

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

In the Matter of the Accusation Against:

William Dennison McIntyre, Jr., M.D.

Physician's & Surgeon's
Certificate No. G 29828

Respondent.

Case No. 800-2018-041681

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 May 7, 2021.

IT IS SO ORDERED April 9, 2021.

MEDICAL BOARD OF CALIFORNIA



Richard E. Thorp, M.D., Chair
Panel B

1 XAVIER BECERRA
Attorney General of California
2 E. A. JONES III
Supervising Deputy Attorney General
3 CHRISTINE R. FRIAR
Deputy Attorney General
4 State Bar No. 228421
California Department of Justice
5 300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
6 Telephone: (213) 269-6472
Facsimile: (916) 731-2117
7 *Attorneys for Complainant*

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

12 In the Matter of the Accusation Against:

13 **WILLIAM DENNISON McINTYRE JR.,**
14 **M.D.**
15 **2319 East Washington Blvd., #1**
Pasadena, CA 91104

16 Physician's and Surgeon's Certificate
17 No. G 29828,

18 Respondent.

Case No. 800-2018-041681

OAH No. 2020080120

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

19
20 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
21 entitled proceedings that the following matters are true:

22 **PARTIES**

23 1. Christine J. Lally brought this action solely in her official capacity as the Interim
24 Executive Director of the Medical Board of California (Board). Since the filing of the Accusation
25 in this matter, William Prasifka replaced Christine J. Lally as the Executive Director of the Board
26 and Mr. Prasifka now maintains the complaint in his official capacity as the Executive Director of
27 the Board. He is represented in this matter by Xavier Becerra, Attorney General of the State of
28 California, by Christine R. Friar, Deputy Attorney General.

1 CULPABILITY

2 9. Respondent admits the truth of each and every charge and allegation in Accusation
3 No. 800-2018-041681.

4 10. Respondent agrees that his Physician's and Surgeon's Certificate is subject to
5 discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the
6 Disciplinary Order below.

7 CONTINGENCY

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

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

21 13. In consideration of the foregoing admissions and stipulations, the parties agree that
22 the Board may, without further notice or opportunity to be heard by the Respondent, issue and
23 enter the following Disciplinary Order:

24 DISCIPLINARY ORDER

25 **A. PUBLIC REPRIMAND.**

26 **IT IS HEREBY ORDERED THAT** Physician's and Surgeon's Certificate No. G 29828
27 issued to William Dennison McIntyre Jr., M.D., shall be and is hereby publicly reprimanded
28 pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This

1 public reprimand, which is issued in connection with the allegations set forth in Accusation No.
2 800-2018-041681, is as follows:

3 “You failed to timely and appropriately follow-up on significant abnormal diagnostic tests
4 in your care and treatment of one patient, in violation of the Business and Professions Code,
5 as more fully described in Accusation No. 800-2018-041681.”

6 **B. EDUCATION COURSE.**

7 **IT IS FURTHER ORDERED THAT** within 60 calendar days of the effective date of this
8 Decision, Respondent shall submit to the Board or its designee for its prior approval educational
9 program(s) or course(s), which shall not be less than 40 hours to be completed within one (1) year
10 of the effective date of this Decision. The educational program(s) or course(s) shall be aimed at
11 correcting any areas of deficient practice or knowledge and shall be Category I certified. The
12 educational program(s) or course(s) shall be at Respondent’s expense and shall be in addition to
13 the Continuing Medical Education (CME) requirements for renewal of licensure. Following the
14 completion of each course, the Board or its designee may administer an examination to test
15 Respondent’s knowledge of the course. Respondent shall provide proof of attendance for 65
16 hours of CME of which 40 hours were in satisfaction of this condition.

17 Respondent shall submit a certification of successful completion to the Board or its
18 designee not later than fifteen (15) calendar days after successfully completing the education
19 course requirement.

20 Failure to timely and successfully complete the education course requirement outlined
21 above shall constitute unprofessional conduct and is grounds for further disciplinary action.

22 **C. PRESCRIBING PRACTICES COURSE.**

23 **IT IS FURTHER ORDERED THAT** within sixty (60) calendar days of the effective date
24 of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance
25 by the Board or its designee. Respondent shall provide the approved course provider with any
26 information and documents that the approved course provider may deem pertinent. Respondent
27 shall participate in and successfully complete the classroom component of the course not later
28 than six (6) months after Respondent’s initial enrollment. Respondent shall successfully

1 complete any other component of the course within one (1) year of enrollment. The prescribing
2 practices course shall be at Respondent's expense and shall be in addition to the Continuing
3 Medical Education (CME) requirements for renewal of licensure.

