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

In the Matter of the Second Amended Accusation Against:	)	
Robert Michael Biter, M.D.	)	Case No. 10-2009-202129
Physician's and Surgeon's Certificate No. A77870	)	
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 September 7, 2012.

IT IS SO ORDERED: August 10, 2012.

MEDICAL BOARD OF CALIFORNIA

Janet Salomonson, M.D., Vice Chair
Panel A

KAMALA D. HARRIS
Attorney General of California
THOMAS S. LAZAR
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: **ROBERT MICHAEL BITER, M.D.** **940 Gardena Road** **Encinitas, CA 92024** Physician's and Surgeon's Certificate No. A77870, Respondent.	Case No. 10-2009-202129 OAH No. 2011080959 **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. Linda K. Whitney (Complainant) is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Beth Faber Jacobs, Deputy Attorney General.

2. Respondent Robert Michael Biter, M.D. (Respondent) is represented in this proceeding by DiCaro, Coppo & Popke, by attorney David M. Balfour, Esq., whose address is 2780 Gateway Road, Carlsbad, CA 92009-1730.

3. On or about February 6, 2002, the Medical Board of California issued Physician's and Surgeon's Certificate No. A77870 to Robert Michael Biter, 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 Second Amended Accusation No. 10-2009-202129 and will expire on September 30, 2013, unless renewed.

JURISDICTION

4. Accusation No. 10-2009-202129 was filed before the Medical Board of California (Board), Department of Consumer Affairs, on July 13, 2011. A true and correct copy of the Accusation and all other statutorily required documents were properly served on Respondent. Respondent timely filed his Notice of Defense contesting the Accusation. Thereafter, on September 2, 2011, First Amended Accusation No. 10-2009-202129 was filed against Respondent and properly served, together with all statutorily required documents. On March 23, 2012, Second Amended Accusation No. 10-2009-202129 was filed against Respondent and properly served on Respondent, together with all statutorily required documents. Second Amended Accusation No. 10-2009-202129 is currently pending against Respondent.

5. A true and correct copy of Second Amended Accusation No. 10-2009-202129 is attached hereto 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 Second Amended Accusation No. 10-2009-202129. 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 Second 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;

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and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

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 Second Amended Accusation No. 10-2009-202129 and that he has thereby subjected his Physician's and Surgeon's Certificate No. A77870 to disciplinary action.

10. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Medical Board of California, all of the charges and allegations contained in Second Amended Accusation No. 10-2009-202129 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving respondent in the State of California.

11. Respondent agrees that his Physician's and Surgeon's Certificate No. A77870 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

12. The parties agree that this Stipulated Settlement and Disciplinary Order shall be submitted to the Board for its consideration in the above-entitled matter and, further, that the Board shall have a reasonable period of time in which to consider and act on this Stipulated Settlement and Disciplinary Order after receiving it.

13. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Settlement and Disciplinary Order, the Board may receive oral and written communications from its staff and/or

the Attorney General's office. Communications pursuant to this paragraph shall not disqualify the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Board, in its discretion, does not approve and adopt this Stipulated Settlement and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should the Board reject this Stipulated Settlement and Disciplinary Order for any reason, respondent will assert no claim that the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Settlement and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

14. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

15. The parties agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures of the parties, may be used in lieu of original documents and signatures and, further, that facsimile copies shall have the same force and effect as originals.

16. In consideration of the foregoing admissions and stipulations, the parties agree the Board may, without further notice to or opportunity to be heard by respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A77870 issued to Respondent Robert Michael Biter, M.D. (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for seven (7) years from the effective date of this Decision on the following terms and conditions.

1. **ACTUAL SUSPENSION**. As part of probation, Respondent is suspended from the practice of medicine for sixty (60) days beginning the first day after the effective date of this Decision.

2. **PRESCRIBING PRACTICES COURSE**. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program 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. **WRONG-SITE SURGERY COURSE**. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in the Wrong-Site Surgery Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program). Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete all components of the course not later than six (6) months after Respondent's initial enrollment. The Wrong-Site Surgery Course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. 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. **MEDICAL RECORD KEEPING COURSE.** Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program 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 fifteen (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.

5. **PROFESSIONALISM PROGRAM (ETHICS COURSE).** Within sixty (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. 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.

6. **CLINICAL TRAINING PROGRAM**. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program"). 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 program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decisions, Second Amended Accusation, and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on Respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation or recommendations for the scope and length of any additional educational or clinical training,

treatment for any medical condition, treatment for any psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. Determination as to whether Respondent successfully completed the examination or successfully completed the program is solely within the program's jurisdiction. If Respondent fails to enroll, participate in, or successfully complete the clinical training 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 training program have been completed. If the Respondent did not successfully complete the clinical training 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 thirty (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 and Second Amended Accusation, and a proposed monitoring plan. Within fifteen (15) calendar days of receipt of the Decision, Second Amended Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Second

Amended Accusation, 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 sixty (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 sixty (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(s) 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 ten (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 sixty (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.

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In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, 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 sixty (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 sixty (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. **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 or changes in hospitals, other facilities or insurance carrier.

