report prior to having received or reviewed medical records for Patient A. Dr. Marco testified that he is familiar with the standard of care for internal medicine in southern California during the time frame respondent provided treatment for all of the patients at issue in this matter. He testified that the standard of care is the degree of care and skill required of physicians under the circumstances that meets the professional skill or qualifications of other physicians in that community or any community. He testified he is familiar with the standard of care based upon his 40 years of practice as a physician in Southern California.

Treatment and Documentation of Patient A and Patient B

34. Dr. Marco testified that he failed to review the medical records regarding Patient A prior to drafting his expert report. However, he stated he did review the medical records for Patient A later and made no changes to his expert report as a result. Notably, the entirety of information in Dr. Marco's expert report regarding Patient A and Patient B is as follows:

> There is no gross negligence. This opinion will be based on the accepted definition of "gross negligence" in the setting of medical practice, and the facts involved in the cases of patients A & B, and that specifically all of the criticisms leveled against respondent in these two cases are really manifestations of failure in documentation rather than negligent acts or omissions. There are not repeated negligent acts involving patients A through K. . . . Specifically, the issues involved in patients A and B are irregularities of documentation as opposed to deficiencies of observation or acts or omissions of treatment. . . . Respondent did not fail to maintain adequate and accurate records relating to his care and treatment of Patients A, B, C, E, F, 51 [I], 52 [J], and 56 [K] as alleged. This opinion will be based on respondent's admitted inexperience with and misunderstanding of the charting and documentation requirements of medical practice in the hospital and skilled nursing facility settings, which are deficiencies more appropriately remedied by education and monitoring of respondent that [sic] by

> disciplinary action affecting his ability to practice his profession.

Dr. Marco provided no further information in his expert report regarding Patient A or Patient B.[13] Dr. Marco stated that respondent's failures regarding medical record keeping were not issues related to quality of care at all, but rather were only "technical errors" based on respondent's ignorance of electronic medical record (EMR) systems.

Treatment and Documentation of Patient C

35. Dr. Marco summarized his opinion regarding respondent's treatment of Patient C in his expert report as follows:

> Regarding patient C, there can be no allegation beyond inadequate documentation because the prescription of Ativan to premeditate [sic] an agitated patient for a needed MRI is a RELATIVE (as opposed to an ABSOLUTE) contraindication and in this factual set of circumstances the benefits of Ativan outweighed the risks (hence, the act was not negligent); moreover, the medical records indicate that the respondent did in fact reassess the patient in light of her clinical deterioration .... Respondent was not incompetent in his care of patients C and D. This opinion will be based on the medical records involving these two cases, the medical literature regarding contraindications and precautions in the prescription of Ativan, the medical standards in the treatment of DKA, and the transcripts of testimony offered in hearings regarding the treatment of patient D's DKA by respondent, all of which will contradict the claim of incompetence by respondent in his treatment of patients C and D.

Notably, during his testimony Dr. Marco admitted that he never reviewed any transcripts prior to expressing his expert opinions despite the statement in his expert report to the contrary. He testified that he put a statement in his expert report that he reviewed transcripts by error. Additionally, Dr. Marco admitted during his testimony that he did not review the medical literature regarding contraindications and precautions in the prescription

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[13] Pursuant to Business and Professions Code section 2334 portions of Dr. Marco's testimony were excluded on the basis that his expert report did not provide any information on his opinions on those issues. Specifically, Dr. Marco's expert report failed to include any information regarding the standard of care regarding the time within which a physician is required to see a patient in a skilled nursing facility after admission, all opinions regarding the mental health assessment, physical assessment of Patient A and medical documentation regarding Patient A, and all testimony regarding medical documentation for Patient B, including documentation of the WBC for Patient B.

of Ativan in preparation for his opinions in this matter. He again stated that he put that statement in his expert report in error because he did no such review. He stated that he only reviewed medical records of Patient C for his opinions in this matter and relied on his 40 years of experience.

36. Dr. Marco testified that, based on his review of the medical records, Patient C was seen by respondent in October 2015, after her admission to the hospital. Her medical history indicated she had hypertension, nausea and vomiting, and a history of a stroke approximately one year prior. During the course of her hospitalization, respondent felt that it was necessary to determine if Patient C had a new stroke. Dr. Marco stated that while a CT scan had been performed on Patient C when she was admitted through the emergency room and it was negative for signs of a new stroke, respondent ordered an MRI scan later during her hospitalization, the results of which showed that Patient C had incurred a second stroke, which is critical information for the continued treatment of Patient C. Accordingly, Dr. Marco opined that obtaining the MRI was necessary. Dr. Marco opined that respondent did not deviate from the standard of care by giving Patient C Ativan prior to her MRI scan because "the patient was agitated, vomiting, and needed suction frequently." As a result, the nurses were advising respondent that Patient C could not tolerate lying down for the MRI. Dr. Marco stated that, in response, respondent gave Patient C Ativan "to settle her agitation." On cross-examination, Dr. Marco admitted that there was nothing written in Patient C's medical records stating that she was agitated, but he inferred that the patient was agitated because the patient "was vomiting and needed suction." He also acknowledged that there was no documentation in Patient C's medical record to indicate that respondent gave her the Ativan because she was agitated. Dr. Marco opined that respondent gave Patient C the Ativan "not to address the agitation at the time of the MRI, but to prevent future aspiration caused from agitation and to help the patient lay flat." Dr. Marco admitted that just prior to the MRI, Patient C was calm and oriented. Dr. Marco stated that he believed respondent's prescription of Ativan to Patient C was appropriate, and that other specialists including a pulmonologist and neurologist knew that Patient C was getting an MRI and did not object. He further stated that the neurologist knew that Patient C was getting an MRI, saw the prescription for Ativan, and did not object. Dr. Marco stated that respondent properly ordered that Patient C be suctioned frequently to prevent her aspiration. He opined that if respondent's orders had been followed appropriately and had Patient C been sent to MRI with a suction machine, Patient C would likely not have aspirated.

37. With regard to the medical record documentation, Dr. Marco opined that respondent did not deviate from the standard of care regarding his documentation for Patient C. He stated respondent properly documented his assessment of Patient C and her deterioration. Dr. Marco stated he disagreed with complainant's assertion that respondent provided inaccurate or conflicting information in Patient C's H & P that she was awake and alert and able to give information for a review of systems despite the fact that she was intubated and sedated as he opined it was still possible for respondent to get that information even if Patient C was sedated and intubated. However, he admitted that it is important that physicians make sure the record is accurate. Dr. Marco stated he is not familiar with the pre-population of electronic medical records and has never experienced that. On cross-

examination Dr. Marco admitted that he saw no documentation from respondent showing he reassessed Patient C after her decline.

Treatment and Documentation for Patient D

38. Dr. Marco testified that his review of medical records for Patient D showed that, at the time Patient D was admitted to the hospital in September 2015 through the emergency room, Patient D did not have DKA. Specifically, at the time of her admission, Patient D's blood-glucose level was only 252, which is not sufficiently high for a diagnosis of DKA. He stated that her blood-glucose level must be over 500 for a diagnosis of DKA to be appropriate. He further opined that there was no evaluation of whether ketones were present in Patient D's urine or blood and no recording of the PH of her blood to show it was acidic. Accordingly, while she was in the ER, Patient D did not have a diagnosis of DKA. Dr. Marco admitted that "arguably" the following day after her admission Patient D was in DKA, although that was never documented in her records. Dr. Marco opined that respondent took appropriate steps to address Patient D's condition by giving her Lantis insulin, but the nursing staff failed to follow his orders. After respondent learned this, he ordered Patient D be given Lantis insulin again, and he consulted a diabetes registered nurse practitioner, which was appropriate. Dr. Marco opined that respondent's treatment of Patient D was within the standard of care and was appropriate.

Treatment and Documentation for Patient E

39. Dr. Marco testified that his review of the medical records for Patient E showed that Patient E was an elderly woman who suffered a hip fracture, had multiple complications, and subsequently expired after a cardiac arrest. Dr. Marco's expert report provided the following information regarding Patient E:

> As for the allegations regarding patients E and F, the alleged delays in signing progress notes do not reflect negligent acts or omissions but rather are manifestations of respondent's deficiencies in documentation and charting that are remediable through education (of respondent) regarding charting requirements rather than action against his license to practice his profession.

Dr. Marco admitted during his testimony that respondent failed to sign a progress note related to Patient C until after Patient C died. Also, as noted above, respondent stipulated to the truth and accuracy of paragraph 27 of the First Amended Accusation, which alleged that he failed to sign or complete his progress note on Patient E until after her death. Dr. Marco admitted during his testimony that respondent's failure to complete the progress note until after the death of Patient E was a simple departure from the standard of care.

Treatment and Documentation for Patient F

40. Dr. Marco testified that his review of the medical records for Patient F showed that on May 4, 2015, Patient F was scheduled to have an out-patient removal of a biliary stent by a gastroenterologist. However, when the gastroenterologist saw her, Patient F was very ill with a fever and sepsis and the gastroenterologist sent her to the emergency room instead. Dr. Marco explained that there were complicated issues surrounding whether or not a gastroenterologist was consulted on Patient F, but ultimately another gastroenterologist was consulted on this patient. Dr. Marco stated that the daughter of Patient F was unhappy, but it was not because of a lack of communication by respondent. Rather, it was because of issues with Patient F's insurance and her inability to get the biliary stent removed during the time Patient F had sepsis.

