

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

In the Matter of the Accusation Against:)

HRAYR KARNIG SHAHINIAN, M.D.)

**Physician's and Surgeon's
Certificate No. A 60898**)

Respondent)

Case No. 11-2010-206785

OAH No. 2014120364

ORDER CORRECTING NUNC PRO TUNC DECISION

On its own motion, the Medical Board of California (hereafter "board") hereby corrects the signature block of this Decision to indicate the correct signer.

IT IS SO ORDERED September 8, 2016.

MEDICAL BOARD OF CALIFORNIA

By: 
Michelle Bholat, Vice Chair
Panel B

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

In the Matter of the Accusation)	
Against:)	
)	
)	
HRAYR KARNIG SHAHINIAN, M.D.)	Case No. 11-2010-206785
)	
Physician's and Surgeon's)	
Certificate No. A 60898)	
)	
Respondent)	
_____)	

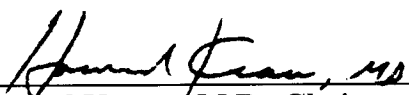
DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on September 9, 2016.

IT IS SO ORDERED: August 11, 2016.

MEDICAL BOARD OF CALIFORNIA



Howard Krauss, M.D., Chair
Panel B

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

In the Matter of the Accusation Against:

HRAYR KARNIG SHAHINIAN, M.D.,
Physician's and Surgeon's Certificate
No. A 60898,

Respondent.

Case No. 11-2010-206785

OAH No. 2014120364

PROPOSED DECISION

Howard W. Cohen, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on March 7, 8, 10, and 14 through 17, April 11, and June 6 and 7, 2016, in Los Angeles.

Robert McKim Bell, Supervising Deputy Attorney General, represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board), Department of Consumer Affairs, State of California.

Henry Lewin, Attorney at Law, of Lewin & Levin, represented respondent Hrayr Karnig Shahinian, M.D.

Prior to the presentation of evidence, respondent brought motions in limine. The ALJ considered and ruled on those motions as well as on motions made during the course of the hearing, as reflected on the record.

Oral and documentary evidence was received. The record was closed and the matter was submitted on June 7, 2016.

Amendment to Accusation

During the hearing, the Accusation was amended as follows: Paragraphs 26D and 29I were changed from "His performance of deep intradural brain surgery without completion of a neurosurgical residency training program is an extreme departure from the standard of care" to read "He performs deep intradural brain surgery of patients other than patient GR, without completing a neurosurgical residency training program, and doing so is an extreme departure from the standard of care."

Protective Order

The parties stipulated to protecting confidential information of third parties. A Protective Order Sealing Exhibits 6, 12, 13, 15, and 38 issued on July 6, 2016. Redaction of the documents to obscure this information was not practicable and would not have provided adequate privacy protection. Those exhibits shall remain under seal and shall not be opened, except by order of the Medical Board of California (Board), by OAH, or by a reviewing court.

FACTUAL FINDINGS

Jurisdiction

1. Complainant filed the Accusation in her official capacity. Respondent timely filed a notice of defense.

2. The Board issued Physician and Surgeon's Certificate No. A 60898 to respondent on September 18, 1996. That license is scheduled to expire on January 31, 2018, unless renewed.

Respondent's Background

3. Respondent was born in Beirut, Lebanon, and attended the American University of Beirut (AUB) for pre-medical studies, which he completed in 1978, and medical school, which he attended from 1981 to 1985.

4. At times from September 1982 to June 1984, while still in medical school at AUB, respondent performed clinical rotations at the University of Chicago by arrangement with AUB, for which he received academic credit at AUB. He returned to AUB to complete a one-year internship, and received his medical degree from AUB in 1985.

5. Respondent maintains that he completed two full academic years of clinical rotations at the University of Chicago, though his license application does not reflect that information. He claims, without documentary support, that he received a stipend from the University of Chicago as a visiting research associate for one year after he graduated from AUB; he did not list that job on his license application. Respondent's professional website for years misleadingly listed the University of Chicago as an institution from which he received a medical degree; during the course of the hearing he corrected the website, and also caused his Wikipedia page to be corrected. Despite conflicting evidence of respondent's whereabouts during his junior and senior years, complainant did not establish by clear and convincing evidence that, from September 1982 to June 1984, respondent did not perform most of his clinical rotations in Chicago or deliberately submitted untruthful information in his license application. Clear and convincing evidence does establish that respondent's website contained misleading information about his educational credentials.

6. Respondent attended Vanderbilt Medical School for his residency from 1986 to 1991. Respondent was made Executive Chief Resident, and completed his residency in 1991. He applied to New York University (NYU) for a three-year residency and fellowship. At NYU, respondent studied microsurgery and removed tumors using traditional approaches.

7. Respondent designed his own training program in order to become a skull base surgeon. After leaving NYU, respondent obtained a neuro-otology and skull base fellowship at the University of Zurich under Dr. Ugo Fisch, an eminent skull base surgeon. Respondent worked with Dr. Fisch from 1993 to 1994. Respondent maintains that he eventually performed two surgeries per day, three or four days per week, with Dr. Fisch observing. No documentation was offered to support respondent's testimony. Respondent also worked with Professor Mario Sanna in Rome and Professor Jacques Magnan in Marseille; Prof. Magnan used both endoscopy and microscopy during surgery.

8. Respondent returned to the United States and was appointed Assistant Professor of Surgery at State University New York (SUNY), where he was recruited by the head of surgery, Dr. Naji N. Abumrad. Respondent acquired staff privileges at SUNY Stony Brook and at NYU. He was appointed co-director with a neurosurgeon, Dr. Davis, of the division of skull base surgery at SUNY. Respondent performed skull base surgeries exclusively, including acoustic neuroma surgery. He began using endoscopy in sheep studies in the animal laboratory, and then in human patients. Respondent was made director of the skull base surgery division in his last year at SUNY. Between 1994 and 1996, respondent performed about 250 to 300 skull base procedures at NYU and SUNY.

9. In 1996, Cedars-Sinai Medical Center (Cedars) contacted respondent and asked him to open a Skull Base Institute there as a division of the surgery department. The institute was not connected to the neurosurgery division because respondent was not a trained neurosurgeon. Respondent was monitored and proctored by numerous surgeons, including neurosurgeons, and received staff privileges to perform skull base surgery. Respondent has been licensed in California since 1996 and is a diplomate of the American Board of Surgery.

10. At Cedars, respondent used endoscopy on sheep and pigs from 1995 to 1998, and performed his first fully endoscopic acoustic neuroma surgery in 2003, with the approval of his review board.¹ Respondent's staff privileges were modified to allow him to perform fully endoscopic acoustic neuromas; the record contains no evidence that respondent's privileges were conditioned on the presence of another surgeon in the operating room during the fully endoscopic procedures. In 2006, respondent applied for staff privileges at Brotman Medical Center (Brotman) in Culver City, informing the hospital that he performed fully endoscopic acoustic neuroma surgery without the assistance of another surgeon. Privileges were granted after respondent was monitored. Respondent performed about 200 to 250 skull base surgeries at Brotman each year in 2006 and 2007.

¹ An acoustic neuroma is a tumor of the cranial nerves.

11. Respondent claims to have performed over 7000 procedures. He has performed several methods of acoustic neuroma surgery, and has authored articles and published a book on endoscopic surgical procedure. He testified that perhaps from one to five other surgeons in the United States use a fully endoscopic surgical method. Respondent asserts that his work is becoming more prevalent in mainstream medicine, but offered scant evidence to support this proposition.

Treatment of Patient GR

12. Patient GR lost all hearing in his right ear at an early age due to mumps. In mid-2005, GR, then 43 years old and living in Maryland, noticed he was losing hearing in his left ear. An MRI performed in Maryland on February 7, 2006, revealed a three-millimeter by six-millimeter acoustic neuroma growing on nerve bundles connected to patient GR's inner ear and filling the distal end of his left internal auditory canal (IAC).²

13. GR's Maryland physician, David Eisenman, M.D., proposed removing the tumor by utilizing the middle fossa surgical approach, accessing the tumor by entering through the side of the patient's skull. Such an operation could potentially involve a one to two week hospital stay and four to eight weeks of recovery at home. Dr. Eisenman also told GR the approach was not guaranteed to preserve GR's hearing.