10. **SUPERVISION OF PHYSICIAN ASSISTANTS**. During probation, Respondent is prohibited from supervising physician assistants.

11. **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.

12. **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.

13. **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. nder 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 residence. Respondent shall not engage in the practice of medicine in a patient's place of residence, unless (1) the patient resides in a skilled nursing facility or other similar licensed facility, or (2)

respondent is accompanied by another physician and surgeon who holds an active California Physician's and Surgeon's Certificate in good standing and current Board Certification in OB/GYN, who is present at all times respondent provides care and treatment to the patient at the patient's residence, and who makes a timely chart entry reflecting his or her name, license number, and presence during that care and treatment provided by respondent.

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 thirty (30) calendar days prior to the dates of departure and return.

14. **INTERVIEW WITH THE BOARD OR ITS DESIGNEE.** Respondent shall be available in person upon request 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.

15. **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. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or

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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 a clinical training 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 will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

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

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 or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining 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 fifteen (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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, David M. Balfour, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A77870. 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: 5/15/12

ROBERT MICHAEL BITER, M.D.
Respondent

I have read and fully discussed with Respondent Robert Michael Biter, 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: 5/15/12

DICARO, COPPO, & POPKE

DAVID M. BALFOUR, ESQ.
Attorneys for Respondent

ENDORSEMENT

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

Dated: May 16, 2012

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
THOMAS S. LAZAR
Supervising Deputy Attorney General

BETH FABER JACOBS
Deputy Attorney General
Attorneys for Complainant

SD2011800381705653O3

Exhibit A

Second Amended Accusation No. 10-2009-202129

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

In the Matter of the First Amended Accusation Against: **ROBERT MICHAEL BITER, M.D.** **940 Gardena Road** **Encinitas, CA 92024** **Physician's and Surgeon's Certificate No. A77870** Respondent.	Case No. 10-2009-202129 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Linda K. Whitney (hereinafter "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.

2. On or about February 6, 2002, the Medical Board of California issued Physician's and Surgeon's Certificate Number A77870 to Robert Michael Biter, M.D. (hereinafter "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 September 30, 2013, unless renewed.

JURISDICTION

3. This Second Amended Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws.

4. Section 2227 of the Code[1] provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded, or have such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states in pertinent part:

"The Division of Medical Quality[2] shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

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

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

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[1] All section references are to the Business and Professions Code (Code) unless otherwise indicated.

[2] California Business and Professions Code section 2002, as amended and effective January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in the State Medical Practice Act (Business and Professions Code, sections 2000, et. seq.) means the "Medical Board of California," and references to the "Division of Medical Quality" and "Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

"(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.

". . . .

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

". . . ."

6. Under Business and Professions Code section 2234, unprofessional conduct includes 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. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

7. Section 2242 of the Code provides in pertinent part:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

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(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

. . . .

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

8. Section 2266 of the Code states: "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

Patient J.W.

9. Respondent is subject 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 J.W. The circumstances are as follows:

A. Patient J.W., had a history of endometriosis and chronic pelvic pain. She started treating with respondent in May, 2007, when she was 21 years old. He next saw the patient on or about March 19, 2008. Patient J.W. reported pain in her upper right quadrant. Respondent conducted a physical examination, but did not chart his findings. Respondent ordered an ultrasound, which was performed in his office. Respondent diagnosed patient J.W. as having polycystic ovaries.

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B. During the next few months, respondent treated the patient with Metformin, but the medication did not alleviate her problems. On or about May 22, 2008, respondent performed a hysteroscopic polypectomy and cystectomy, and he removed polyps from her uterus and removed cysts from both ovaries.

C. Respondent conducted a post operative recheck on or about May 28, 2008. Her pain persisted. He recommended she undergo an MRI, but he did not chart his recommendation.

D. On or about June 7, 2008, patient J.W. underwent an MRI of the pelvis. Respondent received the MRI report on or about June 10, 2008. It showed pathology in the right ovary – that the right ovary measured 7.3 x 4.6 cm and contained 4 cysts. According to the MRI report, the left ovary was normal.

E. Patient J.W. saw respondent on or about June 12, 2008 and on or about July 1, 2008 with complaints of continued pain. Respondent reviewed the MRI report with the patient and decided that the best course of treatment was to remove the right ovary. The patient requested a hysterectomy and removal of both tubes and ovaries, but respondent did not believe a hysterectomy was indicated. He explained that after he removed the right ovary, she would have one healthy remaining ovary and that this would be beneficial for her. Respondent charted his plan to remove the right ovary. Surgery was scheduled for July 10, 2008.

F. The patient came to the Scripps Encinitas Surgery Center for her right ovary removal surgery on or about July 10, 2008. Respondent completed a history and physical form. He charted that the proposed surgery was a laporoscopic right salpingo-oophorectomy.[3] Patient J.W. signed a release for a laparoscopy and right salpingo-oophorectomoy. The patient's husband waited in the waiting room during the surgery.

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[3] A salpingo-oophorectomy is the surgical removal of a fallopian tube and ovary.

