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

In the Matter of the First Amended Accusation Against:	)	
Arun Kumar Softa, M.D.	)	**Case No. 800-2015-012107**
Physician's and Surgeon's Certificate No. A 53661	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order 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 April 26, 2019.

IT IS SO ORDERED March 28, 2019.

MEDICAL BOARD OF CALIFORNIA

By: Kristina Lawson

Kristina D. Lawson, J.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **ARUN KUMAR SOFTA, M.D.** **Primecare Phys Med Group** **9900 Stockdale Hwy # 200** **Bakersfield, CA 93311** **Physician's and Surgeon's Certificate No. A 53661** Respondent.	Case No. 800-2015-012107 OAH No. 2018021076 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Michael C. Brummel, Deputy Attorney General.

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2. Respondent Arun Kumar Softa, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, Esq., whose address is: 5440 Trabuco Road Irvine, California 92620.

3. On or about October 26, 1994, the Board issued Physician's and Surgeon's Certificate No. A 53661 to Arun Kumar Softa, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2015-012107, and will expire on February 29, 2020, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2015-012107 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent. Respondent timely filed his Notice of Defense contesting the First Amended Accusation.

5. A copy of First Amended Accusation No. 800-2015-012107 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2015-012107. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent does not contest that, at an administrative hearing, complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2015-012107 and that he has thereby subjected his license to disciplinary action.

10. Respondent agrees that his Physician's and Surgeon's Certificate No. A 53661 is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

11. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

12. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

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DISCIPLINARY ORDER

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED that Respondent Arun Kumar Softa, M.D., Physician's and Surgeon's Certificate No. A 53661, shall be and is hereby Publicly Reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Respondent's medical record keeping and quality of care in the treatment of a single patient as set forth in Accusation No. 800-2015-012107, is as follows:

> This Public Reprimand is issued pursuant to Code section 2227 as a result of the allegations set forth in the First Amended Accusation, relating to the failure to maintain adequate and accurate records.

B. 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 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 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.

C. **FAILURE TO COMPLY**

Any failure by Respondent to comply with the terms and conditions of the Disciplinary Order set forth above shall constitute unprofessional conduct and grounds for further disciplinary action.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 11/29/2018

ARUN KUMAR SOFTA, M.D., *Respondent*

I have read and fully discussed with Respondent Arun Kumar Softa, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: November 29, 2018

RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

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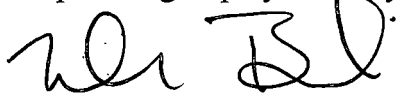
ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 11/29/2018

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General



MICHAEL C. BRUMMEL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2015-012107

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO NOV 28 2018
BY [illegible] ANALYST

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

In the Matter of the First Amended Accusation Against: **Arun Kumar Softa, M.D.** **Primecare Phys Med Group** **9900 Stockdale Hwy # 200** **Bakersfield, CA 93311** **Physician's and Surgeon's Certificate No. A 53661,** Respondent.	Case No. 800-2015-012107 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about October 26, 1994, the Medical Board issued Physician's and Surgeon's Certificate No. A 53661 to Arun Kumar Softa, 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 February 29, 2020, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code states:

"(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 provision 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."

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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:

". . .

"(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.

". . ."

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."

CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence)

7. Respondent has subjected his Physician's and Surgeon's License No. A 53661 to disciplinary action under section 2227, as defined by section 2234 (c), of the Code, in that he committed repeated negligent acts in the care and treatment of Patient A[1], as more particularly alleged hereafter.

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[1] The patient is not identified by name to protect her privacy.

8. On or about October 23, 2013, Patient A presented to Respondent for treatment as an eighty-two-year-old female patient seeking a new primary care physician. Respondent documented a normal physical examination with the exception of left side tenderness. Respondent documented a normal genitourinary examination with no signs of lesions, discharge or hernias. Respondent states that he ordered a mammogram for Patient A.

9. On or about November 9, 2013, Patient A missed a follow up appointment that was previously scheduled with Respondent.

10. On or about December 2, 2013, Patient A returned to Respondent complaining of back pain, requesting medication refills, and seeking a referral to a pain management specialist. Respondent documented a physical examination that included a genitourinary examination that was normal with no lesions, discharge or hernias.

11. On or about February 5, 2014, Patient A had a mammography performed under the orders from her prior primary care physician. The impression section of the test stated that there were "[n]o suspicious mammographic findings in either breast." The comments section cautioned that breast cancer is not always detected by mammography and that suspicious palpable lumps or nipple discharges should be evaluated with a diagnostic mammogram and breast ultrasound. It further stated that "negative imaging should not deter biopsy of a clinically suspicious lump."