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

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

12 Failure to timely and successfully complete the prescribing practices course outlined above
13 shall constitute unprofessional conduct and is grounds for further disciplinary action.

14 **D. MEDICAL RECORD KEEPING COURSE.**

15 **IT IS FURTHER ORDERED THAT** within 60 calendar days of the effective date of this
16 Decision, Respondent shall enroll in a course in medical record keeping approved in advance by
17 the Board or its designee. Respondent shall provide the approved course provider with any
18 information and documents that the approved course provider may deem pertinent. Respondent
19 shall participate in and successfully complete the classroom component of the course not later
20 than six (6) months after Respondent's initial enrollment. Respondent shall successfully
21 complete any other component of the course within one (1) year of enrollment. The medical
22 record keeping course shall be at Respondent's expense and shall be in addition to the Continuing
23 Medical Education (CME) requirements for renewal of licensure.

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

1 Respondent shall submit a certification of successful completion to the Board or its
2 designee not later than 15 calendar days after successfully completing the course, or not later than
3 15 calendar days after the effective date of the Decision, whichever is later.

4 Failure to timely and successfully complete the medical record keeping course outlined
5 above shall constitute unprofessional conduct and is grounds for further disciplinary action.

6 **E. PROFESSIONALISM PROGRAM (ETHICS COURSE).**

7 **IT IS FURTHER ORDERED THAT** within 60 calendar days of the effective date of this
8 Decision, Respondent shall enroll in a professionalism program, that meets the requirements of
9 Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in
10 and successfully complete that program. Respondent shall provide any information and
11 documents that the program may deem pertinent. Respondent shall successfully complete the
12 classroom component of the program not later than six (6) months after Respondent's initial
13 enrollment, and the longitudinal component of the program not later than the time specified by
14 the program, but no later than one (1) year after attending the classroom component. The
15 professionalism program shall be at Respondent's expense and shall be in addition to the
16 Continuing Medical Education (CME) requirements for renewal of licensure.

17 A professionalism program taken after the acts that gave rise to the charges in the
18 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board
19 or its designee, be accepted towards the fulfillment of this condition if the program would have
20 been approved by the Board or its designee had the program been taken after the effective date of
21 this Decision.

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


25 Failure to timely and successfully complete the professionalism program outlined above
26 shall constitute unprofessional conduct and is grounds for further disciplinary action.

27 **ACCEPTANCE**

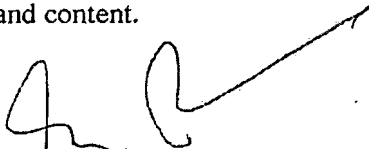
28 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully

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discussed it with my attorney, Kent. T. Brandmeyer. 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: 12/02/2020 
WILLIAM DENNISON MCINTYRE JR., M.D.
Respondent

I have read and fully discussed with Respondent William Dennison McIntyre Jr., 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: 12-2-20 
KENT T. BRANDMEYER
Attorney for Respondent

ENDORSEMENT

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

DATED: December 7, 2020

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


CHRISTINE R. FRIAR
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2018-041681

1 XAVIER BECERRA
Attorney General of California
2 E. A. JONES III
Supervising Deputy Attorney General
3 CHRISTINE R. FRIAR
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4 State Bar No. 228421
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MEDICAL BOARD OF CALIFORNIA
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12 In the Matter of the Accusation Against:

Case No. 800-2018-041681

13 **WILLIAM DENNISON McINTYRE JR.,**
14 **M.D.**
2319 East Washington Blvd., #1
Pasadena, CA 91104

A C C U S A T I O N

15 Physician's and Surgeon's Certificate
16 No. G 29828,

17 Respondent.

18
19
20 **PARTIES**

21 1. Christine J. Lally (Complainant) brings this Accusation solely in her official capacity
22 as the Interim Executive Director of the Medical Board of California, Department of Consumer
23 Affairs (Board).

