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

In the Matter of the Accusation
Against:

LEIGH E. CONNEALY, M.D. File No. 8002014009657

Physician's and Surgeon's
Certificate No. G57433

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 December 29,
2017.

IT IS SO ORDERED December 1, 2017.

MEDICAL BOARD OF CALIFORNIA

By: __________________________
Ronald Lewis, M.D.
Chair, Panel A
BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

LEIGH E. CONNEALY, M.D.
6 Hughes, Suite 100
Irvine, CA 92618

Physician's and Surgeon's Certificate No. G 57433,

Respondent.

Case No. 800-2014-009657
OAH No. 2017060854

STIPULATED SETTLEMENT AND DISCIPLINARY ORDER

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

PARTIES

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

2. Respondent Leigh E. Connealy, M.D. (Respondent) is represented in this proceeding by attorney Richard A. Jaffe, whose address is: 770 L Street, Suite 950, Sacramento, CA 95814.

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3. On June 16, 1986, the Board issued Physician's and Surgeon's Certificate No. G 57433 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2014-009657, and will expire on July 31, 2019, unless renewed.

JURISDICTION
4. Accusation No. 800-2014-009657 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 13, 2017. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2014-009657 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS
6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2014-009657. 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 her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

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

CULPABILITY
9. Respondent understands that the charges and allegations in Accusation No. 800-2014-009657, if proven at a hearing, constitute cause for imposing discipline upon her Physician’s and Surgeon’s Certificate.
10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2014-009657 and that Respondent hereby gives up her right to contest those charges.

11. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

**CIRCUMSTANCES IN MITIGATION**

12. Respondent has never been the subject of any disciplinary action in over thirty years of practice. She is admitting responsibility at an early stage in the proceedings.

**CONTINGENCY**

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

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

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

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 57433 issued to Respondent shall be and is hereby Publicly Reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Accusation No. 800-2014-009657, is as follows:

“Documentation of symptoms and treatment for your patients L.S. and A.H. in the patients’ medical records was inadequate or inaccurate in violation of Business and Professions Code sections 2234 and 2266.”

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

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

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

ACCEPTANCE

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

DATED: 10/2/17

LEIGH E. CONNEALY, M.D.
Respondent

I have read and fully discussed with Respondent LEIGH E. CONNEALY, 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: 10/2/17

RICHARD A. JAFFE
Attorney for Respondent

ENDORSEMENT

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

Dated: October 2, 2017

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

Beneth A. Browne

Beneth A. Browne
Deputy Attorney General
Attorneys for Complainant

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Exhibit A
Accusation No. 800-2014-009657
BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Case No. 800-2014-009657

LEIGH E. CONNEALY, M.D. ACCUSATION
6 Hughes, Suite 100
Irvine, CA 92618

Physician's and Surgeon's Certificate
No. G 57433,

Respondent.

Complainant alleges:

PARTIES

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

2. On or about June 16, 1986, the Medical Board issued Physician's and Surgeon's Certificate Number G 57433 to Leigh E. Connealy, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2017, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.
4. Section 2229, subdivision (a), of the Code states:
   “Protection of the public shall be the highest priority for the Division of Medical Quality,[1]
   the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality
   Hearing Panel in exercising their disciplinary authority.”

5. Section 2004 of the Code states:
   “The board shall have the responsibility for the following:
   “(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice
   Act.
   “(b) The administration and hearing of disciplinary actions.
   “(c) Carrying out disciplinary actions appropriate to findings made by a panel or an
   administrative law judge.
   “(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of
   disciplinary actions.
   “(e) Reviewing the quality of medical practice carried out by physician and surgeon
   certificate holders under the jurisdiction of the board.
   “…”

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

7. Section 2234 of the Code, states:
   “The board shall take action against any licensee who is charged with unprofessional
   conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not
   limited to, the following:
   “(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the
   violation of, or conspiring to violate any provision of this chapter.

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[1] Pursuant to Business and Professions Code section 2002, the “Division of Medical Quality” or “Division” shall be deemed to refer to the Medical Board of California.
“(b) Gross negligence.

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

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

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

“(d) Incompetence.

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

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

“...”

“(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.”