41. With regard to the allegation that respondent failed to sign the May 15, 2015, progress note for Patient F in a timely manner, Dr. Marco agreed and testified that respondent did sign that progress note late and his actions constituted a simple departure from the standard of care, which required him to sign progress notes within 24 hours of his assessment of the patient.

Treatment and Documentation for Patient G

42. Dr. Marco testified that his review of the medical records for Patient G showed that on October 18, 2011, Patient G was admitted to the hospital from the ER and was very ill with sepsis and an abdominal infection. Patient G was admitted at 1:00 a.m. on October 18, 2011, and he died at 6:00 p.m. that same day. Dr. Marco opined that the reason for Patient G's abdominal infection was unknown at the time of his admission, and it was critical to know the cause of the infection in order to properly treat Patient G with either exploratory surgery or surgery focused on the gallbladder. Respondent and others suspected, but did not know for certain, that the cause of the infection was the gallbladder, i.e., cholecystitis. In order to rule out cholecystitis, a HIDA scan was necessary. Dr. Marco opined that because Patient G was critically ill, and surgery had to be done on an emergency basis, there was "no time to stabilize" Patient G before the HIDA scan. Dr. Marco stated that the surgeon needed the HIDA scan in order to know what surgery to perform and Patient G's "life hanged in the balance." As a result, Dr. Marco opined that respondent did not depart from the standard of care for the treatment of Patient G. Dr. Marco stated that the surgeon, Dr. Hernandez, did not object to Patient G being taken for the HIDA scan prior to stabilizing the patient. In his expert report he wrote that "transferring an unstable patient from the ICU" for the HIDA scan was "recommended and endorsed by an entire team of qualified and competent physicians and surgeons." However, on cross-examination Dr. Marco admitted that Dr. Hernandez did not explicitly recommend and endorse that Patient G get the HIDA scan before he was stabilized, but rather he did not object to the HIDA scan under those circumstances. Additionally, Dr. Marco also admitted that the only other physician who knew about the HIDA scan for Patient G was the infectious disease physician, and Dr. Marco did not know if that physician knew whether Patient G was stable prior to the HIDA scan.

Treatment and Documentation for Patients H, I, J, and K

43. Dr. Marco offered no opinions regarding the treatment and medical documentation for Patients H, I, J, and K.

RESPONDENT'S TESTIMONY

44. Respondent testified that when he started practicing Internal Medicine, the average age of his patients was 14 years, but now the average age is 50 years and older. He also stated that for more than five years, from 2010 to 2014, he held the status as the "number one" admitting physician at Scripps Hospital Chula Vista based on the number of admissions per physician. He stated that in that time period, he was admitting other physician's patients to the hospital upon the request of those other physicians. During that time he also had his own office practice, but he worked primarily in the hospital. Additionally, during that same time period, respondent had a nursing home practice with affiliations with seven skilled nursing facilities.

Treatment and Documentation for Patient A

45. Respondent testified that Patient A was admitted to a skilled nursing facility after he was admitted to Scripps Hospital Chula Vista for osteomyelitis of the left foot and gangrene of the left toe. Respondent stated that he ordered intravenous antibiotics to be given to Patient A for 39 days to address the left foot issues. He also ordered betadine to be painted on the left toe daily, as well as cleansing and drying the foot daily to treat the infection issues. Respondent testified that he understood the standard of care required a physician to see a patient admitted into a skilled nursing facility within 72 hours after the physician has been notified of the patient's admission, rather than 72 hours after the patient has been admitted to the skilled nursing facility. He emphasized that he is not aware of any rule from Castle Manor that required his evaluation of a patient within 72 hours of admission to the facility. Respondent has seen thousands of patients in skills nursing facilities and stated that he has never been criticized for not seeing an admitted patient in a timely manner. With regard to Patient A, respondent testified that, based on the notes in the medical record, he "would have been notified" of Patient A's admission to the facility at or about 11:00 p.m. on March 31, 2015. Respondent stated he did assess Patient A within 72 hours of admission to the facility. Respondent stated that there are two entries in the medical records showing that he assessed Patient A on both March 31, 2015, and on April 6, 2015. Respondent admitted that he failed to write down the time of day he visited Patient A and, therefore, he has no idea what time he first saw the patient. Respondent also admitted that both of these progress notes failed to provide any information regarding respondent's assessment of Patient A's foot and toe. He stated that, based on those notes, he can't say whether or not he inspected the foot and toe on those dates, but it is his general practice to do so. Respondent stated that he has since taken additional courses on medical record keeping and in the future will make sure he records his assessment information. Respondent also testified that it was his understanding of applicable law that a treating physician must see a patient in a skilled nursing facility at least every 30 days for a re-evaluation. Respondent stated that, after his

first assessment of Patient A on March 31, 2015, he next assessed the patient on April 6, 2015, only seven days later, because Patient A "had an acute problem" requiring respondent to reassess Patient A more often than every 30 days. He testified that, after his April 6, 2015, assessment respondent was not notified by the nursing staff at the facility that Patient A's condition had deteriorated. On April 15, 2015, Patient A's daughter contacted respondent by telephone to inform him that Patient A's foot had worsened. Respondent emphasized that if Patient A's foot had worsened from his last assessment on April 6, 2015, the nursing staff of the facility had an obligation to notify respondent, but failed to do so.

46. With regard to respondent's March 31, 2015, assessment of Patient A on the "Admission and Physical Examination" form where he wrote "See Hosp. H & P," respondent testified that he checked the box indicating that Patient A was informed of his condition, understood his condition, and had the capacity to make decisions because respondent talked to Patient A in Spanish, his native language. He said that Patient A was hard of hearing, but he "appeared to understand" based on his words and body language. Respondent stated that by checking the "yes" answer box for each of the inquires: "patient informed of condition," "patient understands condition," and "resident has capacity to make decisions" he was in no way changing or negating the fact that Patient A's daughter was the medical decision maker for Patient A. Respondent asserted that medical professionals would understand that the daughter would remain the medical decision maker regardless of the boxes respondent checked.

Treatment and Documentation for Patient B

47. Respondent testified during the time Patient B was in the hospital, respondent assessed Patient B daily, and documented her WBC on a daily basis. Respondent admitted that he signed the progress notes from August 4, 2015, through August 13, 2015, for Patient B on August 14, 2015, all within a few minutes of each other. Respondent first began working with electronic medical records in September or October of 2014, after he had already practiced medicine for about 30 years. Respondent stated that in August 2015 he was not aware that he was required to press a certain button on the computer to sign his progress notes and publish them. Instead, he thought as he drafted the progress notes that they were visible to others. Respondent found EMR to be very challenging because he is not "computer competent." He stated he has had additional training and now understands how to sign and publish his progress notes.

Treatment and Documentation for Patient C

48. Respondent first saw Patient C in the emergency room when she was admitted to the hospital. At that time, respondent stated Patient C did not show signs of agitation or anxiety. However, on the H & P for Patient C dated September 7, 2015, right after she was admitted to the hospital, respondent noted under "allergies" as follows "She feels very anxious and sometimes she vomits to it." Respondent explained that this note was to show that Patient C gets very anxious causing her to vomit. On September 8, 2015, respondent determined that Patient C needed an MRI. On that date, Patient C seemed "anxious" but his

progress notes for Patient C do not show this. Respondent stated that many people get anxious in an MRI machine. He stated he ordered the MRI to determine if Patient C had incurred another stroke. He also consulted a neurologist for Patient C. Respondent testified that sometime prior to the MRI, a nurse called him to inform him that Patient C's daughter said the patient was nervous and would not tolerate an MRI scan. As a result of this information respondent ordered Ativan for Patient C along with suction "to be continuous." Respondent admitted that he was advised by the nursing staff that Patient C was having swallowing issues prior to the MRI. Respondent got a pulmonology consult with Dr. Lozano to make sure it was appropriate to send the patient for an MRI scan. Respondent testified that he "told" Dr. Lozano that he was sending the patient to MRI and was prescribing her Ativan. According to respondent, Dr. Lozano "told" him that she was "ok" with Patient C getting an MRI and was "ok" with giving the patient Ativan, but that "she was nervous" about the Ativan. Notably, Dr. Lozano did not document that she was ok with giving Patient C Ativan prior to the MRI in her consultation note. Respondent also admitted that he ordered the Ativan for Patient C prior to consulting with Dr. Lozano. Respondent stated he gave Patient C Ativan because he wanted her to cooperate in having the MRI.

49. Respondent stated that Patient C did not show signs of deterioration until she "coded" while in the MRI department. Respondent stated that he did not document any deterioration in Patient C's condition because he did not observe any deterioration in her condition. However, on cross-examination respondent admitted that he was aware Patient C was having difficulty swallowing and that is a sign of neurological deterioration. With regard to the progress note dated September 9, 2015, where it was written that Patient C was "oriented to time and place," respondent did not recall if the patient was intubated at that time. He believed that if he had made that notation, it was because he talked to the patient. However, he admitted that this information could be incorrect and caused by pre-population of the EMR with older information.

50. Respondent admitted that he did not sign his progress notes for Patient C dated September 9 and 10, 2015, until September 12, 2015, three days later. Respondent explained that he did not know when he drafted the September 9 and 10, 2015, progress notes that they would not be visible to other medical providers until he hit a particular button to sign them.