24 2. On or about July 1, 1975, the Board issued Physician's and Surgeon's Certificate
25 Number G 29828 to William Dennison McIntyre Jr., M.D. (Respondent). That license was in full
26 force and effect at all times relevant to the charges brought herein and will expire on December
27 31, 2021, unless renewed.

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1 JURISDICTION

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

5 STATUTORY PROVISIONS

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

10 5. Section 2234 of the Code states:

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

13 ...

14 (b) Gross negligence.

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

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

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

27 (d) Incompetence.

28 ...

29 6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain
30 adequate and accurate records relating to the provision of services to their patients constitutes
31 unprofessional conduct."

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1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Gross Negligence)**

3 7. Respondent William Dennison McIntyre Jr., M.D. is subject to disciplinary action
4 under Code section 2234, subdivision (b), in that he committed gross negligence in the care and
5 treatment of Patient 1¹ when he failed to timely and appropriately follow-up on significant
6 abnormal diagnostic tests. The circumstances are as follows:

7 8. On or about May 31, 2012, Patient 1, a sixty-six (66) year old female, established
8 care with Respondent, a primary care physician practicing in Pasadena, California.

9 9. At all times relevant herein, Patient 1 suffered from bipolar disorder, among other
10 ailments, and was on long-term Lithium treatment.²

11 10. At all relevant times herein, Patient 1 treated with Respondent, as her primary care
12 provider, concurrent with a psychiatrist, who managed her bipolar disorder and Lithium
13 prescription. Respondent, as her primary care provider, monitored Patient 1's serum Lithium
14 levels.

15 11. Although Respondent was monitoring Patient 1's Lithium levels, he did not routinely
16 send the results to Patient 1's psychiatrist. Instead, Respondent's practice was to hand the paper
17 copy of the lab results with the Lithium levels to Patient 1, who was then expected to deliver the
18 results to her psychiatrist.

19 12. On or about April 24, 2017, Respondent saw Patient 1 for new neurologic symptoms,
20 specifically, confusion. His assessment was "disorientation." As part of his evaluation,
21 Respondent ordered a Lithium level. Patient 1's Lithium level was elevated to 1.9 mmol/L,
22 which was an increase from her level of 1.4 mmol/L on April 12, 2017. (The upper limit of
23 normal for that laboratory is 1.2 mmol/L.) Respondent did not follow-up with Patient 1 or her
24 psychiatrist regarding these abnormal results. Instead, Respondent, knowing that Patient 1 was

25 _____
26 ¹ The patient is designated as "Patient 1" to address privacy concerns. Patient 1's identity
is known to Respondent.

27 ² Lithium is a prescription medication used to treat and prevent manic episodes associated
28 with bipolar disorder. Lithium affects the flow of sodium through nerve and muscle cells in the
body, which in turn affects excitation and mania.

1 suffering from confusion, assumed she had a copy of her lab results and had delivered them to her
2 psychiatrist.

3 13. Respondent did not document in Patient 1's records his assessment of the significance
4 of her abnormal Lithium result, any attempt to communicate with Patient 1's prescribing
5 psychiatrist regarding the result or even any attempt to transmit the results to her psychiatrist.

6 14. Respondent saw Patient 1 again on May 23 and May 24, 2017, with Patient 1
7 continuing to suffer from confusion and disorientation.

8 15. From May 24 to June 1, 2017, Patient 1 was hospitalized at USC Verdugo Hills
9 Hospital, requiring hemodialysis for a diagnosis of chronic Lithium toxicity. Notably, her
10 admission Lithium level on May 24, 2017, was 2.2. mmol/L. After removal of the Lithium from
11 her system, Patient 1's neurologic status greatly improved.

12 16. The standard of care in the medical community requires a physician to follow up on
13 diagnostic tests by taking appropriate and timely action on the results. The standard of care
14 requires a physician, where indicated, to route diagnostic tests to appropriate specialists directly
15 and in a timely fashion, generally electronically, and to discuss those results. It is not within the
16 standard of care to rely on the patient as the sole courier to transport important diagnostic tests
17 between providers.

18 17. Respondent's failure to either act on important diagnostic tests in a timely manner or
19 communicate with the relevant specialist, in the setting of a symptomatic and confused patient,
20 and his reliance on that patient to courier diagnostic tests between her physicians, while disabled,
21 constitutes an extreme departure from the standard of care.