14. GR's wife, LR, researched GR's condition on the internet and found a website for the Skull Base Institute, owned by respondent, in Southern California. The website claimed that respondent removed acoustic neuromas using a minimally invasive procedure that would require a briefer surgery, minimal hospitalization, and minimal recovery time. The website did not disclose that respondent is not a neurosurgeon. By telephone, respondent or his staff told LR that respondent proposed to remove GR's tumor by guiding an endoscope through the base of his skull under his ear and that this approach would result in briefer hospitalization and less recovery time than the middle fossa approach. Respondent promised a 98 percent chance of preserving patient GR's hearing.³ Based upon respondent's representations, GR and LR chose respondent to perform the removal of the tumor. GR then had his medical records and an initial payment of \$600 sent to respondent in California for a consultation.

² The IAC is a bony passage in the skull enclosing nerves connecting the inner ear to the brain; the distal end is the part of the canal farthest from the brain. Because the canal is encased in bone, it cannot expand to accommodate a growing tumor. Thus, an expanding tumor compresses soft tissue, including nerves and blood vessels, in the canal and usually grows medially through the canal toward the brain. Acoustic neuromas are the most common tumors of cranial nerves, and are usually benign; they grow from certain cells, called "schwann cells," of the eighth cranial nerve, which has two branches, the vestibular nerve and the cochlear nerve.

³ (See collateral estoppel ruling set forth in Order dated March 4, 2016.)

15. On or about February 16, 2006, respondent evaluated GR by telephone. After the telephone conversation respondent dictated a consultation note wherein he documented that the patient “was seen” in a surgical consultation to decide whether he was a candidate for endoscopic resection of his tumor. Respondent also documented detailed neurological and physical examinations of GR, all using the date of February 16, when respondent talked to GR on the telephone. Respondent testified that the physical examination information came from documents GR obtained from his Maryland physicians on February 22, 2006, and from respondent’s head and neck examination of GR prior to the surgery on February 28, 2006. Respondent testified that his practice at the time was to add entries to his notes but not to date each additional entry. He now uses an electronic medical record system that dates each entry.

16. During the consultation, respondent claims, he discussed non-interventional observation to the patient, but he did not document it as an option in his consultation note. Respondent did not offer an independent consultation with a radiation oncologist regarding management of GR’s lesion. Respondent documented that he told GR and his wife that that using an alternative procedure, gamma knife radiation, to treat the tumor “will burn the tumor and cause it to shrink in size, but the tumor will continue to grow,” an inaccurate description of that procedure. Respondent told GR that the fully endoscopic approach that he was recommending involved “no manipulation or retraction of brain tissue,” which was not accurate, as a post-operative MRI revealed a retraction injury to GR’s cerebellum.

17. Patient GR and his wife LR traveled to California and met respondent on February 28, 2006. Respondent did not conduct and did not document a systemic physical examination of GR on that date. Respondent did conduct an examination of GR’s head but made no record of this examination for that date. GR told respondent that his first priority was to preserve his hearing. Araksi “Roxy” Bekhloyan, a surgical technician, worked as respondent’s office manager and operating room technician in 2003 through 2007, and had contact with patients when they called respondent for consultations. Respondent’s Skull Base Institute website at the time of GR’s surgery referred to Bekhloyan as a registered nurse. She is not a registered nurse, and is not licensed by any state as a nurse. Bekhloyan denied ever informing patients of the risks and benefits of any procedure respondent would perform. The evidence shows, however, that Bekhloyan, in a discussion with LR, referred to the middle fossa approach to acoustic neuroma surgery, an approach not used by respondent, as “barbaric.”

18. On March 1, 2006, at Brotman, respondent performed surgery on GR using a 0-degree endoscope. Respondent did not involve any collaborating specialist, but performed the procedure alone. During the procedure, respondent observed and excised what he thought to be GR’s acoustic neuroma, even though the location of the lesion he excised was not consistent with the location of the acoustic neuroma on the MRI imaging available to him at the time. The material respondent excised was sent to pathology in a container labeled “left acoustic neuroma.” In his operative note, respondent did not document that a specimen was sent to pathology or how it was labeled.

19. At the administrative hearing, respondent explained his approach to GR’s treatment. Respondent understood GR had an acoustic neuroma, based on the February 2006

MRI images and on the February 7, 2006 MRI report. Respondent believed the tumor was in the lateral portion of the IAC. The average IAC is 8mm to 10mm long, so respondent thought he would have to drill up to 6mm into the IAC to reach the tumor while avoiding the cochlea, which was distal to the IAC. Damaging the cochlea would render GR completely deaf in his left ear.

20. Respondent made a one-inch incision behind GR's left ear, accessed the intradural space, and drained cerebrospinal fluid (CSF) to relax the brain and provide more space for the endoscope. Then respondent introduced the endoscope into the posterior fossa and advanced it into the area of the IAC. Respondent opened the bony IAC 1mm or 2mm with a diamond drill, and then used a shear tip to open the IAC another 1mm. He saw a 3mm x 4mm brown lesion on the 7/8 nerve, and a 3mm x 3mm lesion on the fifth cranial nerve. Respondent then opened the IAC another 3mm. Respondent dissected the brown lesion off the 7th/8th nerve, 6mm into the IAC. Respondent then removed another 1mm or 1.5mm of the IAC and tapped on the fundus at the lateral end of the IAC. By the conclusion of the operation, respondent had opened GR's IAC to a distance of 7.5mm. He incorrectly believed the tumor he removed from within the IAC was the tumor revealed in the February MRI. In fact, respondent had completely missed the tumor.

21. Respondent, as was his custom, took pictures early in the procedure and then after removing the tumor. He did not, however, take a picture of the brown lesion before removing it. The photographs he did take show a metal object touching the cerebellum. The object was a device used to suction out the CSF. After respondent removed the brown lesion, a technician gave it to Victor Marquez, who testified at this hearing. Marquez, a registered nurse since 1998, worked on hundreds of cases and does not remember the GR surgery. His practice was to place the removed tissue in a labeled container for a courier from the pathology laboratory to pick up. His operative record of GR's surgery shows that he labeled the container "1. left acoustic neuroma." This was an intraoperative note, not at end of the operation. At the end of an operation, Marquez would generally put tissue suctioned by respondent during surgery into a cavitation ultrasonic surgical aspiration (CUSA) stockinette bag to send to the pathology laboratory. Marquez does not recall whether there was a CUSA bag in GR's case, but there is no note in the operative report showing that tissue in a CUSA bag was sent to the pathology department. According to the pathology report, the pathology laboratory received only one sample from GR's surgery.

Post-Surgical Events

22. Immediately after completing the operation, respondent told LR that he had successfully removed the entire tumor. Shortly afterward, LR told respondent that patient GR was experiencing very painful headaches, and that she was concerned there might be intracranial bleeding. Respondent believed the danger of bleeding by that time was minimal but ordered a post-operative MRI. The weight of the evidence indicates that, although an MRI taken so close in time after the surgery would show swelling and other artifacts of surgery, the areas of enhancement on the intracanalicular portion of the left 7/8 nerve complex, as seen in the preoperative MRI, remained in the post-operative MRI. (See Ex. 17.) This would be consistent

with a failure to remove the tumor. The radiologist believed that the tumor remained, but respondent maintained that the MRI, taken so soon after surgery, revealed only postsurgical scarring and artifacts and that the operation was successful.

23. On March 7, 2006, the pathology department sent respondent's office a pathology report stating that there was no tumor tissue in the sample respondent had removed from GR during surgery. Bekhloyan received a version of the report that had spelling mistakes and typographical errors; she returned it to the pathology department with instructions to correct it, which the pathology department did. Both the uncorrected and corrected versions confirm that no tumor tissue was present in the sample sent to the department. (Ex. 15, p. 100, Ex. 13, p. 209.)

24. Respondent, after the surgery and after reviewing the surgical pathology report and the post-operative MRI, intentionally misrepresented to GR and LR that he had successfully removed the tumor. He told LR that he was "ecstatic." Respondent then intentionally sent or directed someone to send to GR and LR a falsified, third version of the pathology report showing the tumor had been removed when, in fact, it had not been removed. (Ex. 13, p. 210.) Bekhloyan denied altering the pathology report, and denies knowing who did. She does not know whether respondent made the changes.⁴

25. Accepting respondent's assurances that all was well, GR and LR returned to Maryland after the surgical wound had sufficiently healed.