Treatment and Documentation for Patient D

51. Respondent testified that when Patient D was admitted to the hospital through the emergency room, Patient D did not have DKA because her blood-glucose level was only 252. He stated Patient D had been taking Lantis insulin before her admission to the hospital, and respondent and the emergency physician ordered that the Lantis insulin be continued. The day after Patient D was admitted into the hospital, her blood-glucose began to rise. As a result, respondent asked the nurse if the Lantis insulin had been given to Patient D as ordered, and he was told that it had not been given. Respondent instructed the nurses to immediately administer the Lantis insulin and call the diabetes nurse practitioner for a consultation. Respondent testified that Patient D responded well to the insulin and his treatment of Patient D was appropriate.

Treatment and Documentation for Patient E

52. Respondent testified Patient E was older with multiple health problems and was in the hospital for a hip fracture surgery. Respondent stated he assessed Patient E in a timely manner before she died in the hospital on June 26, 2015. Respondent admitted that he drafted the progress note for Patient E on June 25, 2015, but did not sign that progress note until two days later on June 27, 2015, after Patient E had already died. Again, he stated that he did not understand EMR at the time and did not understand he had to hit a particular button to sign the document.

Treatment and Documentation for Patient F

53. Patient F had a biliary stent and acute cholecystitis. Respondent testified that he notified Patient F's daughter on multiple occasions that Patient F's biliary stent would not be removed during her hospitalization because it was too dangerous to do so. Respondent did not record those conversations in the medical records but stated that nursing notes indicate he had them with Patient F's daughter. Respondent testified that he consulted with three different gastroenterologists regarding Patient F while she was in the hospital.

54. Respondent admitted that he drafted a progress note for Patient F on May 15, 2015, but he did not electronically sign it until May 17, 2015 at 11:13 p.m., which is outside of the required 24-hour time period. Respondent stated this happened because of his misunderstanding of EMR at that time.

Treatment and Documentation for Patient G

55. Patient G was admitted to the hospital through the emergency room of Scripps Hospital Chula Vista with an initial diagnosis of DKA, but lab results showed he did not have DKA. Respondent thought Patient G had acute cholecystitis, sepsis, and severe abdominal infection. When respondent first assessed Patient G, it was obvious Patient G was extremely ill. Respondent obtained a consultation from a surgeon, Dr. Hernandez, and they both agreed that Patient G needed a HIDA scan to rule out acute cholecystitis. Respondent testified that Dr. Hernandez told him that it "was urgent" to get the HIDA scan to rule out acute cholecystitis. The surgical consultation note from Dr. Hernandez states that Dr. Hernandez saw Patient G in the ICU just prior to being sent out of the ICU to get a HIDA scan. Dr. Hernandez also noted that Patient G was tachypneic, meaning he had rapid breathing, and was very ill. Respondent testified that Dr. Hernandez did not object to removing Patient G from the ICU to go to the HIDA scan. Respondent was concerned that if he did not rush Patient G into surgery, Patient G would die. The HIDA scan was urgently needed to determine what surgery should be performed. Respondent stated this was why he "did not wait" for the patient to be stabilized. Respondent stated that, prior to sending Patient G from ICU to nuclear medicine for the HIDA scan, a nurse from ICU told him, and made a note in Patient G's records, that she was not comfortable taking Patient G out of ICU for the HIDA scan because of the patient's rapid and erratic breathing. Accordingly, respondent increased the oxygen given to Patient G and sent him to the HIDA scan with a

nurse. After the patient arrived in nuclear medicine he went into respiratory and cardiac arrest and later died.

Admissions Regarding Patients H, I, J, and K

56. Respondent admitted the truth of the allegations made in paragraphs 30, 31, 32, and 33 of the First Amended Accusation. Thus, he admitted he failed to dictate an H & P for Patients H, I, J, and K within 24 hours after admission to the hospital as required under the standard of care. Specifically, for Patient H respondent was approximately 21 hours late dictating the H & P because he did so approximately 45 hours after Patient H was admitted to the hospital. With regard to Patient I, respondent was approximately two hours late dictating the H & P because he did so approximately 26 hours after Patient I was admitted to the hospital. With regard to Patient J, respondent was approximately one hour late dictating the H & P because he did so approximately 25 hours after Patient J was admitted to the hospital. With regard to Patient K, respondent was approximately one hour late dictating the H & P because he did so approximately 25 hours after Patient K was admitted to the hospital.

Respondent testified he had difficulty with EMR and first started training on how to use EMR in September 2014. He said he never really received guidance on "logging in and logging out completely" from anyone. Respondent said that if he had a question regarding EMR, the question was answered by the trainers. However, he claimed he never really got comprehensive "start to finish" training on EMR. Respondent stated that in June or July 2013, enrolled in the Physician Assessment and Clinical Education Program (PACE) record keeping course, which is a continuous 12 month-long course, to improve his record keeping with EMR. Respondent stated that, since he received proper training from PACE, he will never repeat the same mistakes as those at issue in this matter.

October 2010 Incident

57. With regard to Ms. Horowitz's allegations that respondent touched her breast in October 2010, respondent testified that Ms. Horowitz never told him that he had done anything inappropriate. Accordingly, he had no knowledge of the incident and first learned of her allegations in December 2010 when another physician told him about the allegations and that the hospital would be conducting an investigation. Respondent stated that he had no recollection of intentionally touching or trying to touch Ms. Horowitz's breast. He stated that, on one occasion, he was behind Ms. Horowitz asking about a patient while she was sitting in a rolling chair. According to respondent, Ms. Horowitz abruptly got up and the chair came toward respondent. However, he "does not think" he touched her. Respondent stated that, after October 2010, Ms. Horowitz never changed her behavior towards him, was always helpful to him, and treated him the same as she had before that date.

January 16, 2014, Incident

58. With regard to Ms. Miller's accusations that respondent touched her breast in January 2014, respondent testified he did not intentionally touch Ms. Miller's breast. He

testified he had a professional relationship with Ms. Miller. Respondent also testified that at some point their relationship "became more than professional" when Ms. Miller sat next to him and began discussing her husband's alcohol consumption with him. Respondent stated there were times he and Ms. Miller would engage in a friendly hug, sometimes initiated by her and sometimes by him. However, respondent clarified that, when he would hug any woman, the only thing on his body touching hers was his shoulder. Ms. Miller contacted respondent to ask for help in getting additional jobs at nursing homes. Respondent stated he would, at times, also talk to Ms. Miller about his soccer schedule.

59. Respondent stated that, after the January 16, 2014, incident and after he learned the incident was reported to the hospital's HR department, Ms. Miller approached him to talk about the incident. According to respondent, he told her that he was instructed by HR not to talk to her about the incident and only to talk with her about patient care. Respondent testified that several weeks after that conversation, respondent was in the ICU and Ms. Miller was standing by him at the nurses' station, and she told him again she wanted to talk with him about the incident. According to respondent, he told her he was advised not to speak with her about it, but he said "if you text me we can talk about it later." He stated that later that same day Ms. Miller told him verbally that "the allegations are crazy and not good" and that she "would help" him. He stated that the text exchange in March 2014 where she wrote that she believed it was an accident confirmed their earlier verbal conversation.

Mitigation and Rehabilitation

60. Respondent testified he enrolled in the PACE record keeping course related to EMR in June or July of 2013 and completed the course. Additionally, respondent provided documentation of his completion of the PACE Professional Boundaries Program on April 3-5, 2014. After taking the professional boundaries course, respondent changed his behavior with regard to how he interacts with all women at work, and he no longer gives or receives hugs from women at work. Respondent stated he has had no complaints regarding inappropriate touching since 2014.

TESTIMONY OF VERONICA DEL VILLAR

61. Veronica Del Villar currently works as a receptionist in respondent's medical office. She has held that position for the past 19 years and has worked in medical offices for 20 years. During these 19 years she worked in respondent's medical office, Ms. Del Villar has seen and interacted with respondent on a daily basis and has seen him interact with nurses and patients in his office. As part of her job, Ms. Del Villar greets all patients who arrive at the office and, on occasion, if respondent needs a witness in the examination room, Ms. Del Villar goes in the examination room as a witness. She stated that although respondent is her boss and pays her salary, that fact does not impact her ability to testify truthfully. She stated that, during the time she has known respondent, he has never treated or touched her inappropriately, and she has never seen him treat or touch any patient or staff in an inappropriate way. She has also never heard of any complaints from anyone regarding respondent's actions being inappropriate.

TESTIMONY OF ARTURO VALDERRAMA, M.D.

62. Dr. Arturo Valderrama studied medicine at the University of Guadalajara and received his Doctorate of Medicine degree in 1989. After he received his M.D. degree, Dr. Valderrama worked in hotels for three years before passing his examinations to be a medical doctor in the United States. He then completed his residency in Internal Medicine in 1996 at Cabrini Medical Center in New York. Dr. Valderrama became board certified in Internal Medicine in 1996, and thereafter worked for three years in the Bronx in New York. Dr. Valderrama moved to San Diego in 2001 and was licensed to practice medicine in California in 2001. He currently has a private practice in Internal Medicine in Chula Vista and has hospital privileges at Sharp Hospital Chula Vista and Scripps Hospital Chula Vista.