G. Prior to commencing the surgery, respondent circled the left lower quadrant of the patient drawing on the chart, and both respondent and the patient initialed the drawing. Respondent then proceeded laparoscopically. He removed patient J.W.'s left fallopian tube and ovary. The anesthesia record initially noted the right ovary was removed; but that entry was crossed out and changed to "left." Respondent did not chart any explanation in the operative report or any portion of the patient's medical record as to why he removed the left tube and ovary instead of the right. In addition, his operative note fails to describe or even mention the right ovary.

H. Respondent did not speak with the patient's husband, T.W., following the surgery. At some point following the surgery, however, the nurses told T.W. that his wife was ready and he could drive her home. No one advised patient J.W. or her husband T.W. that her left ovary had been removed.

I. The pathology report for the left ovary showed the left ovary had a corpus luteal cyst[4] and measured 3 x 2 x 1.3 cm.

J. Patient J.W. had a post surgical follow-up visit with respondent on or about July 23, 2008. She told respondent she was feeling better since the surgery.

K. Respondent never advised the patient or her husband that he took out the left ovary instead of the right ovary.

L. The patient's right-sided pelvic pain returned. She decided to seek another medical opinion and ordered her medical records from respondent. In November, 2008, when J.W. reviewed her medical records, she and her husband first learned that respondent had removed her left ovary and not her right ovary when he performed surgery on or about July 10, 2008. Patient J.W. brought the medical records to another treater, Dr. O.T., who performed an ultrasound on or about November 6, 2008. The ultrasound showed that patient J.W. still had her right ovary

[4] A corpus luteal cyst is a normal type of cyst that can be produced every month after an egg has been released from a follicle. When a woman is not pregnant, it does not usually produce symptoms and most typically breaks down and disintegrates on its own.

and did not have a left ovary, that her right ovary measured 4 x 3.5 x 3.9 cm. and contained a hemorrhagic cyst.

M. During respondent's interview with the Board on or about September 15, 2011, respondent told Board representatives that he made a conscious decision to remove the left ovary instead of the right when he performed the laparoscopy and visualized her ovaries and the left appeared more diseased than the right ovary. Respondent also falsely stated during the interview that following the surgery, he told the patient that he removed the left ovary and why he had done so, and that he separately spoke with the patient's husband following the surgery and advised him that he removed the left ovary and the reasons he did so.

N. Patient J.W. continued to have pelvic pain.

10. Respondent was grossly negligent his care, treatment, and management of patient J.W., which included, but was not limited, to the following:

A. Before starting the surgery, respondent marked the incorrect side on the patient on the chart, reflecting that he intended to remove the left ovary.

B. Respondent removed patient J.W.'s left ovary without consent.

C. Though the MRI showed that the right ovary was the diseased ovary and that the left was normal, in his operative note, respondent only described the left ovary and failed to describe or even mention the right ovary.

D. If the decision to remove the left ovary was a conscious decision made after he visualized the ovaries, as respondent stated during his interview with the Board, the charting was additionally grossly negligent because respondent failed to articulate his rationale for the removal of the left ovary, for which there was no consent from patient J.W. for its removal.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

Patient J.W.

11. Respondent is further subject to disciplinary action under section 2227 and 2234, as defined by section 2234, subdivision (c), in that Respondent was repeatedly negligent in the care, treatment and management of patient J.W. as described above in paragraphs 9 and 10, which are incorporated by reference herein.

Patient P.L.

12. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that respondent committed repeated negligent acts in his care and treatment of patient P.L. The circumstances are as follows:

A. On or about July 16, 2008, patient P.L., then a 67-year old female, consulted with respondent for complaints of bulging in her vagina that had been going on for approximately three years. Patient P.L. also noted "leaking urine" in her medical history form.

B. Respondent's charted assessment was severe pelvic prolapse with resulting urine retention. Respondent did not chart components of the prolapse, nor identify if it was uterine, cystocele, enterocele, or rectocele.

C. Respondent did not take an adequate history or document having taken an adequate history. He failed to document the duration of her complaint of leaking urine. He did not document that she refused catheterization, which could have resolved the urine retention issue. He did not document any discussion regarding the risks and benefits of having a subtotal hysterectomy.

D. Respondent did not perform an adequate physical examination prior to recommending or commencing surgery on July 17, 2008, or if he did, he did not document having performed an adequate physical examination.

E. Respondent's initial recommendation was "complete pelvic reconstruction," but the patient would not consent to any procedure other than a

hysterectomy, as she wanted a procedure with a quicker recovery time so she could go to her upcoming high school reunion. Respondent did not chart this initial recommendation, the patient's rejection of his initial recommendation, or the patient's insistence on a hysterectomy.

F. Respondent charted that his plan was to perform an emergent hysterectomy.[5] He did not chart the reasons for concluding the hysterectomy was needed on an emergency basis.

G. On or about July 17, 2008, respondent performed a laparoscopic subtotal hysterectomy[6] with bilateral salpingo-oophorectomy,[7] and uterosacral ligament suspension[8] on patient P.L.

H. On or about July 25, 2008, patient P.L. was seen by respondent for a post-operative follow up. Respondent noted that there were no complaints regarding urination, that there was excellent support, and that patient P.L. "feels great." P.L. was instructed to return to the office for evaluation on or about September 8, 2008.