26. GR continued to experience headaches and hearing loss. On or about March 25, 2006, in response to a request to respondent for his records, GR received two separate envelopes in the mail. The two envelopes sent or caused to be sent by respondent contained different versions of the pathology report from GR's operation. The two versions of the pathology report recorded diametrically opposite results. One report stated the pathologist had detected no tumor tissue—the operative language being "no features of acoustic neuroma are seen" in the material respondent took from GR's skull, meaning respondent had not removed

⁴ Respondent is estopped to deny that shortly after the surgery he knew the tumor had not been removed, that he intentionally misrepresented to GR and LR that he had successfully removed the tumor, and that he sent GR and LR the falsified pathology report or caused it to be sent to them. (See Order dated March 4, 2016, regarding the collateral estoppel effect of the decision in a civil lawsuit, *GR, et al. v. Brotman Medical Center, et al.* (Super. Ct. Los Angeles County, 2010, No. BC362005).) Respondent denies that he altered the pathology report or assigned anyone to alter it, and he denies knowing who altered it. He may not deny, however, that he sent it or caused it to be sent to GR. Respondent collaterally attacked Judge Czuleger's decision in the civil case, claiming that the judge relied on perjured testimony. Any inferences from the documentation respondent submitted on this issue and from complainant's decision not to depose GR and LR in this matter are insufficient to give rise to an implication of perjury and do not successfully challenge Judge Czuleger's decision, which was upheld on appeal.

the tumor. This pathology report concluded: “No tumor seen.” The other pathology report was an altered copy of the original report, with the words “no” and “no tumor seen” redacted to change the report’s significant language to suggest that respondent had removed GR’s tumor.

27. In early April 2006, Dr. Eisenman ordered another MRI of GR. The new MRI showed that GR still had a tumor in his IAC. It appeared to be identical to the image in the preoperative MRI. The Maryland doctors proposed a middle fossa approach, from under the temporal lobe, to remove the tumor. Most patients with this approach would have up to a 60 percent chance of retaining hearing. The several nerves passing through the IAC control facial muscles, balance, and hearing. The danger of hearing loss arises from operating so close to the cochlear nerve.

28. On May 25, 2006, Dr. Eisenman, as surgeon, and Dr. Howard Eisenberg, as co-surgeon, operated on GR and successfully removed the tumor. As a result of the surgery, GR lost all hearing in his left ear and was rendered completely deaf.

29. The May 25, 2006 operative report identifies the preoperative diagnosis as “Left intracranial acoustic neuroma.” (Ex. 12.) The postoperative diagnosis is identical. The report describes the operative procedure as a “middle fossa skull-base approach” and “resection of tumor.” (*Ibid.*) The report describes the “Indications” as follows: “This was a combined skull-base approach with the neurological service. Neurosurgery did the craniotomy and exposure of the floor of the middle cranial fossa, and I exposed and opened the internal auditory canal and resected the tumor. The reconstruction was done by neurosurgery.” (*Ibid.*)

30. The “Operative Findings” include the following:

Far lateral intercanalicular tumor, with extension into modiolus, possibly arising from the cochlear nerve.

... [E]xposure of the middle cranial fossa floor was obtained by neurosurgery. ... The internal auditory canal was skeletonized around approximately 270 degrees of its circumference medially. The dissection was then carried out laterally to the fundus working with progressively smaller diamond drill bits. ... The tumor was identified in the very far lateral portions of the internal auditory canal deeply impacted into the cochlear modiolus. ... [T]he tumor was delivered from under the facial nerve. The superior vestibular nerve was identified and transected. The tumor was then dissected out from off the eighth nerve. The very far lateral portions needed to be dissected in a lateral-to-medial direction. The entirety of the tumor was removed. There were some cochlear fibers visible still intact after the procedure, though the entirety of the nerve was definitely not intact.” (Ex. 12.)

31. The report did not characterize the tumor as a cochlear schwannoma, but as an acoustic neuroma that penetrated the cochlea. Respondent maintains, however, that GR’s tumor was unequivocally a cochlear schwannoma, a rare form of acoustic neuroma outside the IAC.

The report of the surgeons who performed the operation and removed the tumor is given more weight than respondent's opinion. Respondent never saw the tumor that was removed; the Maryland surgeons did.

32. Respondent argued that GR suffered no damage from respondent's failure to remove the tumor. Removal of the brown lesion involved no intrusion into the cochlea and no hearing loss. GR lost his hearing, not because of anything respondent did, but because the tumor penetrated the cochlea. Nevertheless, GR was harmed by respondent's unsuccessful surgery and inaccurate reports of the result of that surgery. He traveled across country and made partial payment for a fruitless operation. He risked experiencing swelling, possible hearing loss, infection, and meningitis. He was led to believe that the operation was successful when it was, in fact, a failure, raising and then destroying his hopes that he could retain his hearing.⁵

33. Respondent testified that, if he had known the tumor was inside the cochlea, he would have told GR that he could not remove the tumor without damaging GR's hearing. GR's IAC was not unusually long, about 8 mm. Respondent opened it 7.5mm, and claims he tapped the fundus. GR's IAC was measured incorrectly by the preoperative MRI technician as 12mm, because the technician did not realize that some portion of the tumor was outside the IAC, in the cochlear canal. Respondent, too, thought GR had an unusually long IAC because of the location of the tumor. But this was, in fact, an unusual case of an acoustic neuroma extending distally from the IAC into the cochlea. Respondent, however, maintains that none of the tumor was in the IAC, that it was a cochlear schwannoma and entirely extracanalicular, i.e., outside the IAC. This contradicts the explicit operative findings of the surgeons who removed the tumor.

Expert Witnesses

34. Complainant offered the testimony of Robert S. Carter, M.D., to establish the standard of care for the treatment of patient GR in this case. Dr. Carter is a professor of surgery and neuroscience and Chair of the department of neuroscience at the University of California, San Diego (UCSD). He is Chief of Neurosurgery at Scripps Memorial Hospital and oversees neurological surgeries there. Dr. Carter obtained his joint medical degree and doctorate degree in genetic epidemiology from Johns Hopkins Medical School in 1992. He has been licensed as a physician in California since 2010, and is a diplomate of the American Board of Neurological Surgery. Before coming to California, Dr. Carter was a professor at Harvard Medical School and was on staff for 10 years at Massachusetts General Hospital, where he performed neurological surgery. Dr. Carter specializes in brain tumor surgery at UCSD. He has treated acoustic neuromas for the past 15 years. During his post-graduate training Dr. Carter performed 12 acoustic neuroma surgeries using what is known as the middle fossa approach, with the participation of a neuro-otologist; he performed eight such surgeries while in practice in Massachusetts. At UCSD, the surgeons primarily use the retrosigmoid or translabyrinthine

⁵ Although patient harm is not required in order to support a finding that a physician committed gross negligence or other violations of the Medical Practice Act, it is considered when determining the level of discipline to impose.

approaches, rather than the middle fossa approach. Dr. Carter has used an endoscope in surgery but has never performed or seen a fully endoscopic acoustic neuroma surgery.

35. Respondent offered the testimony of John M. Tew, Jr., M.D. to establish the standard of care for the treatment of patient GR in this case. Dr. Tew is a neurological surgeon, licensed in North Carolina, Kentucky, and Ohio. He was first licensed in 1961. Dr. Tew obtained his medical degree from Wake Forest University in 1961 and completed an internship at Cornell University. He was a resident in neurosurgery at Peter Bent Brigham Hospital from 1963 to 1969. He had a fellowship in Switzerland for six months, where he was trained by Dr. Ugo Fisch in microneurosurgery. In 1969 he joined the Mayfield Clinic in Cincinnati; he led the neurosurgery department there until 2002, when he retired as Chair. He became director of the Neuroscience Institute, leaving in 2014 to join the faculty at the University of Cincinnati College of Medicine. He performs acoustic neuroma surgery, using a variety of approaches. Dr. Tew uses endoscopy to visualize, photograph, and teach anatomy, and is aware endoscopy is more frequently used now as an adjunct to surgical treatment.

36. Respondent offered the testimony of Babak Shayestehfar, M.D., to establish the standard of care for the treatment of patient GR in this case. Dr. Shayestehfar is a general practitioner, with an emphasis on neuroradiology and musculoskeletal radiology, and has been licensed in California since 1996. He attended the University of California, Los Angeles (UCLA) Medical School from 1989 to 1994, interned at Mercy Hospital for one year, did his residency in radiology at UCLA from 1995 to 1999 and a fellowship at the University of Southern California from 1999 to 2000. He worked at Olive View-UCLA Medical Center as chief of musculoskeletal imaging. Respondent has referred about 100 cases to Dr. Shayestehfar to serve as the interpreting radiologist.