63. Dr. Valderrama testified that he has known respondent since 2003, has referred patients to respondent for treatment, and has always received very positive feedback from his patients regarding respondent's treatment. Dr. Valderrama has observed respondent in a hospital setting interacting with patients. Based on those observations, Dr. Valderrama believes that respondent provides a good quality of care for his patients. Dr. Valderrama has also reviewed respondent's medical documentation and notes and considers respondent's medical documentation to be very good. For about 10 years, he has seen respondent interact with hospital staff and personnel and has never seen anything inappropriate. Dr. Valderrama stated that if he had observed any inappropriate behavior from respondent, Dr. Valderrama would have reported that behavior. Dr. Valderrama believes that respondent is a very hard-working, responsible physician who cares for his patients. He stated that respondent has dedicated his life to his career and is dedicated and focused on his patients. Dr. Valderrama stated that he trusts respondent with his (Dr. Valderrama's) patients and his family. He stated respondent was the treating physician for Dr. Valderrama's wife at one time. He believes that respondent is an asset to the medical community.

64. Dr. Valderrama testified on cross-examination that he was aware respondent's privileges at Sharp Hospital Chula Vista were suspended, but stated he was not working with respondent at that time and does not know what led to the suspension. He is also not aware of any issues regarding respondent's privileges at Scripps Hospital Chula Vista. Dr. Valderrama testified that he is not aware of any complaints made to the board regarding respondent's medical record keeping. Dr. Valderrama stated that from 2013 to 2014 many Internal Medicine physicians were struggling to keep up with medical documentation because of the introduction of electronic medical records. Dr. Valderrama admitted that he also struggled to dictate his progress notes and patient records in a timely manner and had been suspended by the hospital a few times because of those issues, although he was never suspended from hospital privileges. He stated that about 50 to 60 percent of physicians at Sharp Hospital Chula Vista were struggling with issues with EMR during the time period of 2013 to 2014. Dr. Valderrama testified that the physicians at Sharp Hospital Chula Vista were given training on EMR for two months on a daily basis depending on individual need.

The Parties' Recommendations

65. Complainant stressed that this case involves multiple patients and victims. While many of the medical record keeping violations were simple departures from the standard of care, other violations were extreme departures from the standard of care. Complainant emphasized that, given the number of departures from the standard of care, some of which were extreme, a public reprimand pursuant to Business and Professions Code section 2233 is not appropriate. Complainant argued respondent has shown no remorse for his actions, denies that the breast touching incidents occurred, and has shown no rehabilitation. Complaint argued that a probationary term of seven years is appropriate in this case, with conditions including all standard terms plus requiring that respondent enroll in and complete courses in the following areas: education, prescribing, medical record keeping, ethics, professional boundaries, and clinical competence. Complaint also argued the terms of probation should require respondent be supervised by a practice monitor, prohibited from having a solo practice, and required to have a chaperone when treating female patients.

66. Respondent argued that complainant failed to meet her burden to prove many of the allegations in the First Amended Accusation including: failure to assess Patient A within 72 hours of admission to the nursing home, failure to assess and treat Patient A's foot, failure to document the WBC changes for Patient B, failure to timely assess Patient B, failure to address clinical deterioration in Patient C, failure to manage Patient D's DKA appropriately, failure to communicate or document communication with Patient F's daughter regarding why a gastroenterologist had not seen Patient F, and failure to deviate from the standard of care for Patient G. With regard to the medical record documentation issue, respondent argued that he had issues with computers and with EMR as many physicians did, and his lack of knowledge regarding EMR caused his problems. Respondent argued his lapses in medical record keeping were only simple departures from the standard of care and have since been addressed in his practice. Respondent argued that while some discipline may be appropriate in this case given the medical record lapses, public safety is not at risk, and a probationary term is unjust and unwarranted, and a public reprimand would be more appropriate.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. Complainant bears the burden of proof of establishing that the charges in the accusation and petition to revoke probation are true.

2. With respect to the accusation portion of the pleadings, the standard of proof required is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The obligation to establish charges by clear and convincing evidence is a heavy burden. It requires a finding of high probability; it is evidence so clear as to leave no substantial doubt, or sufficiently strong evidence to

command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

The Physician-Patient Relationship

3. "There is no other profession in which one passes so completely within the power and control of another as does the medical patient." (*Fuller v. Bd. Of Medical Examiners* (1936) 14, Cal.App. 2d 734, 741.) The physician-patient relationship is built on trust. (*Shea v. Bd. of Medical Examiners* (1978) 81 Cal.App.3d 564, 578.)

4. Because the main purpose of license discipline is to protect the public, patient harm is not required before the board can impose discipline. It is far more desirable to impose discipline on a physician before there is patient harm than after harm has occurred. Prevention of future harm is part of public protection. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 772-773.)

Applicable Disciplinary Statutes

5. Business and Professions Code section 2227 provides as follows:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> > (1) Have his or her license revoked upon order of the board.
> >
> > (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
> >
> > (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
> >
> > (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
> >
> > (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

6. Under Business and Professions Code section 2234, the board shall take action against a licensee charged with unprofessional conduct. Grounds for unprofessional conduct include, but are not limited to, gross negligence (subdivision (b)), repeated negligent acts (subdivision (c)), and incompetence (subdivision (d)).

7. It is also unprofessional conduct for a physician and surgeon to fail to maintain adequate and accurate records relating to the provision of services to his or her patients. (Bus. & Prof. Code, § 2266.)

The Standard of Care, Gross Negligence, and Ordinary Negligence

8. Medical providers must exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances. (*Powell v. Kleinman* (2007) 151 Cal.App.4th 112, 122.) Because the standard of care is a matter peculiarly within the knowledge of experts, expert testimony is required to prove or disprove that a medical practitioner acted within the standard of care unless negligence is obvious to a layperson. (*Johnson v. Superior Court* (2006) 143 Cal.App.4th 297, 305.)

9. "Gross negligence" long has been defined in California as either a "want of even scant care" or "an extreme departure from the ordinary standard of conduct." (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 195-198; *City of Santa Barbara v. Superior Court* (2007) 41 Cal.4th 747, 753-754.)

10. Ordinary or simple negligence has been defined as a departure from the standard of care. It is a "remissness in discharging known duties." (*Keen v. Prisinzano* (1972) 23 Cal.App.3d 275, 279; *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1055-1056.)

11. Repeated negligent acts mean one or more negligent acts; it does not require a "pattern" of negligent acts or similar negligent acts to be considered repeated. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468.)

12. Incompetence generally refers to an absence of qualification, ability or fitness to perform a specific professional function or duty. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040; *Pollack v. Kinder* (1978) 85 Cal.App.3d 833.)

13. A physician's failure to complete or maintain patient records can constitute gross or simple negligence, depending on the circumstances. (*Kearl v. Board of Medical Quality Assurance, supra, at pp.* 1054.)

Evaluation

14. The primary purpose of disciplinary action is to protect the public. (Bus. & Prof. Code, § 2229, subd. (a).) The Medical Practice Act emphasizes that the board should "seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies." (Bus. & Prof. Code, § 2229, subd. (c).) However, "[w]here rehabilitation and protection are inconsistent, protection shall be paramount." (Bus. & Prof. Code, § 2229, subd. (c).)

GENERAL UNPROFESSIONAL CONDUCT

15. Complainant alleged respondent engaged in general unprofessional conduct with regard to two incidents of inappropriate touching, one in October 2010 and the other in January 2014. The issue of whether respondent inappropriately touched Ms. Horowitz's breast and Ms. Miller's breast turns upon the credibility of the witnesses. Two credible witnesses testified that respondent inappropriately touched Ms. Miller's breast in January 2014. One credible witness testified that respondent inappropriately touched Ms. Horowitz's breast in October 2010.

During her testimony Ms. Horowitz answered questions directly and without hesitation or exaggeration. Ms. Horowitz's demeanor and manner while testifying were consistent with telling the truth. The character and quality of her testimony was more compelling that that provided by respondent. Ms. Horowitz recalled and testified about a great number of details, and she had no interest in the outcome of this accusation.

During her testimony Ms. Miller also answered questions directly and without hesitation or exaggeration. Ms. Miller's demeanor and manner while testifying were consistent with telling the truth. Her testimony that respondent intentionally touched her breast in January 2014 was supported by the testimony of her supervisor, Ms. Coleman. Ms. Coleman observed respondent put his hand on Ms. Miller's breast and keep it there for a matter of seconds. Ms. Coleman also observed Ms. Miller after the incident, and they both reported the incident within 15 minutes of its occurrence. The testimony of both of those individuals was forthright, direct and credible. As it is well established, the testimony of one credible witness may constitute substantial evidence. (*In re Frederick G.* (1979) 96 Cal.App.3d 353, 365 cert. den. 100 S.Ct. 2150; *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052-1053.) In this case Ms. Miller was a credible witness testifying that respondent inappropriately touched her breast, and another credible witnesses supported that testimony by stating that she saw respondent inappropriately touch Ms. Miller's breast.

By comparison, respondent has a stake in the outcome of this accusation because any discipline placed on his license can affect his employment. Respondent's recollection of one incident where he was standing behind Ms. Horowtiz and she got up from her chair abruptly but he did not touch her breast, was less credible than Ms. Horowitz's testimony regarding the October 2010 incident. Respondent's testimony that at the time he hugged Ms. Miller he only touched her with his shoulder was less believable than Ms. Miller and Ms. Coleman's version of events. Respondent's testimony regarding both the October 2010 incident and the January 2014 incident is simply less credible than the testimony of Ms. Horowitz, Ms. Miller, and Ms. Coleman.