8. Section 2266 of the Code states: “The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.”

**FIRST CAUSE FOR DISCIPLINE**

*(Repeated Negligent Acts)*

9. Respondent Leigh E. Connealy, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the Code in that she engaged in repeated negligent acts in the care and treatment of two patients. The circumstances are as follows:

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Patient A.H.

10. On or about June 6, 2012, patient A.H., a 68-year old woman, supplied the Center for New Medicine (CNM), Respondent’s medical practice, with a patient medical history to become a new patient. She reported no gynecological or genitourinary symptoms or illnesses.

11. On or about June 21, 2012, patient A.H. presented to the CNM for a comprehensive evaluation. In the medical record, the chief complaint is listed as “new patient consult.” There are no gynecologic and genitourinary symptoms, illnesses or physical findings noted in the patient’s medical records.

12. On or about August 22, 2012, patient A.H. returned for a second visit. Medical records indicate “Follow-up – results of expanded panel. . . .” There are no gynecologic and genitourinary symptoms, illnesses or physical findings noted in the patient’s medical records.

13. On or about October 16, 2012, patient A.H. presented at CNM. The chief complaint was recorded as “Annual Pap.” There are no gynecologic and genitourinary symptoms, illnesses or physical findings noted. The physical exam documents “Vulva, BUS, Introitus, Vagina, cervix, uterus, adnexa, rectal NML.” The Annual Pap is performed. The signature on the note is Respondent’s nurse practitioner. A urinalysis on October 16 is negative for blood.

14. On October 17, 2012, the result of the Pap smear is, “negative for intraepithelial lesion or malignancy” but it does reveal atrophic vaginitis.

15. On or about November 6, 2012, patient A.H. returned to CNM for a fourth time. The appointment was with Respondent. Respondent documented physical findings as “Pap good.” Respondent noted no additional gynecologic symptoms, illnesses or physical findings beyond “Pap good.”

16. On or about January 8, 2013, patient A.H. returned to CNM for a fifth visit. The appointment was with Respondent. Patient A.H. showed Respondent pictures from her cell phone showing blood she had observed in the toilet after urinating on January 5, three days prior.

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22 Initials are used to protect the privacy of the individuals.
23 "BUS" references the urethra.
24 Presumably, “NML” is used as an abbreviation for “normal.”
earlier. Respondent counseled patient A.H. to “keep an eye on it” and to let her know if it
happens again. Respondent wrote the chief complaint as, “Follow up Bone Density results 5
months ago. . .” Respondent’s review of symptoms stated, “One week ago c/o blood while
urinating (from vagina). It is gone now. Pt advised to come in and get evaluated.” Respondent
documented no further gynecologic and genitourinary symptoms.

17. On or about March 27, 2013, patient A.H. returned to CNM for a follow up. Patient
A.H. again mentioned the blood in her urine to Respondent. Respondent documented the visit as
a follow up but did not document any gynecologic and genitourinary symptoms, illnesses or
physical findings in the progress note.

18. On or about May 2, 2013, patient A.H. returned to CNM and was seen by nurse
practitioner L.L. Patient A.H. again complained of vaginal bleeding and brought in pictures. The
nurse practitioner performed a pelvic examination. Later the same day, patient A.H. returned and
a pelvic ultrasound was performed.

19. On or about May 21, 2013, a urinalysis lab test for patient A.H. was negative for
blood.

20. On or about May 24, 2013, patient A.H. returned for a visit and saw nurse practitioner
L.L., who documented the chief complaint as, “history of DUB\(^5\) -> no more bleeding. . .” The
impression is also documented as “history of DUB. . .” The plan is documented as “needs
follow up in 2 weeks.” The records for the visit contain no further documentation regarding any
gynecologic and genitourinary symptoms, illness or physical findings.

21. On or about June 7, 2013, patient A.H. returned for a visit and saw nurse practitioner
L.L. A pelvic ultrasound was performed. The report from the pelvic ultrasound found that “the
endometrial strip measures 4.4 mm.” It further states, “IMPRESSION: 1. The uterus is diffusely
heterogeneous, perhaps due to several small fibroids. 2. The endometrium is normal. . .”
Patient A.H.’s medical records contained two copies of the pelvic ultrasound. One has a
handwritten notation, “Dr. C 9/3/13.” The other is stamped June 18, 2013 and it includes a

\(^5\) “DUB” is an acronym for “dysfunctional uterine bleeding.”
handwritten notation indicating that patient A.H. has an appointment scheduled for June 21, 2013.