37. Drs. Carter, Tew, and Shayestehfar were qualified to testify as experts on the standard of care in this case. Any additional weight given to one expert's testimony over the other's was based on the content of their testimonies and bases for their opinions, as set forth more fully below.

Standard of Care for the Treatment of GR

38. Dr. Carter opined that respondent's documentation of a physical examination of GR during a telephone conversation February 16, 2016 is a simple departure from the standard of care. Respondent recorded in GR's medical records that the patient was seen for a surgical consultation. There was no possibility of respondent performing a physical or neurological examination of GR on that date. Respondent met GR on February 28, 2006; no systemic physical examination on that date is reflected in the records. Dr. Carter did not find that the inaccuracy of the pre-operative records was fraudulent or purposeful; the failure to date events accurately can be cured with the use of electronic medical recordkeeping.

39. Dr. Carter opined that respondent's incomplete and inaccurate characterization of alternative options of treatment for GR's acoustic neuroma was a simple departure from the standard of care for obtaining a patient's informed consent for surgery.

a. Options in the case of a small IAC acoustic neuroma include watchful waiting, various surgical modalities, and radiation treatment. Dr. Carter found that respondent did not document in his consultation note a full discussion of alternatives to his proposed surgery, and respondent mischaracterized the effect of one of the alternatives as burning the tumor. Respondent argues that because GR already knew of alternatives to endoscopic surgery before contacting respondent, respondent did not have to explain all of them to obtain informed consent. Dr. Carter's testimony that each physician is responsible for discussing all alternatives and cannot assume the patient is sufficiently informed to give the required consent is persuasive. Also, a technician, such as Bekhloyan, is not qualified to opine on differences between procedures or to tell patients that a particular method is barbaric. Dr. Tew agreed that that characterization was inappropriate. Dr. Carter opined that respondent's surgical plan had a low likelihood of succeeding in its goal of preserving patient GR's hearing, given the extreme lateral location of the tumor in the IAC. Removing the tumor would require extensive drilling of the bony canal lip and risk impinging on the semicircular canals near the cochlea, causing hearing loss.

b. Respondent promised GR that there would be no retraction of brain tissue when, as reflected in the post-operative MRI, there was edema consistent with retraction injury. Dr. Tew opined that, although post-operative imaging revealed edema of the cerebellum, it does not establish that the cerebellum was retracted or damaged. Dr. Shayestehfar testified that whenever a surgeon touches the dura and disrupts the blood/brain barrier, there is enhancement in the MRI image; it could be retraction injury. Dr. Shayestehfar testified that he lacked the expertise to disagree with Dr. Carter's characterization of the image as being consistent with retraction injury to cerebellum.

40. Dr. Carter opined that respondent's failure to identify a radiographic/clinical correlation inconsistency during the operation, and his assuming that the acoustic neuroma had been removed when in fact it had not been removed, was an extreme departure from the standard of care. Dr. Carter testified, and wrote in his report, that the standard of care for acoustic neuroma surgery requires the surgeon to accurately correlate preoperative imaging studies with intraoperative findings and to correctly identify normal and abnormal structures, including tumor masses. (Ex. 12.) When using the middle fossa approach, the surgeon tries to correlate what he or she visualizes of the tumor with the preoperative MRI. Dr. Carter opined that respondent should have known the lesion he found and removed was not the tumor identified in the preoperative MRI images, as it was not at the far lateral portion of the IAC.⁶ Dr. Carter's opinion is persuasive. Respondent found a lesion that was not near what would be the far lateral end of what respondent believed to be a 12 mm-long IAC. Respondent continued to

⁶ Dr. Carter testified that respondent incorrectly identified the location of the tumor as being on the 5th cranial nerve rather than the 7th/8th nerve complex. Respondent's explanation, that he circled a 5th nerve lesion on a photograph to demonstrate what the lesion he had removed looked like was credible; respondent had not photographed the lesion he removed.

drill the bone of the IAC until he could tap the fundus, which was 7.5 mm from the lip of the IAC, not 12 mm from the lip. Yet it apparently did not occur to respondent that the discrepancy between the location of the tumor revealed in the preoperative MRI and the location of the lesion he removed did not support his conclusion that he had removed the tumor. Dr. Carter opined that, when respondent drilled and did not see the expected tumor, respondent should have discontinued the surgery and told the patient, rather than continuing to drill and risk hearing loss. No method of removing the tumor could have preserved GR's hearing, the tumor being located, in part, in the cochlear modiolus.

41. Dr. Carter opined that respondent's failure to recognize the tumor on post-operative imaging was a simple departure from the standard of care, which requires that a surgeon accurately interpret post-operative imaging findings following tumor resection. The post-operative MRI revealed a pattern of nodular enhancement consistent with and in the same location as in the preoperative imaging findings. It at least should have raised a concern that some residual tumor was present. (Ex. 16F, 16C.) The MRI, combined with intraoperative findings about the location of the lesion that was removed, and the pathology report that issued shortly after the postoperative MRI, should have alerted respondent to the fact that he had not removed the tumor.

42. Dr. Carter opined that respondent's failure to accurately document in his operative note the pathologic specimens that were obtained at surgery and sent for analysis was a simple departure from the standard of care. The standard of care requires that a pathological specimen be sent to the pathology department in every acoustic neuroma operation, and that any deviation from this practice be explained in the medical record and to the patient. The operative record documents a single specimen, "left AN," as does the pathology report. "The pathologist found the specimen in a stockinette bag, as if from the ultrasonic aspirator." (Ex. 12.) Respondent's statement that two samples were sent to the pathology department, and that the stockinette specimen is not the correct sample, is not supported by the documentary evidence.

43. Dr. Carter opined that respondent's failure to communicate to GR or his wife the evidence of his failure to remove the tumor when this information became available to him was an extreme departure from the standard of care. The standard of care requires a physician to accurately and timely communicate results to patients. GR only learned of respondent's failure to remove the tumor when he received two pathology reports, one of them falsified, in the mail, and obtained another MRI from his Maryland physician.

44. Dr. Carter opined that respondent's website advertising and communication with GR and LR, which were untrue or misleading in that they overstated respondent's training and qualifications to perform GR's acoustic neuroma surgery, constituted a simple departure from the standard of care for obtaining valid informed consent. The standard of care requires that physicians accurately disclose all information material to patient's decision to undergo surgery, including the physician's credentials. Respondent's website stated he had received medical degrees from AUB and the University of Chicago, when he had received only one degree, from AUB. Respondent's website says he has had "lengthier and more specialized training" than other brain surgeons, likely to create a misimpression concerning respondent's training relative

to the training received by a neurosurgeon. Respondent corrected the information on his website and in a Wikipedia article concerning respondent, but he was responsible for assuring the correctness of the information posted and allowed it to inaccurately represent his educational background for many years.

45. Dr. Carter opined that respondent's failure to involve a collaborating specialist, either a neuro-otologist with special expertise in facial/cochlear nerve/IAC anatomy or a neurosurgeon with expertise in intradural acoustic neuroma brain surgery, in GR's care, was an extreme departure from the standard of care. The standard of care requires that acoustic neuroma surgery be performed in multidisciplinary fashion by surgeons with neuro-otological and neurosurgical training. For authority, Dr. Carter referred to materials not clearly relevant to the standard of practice in the United States. Dr. Carter could not opine on whether respondent is qualified to perform skull base acoustic neuroma surgery, and conceded that respondent may have had some success performing endoscopic surgery, although he was in error about the results of the surgery on patient GR. Dr. Carter testified that whether respondent's craniofacial fellowship and skull base fellowship with Dr. Fisch in Zurich is equivalent to a neurosurgical residency training program depends on the training respondent actually received with Dr. Fisch, which was evidenced only by respondent's unsupported testimony. Respondent was granted staff privileges at Cedars and at Brotman, after being vetted and proctored, to perform fully endoscopic acoustic neuroma surgery alone. Dr. Carter nevertheless opined that a collaborative approach, which would generally be less financially advantageous for respondent, might have identified the likelihood of failure of respondent's choice of approach in GR's case, reduced the risk of brain retraction injury, and reduced the risk of failure to remove the tumor. While that may have been preferable, it is not sufficient to establish a deviation from the standard of care.