GROSS NEGLIGENCE

16. Complainant alleged respondent committed gross negligence in his treatment and documentation for Patient A and Patient B. Complainant's expert, Dr. Hoxie, provided expert testimony regarding respondent's treatment and medical documentation related to Patient A, and his testimony was credible. The opinions of respondent's expert, Dr. Marco, regarding Patient A were excluded pursuant to Business and Professional Code section 2334 for failure to provide his opinions in his expert report. Additionally, Dr. Marco testified he wrote his expert report prior to receiving and reviewing the medical records for Patient A. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.) With regard to complainant's allegation that respondent failed to assess and or document his assessment of Patient A's decision-making capacity, Dr. Hoxie testified the medical record showed Patient A was deaf and severely demented to the extent that assessment of his mental capacity would be impossible, and that Patient A's daughter was responsible for medical decisions for Patient A. Dr. Hoxie also testified that respondent's failure to provide any information in the medical record showing how he assessed the mental capacity of Patient A, as well as his contradictory and summary conclusion that Patient A understood his condition and had decision making authority, which negated his daughter's authorization for medical decision-making for Patient A, was an extreme departure from the standard of care. Dr. Hoxie's testimony in this regard was more credible than that of respondent's.

17. With regard to the allegation that respondent failed to assess or document his assessment of Patient A's left foot and toe, Dr. Hoxie testified credibly that there was no indication in Patient A's medical records showing any assessment or treatment plan for Patient A. While there was documentation regarding orders for treatment, including IV antibiotics, there was no documentation regarding his assessment and plan. Respondent testified that he had assessed the left foot and toe, but admitted that assessment was not documented in Patient A's medical record. While it appears respondent actually assessed Patient A's foot and toe at some point, he failed to document his assessment in the medical records. Dr. Hoxie testified that respondent's failure to document his assessment of Patient A's foot and toe in the H & P and in two progress notes, was an extreme departure from the standard of care, particularly because these were the conditions for Patient A was in the

nursing home. Dr. Hoxie's testimony concerning Patient A was more credible than that of respondent's.

18. With regard to complainant's allegations that respondent failed to timely sign over a week's worth of progress notes related to his treatment of Patient B, one of which was ten days late, Dr. Canning testified respondent's failure to do so constituted an extreme departure from the standard of care because it was over a week's worth of progress notes and they were late by up to 10 days. She testified that his failure deprived other medical care providers of important medical information. Dr. Marco's opinions regarding Patient B were excluded pursuant to Business and Professions Code section 2334. Respondent admitted he signed more than one weeks' progress notes later than the required 24-hour time period. However, respondent argued that his failure to do so was the result of his lack of understanding of EMR. Dr. Canning's testimony in this regard was more credible than that of respondents.

19. With regard to complainant's allegation that respondent failed to document the increase in WBC for Patient B, the parties stipulated that the daily progress notes for Patient B, as shown in Exhibit L, documented a daily WBC count for Patient B in each daily entry. Accordingly, complainant failed to establish this allegation.

REPEATED NEGLIGENT ACTS

20. Complainant alleged respondent committed repeated negligent acts with regard to his treatment and documentation of Patient A, B, C, D, E, F, G, H, I, J, and K. Complainant alleged the same allegations for Patient A and B as that alleged for gross negligence, as well as one additional allegation for Patient A. Specifically, with regard to Patient A complaint alleged respondent committed repeated negligent acts by failing to visit Patient A within 72 hours of his admission to Castle Manor. Dr. Hoxie testified that the medical record did not contain enough information to know exactly when respondent first visited Patient A in Castle Manor. Accordingly, his conclusion that respondent did not visit Patient A within that 72-hour time frame is not supported by evidence. Accordingly, complaint failed to establish this allegation.

21. With regard to Patient C, complainant alleged respondent failed to timely document and/or maintained inadequate or incomplete medical records related to the treatment of Patient C. Dr. Canning testified Patient C developed a difficulty in swallowing after she was admitted to the hospital and a rapid response team was called for consultation in the middle of the night because of an acute, significant clinical change showing her status was deteriorating. Dr. Canning opined respondent failed to document the clinical deterioration or a plan to deal with it in Patient C's medical record and erroneously documented that Patient C was awake and alert and able to give information for a review of systems despite the fact that she was in ICU, sedated and intubated. Respondent's expert Dr. Marco testified respondent properly documented his assessment of Patient C and her deterioration. Dr. Marco stated he disagreed with complainant's assertion that respondent provided inaccurate or confliction information in Patient C's H & P that she was awake and

alert and able to give information for a review of systems when she was intubated and sedated at the time as he opined that it was possible for respondent to get the information he reported despite the fact that Patient C was sedated and intubated. Dr. Marco admitted that it is important for physicians to ensure correct information in the medical record. Dr. Canning's testimony in this regard was more credible than that of Dr. Marcos. Respondent also admitted to failing to sign two progress reports for Patient C within the required 24-hour period.

22. With regard to Patient D, complainant alleged respondent was incompetent in his treatment of Patient D's DKA. However, complainant did not specifically allege repeated negligent acts with regard to the treatment of Patient D in the First Amended Accusation other than listing Patient D in the list of patients in the preamble of paragraph 34 of the First Amended Accusation. Accordingly, complainant failed to establish repeated negligent acts with regard to Patient D.

23. Complainant also alleged respondent failed to sign or complete his progress notes for Patient E until after Patient E's death. Respondent stipulated to the truth and accuracy of this allegation. Dr. Marco also admitted during his testimony that respondent's failure to complete the progress note until after the death of Patient E was a simple departure from the standard of care.

24. With regard to Patient F, complainant alleged respondent failed to timely sign and complete one progress note within the required 24 hours and alleged this was a simple departure from the standard of care. Respondent admitted he failed to complete the progress note within the required 24 hours. Complainant also alleged respondent failed to properly communicate or document his communication with Patient F's daughter the reasons why a gastroenterologist had not seen Patient F within three to four days of Patient F's admission. While there was no documentation in the medical record regarding respondent's communication with Patient F's daughter, respondent and Dr. Marco testified that at least one gastroenterologist was consulted for Patient F during her hospital stay. Respondent testified he had multiple conversations with Patient F's daughter regarding the gastroenterologist issue, but did not document those discussions. Respondent's testimony regarding the content and circumstances of his discussions with Patient F's daughter was credible. On balance complainant failed to establish this allegation by clear and convincing evidence.

25. With regard to Patient G, complainant alleged respondent made a simple departure from the standard of care for failing to properly stabilize Patient G prior to transferring him from the ICU to nuclear medicine for a HIDA scan. Complainant's expert, Dr. Acheatel, testified that the standard of care in this situation requires that all attempts should be made to stabilize the patient before he or she is moved outside of the ICU for any reason, including any diagnostic tests, because it is not safe to send an unstable patient outside of the ICU. Dr. Acheatel opined that this was an error in judgment on the part of respondent and accordingly, it is a simple departure from the standard of care. Respondent's expert, Dr. Marco, testified that because Patient G was critically ill, and surgery had to be

done emergently, there was "no time to stabilize" Patient G before sending him for the HIDA scan. Both experts agreed that information from the HIDA scan was needed and getting the HIDA scan was appropriate. However, Dr. Acheatel testified that sending a critically ill patient outside of ICU to a location in the hospital without similar resources without first stabilizing his breathing is very dangerous. Dr. Acheatel's testimony in this regard was more credible than that of Dr. Marcos.

26. With regard to Patients H, I, J, and K, respondent admitted that he failed to dictate an H & P for each of these patients within 24 hours after their admission to the hospital as required under the standard of care.

INCOMPETENCE

27. Complainant alleged respondent was incompetent in his treatment and care of Patient C and Patient D. With regard to Patient C, complainant alleged respondent displayed a lack of knowledge by ordering Ativan for Patient C as a pre-medication for the MRI despite the fact that doing so was contraindicated for a patient with declining neurologic function. Dr. Canning testified the medical record showed Patient C was having difficulty breathing and swallowing at the time respondent gave her Ativan and the risk of giving her Ativan far outweighed any benefits in light of Patient C's respiratory problems. In contrast, Dr. Marco testified that respondent's prescribing Ativan to Patient C for her agitation is a relative contraindication and, in this factual set of circumstances, the benefits outweighed the risks. However, the medical record contained no information to indicate Patient C was agitated prior to the MRI. Dr. Marco also admitted that he did not review the medical literature regarding contraindications and precautions in the prescription of Ativan in preparation for giving his expert opinions in this matter, despite his notation in his expert report otherwise. Dr. Canning's testimony in this regard was more credible than that of Dr. Marcos. Respondent demonstrated a lack of knowledge of the contraindications of Ativan for a patient with signs of clinical decline and difficulty breathing and managing secretions, particularly when laying down as she would do for an MRI.

28. Complainant also alleged respondent was incompetent because he displayed a lack of knowledge in his management and diagnosis of Patient D's DKA. Dr. Canning testified that, upon admission to the hospital, Patient D had an anion gap of 28 indicating DKA and Patient D's blood-glucose level increased dramatically over the next day. Dr. Canning stated although respondent did treat Patient D with a long-acting insulin and the next day a short-acting insulin, his H & P was devoid of any discussion of DKA, it was unclear whether he recognized DKA as an issue, and he failed to treat Patient D appropriately for the DKA, which requires treatment with a short-acting insulin and fluids immediately which was not given until the next day. In comparison, Dr. Marco testified that there was no evaluation of whether ketones were present in Patient D's urine or blood and no recording of the PH of her blood to show it was acidic and she had DKA at the time she was admitted. However, Dr. Marco never addressed that Patient D had an anion gap of 28 upon admission showing acidosis. Additionally, Dr. Marco opined respondent took appropriate steps to address Patient D's condition by giving her Lantis (long-acting) insulin. Dr.