I. On or about September 23, 2008, respondent saw patient P.L. for a follow up evaluation. Respondent noted that there was no urine leakage but that he found patient P.L. to have a cystocele.[9] Respondent's plan for the patient was to recommend an anterior repair with graft to be performed in or about March, 2009.

J. On or about December 1, 2008, patient P.L. contacted respondent's office to notify respondent that she moved to Puerto Vallarta, Mexico, that she felt she had

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[5] Hysterectomy is the surgical removal of the uterus.

[6] Subtotal hysterectomy is the surgical removal of the uterus but not the cervix.

[7] Salpingo-oophorectomy is the surgical removal of the fallopian tube and ovary.

[8] Uterosacral ligament suspension involves suturing the uterosacral ligament to the apex of the vagina in order to prevent vaginal prolapse.

[9] A cystocele occurs when the wall between a woman's bladder and her vagina weakens and allows the bladder to droop into the vagina.

an emergency situation, and requested that the anterior repair procedure be moved up to January 8, 2009.

K. Though respondent agreed to perform the surgery on or about January 8, 2009, he had not discussed or documented discussing with the patient the known risks of repair with a graft, including, but not limited to, mesh erosion or failure of the procedure.

L. On or about January 8, 2009, respondent performed an anterior repair on patient P.L. using of a "Pinnacle" graft[10] from Boston Scientific.

M. Respondent saw patient P.L. post-operatively on or about January 9, 2009 and another physician in respondent's office saw P.L. on January 14, 2009, for post-operative follow up. The physician noted that patient P.L. was doing well with the bladder well supported.

N. On or about March 11, 2009, patient P.L. sent respondent a faxed note stating that she was having a "big problem" regarding her bladder surgery and that she wanted a revision surgery scheduled for that week. Respondent also received a letter from Dr. P.G. in Puerto Vallarta, Mexico, dated March 10, 2009, reflecting the patient had mesh erosion; Dr. P.G. stated that he had seen patient P.L. for a foreign body sensation in her vagina which had persisted since on or about January 21, 2009, after she had moved a couch. Dr. P.G. stated that on examination, he found a mesh-like material perforating into the right lower middle third of patient P.L.'s vagina, and that the anterior wall of the vaginal vault was felt to prolapse down to the introitus[11] upon standing.

O. On or about March 13, 2009, respondent performed a revision of the anterior repair with allograft and a cystoscopy.

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[10] A Pinnacle graft is a type of synthetic mesh used for pelvic floor repair.

[11] The vaginal opening.

P. The next day, March 14, 2009, patient P.L. was seen by respondent for complaints of increased pressure in her vagina. Respondent noted that patient P.L. wanted respondent to attempt to support her anterior vaginal compartment. Respondent, who had a business relationship with Boston Scientific, discussed with a representative from Boston Scientific, patient P.L.'s failed repair and the use of the Boston Scientific "Pinnacle" graft.

Q. Respondent's plan was to perform a "lift of sling" procedure in his office with the Pinnacle graft. Respondent had not done this procedure previously, did not know if the procedure could be safely done, or if the pain could be controlled during the procedure, and he was concerned he might not achieve the best result in the outpatient setting. The patient requested that the procedure be done in a hospital setting.

R. Despite the foregoing, on or about March 17, 2009, respondent performed the "lift of sling" procedure on patient P.L. in his medical office.

S. On or about March 21, 2009, patient P.L. was seen by respondent for complaints of excessive pain with complete collapse of the vagina and spotting at the vaginal cuff. Respondent determined that patient P.L. required anterior and posterior repair, sacrospinous ligament suspension,[12] repair of enterocele,[13] and grafting.

T. On or about March 25, 2009, respondent performed a laparoscopic sacral colpopexy[14] on patient P.L. for the diagnosis of vaginal eversion. Respondent used the Boston Scientific polyform permanent grafting that he sutured through the sacrum. He also sutured the right edge of the vagina to the right uterosacral ligament.

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[12] Sacrospinous ligament suspension is a technique that secures the upper vaginal vault to the sacrospinous ligament, effectively restoring support to the vaginal wall and correcting prolapse.

[13] An enterocele (small bowel prolapse) occurs when the small bowel presses against and moves the upper wall of the vagina.

[14] Colpopexy is a surgical procedure to suture a relaxed vagina to the abdominal wall.

U. Over the next several months, the patient continued to have problems. She had urinary incontinence, pain with intercourse, and developed mesh erosion (the mesh was eroding through her cervix and vagina), and she had distal anterior wall prolapse.

V. On or about August 4, 2009, patient P.L. was seen by Dr. C.N. at the University of California San Diego for evaluation and treatment. Dr. C.N. confirmed the presence of mesh erosion, stress incontinence, and distal anterior wall prolapse. He also informed patient P.L. that all of her previous surgeries were prolapse surgeries and were not procedures to address her incontinence.

W. On or about September 14, 2009, Dr. C.N. performed a complete excision of anterior wall vaginal mesh, a tension-free vaginal tape mid-urethra sling, and cystoscopy on patient P.L. As of October 27, 2009, P.L. no longer had symptoms of urinary incontinence, stress incontinence, bulge or prolapse.