46. Dr. Carter opined that respondent's performance of deep intradural brain surgery to remove pineal tumors, which he claims to perform, without completion of a neurosurgical residency training program, is an extreme departure from the standard of care, which requires such surgery to be performed by a surgeon who has completed neurosurgical residency training. Respondent's ability to access a certain area of the brain is not, according to Dr. Carter, equivalent to receiving the neurosurgical training to manipulate the brain, remove brain tumors, and deal with complications. Only trained neurosurgeons could provide meaningful peer review of such procedures. Board-certified neurosurgeons are re-examined every 10 years; respondent's board certification in surgery does not require periodic examination of his knowledge of skull base brain surgery.

47. Dr. Tew opined that, in GR's case, based on the preoperative MRI, it was reasonable for respondent to drill into the IAC about 6 mm to try to locate the tumor, and to conclude that the brown lesion was the tumor. It would have been reasonable for respondent to tell LR that he thought he had removed the tumor, though he could not be sure for some months. What respondent removed was most likely a staining on the vestibular nerve, resulting from a prior infection, such as mumps. The preoperative MRI images reveal an intracanalicular mass with abnormal enhancement. Post-operative images demonstrate the same. The preoperative and post-operative images both show a 3mm x 6mm mass, as does the image obtained in Maryland before GR's May 2006 surgery. Dr. Tew agrees that the tumor is visible

on all the MRI images. Respondent misinterpreted those images because the tumor was outside his operative field in the IAC, where he expected to find the tumor.

48. Dr. Tew opined, after reviewing the records of the May 2006 surgery, that the tumor originated in the cochlea and grew outward, i.e., it was a cochlear neuroma, which is very rare. This opinion contradicts the findings of the surgeons who actually saw and removed the tumor, and is not persuasive.

49. Dr. Tew observed respondent perform a fully endoscopic acoustic neuroma shortly before the administrative hearing began. He testified that he has never seen an acoustic neuroma surgery done better in 50 yrs. He invited R to come to Cincinnati to speak to students about his procedure. He testified that "There are few maestros in the world, but he is one."

50. Dr. Tew testified, however, that it is not yet known whether a fully endoscopic approach to removing an acoustic neuroma is safer than the more common microsurgical approach. There is no evidence that respondent's fully endoscopic method has a better outcome rate than currently prevalent methods. Removing an acoustic neuroma using an endoscope exclusively is not generally accepted practice in the United States. The standard of care, however, is always changing. It is also the standard of care for the surgery to be performed by a team comprised of a neurosurgeon and neuro-otologist. Dr. Tew might allow respondent to do his procedure alone, though respondent is a general surgeon, not a neurosurgeon. But Dr. Tew's institution would not allow that, and Dr. Tew would not recommend establishing a center run by someone who had not done a neurosurgery residency.

51. Dr. Shayestehfar reviewed the preoperative MRI images and the March 2, 2006 post-operative images. He interprets the images to reveal an acoustic neuroma within the lateral aspect of the left IAC. An acoustic neuroma generally grows medially, toward the brain; a tumor usually follows the path of least resistance. Dr. Shayestehfar described the fundus at the end of the IAC as a bony structure preventing any tumor from growing out to the ear. This testimony is unpersuasive in light of the findings of the Maryland surgeons and his own testimony that a tumor may grow through the opening the cochlear and other nerves traverse between the cochlea and the IAC.

52. Dr. Shayestehfar agreed with respondent that, to accurately determine whether the tumor remained, one should take a post-operative MRI three months after the surgery. A post-operative MRI taken sooner would show post-operative changes and be difficult to interpret. The post-operative MRI report from March 1, 2006, does reveal some persistent enhancement along the 7th/8th nerve complex in the IAC, however, in the same location as the preoperative MRI, as well as some abnormal signal on the cerebellum. The post-operative MRI report says "images still demonstrate the same pattern of enhancement." (Ex. 17, p. 2, Impression 1.) Dr. Shayestehfar compared the pre- and post-operative MRI images, and found them to be similar. The post-operative MRI report should have alerted respondent that the tumor could still be present.

53. Dr. Shayestehfar believes the May 25, 2006 operative report describes a schwannoma starting at the far lateral aspect of IAC and following the course of the cochlear

nerve laterally into the modiolus of the cochlea. Up to this point, all the doctors who identified the tumor as being entirely inside the IAC were wrong. This tumor started in the far lateral IAC, but then grew laterally instead of medially toward the brain.

54. Regarding whether respondent engaged in negligent acts in his care of GR, the opinion of Dr. Carter was, for the most part, more persuasive than the opinions of Drs. Tew and Shayestehfar. Therefore, the opinions of Dr. Carter, set forth in Factual Findings 38 to 46, are adopted as facts herein, except where stated otherwise. Certain opinions of Drs. Tew and Shayestehfar, as set forth in Factual Findings 47 to 53 are also adopted herein, except where stated otherwise.

55. Dr. Carter's, Dr. Tew's, and Dr. Shayestehfar's testimony established that other approaches to the surgery might have been employed to increase safety and efficacy, and all three highlighted that there was a difference of medical opinion concerning the desirability of using a team of surgeons to perform the acoustic neuroma surgery. That testimony does not establish that respondent's decision to operate alone was negligent. (See Legal Conclusion 4.)

Character Evidence

56. Naji N. Abumrad, M.D., testified on respondent's behalf. Dr. Abumrad is a surgeon licensed in Tennessee and New York. His license was suspended, with the suspension stayed, by the New York Board of Professional Medical Conduct, which found Dr. Abumrad incompetent and negligent in 1997. Dr. Abumrad completed the suspension and his license was fully restored. In 2014, he was made a fellow of the American Academy for the Advancement of Sciences. Dr. Abumrad met respondent when respondent interviewed for a general surgery residency program at Vanderbilt in 1985. Respondent expressed interest in skull base surgery, then a new area requiring skill in multiple disciplines including general surgery and plastic surgery. In 1992 Dr. Abumrad became head of surgery at SUNY Stony Brook; he recruited respondent and made respondent co-director of the skull base program there. Dr. Abumrad observed respondent performed skull base surgery while at SUNY; respondent received positive reports from neurosurgeons who observed his procedures. Dr. Abumrad left SUNY in 1996. He is now the Executive Director of Patient Care Center at Vanderbilt, and Emeritus Chair of the Department of Surgery. He wrote the forward for respondent's book on endoscopic procedures; he believes endoscopic surgery to be a paradigm shift, and testified that he would allow respondent to operate on his family members.

57. Reza Jarrahy, M.D., is a surgeon licensed in California since 1998; he performs craniofacial surgery, not skull base surgery. Dr. Jarrahy met respondent in medical school; respondent was a member of the faculty at SUNY Stony Brook and mentored Dr. Jarrahy. After finishing his residency at UCSD after 1998, Dr. Jarrahy did research with respondent at Cedars-Sinai Hospital, when respondent was the Director of the Skull Base Surgery Division within the Surgery Department. When working with respondent at Cedars-Sinai, surgeons were shifting from using microscopes to using endoscopes during surgery as a better, less cumbersome, light source. He observed respondent perform over 100 surgeries. He believes respondent is "a master surgeon." He has referred patients to respondent over the years.

58. Maj. Bartley J. Holmes, USAF, testified on respondent's behalf. Major Holmes was diagnosed with a 4.5 cm vestibular schwannoma in 2009. Surgeons he contacted offered to perform translabyrinthine surgery, which, they told him, would damage his inner ear, causing vertigo, and terminate his military career. Maj. Holmes talked to respondent, who told him he could perform a procedure that would not result in vertigo. Major Holmes chose to have respondent perform the surgery in January 2010. He was fully informed that he could lose all hearing in his left ear, and he did. But he was able to return to full duty and has been deployed twice with no problems. He is grateful to respondent.

59. David Offitzer, a roofing contractor in San Pedro, was diagnosed with an acoustic neuroma in early 2013, and experienced hearing degradation in his left ear. Offitzer asked respondent to perform surgery. Respondent told him there was only a 30 percent chance of saving his hearing; he told respondent he would sacrifice his hearing to have the tumor removed. Respondent operated in August 2013. Offitzer is very satisfied with the result, and retains 30 percent of the hearing in his left ear.

Mitigation and Rehabilitation

60. This case involves a single patient who had surgery 10 years ago. Respondent characterizes his failure to correctly identify GR's tumor as "one honest mistake." Respondent has performed hundreds of similar operations since the GR operation, and evidence shows that many patients have been satisfied with the results. He believes his procedure is much safer than alternative surgical methods and succeeds for patients. Respondent asserts that he is a victim of a conspiracy of neurosurgeons who feel threatened by his less invasive surgical alternative. Respondent testified that the lawsuit brought by GR and LR, and this administrative matter, have caused him to experience isolation, drained his financial resources, and unfairly damaged his reputation. Respondent continues to attack the judgment against him, though it was upheld on appeal, maintaining that Judge Czuleger relied on perjured testimony and was denied critical exculpatory evidence.