Canning's testimony in this regard was more credible than that of Dr. Marcos. Respondent demonstrated a lack of knowledge in the recognition or treatment of DKA for Patient D.

FAILURE TO MAINTAIN ADEQUATE AND ACCURATE RECORDS

29. Complainant alleged respondent failed to maintain adequate and accurate records for Patients A, B, C, E, F, H, I, J, and K. With regard to Patients A and B respondent's failure to maintain adequate medical records was an extreme departure from the standard of care as discussed above. With regard to Patients C, E, and F, respondent admitted to failing to timely sign progress notes for these patients, which Dr. Canning opined was a simple departure from the standard of care. With regard to Patients H, I, J, and K, respondent again admitted to failing to dictate timely H & P's for these patients, which Dr. Acheatel opined was a simple departure from the standard of care. While respondent argued that his failure to maintain adequate and accurate records was the result of his misunderstanding of EMR, his failure still deviated from the standard of care.

Cause Exists to Impose Discipline on Respondent's License

30. Cause exists under Business and Professions Code section 2234, subdivision (b), to impose discipline. Clear and convincing evidence established that respondent engaged in gross negligence with respect to his care and treatment of Patient A for failing to adequately or accurately assess or document Patient A's decision-making capacity. Clear and convincing evidence established that respondent failed to adequately document an assessment of Patient A's left foot and toe. Clear and convincing evidence established respondent failed to document a complete H & P examination of Patient A and failed to include an assessment and plan for the treatment of Patient A's foot and toe in his two progress notes. Additionally, clear and convincing evidence established respondent failed to sign multiple progress notes for Patient B in a timely manner. Clear and convincing evidence did not establish respondent failed to document Patient B's increasing WBC count.

31. Cause exists under Business and Professions Code section 2234, subdivision (c), to impose discipline. Clear and convincing evidence established that respondent engaged in repeated acts of negligence with respect to Patients A, B, C, E, F, G, H, I, J, and K. Clear and convincing evidence established respondent committed gross negligence with regard to Patients A and B as discussed. Clear and convincing evidence established respondent failed to timely document an H & P for Patient C and failed to adequately document a reassessment of Patient C as her condition was deteriorating. Clear and convincing evidence established respondent failed to timely complete progress notes for Patients E and F, and failed to timely dictate an H & P for Patients H, I, J, and K. Clear and convincing evidence established respondent failed to properly stabilize Patient G prior to transferring him from the ICU to nuclear medicine for a HIDA scan. Clear and convincing evidence did not establish respondent failed to visit Patient A within 72 hours after he was admitted to Castle Manor. Clear and convincing evidence did not establish respondent failed to communicate or document communication with Patient F's daughter regarding why a gastroenterologist had not seen Patient F within three or four days.

32. Cause exists under Business and Professions Code section 2234, subdivision (d), to impose discipline. Clear and convincing evidence established that respondent lacked necessary knowledge and was incompetent in his treatment of Patients C and D due to his lack of knowledge demonstrated by use of Ativan as a premedication for Patient C prior to an MRI scan when it was contraindicated, and for his lack of knowledge in the management of Patient D's DKA.

33. Cause exists under Business and Professions Code section 2266, subdivision (c), to impose discipline. Clear and convincing evidence established that respondent maintained inadequate or inaccurate medical records with respect to Patients A, B, C, E, F, H, I, J, and K, by failing to adequately document if and how he assessed Patient A's decision-making capacity; failing to document an assessment or re-assessment of Patient A's foot and toe; failing to document a complete H & P for Patient A and failing to document an assessment and treatment plan for Patient A; failing to timely sign multiple progress notes for Patient B; failing to timely document an H & P for Patient C; failing to document a reassessment of Patient C after she showed signs of clinical decline; failing to timely document progress notes for Patient E and F; and failing to timely dictate an H & P for Patients H, I, J, and K.

34. Cause exists under Business and Professions Code section 2234 to impose discipline. Clear and convincing evidence established that respondent engaged in general unprofessional conduct with respect to his inappropriate touching of Ms. Horowitz in October 2010, and inappropriate touching of Ms. Miller in January 2014.

Application of Disciplinary Guidelines

35. California Code of Regulations, title 16, section 1361, provides that when reaching a decision on a disciplinary action, the board must consider and apply the "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (12th Edition/2016). Under the Guidelines, the board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the board and proposed settlements submitted to the board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

36. Under the Disciplinary Guidelines, the minimum discipline for gross negligence, repeated negligence, incompetence and failure to maintain adequate medical records is a stayed revocation for five years. The maximum discipline is revocation. Among the conditions of probation, the guidelines recommend an education course, medical record keeping course, professionalism program (ethics course), clinical competence assessment program, a practice monitor, and solo practice prohibition.

37. Respondent has had no history of prior discipline and has a long history of providing competent medical care in a very busy practice. He has had a good reputation in the community and as a physician. Dr. Valderrama practices in his community and praised respondent's professionalism, work ethic and quality of patient care. Respondent has taken steps to address his issues with medical record documentation by completing the PACE medical records course. Additionally, he has taken a professional boundaries course with PACE. Respondent is encouraged to continue his efforts in this regard. However, upon consideration of all the evidence in this matter, public protection dictates that a probationary period with appropriate terms and conditions is the appropriate discipline under these circumstances.

38. Respondent has practiced medicine for over 30 years. However, the absence of meaningful introspection and continued denial regarding the inappropriate touching incidents vitiates any claim that he has a clear understanding of his deficiencies so as to indicate that reoccurrence is unlikely. Additionally, his multiple incidents of deficiencies in his medical record keeping is concerning, particularly as he did have some training in EMR and had access to further EMR training. His lack of knowledge regarding the issues for Patient C, and D, and his repeated negligent acts involving multiple patients raises serious concerns for public safety. Under these circumstances a public reprimand is not appropriate.

39. The public will be protected by placing respondent's certificate on probation for five years, with requirements that he complete certain educational, prescribing practices, medical record keeping, and ethics courses; he complete a professional boundaries program and a clinical competence assessment program; he be subject to a supervision requirement; be prohibited from having a solo practice; and that he be required to have a third party chaperone when he treats female patients. The additional optional conditions recommended in the guidelines including prohibited practice are not appropriate for the circumstances of this case and are therefore not required for public protection. The probation requirements imposed are designed to remediate respondent's deficiencies and ensure that he practices in a safe and professional manner.

ORDER

IT IS HEREBY ORDERED that respondent's Physician's and Surgeon's Certificate, No. A 38504 is revoked. However, the revocation is stayed, and respondent is placed on probation for five years from the effective date of this Decision on the following terms and conditions:

1. 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. 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 provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices 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.

3. 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 approved in advance by the board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course no later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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.

4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program 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 program would have been approved by the board or its designee had the program 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 program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. PROFESSIONAL BOUNDARIES PROGRAM. Within 60 calendar days from the effective date of this Decision, respondent shall enroll in a professional boundaries program approved in advance by the board or its designee. Respondent, at the program's discretion, shall undergo and complete the program's assessment of respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24-hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the Decision(s), Accusation(s) and any other information that the board or its designee deems relevant. The program shall evaluate respondent at the end of the training and the program shall provide any data from the assessment and training as well as the results of the evaluation to the board or its designee.

Failure to complete the entire program not later than six (6) months after respondent's initial enrollment shall constitute a violation of probation unless the board or its designee agrees in writing to a later time for completion. Based on respondent's performance in and evaluations from the assessment, education, and training, the program shall advise the board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that respondent can practice medicine safely. Respondent shall comply with program recommendations. At the completion of the program, respondent shall submit to a final evaluation. The program shall provide the results

of the evaluation to the board or its designee. The professional boundaries program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

The program has the authority to determine whether or not respondent successfully completed the program.

A professional boundaries 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.

6. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence assessment program approved in advance by the board or its designee. Respondent shall successfully complete the program not later than six (6) months after respondent's initial enrollment unless the board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the board or its designee deems relevant. The program shall require respondent's on-site participation for a minimum of 3 and no more than 5 days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the clinical competence assessment, the program will advise the board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, respondent shall receive

a notification from the board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the respondent did not successfully complete the clinical competence assessment program, the respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

7. MONITORING – PRACTICE. Within 30 calendar days of the effective date of this Decision, respondent shall submit to the board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely. It shall be the sole responsibility of respondent to ensure that the

monitor submits the quarterly written reports to the board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

8. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the respondent's practice setting changes and the respondent is no longer practicing in a setting in compliance with this Decision, the respondent shall notify the board or its designee within 5 calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

9. THIRD PARTY CHAPERONE. During probation, respondent shall have a third party chaperone present while consulting, examining or treating female patients. Respondent shall, within 30 calendar days of the effective date of the Decision, submit to the board or its designee for prior approval name(s) of persons who will act as the third party chaperone.

If respondent fails to obtain approval of a third party chaperone within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a chaperone is approved to provide monitoring responsibility.

Each third party chaperone shall sign (in ink or electronically) and date each patient medical record at the time the chaperone's services are provided. Each third party chaperone shall read the Decision(s) and the Accusation(s), and fully understand the role of the third party chaperone.

Respondent shall maintain a log of all patients seen for whom a third party chaperone is required. The log shall contain the: 1) patient initials, address and telephone number; 2) medical record number; and 3) date of service. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the board or its designee, and shall retain the log for the entire term of probation.