13. Respondent committed repeated negligent acts in his care, treatment, and management of patient P.L., which included, but was not limited, to the following:

A. Respondent failed to take and/or document taking an adequate and appropriate history of patient P.L. prior to conducting surgery on July 17, 2008.

B. Respondent failed to perform and/or document performing an appropriate physical examination on patient P.L. prior to conducting surgery on July 17, 2008.

C. Respondent failed to document a thorough explanation of the intent and risks of the proposed surgical procedure to patient P.L. prior to recommending or commencing surgery on July 17, 2008.

D. On or about July 17, 2008, respondent proceeded with an emergent laparoscopic subtotal hysterectomy with bilateral salpingo-oophorectomy, and uterosacral ligament suspension, even through the patient's condition was not so urgent as to constitute a medical emergency and the procedure respondent utilized was not likely to lead to a satisfactory resolution of patient P.L.'s problem.

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E. Prior performing surgery on or about January 8, 2009, respondent failed to document that he explained to patient P.L. the reasonably common procedural risk of mesh erosion or the risk of procedure failure.

F. With respect to each surgery respondent performed on patient P.L., respondent failed to instruct the patient about the post operative activity limitations she should follow, or if he did instruct the patient on post operative activity limitations, he failed to document such instructions.

G. Respondent was negligent on or about March 17, 2009, when he proceeded with the surgical corrective procedure (lift of sling) on patient P.L. in his office, by performing the procedure without sufficient experience and in reliance on the recommendations of the Boston Scientific representative, and with the knowledge he (respondent) had numerous unanswered questions about the procedure's safety, whether he could adequately control the patient's pain, and whether the procedure should be performed in a surgical center rather than his office.

H. Respondent was negligent on or about March 25, 2009, when he performed the sacral colpopexy on P.L. with the Boston Scientific Polyform permanent grafting, insofar as he knew he had limited experience with sacral colpopexy, the patient had already suffered multiple surgical difficulties, and the patient could and should have been referred to a subspecialist.

Patient J.C.

14. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that respondent committed repeated negligent acts in his care, treatment and management of patient J.C., as more particularly alleged herein:

A. On or about October 3, 2008, patient J.C., then a 56-year old female with a history of fibroids, was seen by respondent for her annual examination, and her first visit with respondent. Patient J.C. complained of right pelvic pain and fibroids, and on her history form, noted her cervix was falling and that she leaked urine.

Respondent charted that the patient had been experiencing increased pelvic pressure and/or pain, and that she had fibroids.[15] Respondent did not indicate the size of the fibroids and did not order imaging to determine the size.

B. Respondent decided to perform a laparoscopic hysterectomy and a sacrospinous ligament repair.[16] Respondent assumed that the patient's pain was caused by the fibroids and did not conduct tests or consider any other possible etiologies for her pain that might not be addressed by the proposed operation.

C. During the patient's visit on October 3, 2009, Respondent did not chart that the patient had a pelvic relaxation problem. He did not discuss a sacrospinous ligament repair, or if it was discussed, respondent failed to chart the discussion.

D. On or about October 16, 2008, respondent performed a laparoscopic hysterectomy and sacrospinous ligament suspension on patient J.C. Respondent's operative report listed the operation date as October 30, 2008.

15. Respondent committed repeated negligent acts in his care and treatment of patient J.C., which included, but were not limited to, the following:

A. Respondent failed to adequately document his pre-operative counseling with the patient, his physical findings related to the fibroids, any pre-existing imaging, or the complaints to be addressed by the proposed surgeries petitioner planned to conduct on October 16, 2008.

B. Prior to commencing surgery on or about October 16, 2008, respondent failed to consider or discuss, and/or failed to document having considered or discussed any other causes for the pain that might not be addressed by the surgery.

C. Prior to commencing surgery on or about October 16, 2008, respondent failed to perform a basic laboratory evaluation of patient J.C., including a CBC and urinalysis.

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[15] Uterine fibroids are non-cancerous growths that develop in or just outside a woman's uterus.

[16] A sacropspinous ligament fixation procedure is indicated to correct a pelvic relaxation problem.

D. Petitioner's operative report reflecting the surgery was incorrectly dated October 30, 2008.

Patient T.N.

16. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that respondent committed repeated negligent acts in his care, treatment and management of patient T.N., as more particularly alleged herein:

A. On or about September 26, 2007, patient T.N., then a 43-year old female, was seen for the first time by respondent for complaints of left lower quadrant pain that was described as cyclical, occurred mid-cycle, and had most recently started after she stopped taking oral contraceptives. Respondent performed a pelvic ultrasound and noted that the patient had a 3-5 cm left adnexal[17] mass consistent with pain, two uterine fibroids, and normal stripe (lining of the uterus.)

B. Respondent did not perform a pelvic examination, nor an appropriate physical examination on patient T.N. During his interview with the Medical Board's investigator, respondent stated that he believed a physical examination was unnecessary because an ultrasound superseded a physical examination.