61. Respondent overstated his qualifications on his website. He was careless about the educational background information he presented to the Board on his application. There is insufficient evidence on this record as to whether respondent received hands-on training from Dr. Fisch, in view of questions about respondent's credibility. Respondent communicated to GR an inflated likelihood that GR would retain his hearing. Respondent was found to have engaged in fraud after performing an unsuccessful operation. He intentionally misrepresented the result of the surgery, and sent GR or caused to be sent to GR a falsified pathology report. The existence of a conspiracy of neurosurgeons was not established by the evidence. On the contrary, respondent's expert witnesses testified that, although respondent is an excellent surgeon, his fully endoscopic procedure is not generally accepted practice and their hospitals would not permit such surgery without the presence of a neuro-otologist or neurosurgeon. This further calls into question whether respondent met the standard of care in this case, despite the fact that Cedars and Brotman permitted respondent to perform fully endoscopic acoustic neuroma surgery alone.

62. This matter involves more than an outcome for one patient. All else aside, the facts established by collateral estoppel alone warrant revocation for the protection of the public. Respondent's continued practice at this time, after failing to acknowledge what he was found to have done wrong, creates a further risk to the public. The admissible evidence presented in this matter, and the facts respondent is collaterally estopped to deny, establish that respondent has not taken full responsibility for his acts.

LEGAL CONCLUSIONS

Burden of Proof

1. The rigorous educational, training, and testing requirements for obtaining a physician's license justify imposing on complainant a burden of proof of clear and convincing evidence. (Evid. Code, § 115; see *Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856; *Imports Performance v. Dept. of Consumer Affairs, Bur. of Automotive Repair* (2011) 201 Cal.App.4th 911.)

Applicable Authority

2. The Board's highest priority is to protect the public. (Bus. & Prof. Code, § 2229.)⁷ The Board may take action against a licensee for unprofessional conduct, which includes "[t]he commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon." (§§ 2234, subd. (e), 490.)

3. "A licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper." (§ 2227.)

4. In selecting a method of treatment, skillful members of the medical profession may differ; however, the practitioner must keep within the "recognized and approved methods." (*Callahan v. Hahnemann Hospital* (1934) 1 Cal.2d 447.) If so, negligence is not shown by evidence that other medicines or treatment might have been employed. (*Jensen v. Findlay* (1936) 17 Cal.App.2d 536.) The mere fact that there is a difference of medical opinion concerning the desirability of one particular medical procedure over another does not establish that the determination to use one of the procedures was negligent. (*Clemens v. Regents of Univ. of Cal.* (1970) 8 Cal.App.3d 1, 13.)

⁷ Further statutory references are to the Business and Professions Code except where otherwise stated.

Cause for Discipline

5. Cause exists to suspend or revoke respondent's license under section 2234, subdivision (b), in that he committed gross negligence in his care and treatment of patient GR by failing to identify radiographical/clinical correlation inconsistency during the operation and erroneously concluding that he had removed GR's acoustic neuroma, as set forth in Factual Findings 14 to 33, 38 to 55, 61, and 62.

6. Cause exists to suspend or revoke respondent's license under section 2234, subdivision (b), in that he committed gross negligence in his care and treatment of patient GR by failing to communicate to GR and LR the evidence of his failure to remove the tumor when that information became available to respondent, as set forth in Factual Findings 14 to 33, 38 to 55, 61, and 62.

7. Cause does not exist to suspend or revoke respondent's license under section 2234, subdivision (b), in that it was not established that respondent committed gross negligence in his care and treatment of patient GR by failing to involve a relevant collaborating specialist in GR's operation, where respondent's procedure was approved by the hospital at which he had privileges, as set forth in Factual Findings 14 to 33, 38 to 55, 61, and 62.

8. Cause does not exist to suspend or revoke respondent's license under section 2234, subdivision (b), in that it was not established that respondent committed gross negligence by performing deep intradural brain surgery of patients other than patient GR without having completed a neurosurgical residency training program, as set forth in Factual Findings 14 to 33, 38 to 55, 61, and 62.

9. Cause exists to suspend or revoke respondent's license under section 2234, subdivision (c), in that he committed repeated acts of negligence by: inaccurately documenting a physical examination of GR on February 16, 2006; providing an incomplete and inaccurate characterization of alternative options of treatment for an acoustic neuroma in the process of obtaining GR's informed consent for surgery; failing to identify radiographical/clinical correlation inconsistency during the operation and erroneously concluding that he had removed GR's acoustic neuroma; failing to recognize the remaining tumor on post-operative imaging; failing to document in the operative note the pathologic specimens that were obtained during surgery and sent for analysis; failing to communicate to GR and LR the evidence of his failure to remove the tumor when that evidence became available to respondent; and promulgating advertising and communicating information to his patient that was untrue or misleading by overstating his training and qualifications to perform GR's acoustic neuroma surgery, as set forth in Factual Findings 14 to 33, 38 to 55, 61, and 62.

10. Cause does not exist to suspend or revoke respondent's license under section 2234, subdivision (c), in that it was not established that respondent committed repeated acts of negligence by failing to involve a relevant collaborating specialist in GR's operation, where respondent's procedure was approved by the hospital at which he had privileges, as set forth in Factual Findings 14 to 33, 38 to 55, 61, and 62.

11. Cause does not exist to suspend or revoke respondent's license under section 2234, subdivision (c), in that it was not established that respondent committed repeated acts of negligence by performing deep intradural brain surgery of patients other than patient GR without having completed a neurosurgical residency training program, as set forth in Factual Findings 14 to 33, 38 to 55, 61, and 62.

12. Cause exists to suspend or revoke respondent's license under section 2234, subdivision (e), for unprofessional conduct in committing dishonest or corrupt acts, based on respondent's intentionally misrepresenting to GR the chances of preserving his hearing and the results of the operation, and sending or causing to be sent to GR a falsified pathology report, as set forth in Factual Findings 14 to 33, 38 to 55, 61, and 62.

13. Cause exists to suspend or revoke respondent's license under section 2261 for false representations, based on respondent's intentionally misrepresenting to GR the chances of preserving his hearing and the results of the operation, and sending or causing to be sent to GR a falsified pathology report, as set forth in Factual Findings 14 to 33, 38 to 55, 61, and 62.

14. Cause does not exist to suspend or revoke respondent's license under section 2262 for altering or modifying the medical record of GR with fraudulent intent or creating a false medical record with fraudulent intent, as it was established by clear and convincing evidence only that respondent caused a fraudulent pathology report to be sent to GR, not that he himself prepared the report or caused it to be prepared, as set forth in Factual Findings 14 to 33, 38 to 55, 61, and 62.

15. Cause exists to suspend or revoke respondent's license under section 2266 for failing to maintain adequate and accurate records relating to the provision of services to GR, as set forth in Factual Findings 14 to 33, 38 to 55, 61, and 62.

16. Cause exists to suspend or revoke respondent's license under section 2271 for false and misleading advertising in violation of section 17500 by promulgating advertising on his website and making statements to his patient that were untrue or misleading, and overstating his training and qualifications to perform GR's acoustic neuroma surgery, as set forth in Factual Findings 14 to 33, 38 to 55, 61, and 62.

17. Respondent failed to establish that, although cause exists to suspend or revoke his license, such disciplinary action should not be taken, or lesser discipline should be imposed. Based on Factual Findings 14 to 33, 38 to 55, 61, and 62, the safety of the public cannot be protected if respondent is permitted continued licensure at this time.

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ORDER

Physician and Surgeon's Certificate No. A 60898, issued to Hrayr Karnig Shahinian, M.D., is revoked.

DATED: July 6, 2016

DocuSigned by:

Howard W. Cohen

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HOWARD W. COHEN
Administrative Law Judge
Office of Administrative Hearing

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO FEBRUARY 4, 2013
BY: J. TELLEZ ANALYST

8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 11-2010-206785

13 HRAYR KARNIG SHAHINIAN, M.D.

14 8635 West Third Street, Suite 1170W
Los Angeles, California 90048

A C C U S A T I O N

15 Physician's and Surgeon's Certificate A 60898,
16 Respondent.

17
18 Complainant alleges:

19 PARTIES

20 1. Linda K. Whitney (Complainant) brings this Accusation solely in her official capacity
21 as the Executive Director of the Medical Board of California (Board).