Respondent is prohibited from terminating employment of a board-approved third party chaperone solely because that person provided information as required to the board or its designee.

If the third party chaperone resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the board or its designee, for prior approval, the name of the person(s) who will act as the third party chaperone. If respondent fails to obtain approval of a replacement chaperone within 30 calendar days of the resignation or unavailability of the chaperone, respondent shall receive a notification from the board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement chaperone is approved and assumes monitoring responsibility.

10. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and 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.

11. SUPERVISION OF PHYSICAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

12. 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.

13. 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.

14. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit. Respondent shall comply with the board's probation unit and all terms and conditions of this decision.

Address Changes. Respondent shall, at all times, keep the board informed of respondent's business and residence addresses, email address (if available), and telephone number. 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(b).

Place of Practice. Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California. 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 thirty (30) calendar days.

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.

15. 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 or without prior notice throughout the term of probation.

16. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the board or its designee in writing within 15 calendar days of any periods of non-practice

lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of 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; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

17. 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, 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.

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

19. 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.

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

DATED: October 17, 2018

DocuSigned by:
Debra Nye-Perkins
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DEBRA D. NYE-PERKINS
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Feb. 7 20 18
BY _____ ANALYST

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

In the Matter of the First Amended Accusation Against: **Carlos Tinoco DeCarvalho, M.D.** **340 Fourth Ave., Suite 11** **Chula Vista, CA 91910** **Physician's and Surgeon's Certificate No. A 38504,** Respondent.	Case No. 800-2014-007952 OAH No. 2017090679 **FIRST AMENDED A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about June 14, 1982, the Medical Board issued Physician's and Surgeon's Certificate Number A 38504 to Carlos Tinoco DeCarvalho, 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 December 31, 2019, unless renewed.

JURISDICTION

3. This First Amended Accusation, which supersedes Accusation No. 800-2014-007952, filed on August 29, 2017, in the above-entitled matter, is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code states, in pertinent part:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the division, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

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5. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

"..."

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. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. A38504 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in his care and treatment of Patient A[1] and Patient B, as more particularly alleged hereinafter:

Patient A

9. Patient A was an eighty-eight (88) year-old male who was admitted to Scripps Mercy Hospital in Chula Vista (Scripps Hospital) on March 23, 2015, because his left foot had become infected. The admission report dictated by G.B., M.D., stated that "He [Patient A] is deaf and severely demented." It also stated, "I am unable to obtain an accurate family history," and "I am unable to obtain an accurate review of systems given the patient's mental status." In the physical examination section, G.B., M.D. documented "His [Patient A's] left forefoot is erythematous[2] with induration[3] and his [Patient A's] left great toe does have scabbed areas . . . His [Patient A's] left 5th toe has dry gangrene[4]." Diagnostic studies showed that Patient A had osteomyelitis[5] of his left foot and he was treated with intravenous antibiotics at Scripps Hospital.

10. On or about March 28, 2015, Patient A was transferred to Castle Manor Nursing & Rehabilitative Center (Castle Nursing Center) so that he could continue to receive intravenous antibiotics for the treatment of osteomyelitis of his left foot. Respondent did not visit Patient A within seventy-two (72) hours of his admission to Castle Nursing Center.

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[1] References to "Patient A" and "Patient B" are used to protect patient privacy.

[2] Erythema is redness of the skin usually occurring in patches, caused by irritation or injury to the tissue.

[3] Induration is an increase in fibrous elements in tissue commonly associated with inflammation and marked by loss of elasticity and pliability.

[4] Gangrene refers to the death of body tissue due to either a lack of blood flow or a serious bacterial infection.

[5] Osteomyelitis is an infection of the bone, a rare but serious condition.

11. On or about March 31, 2015, on the admission history and physical examination form, Respondent wrote, "See Hosp. H & P." Respondent also wrote that Patient A understood his condition and had the capacity to make decisions. Respondent failed to document how he reached this conclusion, especially in light of the fact that "See Hosp. H & P" referred to the history and physical examination completed at Scripps Mercy Hospital five days prior to Patient A's admission to the Castle Nursing Center, which is replete with evidence that Patient A is deaf, demented, and unable to provide an accurate history. There was no documentation of an examination of Patient A's left foot and the remainder of the form was blank. Respondent also wrote a progress note, but he neither documented the results of a physical examination nor an assessment and plan for the treatment of Patient A's osteomyelitis and gangrene of his left foot.

12. On or about April 6, 2015, Respondent wrote another progress note regarding Patient A. Respondent neither documented the results of a physical examination nor an assessment and plan for the treatment of Patient A's osteomyelitis and gangrene of his left foot.

13. On or about April 15, 2015, Patient A was transferred to Sharp Chula Vista Medical Center because the infection and gangrene of his left foot had worsened.

14. On or about April 22, 2015, Patient A underwent a left above-the-knee amputation to prevent the progression of his infection.

15. On or about May 2, 2015, Patient A expired from multiple organ failure.

Patient B

16. On or about August 3, 2015, Patient B was admitted to Sharp Chula Vista Hospital (Sharp Hospital) for peritonitis.[6] Respondent was asked to evaluate, consult, and admit Patient B. On August 9, 2015, Patient B's White Blood Cell (WBC)[7] count was 17,800. Over the next day, Patient B's WBC count increased to 27,700, indicating a possible infection. Respondent did not document this increase in Patient B's WBC count in Patient B's Progress Notes.

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[6] Peritonitis is inflammation of the peritoneum, a silk-like membrane that lines your inner abdominal wall and covers the organs within the abdomen, usually due to a bacterial or fungal infection.

[7] White Blood Cells (WBCs) also called leukocytes, are an important part of the immune system. These cells help fight infections by attacking bacteria, viruses, and germs that invade the body.

17. On or about August 14, 2015, Respondent officially signed Respondent's Progress Notes on Patient B dated from August 4, 2015 through August 13, 2015.

18. Respondent committed gross negligence in his care and treatment of Patient A and Patient B, which included, but was not limited to, the following:

(a) Respondent failed to adequately and/or accurately assess Patient A's decision-making capacity and/or failed to document how Respondent reached the conclusion that Patient A had the capacity to make decisions in light of contrary medical records;

(b) Respondent failed to assess and/or failed to document having assessed Patient A's left foot;

(c) Respondent failed to document a complete admission history and physical examination of Patient A and/or failed to include an assessment and plan in the two progress notes Respondent wrote on Patient A regarding the primary problem which required Patient A's admission to Castle Nursing Center; and

(d) Respondent failed to officially sign Respondent's Progress Notes on Patient B in a timely manner and/or failed to document Patient B's increase in WBC count, which indicated a possible infection.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

19. Respondent has subjected his Physician's and Surgeon's Certificate No. A38504 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A[8], Patient B, Patient C, Patient D, Patient E, Patient F, Patient G, Patient H, Patient I, Patient J, and Patient K, as more particularly alleged hereinafter:

20. Paragraphs 8 through 18 above, are hereby incorporated by reference and realleged as if fully set forth herein.

Patient C

21. Patient C had a history of a prior stroke involving left weakness, diabetes, and hypertension. On or about September 8, 2015, Patient C was admitted to Sharp Hospital in Chula Vista (Sharp Hospital) for hypertensive urgency with nausea, vomiting, and dizziness. Initial CT Scan of the head showed only the old stroke and nothing new. On admission, Patient C was awake and alert with old left sided weakness noted. Over the course of next twenty-four (24) hours, Patient C developed progressive dysphagia[9] and at some point, right sided weakness. Patient C was ordered an MRI to look for signs of a stroke. Respondent ordered Ativan[10] as a premedication for the MRI, which generally is contraindicated for a patient with declining neurologic function. Patient C then suffered a code blue[11]. Patient C was resuscitated and sent to the Intensive Care Unit (ICU).

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[8] References are made to Patient A ~ Patient K, in order to protect patient privacy.

[9] Dysphagia refers to having pain and/or being unable to swallow.

[10] Ativan is a medication [sedative] used to treat anxiety.

[11] Code blue refers to an emergency situation announced in a hospital or institution in which a patient is in cardiopulmonary arrest, requiring a team of providers to rush to the specific location and begin immediate resuscitative efforts.

22. Respondent did not document Patient C's history and physical examination until a day later. Respondent failed to sign his Progress Notes on Patient C covering the dates from September 9, 2015 through September 12, 2015 within the same day of each Progress Note. There were discrepancies within Respondent's Progress Notes on Patient C such as whether Patient C was awake, alert, and able to provide ROS.[12]

23. Respondent failed to adequately reassess and/or failed to fully document his adequate reassessment of Patient C, when Patient C showed signs of clinical deterioration.

Patient D

24. On or about September 18, 2015, Patient D was admitted to Sharp Hospital with DKA[13], associated with possible gastroparesis[14] and presented with nausea and vomiting, having stopped her insulin. Patient D had a history of Type 1 diabetes with multiple complications, including end stage renal disease on dialysis.

25. Patient D had a blood sugar level greater than 600 mg/dl and anion gap acidosis[15] greater than 30, whereas a normal level is less than 14. Patient D received IV insulin in the Emergency Room (ER) but this was not continued after her admission. Respondent ordered long acting Lantus® insulin and an insulin sliding scale.[16] Patient D did not receive her evening Lantus insulin in the ER on the same day of admission and Patient D continued to have an elevated anion gap by the next morning. On the next day, Respondent consulted diabetes nurse practitioner for help with diabetes management. In the documentation, Respondent stated "r/o

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[12] ROS refers to a Review of Systems, a technique used by healthcare providers for eliciting medical history from a patient.