22. On or about June 21, 2013, patient A.H. returned for a visit and saw nurse practitioner
L.L. Patient A.H. complained of “hair thinning.” There is no documentation of gynecologic and
genitourinary symptoms, illnesses or physical findings noted in the patient’s medical records.

23. On or about June 24, 2013, patient A.H. returned for a visit with Respondent. She
complained again about blood appearing in the toilet when she urinated and she showed
Respondent pictures on her cell phone that she had taken of the blood in the toilet. Respondent
documented chief complaints as follow up on lab results and results of the pelvic ultrasound.
Respondent wrote in the medical record “Pelvic UTZ small fibroids endometrium 4.4.”
Respondent documented an impression and plan which included no notations regarding
gynecologic and genitourinary symptoms, illnesses or physical findings.

24. On or about August 5, 2013, patient A.H. returned for her final visit at CNM and with
Respondent. Respondent wrote in the medical records that the visit was for “follow-up lab results
and hair loss.” The medical records contain no documentation regarding gynecologic and
genitourinary symptoms, illness or physical findings.

25. On August 27, 2013, patient A.H. went to a different medical clinic and saw a
different doctor regarding the bleeding she had been having over several months. She told the
doctor that the ultrasound she had recently received had shown normal endometrial thickness.
The new doctor performed an endometrial biopsy which showed endometrial adenocarcinoma. A
new ultrasound showed thickened lining suggestive of malignancy.

26. On or about September 13, 2013, patient A.H. underwent a vaginal hysterectomy,
bilateral salpingo-oopherectomy and staging procedure. Subsequently, she received
chemotherapy and radiation therapy.

27. Respondent was negligent in her care and treatment of patient A.H. when she failed to
quickly investigate post-menopausal bleeding in order to exclude endometrial cancer or to initiate
treatment for it as soon as possible. She failed to perform an early endometrial biopsy with pelvic
ultrasound and/or refer her to a gynecologist.

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Patient L.S.

28. On or about October 18, 2010, patient L.S. had her first of three appointments with Respondent. Respondent documented eight medical problems and a plan to address the problems.

29. On or about November 1, 2010, patient L.S. had her second appointment with Respondent. Respondent documented the chief complaint as a follow up of lab results, hormones and right breast lump. Under physical exam, Respondent documented, “Right breast pea-sized lump.” Respondent documented her impression as “menopause, elevated progesterone and breast lump.” Respondent documented the plan as “mammogram + ultrasound Rx immediately.” Respondent documented the diagnosis as “right breast lump.”

30. On or about November 29, 2010, patient L.S. had her final appointment at CNM. She received a thermography follow-up. Respondent documented that the thermography was abnormal in the right breast.

31. Several months later, on or about March 24, 2011, patient L.S. received a refill of estrogen x3 through a nurse with initials "NC" in Respondent's office. Respondent’s office protocol at CNM permitted a nurse to provide a refill to Respondent’s patient if the patient had been seen within six months.

32. Respondent was negligent in her care and treatment of patient L.S. in that she provided multiple refills of estrogen to a post-menopausal patient whose breast mass remained undiagnosed after over three months.

SECOND CAUSE FOR DISCIPLINE
(Record Keeping)

33. Respondent Leigh E. Connealy, M.D. is subject to disciplinary action under section 2266 of the Code in that she failed to maintain adequate and accurate records of the medical services she provided to two patients. The circumstances are as follows:

34. The facts and circumstances alleged in paragraphs 10 through 26 and 28 through 31 above are incorporated here as if fully set forth.

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THIRD CAUSE FOR DISCIPLINE
(Unprofessional Conduct)

35. Respondent Leigh E. Connealy, M.D. is subject to disciplinary action under section 2234 of the Code in that she engaged in unprofessional conduct. The circumstances are as follows:

36. The facts and circumstances alleged in paragraphs 10 through 34 above are incorporated here as if fully set forth.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 57433, issued to Leigh E. Connealy, M.D.;

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

3. Ordering Leigh E. Connealy, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: March 13, 2017

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

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