22 2. On or about September 18, 1996, the Medical Board of California issued Physician's
23 and Surgeon's Certificate number A 60898 to Hrayr Karnig Shahinian, M.D. (Respondent). That
24 license was in full force and effect at all times relevant to the charges brought herein and will
25 expire on January 31, 2014, unless renewed.

26 JURISDICTION

27 3. This Accusation is brought before the Board under the authority of the following
28 laws. All section references are to the Business and Professions Code unless otherwise indicated.

1 4. Section 2227 of the Code, states:

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

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

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

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

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

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

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

21 5. Section 2234 of the Code, states:

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

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

27 "(b) Gross negligence.

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

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

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

11 "(d) Incompetence.

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

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

15 "(g) The practice of medicine from this state into another state or country without meeting
16 the legal requirements of that state or country for the practice of medicine. Section 2314 shall not
17 apply to this subdivision. This subdivision shall become operative upon the implementation of the
18 proposed registration program described in Section 2052.5.

19 "(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and
20 participate in an interview scheduled by the mutual agreement of the certificate holder and the
21 board. This subdivision shall only apply to a certificate holder who is the subject of an
22 investigation by the board."

23 6. Section 2261 of the Code states:

24 "Knowingly making or signing any certificate or other document directly or indirectly
25 related to the practice of medicine or podiatry which falsely represents the existence or
26 nonexistence of a state of facts, constitutes unprofessional conduct."

27 7. Section 2262 of the Code states:

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

3 “In addition to any other disciplinary action, the Division of Medical Quality¹ or the
4 California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars (\$500)
5 for a violation of this section.”

6 8. Section 2266 of the Code states:

7 “The failure of a physician and surgeon to maintain adequate and accurate records relating
8 to the provision of services to their patients constitutes unprofessional conduct.”

9 9. Section 2271 of the Code states:

10 “Any advertising in violation of section 17500, relating to false or misleading advertising
11 constitutes unprofessional conduct.”

12 FIRST CAUSE FOR DISCIPLINE

13 (Gross Negligence)

14 10. Respondent is subject to disciplinary action under section 2234, subdivision (b), in
15 that he committed acts of gross negligence in his care and treatment of patient George R². The
16 circumstances are as follows:

17 11. When he was a young boy in the late 1960's, George lost his hearing in his right ear
18 from mumps. In mid-2005, George, then 43 years old, and living in Maryland, noticed he was
19 losing his hearing in his left ear. An MRI performed in Maryland, on or about February 7, 2006,
20 revealed a three-millimeter by six-millimeter benign tumor, known as an acoustic neuroma,

21
22
23
24 ¹ Business and Professions Code section 2002, as amended and effective January 1, 2008,
25 provides that, unless otherwise expressly provided, the term "board" as used in the State Medical
26 Practice Act (Bus. & Prof. Code, § 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.

27 ² The name of the patient in this Accusation is designated by his first name and initial to
28 protect his privacy. His full name will be disclosed to the Respondent in response to a Request
for Discovery.

1 growing on nerve bundles connected to George's inner ear and filling the distal end of his left
2 internal auditory canal.³

3 12. Shortly after the results of the MRI were discovered, George's Maryland physician
4 proposed removing the tumor by utilizing the middle fossa surgical approach, by which a surgeon
5 reaches the tumor by entering through the side of the patient's skull. Such an operation could
6 potentially involve a one to two week hospital stay and four to eight weeks of recovery at home.
7 His Maryland physician also told George the approach was not guaranteed to preserve George's
8 hearing.

9 13. Seeking better odds and a quicker recovery, George and his wife discovered on the
10 Internet a website for Respondent's "Skull Base Institute" which, along with its affiliated
11 practice group, Skull Base Medical Group, Inc., is wholly owned by Respondent. As of February
12 10, 2006, and ongoing, Respondent's website represented him as a Skull Base Surgeon who
13 performs "Minimally Invasive Endoscopic Brain Surgery." The webpage for Skull Base and Dr.
14 Shahinian represented that they performed removal of acoustic neuromas using a minimally
15 invasive procedure that would require a briefer surgery, minimal hospitalization, and minimal
16 recovery time. Respondent's website advertised that Respondent's training was "lengthier and
17 more specialized than that of a neurosurgeon." However, on or about February 10, 2006,
18 Respondent's website did not disclose the fact that he is not trained as a neurosurgeon, and had
19 not undergone neurosurgical residency training.⁴ When George's wife asked him about what a
20 "Skull Base Surgeon" was, he made statements to her that his credentials were more advanced
21 than those of neurosurgeons or other practitioners, and that skull base surgeon is "a step above a
22 neurosurgeon." In sum, Respondent's advertising and communications with George and his wife

23 ³ The internal auditory canal is a bony opening in the skull enclosing nerves passing from
24 the inner ear to the brain; the distal end is the part of the opening farthest from the brain. Because
25 the canal exists in bone, the canal cannot expand to accommodate a growing tumor. Thus, an
26 expanding tumor compresses surrounding soft tissue, including nerves and blood vessels in the
canal.

27 ⁴ Dr. Shahinian is not a neurosurgeon. His residency training was in general surgery with
28 fellowships in craniofacial surgery, skull base surgery, and plastic and reconstructive surgery.

1 overstated Respondent's training and qualifications to perform George's acoustic neuroma
2 surgery in relation to other medical practitioners specializing in the treatment of acoustic
3 neuroma.⁵

4 14. During phone conversations with George's wife, Respondent or his staff told
5 her that Respondent had refined the retrosigmoid surgical approach for removing acoustic
6 neuromas. Using that method, Respondent proposed to remove George's tumor by guiding an
7 endoscope through the base of his skull under his ear, and that this approach would result in
8 briefer hospitalization and less recovery time than the middle fossa approach, and promised a 98
9 percent chance of preserving George's hearing. Based upon Dr. Shahinian's representations, Mr.
10 and Mrs. R. chose Dr. Shahinian to perform the removal of the tumor. George then had his
11 medical records and an initial payment of \$600 sent to Respondent in California for a
12 consultation.⁶

13 15. On or about February 16, 2006, Respondent evaluated George over the telephone.
14 Following the telephone conversation, Respondent dictated a consultation note dated February 16,
15 2006, wherein he documented that the patient "was seen" in surgical consultation in order to
16 decide if he would be a candidate for endoscopic resection of his tumor. On that date,
17 Respondent also documented detailed neurological and physical examinations of George that did
18 not take place and could not have taken place over the telephone.

19 16. During the consultation on or about February 16, 2006, Respondent did not mention
20 noninterventional observation to the patient and did not list it as an option in his consultation
21 note, nor did he offer an independent consultation with a radiation oncologist regarding
22 management of George's lesion. Respondent also documented that he told George and his wife
23 that that using Gamma Knife radiation to treat the tumor "will burn the tumor and cause it to
24 shrink in size, but the tumor will continue to grow," which was an inaccurate description of that
25 alternative treatment. Respondent also told the patient that Endoscopic Retrosigmoid Approach,

26
27 ⁵ Acoustic neuroma treatment in the United States is undertaken by three board certified
specialties: radiation oncology, ENT, and neurosurgery. The latter two perform surgery.

28 ⁶ His professional fee was \$53,000.

1 which he was recommending for excising his acoustic neuroma, involved "no manipulation or
2 retraction of brain tissue," which was not accurate, as a post-operative MRI revealed a retraction
3 injury to George's cerebellum.

4 17. George and his wife traveled to California and met Respondent on February 28, 2006.
5 Respondent did not conduct and did not document a systemic physical examination of George on
6 that date. Respondent did conduct an examination of George's head; however, he made no record
7 of this examination.

8 18. On March 1, 2006, at Brotman Medical Center in Culver City, California, Respondent
9 performed surgery on George using a 0-degree endoscope to accomplish the Retrosigmoid
10 Approach. Respondent did not involve any relevant collaborating specialist, but performed the
11 procedure alone. During the procedure, Respondent observed and excised what he thought to be
12 George's acoustic neuroma, even though the location of what he excised was not consistent with
13 the location of the acoustic neuroma on the MRI imaging available to him at the time.
14 Respondent failed to identify a radiographic/clinical correlation inconsistency and assumed,
15 incorrectly, that he removed George's acoustic neuroma. The material which was excised by the
16 Respondent was sent to pathology in a container labeled "left acoustic neuroma." In his operative
17 note, Respondent did not document that a specimen was sent to pathology or how it was labeled.
18 Respondent did not request a frozen section.