[13] DKA, also known as Diabetic ketoacidosis is a serious complication of diabetes that occurs when your body produces high levels of blood acids called ketones. The condition develops when your body can't produce enough insulin.

[14] Gastroparesis is a condition that affects the normal spontaneous movement of the muscles in your stomach.

[15] Anion gap is the difference between the measured cations (positively charged ions) and the measured anions (negatively charged ions) in serum, plasma, or urine.

[16] Sliding scale refers to the progressive increase in pre-meal or night time insulin dose, based on pre-defined blood glucose ranges.

[rule out] DKA" despite the fact that all labs, symptoms, and metrics indicated that DKA was the accurate diagnosis.

Patient E

26. On or about June 19, 2015, Patient E was admitted to Sharp Hospital for a hip fracture with a prior history of multiple myeloma[17], coronary artery disease, cardiomyopathy[18], peripheral vascular disease[19], diabetes, and atrial fibrillation[20]. On or about June 21, 2015, Patient E was taken to the operating room. Patient E's post-operation course was complicated and she suffered a code blue on June 25, 2015. After about a day in the ICU, Patient E was critically ill with prolonged CPR[21] and Patient E's family opted DNR[22] and comfort care, after which Patient E soon expired.

27. Respondent failed to sign and/or complete his Progress Notes on Patient E, until after Patient E's death.

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[17] Multiple myeloma is a cancer formed by malignant plasma cells.

[18] Cardiomyopathy refers to diseases of the heart muscle.

[19] Peripheral artery disease is a blood circulation disorder that causes the blood vessels outside of your heart and brain to narrow, block, or spasm.

[20] Atrial Fibrillation is a quivering, or irregular heartbeat that can lead to blood clots, stroke, heart failure and other heart-related problems.

[21] CPR stands for cardiopulmonary resuscitation, an emergency procedure for a person whose heart has stopped or is no longer breathing.

[22] DNR (Do not resuscitate) is a medical order which instructs health care providers not to perform cardiopulmonary resuscitation (CPR) if a patient's breathing stops or if the patient's heart stops beating.

Patient F

28. On or about May 14, 2015, Patient F was admitted to Sharp Hospital with a history of stroke, hypertension, diabetes, and a biliary stent.[23] Patient F was admitted for sepsis.[24] Patient F was scheduled to have the biliary stent removed, but was instead sent to the ER due to fever and diarrhea. Patient F and family were upset that the gastroenterologist was not called to see Patient F within three to four days of Patient F's admission and that Patient F's stent was not removed during the hospital admission. Respondent failed to adequately communicate and/or failed to document adequate communication with Patient F and/or Patient F's family regarding the reason(s) why a gastroenterologist had not seen the Patient F within three to four days of Patient F's admission. On or about May 17, 2015, Respondent officially signed his Progress Notes on Patient F covering the dates of May 15, 2015, May 16, 2015, and May 17, 2015.

Patient G

29. On or about October 18, 2011, Patient G was admitted to Scripps Mercy Hospital in Chula Vista, California (Scripps Hospital) at around 6:30 a.m., with weakness, syncope[25], abdominal and chest pain. The admitting diagnosis was cholecystitis[26] and sepsis. Thereafter, Patient G had been complaining of abdominal pain and had a syncopal episode. Patient G was admitted to the Intensive Care Unit (ICU). The initial diagnosis was sepsis perhaps secondary to acute cholecystitis or pancreatitis[27]. Respondent ordered Patient G to be transferred from ICU to the radiology department for a HIDA scan[28] even though Patient G could not lie flat, was short of

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[23] A biliary metal stent is a flexible metallic tube specially designed to hold your bile duct open, which has been blocked or partially blocked.

[24] Sepsis is the presence of tissues of harmful bacteria and their toxins, typically through infection of a wound.

[25] Syncope, also known as "fainting" is a loss of consciousness and muscle strength characterized by a fast onset, short duration, and spontaneous recovery.

[26] Colecystitis is inflammation of the gallbladder.

[27] Pancreatitis is inflammation of the pancreas, a large organ behind the stomach that produces digestive enzymes and a number of hormones.

[28] A hepatobiliary (HIDA) scan is an imaging procedure used to diagnose problems of the liver, gallbladder, and bile ducts.

breath, and had a respiratory arrest[29] in the radiology department.

Patient H

30. On or about March 1, 2013, at approximately 2:00 p.m., Patient H was admitted to Scripps Hospital. At the time of Patient H's admission, Respondent did not dictate an admission History and Physical. Instead, Respondent dictated the History and Physical on March 3, 2013 at 7:02 p.m., approximately forty (40) hours after the initial visit.

Patient I

31. Patient I was admitted to Scripps Hospital on February 9, 2014. Respondent dictated History and Physical of Patient I on February 11, 2014 at 6:00 a.m., approximately thirty-two (32) hours after Patient I's admission.

Patient J

32. Patient J was admitted to Scripps Hospital on February 8, 2014. Respondent did not dictate History and Physical of Patient J until February 10, 2014 at 5:35 a.m.

Patient K

33. Patient K was admitted to Scripps Hospital on May 9, 2014 and was seen by another doctor. Patient K then arrived on the floor on May 10, 2014 at 1:06 a.m., to be seen by Respondent. Respondent did not dictate History and Physical of Patient K until May 11, 2014 at 1:46 a.m.

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[29] Respiratory arrest is caused by apena (cessation of breathing) due to failure of the lungs to function effectively.

34. Respondent committed repeated negligent acts in his care and treatment of Patient A, Patient B, Patient C, Patient D, Patient E, Patient F, Patient G, Patient H, Patient I, Patient J, and Patient K, which included, but were not limited to, the following:

(a) Respondent failed to adequately and/or accurately assess Patient A's decision-making capacity and/or failed to document how Respondent reached the conclusion that Patient A had the capacity to make decisions in light of contrary medical records;

(b) Respondent failed to assess and/or failed to document having assessed Patient A's left foot;

(c) Respondent failed to document a complete admission history and physical examination of Patient A and/or failed to include an assessment and plan in the two progress notes Respondent wrote on Patient A regarding the primary problem which required Patient A's admission to Castle Nursing Center;

(d) Respondent failed to visit Patient A within 72 hours of Patient A's admission to Castle Nursing Center;

(e) Respondent failed to officially sign Respondent's Progress Notes on Patient B in a timely manner and/or failed to document Patient B's increase in WBC count, which indicated a possible infection;

(f) Respondent failed to timely document history and physical examination of Patient C and/or had inadequate and/or incomplete medical records related to his care and treatment of Patient C;

(g) Respondent failed to adequately reassess and/or failed to fully document his adequate reassessment of Patient C, as Patient C showed signs of clinical deterioration;

(h) Respondent failed to sign and/or complete his Progress Notes on Patient E, until after Patient E's death;

(i) Respondent did not timely complete his Progress Notes on Patient F;

(j) Respondent failed to adequately communicate and/or failed to document adequate communication with Patient F and/or Patient F's family regarding the reason(s) why a gastroenterologist had not seen the Patient F within three to four days of Patient F's admission;

(k) Respondent transferred Patient G from ICU to radiology department for the HIDA scan, even though Patient G was unstable;

(l) Respondent did not timely dictate history and physical examination of Patient H;

(m) Respondent did not timely dictate history and physical examination of Patient I;

(n) Respondent did not timely dictate history and physical examination of Patient J; and

(o) Respondent did not timely dictate history and physical examination of Patient K.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

35. Respondent has further subjected his Physician's and Surgeon's Certificate No. A38504 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he was incompetent in his care and treatment of Patient C and Patient D, as more particularly alleged hereinafter:

36. Paragraphs 21 through 25, above, are incorporated by reference and realleged as if fully set forth herein.

37. Respondent was incompetent in his care and treatment of Patient C and Patient D, including, but not limited to, the following:

(a) Respondent displayed a lack of knowledge by ordering Ativan for Patient C as a premedication for the MRI, despite the fact that doing so is contraindicated for a patient with declining neurologic function; and

(b) Respondent displayed a lack of knowledge in his management and diagnosis of Patient D's DKA.

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FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

38. Respondent has further subjected his Physician's and Surgeon's Certificate Number A38504 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records relating to his care and treatment of Patient A, Patient B, Patient C, Patient E, Patient F, Patient # 37, Patient # 51, Patient # 52, and Patient # 56, as more particularly alleged hereinafter.

39. Paragraphs 8 through 34, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

40. Respondent has further subjected his Physician's and Surgeon's Certificate No. A38504 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged hereinafter.

41. Paragraphs 8 through 39, above, which are hereby incorporated by reference as if fully set forth herein.

Inappropriate Touching Incident # 1

42. In or around late October 2010, at Scripps Hospital, at the Telemetry Unit, Respondent was alone with M.H. Respondent stood behind M.H., then touched one of her breasts, without her consent.

Inappropriate Touching Incident # 2

43. On or about January 16, 2014, while at Scripps Hospital, Respondent touched one of the breasts of C.M., without her consent.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 38504, issued to Carlos Tinoco DeCarvalho, M.D.;

2. Revoking, suspending or denying approval of Carlos Tinoco DeCarvalho, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Carlos Tinoco DeCarvalho, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: February 7, 2018

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