C. Respondent's plan for patient T.N. was a laparoscopy, possible left oophorectomy,[18] possible myomectomy,[19] lysis of adhesions, and if the treatment could not be completed by way of a myomectomy, then it may require the removal of the uterus.

D. Respondent did not properly document his discussions with patient T.N. regarding the possible hysterectomy, informed consent, the risks and benefits, nor

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[17] Adnexa are the "appendages" of the uterus, namely the ovaries, Fallopian tubes and ligaments that hold the uterus in place.

[18] Oophorectomy is the surgical removal of the ovary.

[19] Myomectomy refers to the surgical removal of uterine fibroids.

surgical alternatives. On or about September 27, 2007, patient T.N. was scheduled for surgery. On or about October 30, 2007, T.N. signed consent for laparoscopy, possible myomectomy, left ovarian cystectomy, and left oophorectomy.

E. On or about November 1, 2007, patient T.N. was taken to the operating room for her scheduled surgery and placed under general anesthesia. Respondent then performed a bi-manual pelvic examination on patient T.N.

F. Respondent proceeded with the laparoscopy. Respondent identified the presence of two large uterine fibroids which prevented him from performing a laparoscopic myomectomy. While patient T.N. was still under anesthesia, respondent left the operating room suite to discuss with the patient's husband the option of performing a laparoscopic hysterectomy.[20] Though the patient's husband did not have the authority to give consent for a hysterectomy, respondent asked the husband for consent, which he obtained, and then performed a laparoscopic hysterectomy, left ovarian cystectomy, and removal of endometriosis[21] implants on patient T.N.

17. Respondent committed repeated negligent acts in his care and treatment of patient T.N., which included, but were not limited to, the following:

A. Respondent failed to perform a pelvic examination on patient T.N. until just prior to surgery, when she was under anesthesia.

B. Respondent failed to properly document his discussions with patient T.N. about a possible hysterectomy, informed consent, the risks, benefits, and alternatives of surgery.

C. Respondent performed a laparoscopic hysterectomy on patient T.N. without obtaining her prior consent.

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[20] Hysterectomy is the surgical removal of the uterus.

[21] Endometriosis is a gynecological medical condition in which cells from the lining of the uterus (endometrium) appear and flourish outside the uterine cavity.

Patient J.R.

18. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that respondent committed repeated negligent acts in his care, treatment and management of patient J.R., as more particularly alleged herein:

A. On or about May 28, 2008, patient J.R., then a 37-year old, gravida[22] 1 with in-vitro fertilization twins, and an estimated date of confinement (EDC) of December 19, 2008, began her prenatal care with respondent. From on or about May 28 to October 22, 2008, patient J.R.'s blood pressures were normal with no indication of pre-eclampsia.[23]

B. On or about October 23, 2008, proteinuria[24] was noted, and on or about October 27, 2008, patient J.R.'s blood pressure was recorded at 130/80 and she had edema. On or about October 30, 2008, patient J.R.'s blood pressure was recorded between 135-140/80 all day.

C. On or about October 31, 2008, patient J.R. was seen in respondent's office at 33 ½ weeks gestation and was noted to have a cervical dilatation of 2-3 cm. She was admitted to the hospital for induction of labor for pregnancy-induced hypertension with increasing uric acid and increasing proteinuria.

D. At the hospital, patient J.R.'s intrapartum blood pressure readings were intermittently elevated with ranges between 134-157/68-95. There were no signs of severe pre-eclampsia or fetal compromise due to pre-eclampsia. Patient J.R.'s induction of labor failed. Respondent decided to perform a cesarean section. Respondent did not perform any test to determine the lung maturity of patient J.R.'s twin fetuses. Patient J.R. underwent a cesarean section and delivered viable twins.

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[22] Gravida refers to the pregnancy number a woman is in.

[23] Pre-eclampsia is a medical condition in which hypertension arises in pregnancy in association with significant amounts of protein in the urine.

[24] Proteinuria is the presence of an excess of serum proteins in the urine.

19. Respondent committed repeated negligent acts in his care and treatment of patient J.R., which included, but were not limited to, the following:

A. Respondent failed to determine the lung maturity of patient J.R.'s twin fetuses once he felt that delivery was indicated at 33 ½ weeks gestation.

B. Respondent induced labor in patient J.R. at 33 ½ weeks gestation, with only mild pre-eclampsia, and without evidence of severe pre-eclampsia or fetal compromise.

Patient M.H.

20. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that respondent committed repeated negligent acts in his care, treatment and management of patient M.H., as more particularly alleged herein:

A. On or about December 18, 2007, patient M.H., then an 84-year old female, was first seen by respondent for complaints of intermittent vaginal bleeding starting in or about November, 2007. Patient M.H. had previously undergone a pelvic ultrasound ordered by Dr. R.B. Respondent performed an endometrial biopsy. His plan was to consider a hysterectomy and wait for the biopsy results.

B. On or about December 19, 2007, respondent received a copy of the pelvic ultrasound report dated December 6, 2007. The report indicated there was a large fibroid uterus and suspected 3.6 cm. endometrial thickening, and the radiologist raised the suspicion of the possibility of endometrial carcinoma. Respondent made a note on the ultrasound report to obtain authorization for a laparoscopic hysterectomy and bilateral salpingo-oophorectomy.[25]

C. On or about December 26, 2007, respondent received the report of the December 18, 2007 endometrial biopsy. The biopsy results indicated atropic[26]

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[25] Salpingo-oophorectomy is the surgical removal of the Fallopian tube and ovary.