19 19. Immediately after completing the operation, Respondent told George's wife that he
20 had successfully removed the entire tumor. In fact, Respondent had completely missed the tumor,
21 which remained intact in George's internal auditory canal.

22 20. Respondent ordered a post-operative MRI of George's skull. The radiologist who
23 interpreted the MRI, taken on or about March 2, 2006, reported small focal areas of enhancement
24 on the mid intracanalicular portion of the left 7th and 8th nerve complex.

25 21. Respondent saw George for a post-operative visit on or about March 6, 2006, and
26 reiterated to George and his wife that the surgery went well and that he had removed the entire
27 tumor. He documented that the incision was healing well, that there was no redness or swelling
28 around the incision, and no sign of infection. Respondent, who had access to George's pre-

1 operative MRI and post-operative MRI's, knew or should have known that the persistence of an
2 identical pattern of nodular enhancement indicated that the tumor remained, but Respondent
3 instead told George and his wife that the post-operative MRI showed that the surgery had
4 succeeded.

5 22. A few days after the surgery, on or about March 6, 2006, Respondent received a
6 pathology report stating that the material which was excised by the Respondent and sent to
7 pathology did not contain tissue consistent with a tumor. Thus, soon after the surgery Respondent
8 had both an MRI and a pathology report available which showed that he failed to excise George's
9 tumor, but he did not communicate this information to George or to his wife. Respondent never
10 informed George or his wife that the surgery failed and that George's acoustic neuroma remained.
11 Accepting Respondent's assurances that all was well, George and his wife returned to Maryland
12 after his surgical wound had sufficiently healed.

13 23. On or about March 25, 2006, in response to a request for his records, George received
14 two separate envelopes in the mail. The two envelopes contained different versions of the
15 pathology report from George's operation. The two versions of the pathology report recorded
16 diametrically opposite results. One report stated the pathologist had detected no tumor tissue – the
17 operative language being "no features of acoustic neuroma are seen" -- in the material
18 Respondent took from George's skull, meaning Respondent had not removed the tumor. This
19 pathology report concluded: "No tumor seen." The other pathology report was an altered copy of
20 the original and true report with the words "no" and "no tumor seen" apparently obliterated to
21 change the report's operative language to suggest that Respondent had removed George's tumor
22 when he had not.

23 24. As a result of these differing reports, in early April 2006, George underwent another
24 MRI in Maryland. This additional MRI again showed that he still had a tumor in his internal
25 auditory canal. It appeared identical to the pre-surgery MRI.

26 25. On or about May 25, 2006, George's Maryland physician operated on George and
27 removed the tumor. Unfortunately, the surgery rendered George completely deaf.
28

26. Each of the following acts or omissions by Respondent constitutes an extreme departure from the standard of care:

A . His failure to identify radiographic/clinical correlation inconsistency at operation and assuming that acoustic neuroma had been removed when in fact it had not been removed was an extreme departure from the standard of care.

B. His failure to communicate to George and/or his wife the evidence of failure to remove the tumor when this information became available to Respondent was an extreme departure from the standard of care.

C. His failure to involve a relevant collaborating specialist, either a neuro-otologist with special expertise in facial/cochlear nerve/internal acoustic canal anatomy or a neurosurgeon with expertise in intradural acoustic neuroma brain surgery, in George's care, was an extreme departure from the standard of care.

D. His performance of deep intradural brain surgery without completion of a neurosurgical residency training program is an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

27. Respondent is subject to disciplinary action under section 2234, subdivision (c) in that he committed repeated acts of negligence. The circumstances are as follows:

28. Allegations of Paragraphs 11 through 25 are incorporated herein by reference as if fully set forth here.

29. Each of the following acts or omissions by Respondent constitutes a departure from the standard of care:

A. His documentation of a physical examination of George on February 16, 2006, was a departure from the standard of care.

B. His incomplete and inaccurate characterization of alternative options of treatment for an acoustic neuroma in the process of obtaining George's informed consent was a departure from the standard of care.

1 C. His failure to identify radiographic/clinical correlation inconsistency at operation and
2 assuming that acoustic neuroma had been removed when in fact it had not been removed was an
3 extreme departure from the standard of care.

4 D. His failure to recognize the remaining tumor on post-operative imaging was a departure
5 from the standard of care.

6 E. His failure accurately to document in the operative note the pathologic specimens that
7 were obtained at surgery and sent for analysis was a departure from the standard of care.

8 F. His failure to communicate to George and/or his wife the evidence of failure to remove
9 the tumor, when this information became available to Respondent, was an extreme departure from
10 the standard of care.

11 G. His promulgation of advertising and specific doctor-to-patient communications, which
12 were untrue or misleading by overstating Respondent's training and qualifications to perform
13 George's acoustic neuroma surgery in relation to other practitioners of acoustic neuroma surgery,
14 was a departure from the standard of care.

15 H. His failure to involve a relevant collaborating specialist, either a neuro-otologist with
16 special expertise in facial/cochlear nerve/internal acoustic canal anatomy or a neurosurgeon with
17 expertise in intradural acoustic neuroma brain surgery, in George's care, was an extreme
18 departure from the standard of care.

19 I. His performance of deep intradural brain surgery without completion of a neurosurgical
20 residency training program is an extreme departure from the standard of care.

21 THIRD CAUSE FOR DISCIPLINE

22 (Corrupt or Dishonest Acts)

23 30. Respondent is subject to disciplinary action under section 2234, subdivision (e) in
24 that he committed acts involving dishonesty or corruption. The circumstances are as follows:

25 31. The allegations of Paragraphs 11 through 25 are incorporated herein by reference as if
26 fully set forth here.

1 FOURTH CAUSE FOR DISCIPLINE

2 (False Representations)

3 32. Respondent is subject to disciplinary action under section 2261 in that he knowingly
4 made or signed a document or documents related to the practice of medicine which falsely
5 represented the existence or nonexistence of a state of facts. The circumstances are as follows:

6 33. The allegations of Paragraphs 11 through 25 are incorporated herein by reference as if
7 fully set forth here.

8 FIFTH CAUSE FOR DISCIPLINE

9 (Alteration of Medical Records)

10 34. Respondent is subject to disciplinary action under section 2262 in that Respondent
11 altered or modified the medical record of George R. with fraudulent intent, or created a false
12 medical record, with fraudulent intent. The circumstances are as follows:

13 35. Allegations of Paragraphs 11 through 25 are incorporated herein by reference as if
14 fully set forth here.

15 SIXTH CAUSE FOR DISCIPLINE

16 (Incomplete or inaccurate Medical Records)

17 36. Respondent is subject to disciplinary action under section 2266 in that he failed to
18 maintain adequate and accurate records relating to the provision of services to patient George R.
19 The circumstances are as follows:

20 37. The allegations of Paragraphs 11 through 25 are incorporated herein by reference as if
21 fully set forth here.

22 SEVENTH CAUSE FOR DISCIPLINE

23 (False or Misleading Advertising)

24 38. Respondent is subject to disciplinary action for unprofessional conduct under section
25 2271 for false and misleading advertising in violation of section 17500. Respondent promulgated
26 advertising and made statements in doctor-to-patient communications, which were untrue or
27 misleading by overstating his training and qualifications to perform George R.'s acoustic
28

1 neuroma surgery in relation to other practitioners of acoustic neuroma surgery, as alleged in
2 Paragraphs 11 through 25 above.

3
4 PRAYER

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

- 7 1. Revoking or suspending Physician's and Surgeon's Certificate number A 60898,
8 issued to Hrayr Karnig Shahinian, M.D.
- 9 2. Revoking, suspending, or denying approval of his authority to supervise physician's
10 assistants, pursuant to section 3527 of the Code;
- 11 3. If placed on probation, ordering him to pay the Medical Board of California the costs
12 of probation monitoring;
- 13 4. Ordering him to pay the Medical Board of California a civil penalty of five hundred
14 dollars (\$500) for each proven violation of Business and Professions Code section 2262.
- 15 5. Taking such other and further action as deemed necessary and proper.

16 DATED: February 4, 2013

17 
18 LINDA R. WHITNEY
19 Executive Director
20 Medical Board of California
21 Department of Consumer Affairs
22 State of California

23 *Complainant*

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