12. On or about February 14, 2014, Patient A returned to Respondent presenting with worsening back pain and short term memory loss. Patient A requested assistance with medication refills, and paperwork related to in home support services and durable medical equipment. Respondent performed a physical examination, and documented a genitourinary examination that was recorded to be normal with no lesions, discharge or hernias.

13. On or about March 17, 2014, Patient A returned to Respondent's office to follow up on a recent MRI of her back. Patient A was treated by a physician assistant operating under Respondent's supervision.

14. On or about June 14, 2014, Patient A presented to Respondent for a follow up visit related to her chronic low back pain and sleep apnea. Patient A's daughter drove her to this appointment and accompanied her during the entire examination.

15. On or about July 17, 2014, Patient A presented to Respondent with back pain and complaining of a lump in her left breast. Respondent performed a physical examination that included a breast examination. Respondent stated he examined both breasts, the nipples and lymph nodes in the axillae and was unable to identify any mass. In the section of the medical record identifying the "Chief Complaint," Respondent documented that Patient A had back pain and a lump in her left breast. In the "objective" section of the medical record Respondent wrote "Chest: Lungs clear, no rales, no rhonchi, no wheezes, no lump in left breast, dimpling noted." Respondent wrote under the section for the genitourinary examination that Patient A had no urinary urgency, dysuria or change in the nature of her urine. Respondent did not document any information related to the breast lump in the section of the medical record designated for subjective symptoms. Respondent did not document an examination of Patient A's axillary or right breast. Respondent wrote in the subjective section of the medical record that Patient A had experienced a fall at home about one week prior to the visit and documented a normal neurologic examination. In the assessment section of the medical record Respondent wrote "No assessment recorded." Respondent documented that the mammogram result was unremarkable, but did not document any assessment related to the test result. In the section of the medical record relating to the plan, Respondent did not include any additional information about Patient A's breast lump, plans for further examination, or document the need for Patient A to return to the office for further examination. Respondent did not document any discussion of the differential diagnosis related to the dimpling of Patient A's left breast. Respondent states that he advised Patient A to return to his office for further examination in two weeks, however, she never returned.

16. Respondent failed to maintain adequate and accurate records for Patient A relating to the July 17, 2014 visit. Respondent did not include the breast lump in the subjective section of his progress notes. Respondent only documented a cursory examination of the breast as a part of the chest examination. Respondent did not include an examination of the axillae or the right breast. Respondent documented dimpling of the left breast, but did not document any additional description of the location, size or nature of the dimpling. Respondent did not document an analysis of Patient A's complaint of a breast lump, the examination findings of the dimpling of

her left breast, and a discussion of the possible causes of the physical findings. Respondent did not adequately document an assessment in Patient A's medical records. Respondent did not include a discussion of the differential diagnosis of Patient A's complaint or the abnormal physical examination that revealed dimpling of her breast. Respondent failed to document a plan for further work up of Patient A's breast complaint or a follow up appointment for additional examination.

17. Respondent documented that he performed a genitourinary examination of Patient A on several visits. A genitourinary examination typically includes at least bimanual examination of the pelvis. Respondent stated that he only palpated the skin in the pelvic area. Respondent noted in the medical record that there was no discharge as a part of the genitourinary examination, which is misleading as the lack of discharge in the context of a genitourinary examination implies that there is no vaginal discharge. Respondent did not examine Patient A's vagina, rectum or perform a bimanual pelvic examination. Respondent stated that when he documents that a genitourinary examination occurred in his medical records, he only intends to convey that he performed a suprapubic examination as a part of the abdominal examination and not a genital or vaginal examination. Respondent stated that the note relating to an absence of a discharge in the genitourinary examination does not relate to the vagina, but indicates that there was no discharge from the skin in the pelvic area. Respondent's documentation of a genitourinary examination was inadequate, inaccurate and/or misleading, as it documents a vaginal pelvic examination that was never performed.

18. Respondent engaged in repeated negligent acts in his care and treatment of Patient A, which included, but was not limited to the following:

A. Respondent failed to maintain adequate and accurate medical records related to Patient A's July 17, 2014 appointment; and

B. Respondent failed to adequately and accurately document the genitourinary examination for Patient A.

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SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

19. Respondent has subjected his Physician's and Surgeon's License No. A 53661 to disciplinary action under section 2227, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records in connection with his care and treatment of Patient A, as more particularly alleged in paragraphs 8 through 17, which are hereby incorporated by reference and realleged as if fully set forth herein.

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 No. A 53661, issued to Arun Kumar Softa, M.D.;

2. Revoking, suspending or denying approval of Arun Kumar Softa, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Arun Kumar Softa, 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: November 28, 2018

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

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