[26] Atropic means the wasting or decrease in size of a body organ, tissue, or part owing to disease, injury, or lack of use.

squamous mucosa that was negative for dysplasia.[27] In addition, the report stated that no endometrial tissue was identified. Respondent should have realized he had not obtained a sample of the endometrium. Instead, he interpreted the report as a "normal biopsy," and planned for surgery.

D. During his interview with the Board, respondent stated that he discussed the results of the biopsy with patient M.H. and her daughter over the phone, and that it was highly predictive of not being cancerous. He further stated during his interview that the patient stated she would have refused chemotherapy or radiation if cancer was found. Respondent did not chart any of these discussions.

E. On or about December 27, 2007, patient M.H. presented to the emergency room at S.M. Hospital for difficulty urinating and lower abdominal pain. She was also in atrial fibrillation.[28] Patient M.H. was admitted to the hospital for urinary retention, and a CT scan showed a 16 cm. uterus.

F. On or about January 1, 2008, patient M.H. was seen by respondent at the hospital for a gynecology consultation. Respondent documented that the patient's pelvic mass was a fibroid, that it was causing the urinary retention, and that there was no evidence of endometrial cancer.

G. On or about January 3, 2008, respondent performed a total abdominal hysterectomy, bilateral salpingo-oophorectomy, and omentectomy[29] on patient M.H. Respondent documented finding a large necrotic uterine mass with frozen section consistent with carcinoma of unknown origin. The pathology showed undifferentiated malignancy involving the endometrium, uterus, ovaries, and omentum.

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[27] Dysplasia is a term used in pathology to refer to an abnormality of development.

[28] Atrial fibrillation is an irregular and often rapid heart rate.

[29] Omentectomy is the surgical removal of the omentum, which is a large fatty structure which hangs off the middle of the colon and drapes over the intestines inside the abdomen.

H. On or about March 1, 2008, respondent performed additional surgery on patient M.H. which consisted of an exploratory laparotomy,[30] adhesiolysis,[31] and debulking of the pelvic mass. On or about March 6, 2008, patient M.H. died as a result of multiple morbidities.

21. Respondent committed repeated negligent acts in his care and treatment of patient M.H., which included, but were not limited to, the following:

A. Respondent failed to properly evaluate patient M.H. preoperatively, and failed to correctly analyze the endometrial biopsy findings from on or about December 18, 2007.

B. Respondent failed to document his discussions with patient M.H. and her daughter about his analysis of the negative endometrial biopsy, and that patient M.H. had told him she would refuse any additional treatments, including chemotherapy or radiation, if cancer was found.

Patient L.S.

22. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that respondent committed repeated negligent acts in his care, treatment and management of patient L.S., as more particularly alleged herein:

A. By way of background, respondent provided gynecological care and treatment to patient L.S. in February, 2008, when he delivered her second child, and thereafter, about 10 months later, when he performed a surgery on patient L.S.

B. In or about the spring of 2010, when patient L.S. became pregnant again, she contacted respondent to arrange for pre-natal care. When she learned that respondent had lost his hospital privileges from Scripps Hospital, Encinitas, patient L.S. told respondent that she wanted to have him deliver her baby at her home.

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[30] A laparotomy is a large incision made into the abdomen.

[31] Adhesiolysis is surgically breaking up scar tissues or adhesions.

Respondent suggested she contact midwives to provide backup assistance with the delivery. Patient L.S. scheduled an examination with San Diego Midwife that would be held in November, 2010, when she was over 32 weeks pregnant. It was the patient L.S.'s understanding that respondent would attend the home birth as her physician and that a midwife from San Diego Midwife would assist him.

C. On or about November 14, 2010, patient L.S. was 32 weeks pregnant, and at about 5:00 a.m., she began spotting. She called respondent at about 7:30 a.m. He called her right back. In response to respondent's questions, L.S. told respondent about the spotting, that she was cramping, and that she had previously been swimming in the ocean. Respondent told her to spend the day in bed.

D. At approximately 6:00 p.m. that night, L.S. started having contractions. She again called respondent at approximately 7:00 p.m. Respondent returned the call at approximately 7:30 p.m. L.S. explained that the contractions were intense. Patient L.S. asked respondent if she should go the hospital. Respondent told her "no." Respondent did not tell her to go to the hospital or to call San Diego Midwife. Instead, and without examining patient L.S., respondent prescribed the drug Nifedipine, a drug commonly prescribed to stop or slow contractions when a woman is in labor. At a time between 7:51 p.m. and 8:13 p.m., respondent called the prescription into the CVS pharmacy in Encinitas.

E. L.S.'s husband went to CVS and picked up the 30 pill prescription. The label indicated that L.S. should take "one capsule by mouth every 3-4 hours as needed for contraction."