22 18. Respondent's acts and/or omissions as set forth in paragraphs 8 through 17, inclusive
23 above, whether proven individually, jointly, or in any combination thereof, constitute gross
24 negligence pursuant to section 2234, subdivision (b), of the Code. As such, cause for discipline
25 exists.

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1 **SECOND CAUSE FOR DISCIPLINE**

2 **(Repeated Negligent Acts)**

3 19. Respondent William Dennison McIntyre Jr., M.D. is subject to disciplinary action
4 under Code section 2234, subdivision (c), in that he committed repeated negligent acts in the care
5 and treatment of Patient 1. The circumstances are as follows:

6 20. Paragraphs 8 through 17 are incorporated by reference and re-alleged as if fully set
7 forth herein.

8 21. The standard of care in the medical community requires a physician to document in a
9 patient's medical record a referral to the Emergency Room.

10 22. On or about May 24, 2017, Respondent referred Patient 1 to the Emergency Room.
11 Specifically, he requested that the staff of her facility arrange for an ambulance for her and called
12 the referring hospital in advance to inform them of her pending arrival. Respondent did not
13 document this referral in his progress note for Patient 1.

14 23. Respondent's failure to document in his progress note his referral of Patient 1 to the
15 Emergency Room constitutes a simple departure from the standard of care.

16 24. Respondent's acts and/or omissions as set forth in paragraphs 20 through 23,
17 inclusive above, whether proven individually, jointly, or in any combination thereof, constitute
18 repeated negligent acts in violation of section 2234, subdivision (c), of the Code. As such, cause
19 for discipline exists.

20 **THIRD CAUSE FOR DISCIPLINE**

21 **(Incompetence)**

22 25. Respondent William Dennison McIntyre Jr., M.D. is subject to disciplinary action
23 under Code section 2234, subdivision (d), in that his care and treatment of Patient 1 constituted
24 incompetence. The circumstances are as follows:

25 26. Paragraphs 8 through 17 and 20 through 23 are incorporated by reference and re-
26 alleged as if fully set forth herein.

27 27. In April 2017, Patient 1 presented to Respondent with new neurologic symptoms,
28 including word-finding difficulty and "blank stares." As part of his evaluation, Respondent

1 ordered a Lithium level, which returned elevated at 1.9 mmol/L. Respondent saw Patient 1 again,
2 on both May 23 and 24, 2017, noting ongoing disorientation. During those evaluations,
3 Respondent failed to recognize that the patient's new neurologic symptoms were due to Lithium
4 toxicity, despite her serum level being elevated.

5 28. The standard of care in the medical community requires that a physician recognize
6 that neurologic symptoms can be a sign of Lithium toxicity.

7 29. Respondent's failure to recognize that Patient 1's neurologic symptoms were due to
8 Lithium toxicity, despite an elevated level, constitutes a lack of knowledge.

9 30. Respondent's acts and/or omissions as set forth in paragraphs 26 through 29,
10 inclusive above, whether proven individually, jointly, or in any combination thereof, constitute
11 incompetence in violation of section 2234, subdivision (d), of the Code. As such, cause for
12 discipline exists.

13 **FOURTH CAUSE FOR DISCIPLINE**

14 **(Inadequate Record Keeping)**

15 31. Respondent William Dennison McIntyre Jr., M.D. is subject to disciplinary action
16 under Code section 2266, in that he failed to maintain adequate records concerning his care and
17 treatment of Patient 1. The circumstances are as follows:

18 32. Paragraphs 8 through 17, 20 through 23, and 26 through 29 are incorporated by
19 reference and re-alleged as if fully set forth herein.

20 33. Respondent's acts and/or omissions as set forth in paragraph 32, inclusive above,
21 whether proven individually, jointly, or in any combination thereof, constitute inadequate record
22 keeping in violation of section 2266 of the Code. As such, cause for discipline exists.

23 **PRAYER**


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

26 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 29828,
27 issued to William Dennison McIntyre Jr., M.D.;

28 ///

- 1 2. Revoking, suspending or denying approval of William Dennison McIntyre Jr., M.D.'s
2 authority to supervise physician assistants and advanced practice nurses;
3 3. Ordering William Dennison McIntyre Jr., M.D., if placed on probation, to pay the
4 Board the costs of probation monitoring; and
5 4. Taking such other and further action as deemed necessary and proper.

6
7 DATED: MAY 07 2020


CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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