F. L.S.'s contractions were coming about 5 minutes apart when she took the first dose at about 9:00 p.m. She texted respondent and asked him long it would take for the drug to work. Respondent did not text her back. By 9:44 p.m., her contractions eased a bit, but then returned. Concerned because of the continuing contractions, L.S.'s husband called respondent. Respondent told L.S.'s husband words to the effect that: "Buddy, your baby is not going to be born tonight." He told

the patient's husband that L.S. should take another Nifedipine and a Benadryl and try to get some sleep.

G. Shortly thereafter, L.S. took a bath. While in the bathtub, her water broke. After arranging for coverage for their children, L.S. and her husband went to the Tri-City Medical Center Emergency Room. They selected TCMC because they knew she was delivering prematurely and TCMC had a NICU. Patient L.S. texted respondent that she was on the way to the hospital. When she arrived, she had advanced cervical dilation and presented with a footling breach. An emergency repeat Cesarean-section was performed.

H. Respondent created chart entries dated November 14, 2010 and November 24, 2010. On or about January 24, 2011, patient L.S. requested and received her medical records from respondent. The records provided to patient L.S. did not include respondent's chart entries for November 14, 2010 or November 24, 2010.

I. Respondent's chart entries for November 14, 2010 and November 24, 2010 are not accurate. The chart entries for both dates falsely state that during his conversations with patient L.S. on November 14, 2010, the patient only conveyed cramping and that "there were no actual contractions." Respondent's entry for 9:06 p.m., falsely states that there are "no signs of labor." The entry for November 14, 2010, at 9:44 p.m., that he discussed with patient L.S.'s husband "use of the closest L&D/ER at TriCity" and that the husband "expressed understanding of same plan follow up with midwives given transfer of care." Both the November 14, 2010 and November 24, 2010 entries fail to state that respondent prescribed Nifedipine for the patient or that he called in the prescription to the pharmacy.

23. Respondent committed repeated negligent acts in his care and treatment of patient L.S., which included, but were not limited to, the following:

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A. Respondent prescribed Nifedipine without an appropriate in person evaluation, which would have included checking the patient's cervix to determine her level of dilation and if she was an appropriate candidate for Nifedipine.

B. Respondent failed to appropriately monitor her condition after prescribing and calling in a prescription for Nifedipine to stop or slow the patient's contractions.

C. Respondent failed to timely place his chart entries for November 14, 2010 and November 24, 2010 into the patient's chart.

THIRD CAUSE FOR DISCIPLINE

(Prescribing without an Appropriate Prior Examination)

24. Respondent is further subject to disciplinary action under section 2227 and 2242, as defined by section 2242, in that he prescribed Nifedipine to patient L.S. without an appropriate prior examination and medical indication for the drug, as more particularly alleged in paragraph 21, above, which paragraph is hereby realleged and incorporated by reference.

FOURTH CAUSE FOR DISCIPLINE

(Dishonesty)

25. Respondent is further subject to disciplinary action under section 2227 and 2234, as defined by section 2234, subdivision (e), in that he engaged in acts of dishonesty with respect to his care and treatment of patients J.W. and L.S., as more particularly alleged hereinafter:

A. Paragraphs 9 through 24, above, are hereby realleged and incorporated by reference.

B. With respect to patient J.W., respondent was dishonest with the Medical Board during his interview with Board representatives on or about September 15, 2011, when he stated he made a conscious decision to remove her left ovary when he visualized it because it looked more diseased to him than the right ovary.

C. With respect to patient J.W., respondent dishonestly claimed, during his interview with the Medical Board on or about September 15, 2011, that following the

patient's surgery and his removal of her left ovary, he told the patient and separately told her husband that he had not removed the right ovary, but removed the left ovary because it appeared to him to be more diseased.

D. In his chart notes dated November 14, 2010, respondent dishonestly charted that during his discussions with patient L.S. that evening, L.S. did not complain of having contractions and that she was not having contractions.

E. In his chart notes dated November 14, 2010, and November 24, 2010, respondent dishonestly charted that he told the patient he could not provide her care and that she should contact San Diego Midwife or go the Emergency Room for her symptoms.

F. By failing to chart that he prescribed Nifedipine or that he called in the prescription for patient L.S., respondent's entries misrepresented the facts and falsely implied he refused to provide care because her care had been transferred to San Diego Midwife.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

26. Respondent is further subject to disciplinary action under section 2227 and 2266, as defined by section 2266, in that he failed to maintain adequate and accurate medical records regarding his care, treatment, and management of patients J.W., P.L., J.C., T.N., J.R., M.H., and L.S., as more particularly alleged herein. Paragraphs 9 through 25, above, are hereby realleged and incorporated by reference.

SIXTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

27. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, in that respondent has engaged in 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 in paragraphs 9 through 26, above, which are hereby incorporated herein by reference.

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 A77870, heretofore issued to respondent Robert Michael Biter, M.D.;

2. Revoking, suspending or denying approval of respondent Robert Michael Biter, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering respondent Robert Michael Biter, M.D. to pay the Board, if placed on probation, the costs of probation monitoring; and

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

DATED: March 23, 2012

Ruth Faber Jacobs, Dep. Atty Gen, for
LINDA K. WHITNEY
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant