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

In the Matter of the Second Amended Accusation Against: Peter Haeyoung Park, M.D. Physician's & Surgeon's Certificate No. G 67513 Respondent.	Case No. 800-2018-048067

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 29, 2022.

IT IS SO ORDERED: August 30, 2022.

MEDICAL BOARD OF CALIFORNIA

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

MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against:

PETER HAEYOUNG PARK, M.D.

Physician's and Surgeon's Certificate Number G 67513

Respondent.

Case No. 800-2018-048067

OAH No. 2021080495

PROPOSED DECISION

Cindy F. Forman, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter remotely by videoconference on May 2 through 6, May 9 through 11, May 13, May 23 through 25, and June 10, 2022.

Claudia Morehead, Deputy Attorney General, represented William Prasifka, Executive Director, Medical Board of California (Board), Department of Consumer Affairs.

Louis H. DeHaas and Mark B. Guterman, Attorneys at Law, represented respondent Peter Haeyoung Park, M.D., who was present on each hearing day.

The ALJ heard testimony and received documentary evidence. The record was closed and the matter was submitted for decision on June 10, 2022.

SUMMARY

Complainant charged respondent with sexual exploitation, sexual abuse and misconduct, gross negligence, repeated acts of negligence, and improper medical record keeping in connection with his treatment of three patients. Complainant proved respondent kept inadequate medical records for the three patients and thus committed repeated acts of negligence. Complainant did not prove the remaining allegations against respondent. Considering respondent's reputation in the community, the absence of any discipline for more than 30 years, and his transition to electronic medical record keeping, neither revocation nor probation of respondent's medical certificate is warranted. A public letter of reproval with the requirement that respondent completes a medical record keeping course is sufficient to protect the public.

FACTUAL FINDINGS

Jurisdiction

1. The Board issued Physician's and Surgeon's Certificate number G 67513 to respondent on November 13, 1989. Respondent's certificate was in full force and effect at all times relevant to the charges alleged in the Second Amended Accusation. The certificate is scheduled to expire on March 31, 2023.

2. Complainant filed the Second Amended Accusation in his official capacity on February 15, 2022. Complainant had previously filed an Accusation against respondent on October 8, 2020, and a First Amended Accusation against respondent on February 15, 2021. The Second Amended Accusation is the operative pleading in this matter. It involves respondent's treatment of three patients, referred to herein as Patient 1, Patient 2, and Patient 3, for confidentiality purposes.

3. Respondent filed a timely Notice of Defense to the Accusation on October 14, 2020.

4. All jurisdictional requirements for this hearing to proceed have been met.

Credibility

5. The analysis in this case is largely based on an assessment of the credibility of the testimony of the complaining patients, respondent, and percipient witnesses. The ALJ assessed the credibility of the testimony of these witnesses pursuant to the factors set forth in Evidence Code section 780: the demeanor and manner of the witness while testifying, the character of the testimony, the capacity to perceive at the time the events occurred, the character of the witness for honesty, the existence of bias or other motive, other statements of the witness which are consistent or inconsistent with the testimony, the existence or absence of any fact to which the witness testified, and the attitude of the witness toward the proceeding in which the testimony has been given.

6. Assessing credibility in this matter was complicated by translation and interpretation difficulties: the first language of respondent, his staff members, Patient 1, Patient 2, and Patient 3 is Korean; many of the pertinent conversations between the

patients and respondent or respondent's staff were in Korean; respondent's staff and Patient 2 testified in Korean; and there were challenges at hearing as to the accuracy of the English translation of several statements written in Korean and testimony in Korean. In several instances, the witnesses testified the import of statements made or written in Korean could not be adequately captured in an English translation, and there were some English words (the word "stool," referring to a backless chair, for instance) that had no equivalent in the Korean language.

Board Investigation

7. This matter was triggered by three separate complaints against respondent filed by Patient 1, Patient 2, and Patient 3 or their representatives in 2018 and 2019. The complaints were assigned to the same investigator, who interviewed witnesses, collected documents, and took part in the October 17, 2019 interview of respondent regarding his treatment of the three patients. The investigator prepared a report for each patient, which included summaries of her interviews, many of which applied to one or more of the patients.

8. During the hearing, several witnesses identified errors in the Board's investigation reports. Specifically, the report regarding Patient 2 erroneously indicated the date of Patient 2's appointment with respondent (the narrative incorrectly stated Patient 2 visited respondent on August 25, 2019, when in fact she had visited respondent on August 25, 2018 (see Ex. 22, p. A244)), the reports for the three patients misstate how long one of respondent's employees worked for him (see Factual Finding 54), and the reports misattribute statements to the wrong employee (see Factual Finding 90). The reports also did not make clear whether the investigator's interviews with respondents' staff, whose primary language is Korean, were conducted with the

help of interpreters. The Board investigator did not testify at hearing and therefore supplied no explanation for the errors. Consequently, this Proposed Decision does not rely on the contents of the investigation reports to support its findings.

Respondent's Education, Work History, and Current Employment

9. Respondent is 64 years old and married with three adult children. He was born in Korea and moved to the United States when he was 15 years old. He earned his Bachelor of Arts degree in 1981 from Johns Hopkins University and his medical degree from Loma Linda University in 1986. Respondent performed and completed his three years of residency in obstetrics and gynecology (ob/gyn) at Sinai Hospital of Baltimore, which was affiliated with the Johns Hopkins University School of Medicine. During his residency, respondent received daily training in performing breast and pelvic examinations and pelvic and obstetric procedures.

10. Respondent has been board-certified since 1992 and is a fellow of the American College of Obstetricians and Gynecologists (ACOG). He recertifies his board membership each year by taking required classes and tests.

11. After finishing his residency, respondent worked as a junior associate doctor as part of a three-doctor ob/gyn group. His practice focused primarily on obstetrics. In 1996, respondent began practicing ob/gyn at a multispecialty clinic in Koreatown. He worked at the clinic for four years.

12. Respondent currently owns and operates his own ob/gyn practice in Koreatown, Los Angeles. He has had his own practice in Koreatown for more than 26 years. Respondent has full staff privileges at Good Samaritan Hospital and Queen of Angels/Hollywood Presbyterian Hospital, both located in Los Angeles. Respondent

works six days a week; five days at his office and one day performing surgery outside the office. Respondent has seen approximately 20,000 patients since his licensure as an ob/gyn physician. Most of respondent's patients are of Korean descent.

13. Respondent is the only physician working in his office. He does not employ any physician assistants, registered nurses, or nurse practitioners. During the relevant time, respondent employed two people, Wendy Park (no relation to respondent), his office manager, and Haeok Kwon. Both worked at the front desk and handled patient appointments, insurance, and payment. Ms. Park has worked for respondent for 20 years; Ms. Kwon has worked for respondent for six years. The front desk employees are never involved with any patient medical issues, present in the exam room with respondent, or assist respondent with patient exams. Respondent also employed two medical assistants (MAs) who acted as patient chaperones and assisted respondent during his examinations. MA Hairi Lee was the chaperone for Patient 1 and Patient 2 in this case. Respondent used an outside service to bill insurance companies. Respondent and his staff are fluent in Korean and communicate with respondent's patients in Korean when necessary.

14. Respondent's practice during the relevant period was 90 percent gynecological and 10 percent obstetrics. Respondent's major focus in his gynecological practice is to detect and prevent cancer in his patients. Ninety percent of his patients return for a later visit. From 1990 to 2019, respondent performed at least 150,000 pelvic and breast examinations and 100,000 ultrasound examinations. To his knowledge, respondent has never failed to detect or diagnose breast or pelvic cancer in any of his patients.

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15. At the time of the exams in question, respondent used handwritten progress notes. Respondent's Progress Notes are pre-printed in part using respondent's own handwriting. There is a space entitled "For," where respondent writes why the patient is there and any other notes from the pre-exam consult. The Notes also have a section entitled "PE" standing for physical examination. Underneath that title and on the left side of the form, there are pre-printed areas for respondent to note his breast, abdomen, and pelvis exam findings, with the pelvic exam section broken down into further components. On the right side of the form is handwritten "U/S" standing for ultrasound, followed by "L OV", "R OV", and "endo", standing for left ovary, right ovary, and endometrium, and at the bottom of the form is "A/P" standing for assessment/plan.

Patient 1

16. Complainant alleges respondent sexually exploited Patient 1 and engaged in sexual misconduct and gross negligence by inappropriately touching Patient 1's breasts without advance notice, explanation, or consent, and making comments of a sexual nature. Complainant further alleges respondent's medical record keeping for Patient 1 was grossly negligent and inadequate.

THE EXAM

17. Patient 1 was 32 years old when she saw respondent for a medical appointment on January 5, 2019. At the time of her appointment and as of the date of the hearing, Patient 1 was a practicing licensed attorney. Patient 1 moved to the United States in 2012, and she is fluent in English and Korean. During her appointment with respondent, Patient 1 and respondent alternated between speaking in Korean and English. Patient 1 testified in English.

18. Patient 1 was insured through an HMO. Patient 1 had not had a Pap smear for several years and her then-boyfriend (now husband) S.Y., who was a board-certified hematologist and oncologist, had expressed concern about the delay and the risk of ovarian cancer. On December 3, 2018, she sought a referral from her primary care physician, Dr. Ahra Cho, M.D., to a gynecologist for a Pap smear. Dr. Cho sought HMO approval for the referral and Patient 1's HMO approved the referral to respondent. Patient 1 assumed based on her referral request to Dr. Cho that her appointment with respondent was for a Pap smear only, with no breast exam. Patient 1 mistakenly believed a Pap smear could detect ovarian cancer.

19. On January 5, 2019, after arriving at respondent's offices, Patient 1 first met with MA Hairi Lee who reviewed Patient 1's medical and family history and vital signs. MA Lee then accompanied Patient 1 to respondent's private office for a pre-exam consult. For the pre-exam consult, respondent was provided with the HMO Referral for Patient 1. That Referral authorized an "Office/Outpatient Visit New." (Ex. 10, p. A87.) The International Classification of Diseases (ICD) Code on the Referral is for an "Encounter for gynecological examination (general) (routine) without abnormal findings" *(Ibid.)* Below the ICD Code section is another section entitled "Clinical Symptoms/Findings." In that section is written "screening pap" followed by respondent's name, the date of the authorization, the name of the referring party, and the following "no obgyn hist no notes meets pass thru approved." (*Ibid.*) Respondent did not have access to Dr. Cho's records delineating Patient 1's request for a Pap smear before he examined Patient 1.

20. Respondent understood from the HMO Referral Patient 1 was a new patient coming in for an outpatient office visit to do a general routine gynecological examination, which included a breast, abdominal, and pelvic examination, not an

ultrasound. Consistent with his understanding, respondent filled out a superbill for Patient 1 which he provided to MA Lee, stating he would be performing a comprehensive and extended office visit with a Pap smear. (Ex. E.)

21. In the pre-exam consult, respondent discussed Patient 1's concerns and reasons for her visit. He wrote on Patient 1's Progress Note that Patient 1's "boyfriend is hematologist and oncologist," and in quotes "pap smear" and "he is paranoid." Respondent testified it was his understanding Patient 1's boyfriend was paranoid about cancer. Patient 1's history indicated her last Pap smear was eight years ago and she had an aunt who had breast cancer, which he believed was of some significance and warranted monitoring. It would have been respondent's practice to inform Patient 1 that he was going to perform a routine examination consistent with the HMO referral, which included a breast, abdominal, and vaginal exam. Respondent also performs a Pap smear, breast exam, abdominal exam, and pelvic exam for all first-time patients.

22. The Progress Note did not reflect any objection by Patient 1 to any part of the examination. Patient 1 did not testify as to any discussion she had with respondent during the pre-exam consult.

23. After respondent completed the pre-consult, MA Lee escorted Patient 1 into what Patient 1 described as a "very small" room with medical equipment and a reclining chair. In the exam room, MA Lee told Patient 1 to unhook her bra and undress from the waist down and handed her a piece of paper to cover her from the waist down. Patient 1 was wearing an undershirt, sweatshirt, and leggings.

24. Patient 1 recalled MA Lee talking with her about the pelvic examination but did not remember her talking about a breast examination. Patient 1 did not ask

MA Lee why she needed to unhook her bra, although she thought it was a bizarre request because she had gone to respondent's office for a Pap smear. Patient 1 testified she presumed MA Lee had asked her to unhook her bra because it would somehow be more relaxing.

25. Respondent did not enter the exam room until MA Lee had confirmed Patient 1 was ready. MA Lee remained in the exam room as the chaperone throughout respondent's examination of Patient 1. Patient 1 recalled having some conversation with respondent regarding her Pap smear but she did not recall whether he explained the medical exam he was going to perform.

26. Respondent first performed a pelvic examination, which included a Pap smear, and then, according to his custom and practice, would have performed an abdominal exam. Patient 1 did not recollect the abdominal exam. Patient 1 did not object to respondent's pelvic or abdominal exam.

27. According to Patient 1, after the pelvic exam, respondent stood up from his stool, moved alongside her, took off his glove, and made a swiping motion with his bare hand under her T-shirt. Patient 1 testified respondent's hand was open, he touched both breasts and nipples, and made a swiping motion from left to right and then to the left. Patient 1 testified respondent did not ask her to lift her sweatshirt, t-shirt, or bra, ask her to lift her arms above her head, examine her armpits, ask her to sit up, or look at her breasts. At one point during direct examination, Patient 1 estimated the touching lasted for less than 30 seconds; under cross-examination, Patient 1 testified the breast exam lasted four seconds in total. She further testified her breasts were not visible during the examination. Patient 1 did not recall what, if anything,

respondent said during the exam. Patient 1 did not object to respondent's touching her breasts while it was occurring.

28. Patient 1 testified she initially felt confused and uncomfortable by respondent's actions because she had not consented to a breast exam. She testified MA Lee never told her respondent was going to perform a breast examination. She did not recall any conversation with respondent in which he explained the medical examination he was going to do. Patient 1 further testified she was young and healthy and did not need or want a breast examination. She never had a breast examination by a physician before her medical appointment with respondent. Patient 1 testified she could not see MA Lee's face when respondent touched her breasts and MA Lee did nothing when respondent touched Patient 1's breasts.

29. Respondent disputed the description Patient 1 provided of his examination of her breasts as contrary to his custom and practice. Although he did not specifically remember examining Patient 1's breasts, respondent testified his custom and practice for examining a patient's breasts have remained unchanged for 10 years. Respondent acknowledged he does not require his patients to take off their shirts and bras because he believes it may be embarrassing for them. Instead, he asks patients to pull up their shirts and raise their arms so he can examine their breasts. He first examines the left breast and the left axillary area, then the right breast and axillary area with a circular motion, and finally the nipples. He mostly uses his right hand to examine the breast unless he feels something abnormal, when he uses both hands. Respondent does not reach under his patients' clothing because he must see the breasts for the examination. Although respondent previously requested his patients to sit up to perform the breast exam, he stopped the practice 10 years ago because he

believed it made women uncomfortable. Respondent believes he is better able to palpate and detect lumps when the patient is lying down.

30. According to respondent, he would never perform a breast examination without visibly examining the patient's breasts. He always would ask the patient to lift her clothes and arms so he could examine the axillary area. Respondent maintained Patient 1 did not object to the breast exam when he performed it and MA Lee did not report any irregularities in Patient 1's exam.

31. Respondent noted the findings of his exam of Patient 1 on Patient 1's Progress Note. (Ex. 10, p. A86.) According to respondent's review of the Progress Note, his breast examination of Patient 1 found her breasts to be non-tender, with no masses and no nipple discharge. Her abdominal examination was benign. Respondent also indicated the findings from Patient 1's pelvic, vaginal, cervix, and uterus examination were normal but noted Patient 1's adnexa had left-sided fullness requiring an ultrasound and a TAR [Treatment Authorization Request]. Under his assessment and plan, respondent indicated a "pap [was] done" and to follow up as needed.

32. After completing the exam, respondent told Patient 1 to meet him in his office after she dressed. During the post-exam meeting, respondent discussed the results of his exam. Patient 1 and respondent had different accounts about what else they discussed.

33. Patient 1 recalled she asked respondent how long it would take to obtain the Pap smear results. She also told respondent her boyfriend wanted to make sure she does not have cancer. She then heard respondent say something to the effect of "will you do everything to make your boyfriend happy," which she interpreted as a

sexual comment, i.e., would she do everything to sexually satisfy him. Patient 1 testified respondent also told her she need an ultrasound examination to detect ovarian cancer but he could not perform the examination without authorization from Patient 1's HMO. According to Patient 1, as part of this discussion respondent also told her he would order a pelvic ultrasound "because he had not gotten to see the full you." Patient 1 perceived this comment as sexual as well because respondent was indicating he wanted to see her full body and, if said in Korean, "it did not sound like a comment that would be made by a doctor" (her words). She reported to the Board she believed respondent wanted to see her undressed. Patient 1 testified she did not respond to these comments because they made her uncomfortable.

34. Respondent agreed he informed Patient 1 she needed insurer authorization to perform an ultrasound. He testified Patient 1 became incredibly angry that respondent was unable to perform the ultrasound as part of her appointment. According to respondent, Patient 1 told him she was a lawyer and was going to make his life miserable. He reflected his frustration with Patient 1 and Patient 1's reaction to his conversation in two post-it notes he attached to Patient 1's medical file, in which he described Patient 1 as apoplectic. (Ex. 11, p. A90, A92.)

35. Respondent denied making sexualized comments to Patient 1. He asserted his reference to "not seeing the full you" related to his inability to perform the ultrasound. He asserted Patient 1's interpretation made no sense; he had already seen Patient 1's genitals and breasts during his examination and her undressing in a subsequent examination would be done under the same circumstances as her first exam, i.e., under the guidance of the MA. Respondent's statement about Patient 1's boyfriend was in response to her description of her boyfriend as wanting her to get a

complete cancer workup because he was paranoid about cancer; it had nothing to do with any sexual performance by Patient 1.

POST-EXAM EVENTS

36. Patient 1 went to the front desk to settle her bill and request an HMO authorization for an ultrasound appointment. Respondent is not involved in the billing for the exam or tests or arranging insurance authorization. Patient 1 did not remember being upset or making threatening remarks to either respondent or the staff about respondent's failure to perform an HPV test or an ultrasound examination. Respondent's staff immediately requested insurer authorization for an ultrasound.

37. Respondent's office manager at the time of Patient 1's visit, Wendy Park (no relation to respondent) corroborated respondent's testimony about Patient 1's anger at the end of her appointment. According to Ms. Park, who testified at hearing and has worked for respondent for 20 years, Patient 1 was upset at the end of her appointment. Ms. Park recalled loud voices coming from respondent's consultation room when respondent was meeting with Patient 1. She believed respondent and Patient 1 were arguing, although she did not know about what. Patient 1 then came to the front desk angry because she required insurer authorization before she could obtain an ultrasound exam. Ms. Park told Patient 1 that once she received authorization from Patient 1's HMO, she would immediately make an ultrasound appointment for her.

38. Patient 1 did not complain about the breast exam to respondent during the exam or in his office after the exam. Patient 1 did not object to respondent's comments to respondent. Patient 1 did not complain about the breast exam or respondent's comments to Ms. Park or any of respondent's other staff.

39. After she left respondent's office, Patient 1 felt discomfited by her experience in respondent's office. She was not sure if she suffered a sexual assault or if the examination was part of a routine procedure, particularly because MA Lee had been present during the examination. Patient 1 later confided in S.Y. about what had happened during her visit with respondent, and S.Y. told her that "in no way in hell" what she experienced was a breast exam. S.Y., who testified at hearing, told Patient 1 there was "no way" a physician would touch a patient's breasts without permission and, if she felt violated, she should report the matter to the police. Patient 1 then concluded respondent had sexually assaulted her because he had not performed a normal breast exam.

40. Patient 1 reported the incident to the Los Angeles Police Department (LAPD) on the evening of January 5, 2019. S.Y. was with Patient 1 during her police interview. According to the LAPD report, Patient 1 reported her boyfriend told her that ob/gyn doctors are "not certified to perform a breast exam," respondent should have asked Patient 1 to conduct a breast exam, a Pap smear does not include a breast examination, and respondent should have never removed his gloves and touched Patient 1's breasts with his bare hands. (Ex. 7, p. A72.) Neither the LAPD nor the District Attorney's Office ever filed charges against respondent in response to Patient 1's LAPD report. Patient 1 filed her complaint with the Board on January 7, 2022, which S.Y. testified he reviewed beforehand.

41. On January 22, 2019, Patient 1 returned to respondent's office to retrieve her Pap smear results because respondent's staff had told her they could not e-mail them. That was her last contact with respondent's office. Patient 1 never returned for an ultrasound appointment.

42. Respondent denied making any sexual overtures to Patient 1 or sexually touching Patient 1's breasts. Although he did not specifically recall the details of his examination of Patient 1, he testified his examination of Patient 1 conformed to his examination practices with all his other patients. (See Evid. Code § 1105 [habit or custom evidence is admissible "to prove conduct on a specified occasion in conformity with the habit or custom"].) Respondent examined every patient presenting for a fully gynecological exam in the same way and same order to ensure his exams were complete and accurate. His protocol requires the presence of a chaperone during each patient exam. He never examines a patient without a chaperone present. Respondent has trained his MAs to inform his patients that his exam includes a breast, abdominal, and pelvic exam. If a patient objects to any part of the exam, the chaperone is to note the objection on a post-it note on the file to alert respondent. Respondent has also instructed chaperones to interrupt the exam if they see something amiss.

43. Also as part of his usual practice, respondent would have informed Patient 1 during the pre-exam consult of his intent to perform a breast, pelvic and abdominal exam and he expected MA Lee, Patient 1's chaperone, to have explained the scope of his exams as well. Respondent testified he would confirm he was performing those exams during the exam itself. It also was respondent's practice to note on the Progress Note if Patient 1 had not consented. Patient 1 never refused a breast examination in his conversations with her, and he did not see any post-it from MA Lee that Patient 1 did not want a breast examination so he assumed Patient 1 had no objection to a breast exam.

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TESTIMONY BY HAIRI LEE

44. MA Lee testified at the hearing. MA Lee was assigned to chaperone Patient 1. Although she did not specifically recall Patient 1, MA Lee corroborated respondent's account of his patient examination procedures. According to MA Lee, respondent never varies in his examination techniques and protocols.

45. MA Lee was born in South Korea in 1985 and came to the United States in 2004. She received an Associate of Arts degree in Allied Health Science from an American college and then graduated from a vocational nursing school in 2012. MA Lee is not a licensed vocational nurse, having failed the examination in 2012. MA Lee testified she believes she failed the exam because she did not study enough.

46. MA Lee's first MA position was with respondent. She worked for respondent from 2013 to 2019. Ms. Lee testified the Board's Investigation Report incorrectly states she only worked for respondent for four years. (See Ex. 3, p. A55.) In 2019, MA Lee left respondent's employ on good terms to work for another doctor, where she still works. She has been accepted into a Bachelor of Science Nursing Program.

47. MA Lee believed her responsibility as respondent's MA was to protect the patient, make the patient feel comfortable, and help respondent in his examination. MA Lee testified she and respondent followed the same protocol for hundreds of patients, if not more. If respondent had circled a Pap smear on the superbill, MA Lee would explain the procedure to the patient. If respondent had circled a full gynecological exam, MA Lee would explain to the patient respondent will perform a pelvic, abdominal, and breast examination and would check whether the patient consents to the exam. She also would tell the patient to unhook her bra,

undress from the waist down, and wear the paper apron across the lower part of her body. If a patient said she did not want a breast exam, MA Lee would note the refusal on a yellow post-it attached to the file to alert respondent of the refusal.

48. MA Lee confirmed respondent was never in the exam room alone with a patient. MA Lee also confirmed the protocol respondent followed with his patients was the same for each exam and respondent explained to the patient what he will do during the exam. For his pelvic examination, it was MA Lee's responsibility to pass respondent gloves, which he always wore during the exam, and a speculum, and then to take the Pap smear sample from him. After completing the pelvic examination, respondent then checked the patient's abdomen and breast, and performed an ultrasound, if necessary. According to MA Lee, the patient lifts her clothing when respondent performed a breast exam; she never saw respondent use his arms to go under a patient's shirt or bra. Respondent also asked the patient to lift both arms and examined the patient's armpits. MA Lee testified she never turned her back to the patient.

49. MA Lee was trained by respondent and her predecessor to report to the front desk staff anything she thought was amiss during respondent's patient examinations. If she saw respondent doing something wrong, MA Lee would have confronted respondent and asked him what he was doing. MA Lee never observed respondent do anything outside of the protocols that would cause concern. She described respondent as "kind and very good at explaining things."

CREDIBILITY ASSESSMENT

50. Respondent, Patient 1, and MA Lee each testified in a forthright, non-evasive, and respectful manner about Patient 1's examination. However, Patient 1's

account suffered from significant weaknesses such that it cannot be considered a clear and convincing report of what happened.

51. First, the credibility of Patient 1 and respondent's accounts is colored by their different expectations as to the nature of Patient 1's appointment. Patient 1 never had a full gynecological exam, which would have included a breast exam. She reasonably believed her appointment with respondent was only to receive a Pap smear. The reason for her request for a referral from Dr. Cho was for the Pap smear, and this belief informed her comfort level going forward. However, respondent did not receive Dr. Cho's referral; instead, he received the HMO Referral, which authorized a full gynecological exam. No evidence was adduced that Patient 1 was privy to or understood the scope of the HMO Referral respondent received. A full gynecological examination, according to ACOG and the billing guidelines published by the Centers for Medicaid and Medicare includes the inspection and palpation of breasts. (Ex. 20, p. A233.) Thus, when respondent reviewed the HMO Referral, it was his understanding Patient 1 was a new patient seeking a regular gynecological examination and was aware of what such an examination would entail. According to respondent, his reference to "paranoid" referred to his understanding that Patient 1's boyfriend was paranoid about cancer, and Patient 1's statement to respondent that her boyfriend was an oncologist confirmed his belief she was there for a full cancer workup. Patient 1's specific request for a Pap smear did not alter his belief because it was part of a full examination. Thus, whatever was said and heard during Patient 1's initial conversations with respondent in his private office, which Patient 1 did not recall, was filtered through the expectations of Patient 1 that she only expected a Pap smear and respondent who believed he was being asked to perform a full exam, including a breast exam, for a new patient.

52. Second, Patient 1's perception of respondent's touching of her breasts as sexual was based on her belief that the purpose of the exam was to perform a Pap smear and there was no reason or basis for a breast exam. S.Y.'s statements regarding the propriety of respondent's exam also affected her perception. S.Y.'s statements, however, were incorrect. Contrary to S.Y.'s statements as Patient 1 described them to the LAPD and the Board, an ob/gyn physician is permitted to perform breast exams, as well as examine a patient's breasts without gloves, and does not need express consent to do so. S.Y. also seemed unaware that respondent's authorization was to perform a full gynecological exam, not simply a pap smear.

53. Third, Patient 1 was adamant that a proper breast examination had not been performed. However, Patient 1 had never had a breast exam before her appointment with respondent, and she relied on S.Y.'s incorrect views in determining what was proper. Moreover, respondent's Progress Note reflects that an appropriate breast exam had been done. In addition, respondent's repeated testimony that he never wavered from his protocol of how he performed his exams cannot be ignored.

54. Fourth, MA Lee's assertion that she had never seen anything inappropriate during respondent's exams is convincing. MA Lee took her responsibilities seriously. She has not been in respondent's employ since 2019. She had no motive to be untruthful.

55. Fifth, Patient 1's testimony about her understanding as to why MA Lee would ask her to unhook her bra and her failure to recollect any disagreement regarding her ultrasound appointment raises questions regarding the accuracy of her account. Considering these issues, there was insufficient evidence to prove Patient 1's account was more credible than that of respondent and MA Lee.

Patient 2

56. Complainant alleges respondent sexually exploited Patient 2 and engaged in sexual misconduct and gross negligence by inappropriately touching Patient 2's breasts without advance notice, explanation, or consent. Complainant further alleges respondent acted negligently when he inserted his fingers inside Patient 2's vagina without warning, consent, or explanation. Complainant also alleges respondent's medical record keeping for Patient 2 was grossly negligent and inadequate.

THE EXAM

57. Patient 2 presented herself to respondent's office on Saturday, August 25, 2018, when she was 38 years old. Patient 2 was born in South Korea and moved to the United States in 2011. Until the pandemic, she managed a clothing shop in Koreatown. Patient 2 testified in Korean at the hearing and conversed with respondent and his staff in Korean.

58. Patient 2 made an appointment to see respondent because she was concerned about a stabbing sensation in her side that caused her pain and discomfort. Patient 2 previously had a tumor removed from her uterus and an ectopic pregnancy so she was sensitive to any issue involving this area. She found respondent on the internet and mistakenly believed from his middle name he was a gynecologist.

59. After she arrived at respondent's office, she filled out a Patient Profile Form and supplied her medical history to MA Lee, which was reflected in an Obstetrics and Gynecology Form. She then met with respondent in his office, where respondent asked about her ailments. She explained the pain she was experiencing. According to

Patient 2, respondent informed her he would perform some tests including an ultrasound to detect the pain source. Patient 2 described respondent's demeanor in the consultation as "frustrated" and "impatient" and testified she did not "feel good" about the examination. Patient 2 did not remember respondent telling her he was going to do a full work-up. However, she acknowledged she did not remember everything said as part of the consult because, in her own words, "so much time has passed."

60. Respondent's Progress Note for Patient 2 indicates that during the pre-exam consult, Patient 2 expressed concern about pelvic pain, which had traveled from her left side to her right, and was then in the center. The Note also indicates the pain followed sexual intercourse. His description of Patient 2's concerns was in Korean. Respondent testified he wrote in Korean because Patient 2 had stated her concerns in Korean. Respondent testified he had explained to Patient 2 that addressing her complaint could require testing for sexually transmitted diseases (STDs). According to respondent, once he mentioned STD testing, Patient 2 had a blank expression, and "he thought he lost her". Respondent testified it would have been his protocol to explain to Patient 2 that because she was a new patient he would perform his regular exam, which included examining her breasts, pelvic area, and abdomen. The Progress Note reflects no objection by Patient 2 to a breast, abdominal, or pelvic exam. Patient 2's superbill reflects respondent's intent to perform a comprehensive exam with a Pap smear. (Ex. 12, p. A122.)

61. MA Lee accompanied Patient 2 to the examination room. MA Lee did not recall Patient 2 but testified she acted in conformity with her custom and practice to tell respondent's patients to unhook their bras and explain the nature of respondent's examination, i.e., it included a pelvic, abdominal, and breast exam. Patient 2 did not

recall MA Lee instructing her to unhook her bra. Patient 2 also did not recall whether MA Lee informed her respondent would conduct a breast examination or vaginal examination; she only recalled MA Lee was unfriendly. According to Patient 2, MA Lee did not inform her she could refuse a breast examination. As his custom and practice, respondent was not present during MA Lee's conversations with Patient 2 or when Patient 2 undressed.

62. MA Lee and respondent entered the exam room after Patient 2 undressed. Respondent did not see a post-it on Patient 2's file so he assumed Patient 2 did not object to any part of the exam. MA Lee was present during the entire exam. Patient 2 was able to see MA Lee's face at all times. MA Lee did not report any irregularities in respondent's examination of Patient 2.

63. Patient 2 could not recall whether respondent examined her breasts from a sitting or standing position; she first testified sitting, then standing, and after further questioning, could not remember. Patient 2 testified respondent reached up from under her clothing and her bra and fondled her breasts with the palm of his bare right hand without warning, explanation, or consent. She described the touching as rubbing the front of her breasts and touching her nipples, swiping from one breast to the other. According to Patient 2, it felt like a brush with no pressure. Patient 2 testified respondent did not ask her to sit up to examine her breasts, never asked her to lift her clothing or her bra, did not examine her armpits, and her breasts were never exposed. Patient 2 further testified she asked respondent what he was doing, and respondent told her an exam, and then repeated the motion one more time. According to Patient 2, after he finished touching her breasts, respondent said, "you don't have breast cancer, you are OK."

64. Patient 2 testified she felt uncomfortable, humiliated, and violated by respondent's breast exam. Patient 2 had not asked for a breast exam and did not have any problems with her breasts. She felt that respondent's touching was sexual because he had not asked for her consent.

65. Before her appointment with respondent, Patient 2 never had a breast exam in the United States. It was Patient 2's belief that a gynecologist is concerned with the vaginal area, not the breasts. In Korea, a gynecologist does not perform a breast exam. The breast exams Patient 2 had in Korea were part of other cancer-related examinations, were painful, and were performed in connection with a mammogram. In Korea, the doctors touch around the breast but do not touch the breast itself. Patient 2 had breast implant surgery but did not discuss the breast implants with respondent.

66. Patient 2 testified respondent then gave her a vaginal examination and performed an ultrasound. She had no recollection respondent performed an abdominal exam. According to Patient 2, before performing the vaginal exam, respondent did not inform her of his intention to do so and did not ask her consent when he inserted his fingers into her vagina. Patient 2 expected an ultrasound examination, but not a vaginal examination. Patient 2 was unaware of the purpose of a Pap smear but acknowledged respondent told her he needed to scrape something from her vagina.

67. Patient 2 recalled little detail regarding the vaginal exam. She did not remember how many fingers he placed in her vagina and did not remember how long they were in the vagina. Patient 2 remembered respondent spoke with her while performing the ultrasound but she could not recall what he said. Patient 2 recalled

respondent used a "finger-protecting rubber" on his fingers, similar to a condom, in performing the vaginal examination, but did not recall whether respondent also wore gloves. She testified she did not recall the specifics of the pelvic examination because of what had happened with the earlier breast examination. When asked on cross-examination about her lack of recall, Patient 2 testified she only remembered the bad things because respondent did not do any good things.

68. Patient 2 testified respondent took a tissue sample during the ultrasound. Patient 2 had no complaints about the ultrasound because that is what she wanted. During the ultrasound, respondent told her she had a fibroid and needed further tests.

69. Respondent disputed Patient 2's characterization of the breast and vaginal exams. Contrary to Patient 2's description, respondent never performs a breast examination before a pelvic examination. As has been his custom and practice, he always first performs a vaginal examination, which he always follows with an abdominal and breast examination. Respondent testified he never varies his exam techniques or sequence to ensure he does not miss anything.

70. Respondent denied seeking or obtaining any sexual pleasure from his breast examination of Patient 2. He testified his breast examination met clinical guidelines and was consistent with his breast exam protocol. He disputed Patient 2's claim that he went under her bra and her clothes or that did not ask her to lift her arms. His Progress Note states Patient 2 had bilateral implants and her breasts were non-tender, with no masses and no discharge. Respondent testified he could not have determined Patient 2 had implants without looking at her breasts.

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71. Respondent testified it would have been his custom and practice to inform Patient 2 of the vaginal examination as part of the pre-exam consult and in the exam room. Respondent maintained his exam of Patient 2's pelvic area comported with his custom and practice. He always uses gloves during the vaginal examination and a condom-like device to cover the ultrasound wand, not his hand, as Patient 2 testified. His pelvic exam includes a visual inspection of the genital area, the insertion of a speculum, a Pap smear, and a bimanual examination, during which he removes one of his gloves. During the pelvic exam, respondent inserts his fingers into a patient's vagina when he applies vaginal gel to the vaginal entry to allow ease of entry with the speculum; he also inserts his fingers to perform the bimanual examination. The Progress Note for Patient 2 indicates his pelvic exam showed the pelvic, vaginal, cervix, uterus, and adnexa were normal. His ultrasound examination revealed a fibroid.

72. After respondent completed the ultrasound examination, he left the exam room. Patient 2 changed and went to respondent's private office. In his office, respondent told her about the fibroid, showed her the ultrasound picture, and discussed the need for further tests. Patient 2 told respondent she did not have insurance, and he indicated his office would accommodate her. According to Patient 2, respondent also asked about her boyfriend, attributed her pain to an STD, and recommended STD testing. Patient 2 became "very upset" about respondent's comments about her boyfriend and STD. Patient 2 testified she only went to see respondent about the pain on her side, she did not see him to find out if her boyfriend was possibly sleeping with other women or if she had an STD. Patient 2 also felt the tests were unnecessary because she had not asked him to check for cancer or STDs.

73. In Patient 2's Progress Note, as part of his assessment and plan, respondent noted that a Pap smear was performed and a sample for STD testing was

taken. Respondent also noted pelvic pain and endometrial changes and recommended a follow-up in one to two weeks. (Ex. 26, p. A266.) Included with the Progress Note are four radiographs of Patient 2's uterus. The radiographs reflect the patient's name, the date they were taken, and various measurements. (*Id.*, p. A267.)

74. After she left respondent's private office, Patient 2 protested to the front desk staff the charges for the Pap smear and the STD tests because she had not requested the testing. Respondent's office credited her $130 for the tests but still charged her $200 for the exam. Patient 2 did not complain to respondent or the front office staff about her breast or pelvic examinations or respondent's statements to her.

POST-EXAM EVENTS

75. Two days later, Patient 2 visited another male gynecologist for a second opinion. Dr. Min Park, no relation to respondent or Wendy Park, found no fibroids, although also recommended STD testing. Dr. Park diagnosed Patient 2's pain as a muscle spasm and told Patient 2 not to be concerned. According to Patient 2's then-boyfriend, A.L., Patient 2 underwent the recommended STD testing and her test results were negative.

76. After receiving Dr. Min Park's diagnosis, Patient 2 returned to respondent's office and demanded a refund of the remaining $200 she paid for respondent's exam. According to Patient 2's account, she was "very upset and angry" about respondent's wrong diagnosis. She testified she did not yell or intimidate respondent or his staff but acknowledged her voice may have been raised. She testified she spoke to respondent face-to-face and told him about Dr. Min Park's findings, while her boyfriend waited for her downstairs. Patient 2 testified respondent called her crazy and then he met privately with a nurse, while Patient 2 waited outside

for her refund. The nurse then agreed to refund the money only if Patient 2 signed a paper in English saying she would not report the matter to Yelp or the Board. Patient 2 signed the paper, although she did not ask for a copy or read it, and then the office staff refunded the remaining money.

77. Patient 2 testified that after her boyfriend reported the matter to the Board and sent a complaint to Yelp, respondent sent her another bill for $200, which she never paid. Patient 2 did not keep a copy of the bill for $200, although the Board investigator had told her to keep all documents. Respondent denied ever requiring Patient 2 to refrain from submitting a complaint to the Board or Yelp as a condition of receiving a refund or consenting to send Patient 2 another bill for $200.

Testimony by A.L.

78. A.L., Patient 1's boyfriend at the time, testified Patient 2 telephoned him on August 25, 2018, to complain about her appointment with respondent. A.L. was living in Northern California when he received Patient 2's call. According to A.L., Patient 2 told him respondent was impatient, did not inform her about the tests he intended to perform, did not obtain consent to touch her breasts or put his fingers in her vagina, and attributed her pain to an STD. Patient 2 also reported respondent provided substandard care. A.L. testified Patient 2 told him during that call about her visit to Dr. Min Park for a second opinion, but A.L.'s recollection is faulty as Patient 2 did not visit Dr. Min Park until August 27, 2018, two days later. A.L. started to prepare a complaint to the Board on Patient 2's behalf the night he received Patient 2's call.

79. A.L. traveled to Los Angeles on August 28, 2018. He recalled driving Patient 2 to respondent's clinic to collect her refund on August 29, 2018. He did not recall entering respondent's offices or speaking with respondent or staff. A.L. recalled

the whole interaction was very quick; Patient 2 went into respondent's offices and less than a minute later returned with her money back. Patient 2 informed him she was told that she could not complain to the Board or Yelp if she wanted a refund.

80. A.L. completed the complaint to the Board on August 28, 2019. At the same time, he prepared a Yelp review on Patient 2's behalf. He reviewed the Board complaint and the Yelp review with Patient 2 to make sure they conformed to her understanding. Because of her limited English proficiency, Patient 2 reviewed the complaint and the Yelp review using a translation app to make sure it was correct.

Testimony by Wendy Park

81. Ms. Park, respondent's office manager at the time, disputed Patient 2's account of what occurred after her examination. Ms. Park testified Patient 2, after leaving respondent's private office, raised her voice and began arguing with her that she had not requested a Pap smear or an STD test and did not want to pay for them. Ms. Park recalled that because Patient 2 made such a scene, Ms. Park immediately refunded the costs of the two tests, which totaled $130. Several days later, on August 28, 2018, Ms. Park testified Patient 2 and A.L. returned to the office, demanding a refund of the remaining $200 Patient 2 had paid for the examination. According to Ms. Park, Patient 2 was screaming and yelling. Because there were other patients in the office, Ms. Park told Patient 2 to return when the office was not busy. Ms. Park then explained the situation to respondent, who told her to refund the $200 exam fee as well. Respondent did not speak with Patient 2 directly regarding the refund. After Patient 2 left, Ms. Park wrote in Patient 2's file, "Do Not Accept this Patient" and that Patient 2 was extremely bad. (Ex. 12, p. A123.) At no time did Ms. Park condition the

payment of any refund on Patient 2 not writing a Yelp review or making a complaint to the Board. Ms. Park did not require Patient 2 to file any paper to receive the refund.

Testimony by Haeok Kwon

82. Ms. Kwon, respondent's office assistant, also disputed Patient 2's account of what occurred after her appointment with respondent. Ms. Kwon came to the United States from Korea in 1982; she received a B.S. in Electrical Engineering in 1990, and she has worked as a medical office assistant for respondent since 2016. Her duties include working at the front desk, buying office supplies, and dealing with patient insurance. Ms. Kwon has never taken part in or chaperoned any medical examination by respondent.

83. Ms. Kwon observed the interactions between Ms. Park and Patient 2 on August 28, 2018, and corroborated Ms. Park's account of the events. On August 29, 2018, a Wednesday when respondent did not see any patients in the office, Ms. Kwon was working by herself when Patient 2 returned to the office with her boyfriend to obtain the remaining $200 in cash. Ms. Kwon gave Patient 2 the money. Ms. Kwon did not ask Patient 2 to sign anything for the refund and did not ask for a receipt. Ms. Kwon did not condition payment on Patient 2 not posting negative reviews on Yelp. Ms. Kwon did not send any new bill to Patient 2 after refunding her payment, and the account register reflects no such billing. (Ex. 12, p. A126.)

84. Ms. Kwon took issue with the Board investigator's summary of her statements in the Investigation Report, which misspelled her name as Kaeok Kwon. (See Ex. 3, p. A54.) Although Ms. Kwon acknowledged she was interviewed by the investigator, she testified she did not discuss respondent's treatment and care or make any statements regarding breast examinations. Ms. Kwon did not take part in any

patient examinations and did not know what occurred during those examinations. The investigator's attribution of statements about respondent's exam protocol to her was therefore mistaken.

CREDIBILITY ASSESSMENT

85. Patient 2's testimony was selective and therefore was not reliable in evaluating what occurred during her appointment with respondent. Patient 2 acknowledged the passage of time had affected her recollection. She was confused about the order of the exam, testifying respondent performed a breast exam first when his practice was always first to perform a pelvic exam, as confirmed by MA Lee. Patient 2's claim she could not remember the details of her vaginal exam because she was still in shock from her breast exam therefore made no sense. Patient 2 did not remember whether she had unhooked her bra for the exam or whether respondent examined her sitting down or standing up. Patient 2 erroneously claimed respondent used a condom on his fingers when he conducted a vaginal exam. There was no documentation to support her claim that respondent billed her after she filed a complaint with the Board and with Yelp; respondent's ledger stated just the opposite. Ms. Park and Ms. Kwon credibly disputed Patient 2's claim that her refund was dependent on her not filing such complaints, and their accounts of the timing and details of the refund make more sense than Patient 2's account. Patient 2 also seemed more upset about respondent's suggestion that she should have STD testing than anything else. It was the STD suggestion that sent her to immediately seek a second opinion and Dr. Min Park's diagnosis sent her back to respondent's office to seek a refund. On cross-examination, when asked about her memory lapses, Patient 2 testified she only recollected the "bad" things respondent had done because he had not done anything good.

86. It is also difficult to ascertain what influence, if any, A.L. had on Patient 2's interpretation of respondent's conduct. A.L. immediately started preparing a complaint to the Board on Patient 2's behalf after receiving her telephone call and he also prepared the negative Yelp review. Although Patient 2 testified she reviewed the complaint and the review before they were filed, she used a translation app to do so because both the review and the complaint were written in English.

87. Based on the weight of the evidence, there is insufficient evidence to clearly and convincingly establish Patient 2's account of what occurred during her examination is correct.

Patient 3

88. Complainant alleges respondent acted negligently when he failed to perform blood type testing for Patient 3 to ascertain her Rh status (positive or negative) and when he conducted a breast exam of Patient 3 that did not meet clinical standards. Complainant also alleges respondent's medical record keeping for Patient 3 was grossly negligent and inadequate. Patient 3 did not testify at the hearing. Complainant relied solely on respondent's medical records for Patient 3 to support the charges against respondent. At hearing, complainant's counsel stated she would not offer any evidence in support of the claim that respondent's breast exam of Patient 3 did not meet clinical standards. As a result, the facts surrounding that allegation will not be addressed.

89. The Board became aware of Patient 3 based on a complaint by Patient 3's husband filed on February 8, 2018, about two medical appointments Patient 3 had with respondent on March 11 and March 25, 2017. Patient 3's husband did not testify at the hearing. His complaint makes no mention of the testing and medical record

keeping issues underlying the Second Amended Accusation. The Board's expert discovered respondent's alleged misconduct while reviewing Patient 3's medical records.

90. According to the medical records, Patient 3 was seen by respondent on March 11, 2017, and March 25, 2017. Her first visit was for a therapeutic abortion, which respondent performed without issue. Patient 3's Obstetric and Gynecology record filled out by respondent's MA indicates that before her March 11 appointment with respondent, Patient 3 had three-live births and three miscarriages. Respondent's medical records do not reflect Patient 3's blood type or whether her blood was Rh negative or positive.

91. Respondent acknowledged he did not order an Rh blood test for Patient 3 before performing her therapeutic abortion. Respondent testified it was his usual practice to ask his patients about their blood type, their Rh status, and whether they ever received a RhoGAM shot before performing a therapeutic abortion. Respondent also testified it was his usual practice to document the patient's response. If a patient did not know her Rh status, respondent would perform a blood test or document in his records why he did not.

92. Respecting Patient 3, respondent saw no need to perform an Rh test because he was confident Patient 3 was aware of her Rh status considering her earlier multiple pregnancies and miscarriages. If Patient 3 was Rh-negative, her past pregnancies and miscarriages would have been accompanied by at least eight injections of RhoGAM, an intramuscular shot of immunoglobulin to prevent harm to the fetus in future pregnancies. Respondent was also concerned about costs considering Patient 3 was a cash patient.

93. Respondent recalled he had asked Patient 3 about her blood type as part of his examination, but then became distracted when he detected a cervical lesion and Patient 3 had refused a Pap smear to diagnose it. Respondent further recalled Patient 3 told him her blood type was A positive. If her blood type had been negative, he would have been sure to act because it would have been a "huge thing" in his own words. Respondent admitted, however, that he was negligent in failing to chart his conversation with Patient 3 about her blood type.

94. Respondent's Progress Note for Patient 3's March 11, 2017 visit indicates Patient 3 was there for a "D&C" (dilatation and curettage). In the "PE" section, respondent testified he indicated he did not examine Patient 3's breasts, abdomen, or pelvic area. However, the Progress Note reflects he found a cervical lesion while performing an ultrasound, and the Progress Note reflects a drawing with the location of the lesion. The Progress Note also states the ultrasound exam of Patient 3's left ovary was normal and there is a small cyst on her right ovary. Under assessment and plan, respondent noted Patient 3's intrauterine pregnancy at five weeks by date.

95. Respondent's Progress Note for Patient 3's March 25, 2017 visit does not show a chief complaint and is blank under the section entitled "for". (Ex. 43, p. A451.) According to respondent, he did not need to identify the reason for the visit because it was a follow-up to Patient 3's March 11, 2017 visit and the Progress Note for that visit indicated the purpose of the follow-up. In the March 25 Progress Note, respondent states that his breast exam found Patient 3's breasts to be non-tender, with no masses or nipple discharge, his abdominal exam was benign, and his examination of Patient 3's pelvic area, vagina, uterus, the adnexa were normal but there was a lesion on the cervix. There is also a handwritten drawing noting the location of the lesion. Respondent also notes his ultrasound examination of Patient 3 found her right and left

ovaries as well as her endometrium normal but with a small fibroid. Under assessment and plan, respondent wrote cervical lesion and pap done, with a follow up in four weeks, at which time Patient 3 may need a loop procedure.

96. Also included in Patient 3's medical file is a consent form for the D&C, a separate record for the D&C procedure, and copies of respondent's ultrasound images of Patient 3's uterus. (Ex. 43, p. A457, A458.) The ultrasound taken before the D&C was to confirm pregnancy and a fetal heartbeat.

Expert Testimony and Analysis

97. Complainant offered the reports (Exs. 19, 20, 36, 37, and 48) and testimony of Jane van Dis, M.D. to support the charges in the Second Amended Accusation. Dr. van Dis has been board-certified in ob/gyn since 2008 and is licensed to practice medicine in California and New York. Dr. van Dis has been a consultant and expert reviewer for the Board since 2015. In addition to practicing medicine, Dr. van Dis is a founder of TIMES UP Healthcare, a national advocacy organization whose aim is to end sexual harassment and discrimination in health care. She also serves as a medical advisor for various companies and has held leadership positions at various organizations. She served on the peer review committee at Bakersfield Memorial Hospital, where she was employed as a hospitalist, from 2017 to 2018.

98. Since 2021, Dr. van Dis has been an Assistant Professor in the Department of Obstetrics and Gynecology at University of Rochester, where she provides gyn/ob care as a hospitalist at the associated medical center, and the Chief Medical Officer of Biorithm, a medical technology start-up. Dr. van Dis also practices telehealth for the Maven Clinic, where she served as medical director from 2018 to 2021. From 2013 to 2021, Dr. van Dis worked as an ob/gyn hospitalist in various

hospitals in the Los Angeles area. Before 2013, Dr. van Dis was an ob/gyn physician with Kaiser Permanente Southern California Physician Medical Group and at the University of Minnesota. Until 2013, Dr. van Dis had a full-scope gynecological practice where she performed breast examinations. Since 2013, her work has been limited to hospital practice, where she treats patients for labor and delivery, pelvic and abdominal pain, pregnancy, ovarian cysts, lacerations, and accidents involving gynecological organs. Dr. van Dis has never worked as a solo practitioner.

99. Respondent relied on the expert testimony and report by Roya Rakhshani, M.D. (Ex. I) in support of his contention that the treatment of Patients 1, 2, and 3 comported with the standard of care. Dr. Rakhshani has been a board-certified ob/gyn physician since 1989 and is licensed to practice medicine in California. She obtained her medical degree in 1983. From 1983 to 1984, Dr. Rakhshani interned at the Los Angeles County University of Southern California Women's Hospital, where she also completed a three-year residency in ob/gyn in 1987. Dr. Rakhshani has only acted as an expert a few times and never testified in a hearing involving the Board.

100. In 1987, Dr. Rakhshani joined a medical practice where she was one of two ob/gyn physicians. She stayed there for 16 years during which she performed well-women exams, including pap smears and breast examinations, and provided obstetric and surgical care. In 2003, Dr. Rakhshani opened her own ob/gyn practice, which is currently located in Costa Mesa. She sees an average of 20 patients per day. Her work is currently 70 percent gynecological and 30 percent obstetrics. Dr. Rakhshani is also an active staff member at Orange Coast Memorial Medical Center and Hoag Memorial Hospital Presbyterian (Hoag) and has served as the chairperson of the ob/gyn department at Fountain Valley Regional Hospital and on the Quality

Assurance Committed at Hoag. In addition to her private practice, Dr. Rakhshani works as a laborist two to three times a month for Hoag.

101. Drs. van Dis and Rakhshani were both qualified to testify as experts about the standard of care in this case based on their education, training, and experience. Differences between their opinions have been resolved by considering their qualifications, the persuasiveness of their opinions, the reasons for each opinion, and the factual basis of their opinions. (See *In re Marriage of Duncan* (2001) 90 Cal.App.4th 617, 632.) California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

PATIENT 1: INAPPROPRIATE SEXUAL CONTACT BETWEEN GYNECOLOGIST AND PATIENT

102. Both experts agreed that the standard of care prohibits a gynecologist from engaging in sexual misconduct or touching a patient's body parts for any purpose other than appropriate examination or treatment.

103. Dr. van Dis concluded respondent's examination of Patient 1 constituted an extreme departure from the standard of care because his examination of Patient 1's breasts was sexual. Per the Board's instructions, Dr. van Dis based her conclusion on Patient 1's perception that "she was being exploited for [respondent's] sexual gain." (Ex. 19, p. A222.) Dr. van Dis found Patient 1's perception was supported by the absence of any medical reason for respondent's examination of Patient 1's breasts. She pointed to ACOG and various other cancer organization guidelines indicating that breast examinations for asymptomatic women under the age of 40 are recommended only every one to three years. She disagreed that breast cancer in Patient 1's aunt

increased the risk of cancer for Patient 1. She interpreted the HMO Referral narrowly to authorize only a "screening pap," and concluded respondent therefore could not infer the referral included a breast or a well-woman exam. Dr. van Dis also pointed out that Patient 1 did not complain to respondent about her breasts. Dr. van Dis discounted the importance of a chaperone during an exam because a chaperone is a paid employee of the practitioner and therefore gains nothing from reporting any malfeasance.

104. In support of her opinion, Dr. van Dis cited Patient 1's statements in her complaint about respondent's failure to inform Patient 1 that he was going to touch her breast, ask for Patient 1's permission to conduct a breast exam, or obtain Patient 1's consent to conduct such an examination. Dr. van Dis asserted the standard of care requires an ob/gyn physician to document verbal consent to each part of a gynecological exam. Dr. van Dis cited the 2007 ACOG Committee Opinion on Sexual Misconduct, which states that examinations should be performed with only the necessary amount of physical contact required to obtain data for diagnosis and that "appropriate explanation" should accompany all examination procedures. (Ex. 53, p. A698.) She also cited an article prepared by the Mayo Clinic Division of Cardiovascular Diseases and Legal Department titled, "Medical Informed Consent: General Considerations for Physicians" (Medical Informed Consent article), which states that the informed consent doctrine requires "physicians to disclose all pertinent information about risks and benefits of the procedure to the patient." (Ex. 57, p. A715.).

105. Dr. van Dis found respondent's examination of Patient 1's breasts did not meet clinical requirements based on Patient 1's description. According to Patient 1's account, she was not seated, respondent's hand went under her clothes, she did not raise her arms, and her breasts were not visible. Dr. van Dis explained the first part of

the breast examination should be done while the patient is sitting up with her hands above her chest to assess symmetry, which respondent did not do. The second part is performed when the patient is supine and entails examining both the breast and axillary area in either a circular or lawn mower fashion. Dr. van Dis stated it was unacceptable to examine the breasts while a patient has her clothes on and without visually inspecting the breast.

106. Dr. van Dis also found respondent did not properly document his findings if he did perform an adequate breast examination. If the exam results are normal, the standard of care required the physician to document at least three negative findings. Dr. van Dis was unable to determine from respondent's medical record keeping that he made any negative findings.

107. Dr. Rakhshani disagreed with Dr. van Dis's conclusions regarding respondent's treatment of Patient 1. Dr. Rakhshani opined respondent had not departed from the standard of care in treating Patient 1. She found, based on his custom and practice, respondent performed a clinically appropriate breast examination, his physical contact with Patient 1 was in the context of a medical examination with a chaperone present at all times, and he provided adequate documentation of his examination and findings.

108. Dr. Rakhshani did not find any inappropriate sexual contact between respondent and Patient 1. Citing the same authorities relied on by Dr. van Dis, she maintained the standard of care recommends starting breast examinations at age 25 and then repeating them every one to three years. Thus, it was medically justified and clinically indicated for respondent to examine Patient 1's breasts, since Patient 1 at age 32 never had a breast exam. Even if the risk of cancer is low, a breast examination is

helpful to obtain a baseline reading for comparison in the future. The HMO Referral for Patient 1 also indicated Patient 1 was authorized for a routine gynecological examination, which includes a breast and a pelvic exam. It is within the discretion of a gynecologist to perform a breast examination for a patient presenting for a routine examination for the first time. It was also respondent's custom and practice to inform his patients he would be performing an examination that includes a breast, pelvic, and abdominal exam.

109. Dr. Rakhshani did not find fault with respondent's method of performing a breast examination. The standard of care acknowledges there are different ways of performing a breast examination. What is important is that physicians are systematic so they do not miss any of the elements. She expected that respondent visibly observed Patient 1's breasts based on his custom and practice. His notations in Patient 1's Progress Note indicated respondent examined Patient 1's breasts; he noted three negative findings.

110. Dr. Rakhshani did not find the standard of care requires an ob/gyn physician to obtain written or express oral consent for every element of the gynecological exam. It is reasonable for a gynecologist to infer consent to any part of the exam if the gynecologist explains the scope and nature of the exam, and the patient does not object. The standard of care only requires a gynecologist to chart if a patient refuses any part of the exam. A gynecologist does not have to chart a patient's oral consent.

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Analysis

111. There is insufficient evidence to establish clearly and convincingly respondent engaged in inappropriate sexual touching during his examination of Patient 1.

112. Dr. van Dis's conclusion of sexual exploitation and misconduct was premised on Patient 1's perception that respondent's motivation in touching her breasts as sexual, which Dr. van Dis was instructed to assume was correct. However, as shown above, Patient 1's perception description of the exam as sexual was not reliable because it was influenced by her assumption that the exam was only to be vaginal, her ignorance of the scope of the HMO referral, and the incorrect statements by S.Y. Dr. van Dis also discounted MA Lee's testimony as untrustworthy, contending a chaperone is motivated to lie because she is in the employ of the accused physician. However, in this case, MA Lee does not have such motivation because she has not worked for respondent for at least three years.

113. In addition, Dr. Rakhshani's conclusion that respondent's breast exam of Patient 1 was medically justified is more convincing than Dr. van Dis's conclusion it was not. The clinical guidelines cited by both experts state that patients between 25 and 40 years old who are asymptomatic and have no risk factors are recommended to undergo a clinical breast exam every one to three years. Patient 1 was 32 years old, and never had a breast examination; therefore examining Patient 1's breasts did not violate these guidelines. Dr. Rakhshani's interpretation of the HMO Referral to authorize a full gynecological exam, which includes a breast exam, instead of simply a Pap smear, is also more persuasive, considering her greater experience as a private practitioner reading HMO Referrals.

114. There was also insufficient evidence to clearly and convincingly establish respondent's exam was not clinically correct. Dr. van Dis's finding that respondent's exam did not meet clinical standards was based on Patient 1's perception, her inability to decipher respondent's notes, and her failure to detect at least three negative findings in those notes. However, respondent noted three negative findings of his exam of Patient 1's breasts, i.e., they were non-tender, with no masses, and with no nipple discharge. Dr. Rakhshani, who was able to review respondent's notes found that he covered the crucial elements of the exam.

115. Dr. van Dis contended the standard of care requires a patient to expressly consent to every component of a gynecological exam, and based on Patient 1's claimed lack of consent, found that respondent departed from the standard of care. However, none of the authorities cited by Dr. van Dis state that the standard of care requires documentation of consent to a routine gynecological examination or any of its components. For instance, the 2007 ACOG Committee Opinion on Sexual Misconduct does not state a physician must obtain or document consent for components of examination; the opinion only states physicians should provide "[a]ppropriate explanation" of the examination. (Ex. 53, p. A698.) Thus, as Dr. Rakhshani convincingly asserted, the standard of care, at least at the time of the incidents in question, allowed an ob/gyn physician to assume patient consent to all components of a gynecological examination if the ob/gyn physician adequately explains those components and receives no objection from the patient.

116. Patient 1 never objected to having respondent examine her breasts either before or during the exam and did not stop him from doing so. The issue then is whether respondent adequately explained the elements of his examination to her. As

set forth in the Credibility Analysis set forth in Factual Findings 50 through 55, *supra,* there was insufficient evidence to establish that respondent or MA Lee had not.

PATIENT 1: INAPPROPRIATE SEXUALIZED LANGUAGE WITH PATIENT

117. Both experts agreed the standard of care requires physicians to avoid sexual innuendo and sexually provocative remarks to their patients. Dr. van Dis found respondent's statements to Patient 1 regarding "seeing the full you" and "doing anything to make her boyfriend happy" constituted sexualized language because Patient 1 perceived the comments to be sexual.

118. Dr. Rakhshani did not find respondent used inappropriate sexualized language with Patient 1. It was her opinion Patient 1 misunderstood respondent's comments. According to Dr. Rakhshani, respondent's comment that he "didn't get to see the full of [Patient 1]" alluded to his inability to perform an ovarian cancer screening. His comment about whether Patient 1 would do everything or anything to make her boyfriend happy was in connection with Patient 1's statement that her boyfriend wanted everything done. Neither of respondent's comments contained a sexual undertone or innuendo.

Analysis

119. There was insufficient evidence to prove respondent made sexualized comments to Patient 1. Dr. van Dis's opinion that respondent departed from the standard of care in making such statements is based solely on Patient 1's interpretation of the statements. However, Patient 1's interpretation does not comport with the evidence. It is more reasonable to interpret respondent's statement about not seeing the "full you" as nonsexual and reflecting respondent's need for an ultrasound

to check for ovarian cancer. The other comment, perhaps inartful, did not necessarily have sexual overtones but was in response to Patient 1's statement that her boyfriend was paranoid and wanted everything done.

PATIENT 1: MEDICAL RECORD DOCUMENTATION

120. Dr. van Dis found respondent's Progress Note for Patient 1 illegible. She could not determine if any of the necessary components of a breast or a pelvic examination were included in the Note. She cited billing guidelines from the Centers for Medicare & Medicaid Services (Medicare Billing Guidelines) as the standard of care as to what must be documented in a patient's medical record. She was not able to decipher whether respondent included the seven of 11 elements required to bill a gynecological exam in his Progress Note. She listed terminology that is commonly used in a breast exam but she was unable to locate on the Progress Note. Dr. van Dis also found fault with respondent's charting of Patient 1's ultrasound. (Ex. 20, p. A234.) Dr. van Dis opined it was contrary to the standard of care not to chart the identity of the chaperone for Patient 1. She also maintained Patient 1's Progress Note lacked a chief complaint or the reason for Patient 1's visit. According to Dr. van Dis, an illegible and incomplete medical record demonstrates respondent's care was incomplete or of poor quality. It also presents issues for the continuity of care for the patient.

121. Dr. Rakhshani found it was within the standard of care for respondent to keep handwritten records. Dr. Rakhshani was able to read the substance of Patient 1's Progress Note. He included breast exam terminology noted as potentially absent in Dr. van Dis's report including, masses, nipple discharge, and skin/texture, i.e., non-tender. Because Dr. Rakhshani practiced before the advent of electronic records, she had experience reading a doctor's handwriting. Dr. Rakhshani opined the standard of care

did not require respondent to chart every unremarkable finding, and the chart identified the pertinent aspects of the exam. Respondent also noted the abnormal finding, i.e., a left side fullness, which justified the request for an ultrasound. Dr. Rakhshani disagreed with Dr. van Dis that the Medicare Billing Guidelines set the standard of care for medical record keeping. She stated the purpose of the Medicare Billing Guidelines was for billing purposes only. She also held the standard of care did not require respondent to identify the chaperone in a patient's medical record. Respondent adequately defined Patient 1's chief complaint, when he wrote "pap smear" on the Progress Note.

Analysis

122. Notwithstanding Dr. Rakhshani's ability to read respondent's Progress Note for Patient 1, portions of the Progress Note are illegible for laypersons and those physicians either unfamiliar with the elements of a gynecological exam or whose experience is only with electronic recordkeeping. Respondent therefore departed from the standard of care by not maintaining legible notes.

123. Dr. Rakhshani's assertion that the standard of care requires a physician to document only pertinent aspects of the exam and not all parts of the exam was more convincing. Dr. van Dis does not have recent experience charting by hand, is most familiar with hospital electronic records, and her reliance on the Medicare Billing Guidelines to set the standard for medical record keeping was misplaced; the Medicare Billing Guidelines refer to billing, not what the standard of care requires to be included in a medical chart. Dr. van Dis also cited no authority for her opinion that the standard of care required respondent to chart the presence of a chaperone or Patient 1's consent to any procedure; the standard of care articulated by Dr.

Rakhshani, i.e., that a physician is not required to chart the presence of a chaperone or consent is more persuasive again because of her experience as a solo practitioner in dealing with situations requiring a chaperone. Dr. van Dis's critique of respondent's ultrasound documentation was not credited because respondent never performed an ultrasound on Patient 1.

PATIENT 2: INAPPROPRIATE SEXUAL CONTACT BETWEEN GYNECOLOGIST AND PATIENT (BREAST)

124. Dr. van Dis found respondent's examination of Patient 2's breasts as sexual and an extreme departure from the standard of care based on Patient 2's stated perception. In addition, Dr. van Dis did not find any reason for respondent to have examined Patient 2's breasts because Patient 2 see respondent for a breast exam or a well-woman exam. A clinical breast exam was also unnecessary according to the medical guidelines, which recommend a breast examination every one to three years for women of Patient 2's age. In addition, Patient 2's medical history reflects she had a mammogram a year before her appointment with respondent. Dr. van Dis credited Patient 2's testimony that she was not informed by MA Lee or respondent that a breast examination would be performed and did not consent to such an exam.

125. Dr. van Dis also found, based on Patient 2's description, that respondent did not meet clinical guidelines in performing the breast exam. The exam, as Patient 2 described it, mimicked a sex act. Dr. van Dis also could not tell whether respondent's exam was proper because respondent's notes were not legible. However, she acknowledged that respondent performed some examination of Patient 2's breasts because his records indicated Patient 2 had breast implants.

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126. Dr. Rakhshani disagreed with Dr. van Dis and found that respondent did not engage in inappropriate sexual conduct with Patient 2, for many of the same reasons she set forth in her opinion about respondent's conduct toward Patient 1. She based her conclusion on respondent's custom and practice of informing his patients he would perform a breast exam and a vaginal exam as part of a full gynecological workup, the presence of a chaperone during Patient 2's exam, his practice of not reaching under the clothes of a patient, and performing a breast and vaginal examination was consistent with ACOG and other screening guidelines.

127. Dr. Rakhshani found Patient 2's breast exam was medically indicated. As Dr. Rakhshani stated with Patient 1, breast exams can be offered per ACOG and other guidelines every one to three years for women ages 25 to 39. It was reasonable and within the standard of care for respondent to perform a breast exam because Patient 2 was a new patient whom respondent expected might return, and it was useful to obtain a baseline examination. Dr. Rakhshani, based on her understanding of respondent's custom and practice, as confirmed by MA Lee, found that respondent advised Patient 2 of the breast exam both during the pre-exam consult and during the examination.

128. Dr. Rakhshani credited respondent's description of his breast examination protocol in finding his examination met the standard of care. According to Dr. Rakhshani, the Progress Note reflects respondent's examination. The exam notes Patient 2 had breast implants and she had no masses, tenderness, or discharge. Dr. Rakhshani explained respondent's notation that Patient 2 had breast implants is consistent with a visual examination. Dr. Rakhshani also pointed out that Patient 2 had not previously undergone a breast examination in the United States and therefore had no experience to gauge the exam done by respondent.

Analysis

129. Dr. van Dis's conclusion that respondent engaged in improper sexual contact with Patient 2 suffers from the same weakness as her conclusion concerning Patient 1, i.e., she assumed Patient 2's perceptions were correct. However, as shown in Factual Findings 85 and 86, *supra*, Patient 2's perceptions of what transpired during her exam are not reliable. Dr. van Dis also failed to show Patient 2's breast exam was not clinically warranted. It was respondent's custom and practice to perform a full gynecological exam for first-time patients, including a breast exam. As noted above, a breast exam is recommended every one to three years for women in Patient 2's age group. Performing a breast examination on a new patient to obtain a baseline reading based on the expectation she will return is consistent with the standard of care and, as Dr. Rakhshani testified, is within the discretion of an ob/gyn physician. Based on respondent's 90 percent patient return rate, it was reasonable for respondent to assume Patient 2 would return.

130. The evidence also failed to establish respondent's breast exam of Patient 2 did not meet clinical guidelines. Dr. van Dis based her claim that his exam did not meet clinical requirements on Patient 2's unreliable description of the breast exam and because Dr. van Dis could not read respondent's notes. As noted above, Dr. Rakhshani asserted a breast exam can be done with a patient in a sitting or supine position if it is thorough and consistent. She also found respondent's notes reflected he had visibly observed Patient 2's breasts by noting they were implants and had examined the breasts for tenderness, discharge, and the existence of masses. According to Dr. Rakhshani, respondent's records reflected a clinically acceptable examination of Patient 2's breasts. Because it was based on the actual review of Patient 2's medical records, Dr. Rakhshani's opinion is entitled to more weight.

131. If Patient 2's account is fully credited, she never expressly consented to respondent's examination of her breasts. However, as noted in Factual Finding 115, it was not shown that express consent is required for every component of a gynecological exam at the time of Patient 2's appointment with respondent. Respondent could assume implicit consent if he explained what he was going to do and Patient 2 did not object. Based on the evidence submitted and given the unreliability of Patient 2's account, it cannot be determined if respondent failed to explain the scope of his examination. Thus, there is insufficient evidence to establish respondent engaged in improper sexual contact with Patient 2 and thereby departed from the standard of care.

PATIENT 2: INAPPROPRIATE SEXUAL CONTACT BETWEEN GYNECOLOGIST AND PATIENT (VAGINA)

132. Dr. van Dis found that the standard of care required respondent to obtain and document Patient 2's consent to a vaginal examination. She credited Patient 2's testimony that respondent failed to inform her of the vaginal examination and Patient 2 never consented to such an exam. Dr. van Dis found respondent's vaginal exam covered little to none of the required standard procedures and his documentation was insufficient. She concluded respondent's failure to obtain Patient 2's consent to a vaginal examination and his inadequate documentation constituted a simple departure from the standard of care.

133. Dr. Rakhshani found respondent's vaginal examination of Patient 2 met the standard of care. Respondent's exam included abdominal palpation, observation of the pelvic area, and an examination of the vagina, cervix, uterus, and adnexa. She also found he adequately documented the findings of his examination. Patient 2 was

informed of what was going to happen based on respondent's custom and practice, and a pelvic exam is reasonable if assessing for postcoital pelvic pain, which was Patient 2's complaint. The standard of care did not require respondent to chart Patient 2's consent.

Analysis

134. Dr. van Dis's opinion is less convincing than that of Dr. Rakhshani. Dr. van Dis failed to cite any authority requiring an ob/gyn physician to obtain or chart express consent to components of an examination. Even if Patient 2's testimony that she never expressly consented to such an examination is credited, her claim that respondent never informed her he would perform a vaginal examination is not substantiated by clear or convincing evidence. Patient 2's recollection has been found problematic. Moreover, Patient 2 testified respondent told her he would be performing various tests to address her complaint of pelvic pain. Her assertion that she did not expect respondent to perform a vaginal exam to assess that pain is not credible. Thus, there is insufficient evidence to establish clearly and convincingly that respondent departed from the standard of care by performing a pelvic exam on Patient 2.

PATIENT 2: MEDICAL DOCUMENTATION

135. Dr. van Dis concluded respondent's medical records for Patient 2 were illegible and incomplete and therefore constituted an extreme departure from the standard of care. Based on her review, she could not locate a chief complaint on the Progress Note and could not read respondent's writing, which appeared to be in Korean, below the "here for" section. Dr. van Dis also could not decipher respondent's findings from his breast exam of Patient 2 except for his notation that Patient 2 had bilateral implants. She found respondent's notes of his abdomen and pelvic exams for

Patient 2 similarly undecipherable. Dr. van Dis found the Progress Note further deficient because it did not reflect whether a chaperone was present or Patient 2's consent to any component of the exam. Dr. van Dis also found fault with respondent's ultrasound images because the images were not labeled and required measurements were not recorded.

136. Dr. Rakhshani was able to interpret all respondent's chart entries on the Progress Note for Patient 2. She found the Note reflected all essential findings from Patient 2's pelvic, breast, and abdominal exams, which is all the standard of care requires. Respondent's failure to chart all the entries set forth in the Medicare Guidelines did not constitute a departure from the standard of care as the Medicare documentation requirements are for billing purposes; they do not establish the standard of care.

137. Dr. Rakhshani found that the copies of the pelvic ultrasound images admitted into evidence and reviewed by the experts were not of good quality. She testified that respondent was not required to identify the body part imaged (in this case, the uterus) because any competent ob/gyn physician could determine the body part. She testified respondent's notations on the ultrasound documents complied with the standard of care as the required measurements were charted on the images themselves.

Analysis

138. The issues of respondent's charting for Patient 2 are similar to the issues surrounding Patient 1's charting. Patient 2's Progress Note is largely illegible to a layperson or anyone not familiar with handwritten records. It is difficult to decipher whether certain notes are in Korean or English. Respondent offered no description to

explain his drawings. While his notations in Korean may explain Patient 2's chief complaint, an English-speaking doctor with no knowledge of Korean cannot understand them. However, as Dr. Rakhshani maintained, the contents of the Notes, once understood, contain the essential elements of respondent's examination, which is all that is required. In addition, the ultrasound images contained the necessary measurements on the images themselves.

PATIENT 3: RH TESTING

139. According to Dr. van Dis, the standard of care requires a physician performing a therapeutic abortion to order a blood type test to ascertain a patient's Rh status and thus decide whether the patient requires a RhoGAM injection. Failure to administer RhoGAM to an Rh-negative mother after an abortion places a future baby at risk. (Ex. 48, p. A666.) Dr. van Dis testified she never took the mother's word regarding her Rh status, even if she had multiple children or said she was not going to have more children, because Dr. van Dis does not trust her patients' recollections and does not believe most mothers are aware of their Rh status. Dr. van Dis found respondent's failure to order an Rh blood test for Patient 3 constituted a simple departure from the standard of care.

140. In her report and her testimony, Dr. Rakhshani disagreed with Dr. van Dis and found the standard of care did not require Rh testing of mothers who had multiple children and miscarriages. She thought it reasonable to conclude that those mothers were aware of their Rh status because they would have received multiple RhoGAM injections. However, she found if an Rh blood test was not performed, the standard of care required that the patient's blood type be charted. Dr. Rakhshani concluded respondent departed from the standard of care by failing to chart his

discussion with Patient 3 regarding her RH positive status. According to Dr. Rakhshani, respondent's omission was a simple departure from the standard of care.

Analysis

141. Dr. van Dis did not cite any authority for her opinion that the standard of care requires an Rh blood test to be ordered if the patient is aware of her blood type. The authority cited in her report states only that Rh-negative women undergoing a therapeutic abortion should receive RhoGAM. (Ex. 48, p. A666.) Dr. Rakhshani's testimony that testing is not required under the standard of care when a woman is aware of her Rh status is more persuasive because it reflects the realities of private practice and is sensitive to a patient's financial needs.

142. Respondent acknowledged the standard of care required him to document a patient's Rh status whether he obtained the information from a test or the patient herself. He also acknowledged he departed from the standard of care by failing to include Patient 3's Rh status on her chart. The evidence was therefore clear and convincing that respondent inadequately charted Patient 3's Rh status.

PATIENT 3: MEDICAL RECORD DOCUMENTATION

143. Dr. van Dis found the Progress Notes regarding respondent's breast and pelvic examinations of Patient 3 illegible. She also found that respondent failed to identify a chief cause on the March 25 Progress Note as contrary to the standard of care. If the Progress Notes were legible, she maintained they did not meet the Medicare Billing Guidelines and did not use terminology commonly found in the documentation of a breast exam.

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144. Dr. van Dis relied on billing codes to determine the standard of care for documentation of ultrasound examinations. According to those billing codes, documentation of a complete female pelvic ultrasound examination should include a description and measurement of the uterus and adnexal structures, endometrium, bladder, and any pelvic pathology. Billing codes required that documentation of a first-trimester transvaginal approach ultrasound include a first-trimester nuchal translucency measurement, and single or first gestation.

145. Dr. van Dis's opinions about the sufficiency of respondent's ultrasound images were difficult to discern. In one part of her expert report, she opined respondent's first trimester ultrasound might be complete but she was unable to determine if the appropriate elements were recorded because the photocopy of the image and respondent's notations on the image were unclear. Later in her report, Dr. van Dis states respondent's records of his ultrasound examinations, both first trimester and pelvic, do not include the sufficient elements of an ultrasound examination, although she fails to specify what elements are not included. (Ex. 48, p. A666.) Dr. van Dis also found fault, with the way ultrasound images were placed in the medical record but failed to articulate the standard for how such images should be placed.

146. Dr. Rakhshani found that respondent had charted all pertinent information on the Progress Notes for his March 11 and March 25 examinations. She was able to read his notations. She also found the findings of respondent's ultrasound examinations sufficiently documented on the ultrasound images, the copies of which she believed were of poor quality. She did not find the standard of care required that an ob/gyn document that information separately.

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Analysis

147. As with the Progress Notes for Patient 1 and Patient 2, Patient 3's Progress Notes are illegible to the lay reader and anyone unfamiliar with handwritten records. The Progress Notes therefore do not meet the standard of care.

148. Dr. van Dis's inability to read the notes or the ultrasound notations does not necessarily make those notes or notations inadequate. As Dr. Rakhshani explained, respondent identified the components of his breast exam and used common terminology cited by Dr. van Dis in her report. Respondent also identified components of his vaginal exam of Patient 3 on the Note. It was not established that the Medicare Guidelines constitute the standard of care for charting breast or pelvic exams. Although the chief complaint section of the March 25 Progress Note was blank, the Note was part of a file that recommended a follow-up, and it was evident the March 25 exam was the recommended follow-up. In addition, it was not proven that respondent's ultrasound images lacked necessary information. However, although respondent met the standard of care in charting most of the elements of his examination of Patient 3, his record keeping was deficient in not recording Patient 3's blood type status.

Evidence of Mitigation, Rehabilitation, and Reputation

149. Respondent has never been found at fault in any malpractice action or settled a claim relating to his practice. Ms. Park, Ms. Kwon, and MA Lee testified they never received any complaints regarding respondent's exams. The complaints triggering the Second Amended Accusation are the first Board complaints regarding respondent's practice.

150. Respondent holds himself to high standards and is dedicated to serving his patients. He repeatedly asserted his respect and the necessity for maintaining strict and consistent protocols to serve his patients. He recently moved into new modernized offices in Koreatown and has endeavored to offer his patients a wide range of gynecological services. He testified that he has tailored his practice to the needs and sensibilities of his community.

151. Respondent showed respect for the Board and these proceedings. He has changed his practice in response to the Board's concerns and shifting norms. Although respondent believes he is the only ob/gyn physician to use one, after the Board's interview with respondent on October 17, 2019, respondent developed a written consent form explaining the components of his examination. Respondent sent the form to the Board, and he has used the form in his practice since December 2019. Respondent gives the consent form to each of his patients. The form states, in Korean and in English, that respondent performs a routine yearly examination for cervical, uterine, ovarian, and breast cancer screening. The form explains respondent will perform a Pap smear and a pelvic examination involving the use of a speculum and he will screen for breast cancer by physical examination. Respondent asks his patients to sign and date the form indicating their agreement and understanding. (Ex. Z.)

152. Respondent has also adopted electronic record keeping for his practice. Starting in January 2022, respondent began converting his practice to electronic record keeping. As of the date of the hearing, respondent had converted his Medicare patients to electronic records. Respondent expects his entire practice will convert to electronic recordkeeping by the end of 2022.

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153. Three witnesses testified to respondent's good character. Although none had reviewed the Second Amended Accusation, each was aware of the allegations of respondent's inappropriate breast examinations of certain of his patients.

154. Song Cho, M.D., is a dermatologist who has practiced in Koreatown since 1994. Dr. Cho has known respondent for more than 25 years. They first met at a Korean doctors' medical association. Dr. Cho refers between 10 and 15 patients a year to respondent; she has never heard of any sexual incidents or other issues with his practice. Dr. Cho emphasized respondent is an asset to the Koreatown community and he helps patients in need or who are in financial trouble.

155. Samuel Lee, M.D., is a urologist who completed his residency in 1995. He has known respondent for 20 years and worked with respondent in surgery. Dr. Lee estimates he takes part in five to 15 surgeries a year with respondent. Dr. Lee believes respondent is an excellent surgeon. He has referred 10 to 15 patients to respondent and has never heard any complaints about his practice. Although Dr. Lee has never seen respondent perform a breast examination, he has seen respondent perform a pre-surgical vaginal examination and did not see anything improper.

156. Jennifer Baik, M.D., is a doctor specializing in allergy and immunology who has practiced in Koreatown since 1996. She has known respondent for more than 25 years. Dr. Baik sees respondent as her ob/gyn physician. Dr. Baik's mother and sister are also patients of respondent, and respondent is the only ob/gyn physician to whom Dr. Baik refers patients, her family, and her friends. She finds respondent to be a very diligent and precise practitioner. She had never heard any complaints about his practices from her patients and none reported respondent had acted or spoken

inappropriately. According to Dr. Baik, respondent is trustworthy and an asset to the Koreatown community.

Costs

157. Complainant requests the reimbursement of $69,557.13 in costs incurred prosecuting this matter by the Department of Justice (DOJ). According to the Supplemental Certification of Prosecution Costs, DOJ has billed the Board $67,313.75 for attorney and paralegal time spent working on this matter. (Ex. 69.) The DOJ costs are broken down as follows: 257.75 hours of attorney time billed at $220 per hour and 51.75 hours of paralegal time billed at $208 per hour. In addition, complainant has incurred $2,243.38 in interpretation and translation fees, which are supported by the pertinent invoices to the interpreting service.

158. Complainant has also requested reimbursement for estimated costs totaling $8,935 consisting of additional hearing preparation totaling $6,335 and expert testimony totaling $2,600. Complainant has offered no evidence the estimated costs were incurred. Nor did complainant supply any invoice reflecting the number of hours billed by complainant's expert.

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CONCLUSIONS OF LAW

Standard and Burden of Proof

1. Complainant has the burden of proof in an administrative action seeking to suspend or revoke a professional license, and the standard is clear and convincing proof to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

2. Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

Governing Law and Legislative Intent

3. The Medical Practice Act governs the rights and responsibilities of the holder of a physician's and surgeon's certificate. (Bus. & Prof. Code, §§ 2000 et seq.) The state's obligation and power to regulate the professional conduct of its health practitioners is well settled. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 577.) Protection of the public is the highest priority for the Board in exercising its disciplinary authority and is paramount over other interests in conflict with that objective. (Bus. & Prof. Code, § 2001.1.)

4. The Board is required to take action against any licensee who is charged with unprofessional conduct. (Bus. & Prof. Code, § 2234.) Unprofessional conduct includes violation of any provision of the Medical Practice Act, gross negligence, and

repeated negligent acts, which consists of two or more negligent acts or omissions. (*Id.,* subd. (a), (b), & (c).)

First Cause for Discipline

5. The Second Amended Accusation alleges respondent is subject to disciplinary action for sexual exploitation under Business and Professions Code sections 729 and 2234, subdivision (a), because he engaged in sexual contact with Patient 1 and Patient 2.

6. Business and Professions Code section 729 states in pertinent part as follows:

> (a) Any physician and surgeon . . . who engages in an act of sexual intercourse, sodomy, oral copulation, or sexual contact with a patient or client . . . is guilty of sexual exploitation by a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor.
>
> (b) Sexual exploitation by a physician and surgeon . . is a public offense:
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> [¶] . . . [¶]
>
> For purposes of subdivision (a), in no instance shall consent of the patient or client be a defense. However, physicians and surgeons shall not be guilty of sexual exploitation for touching any intimate part of a patient or client unless the

touching is outside the scope of medical examination and treatment, or the touching is done for sexual gratification.

(c) For purposes of this section:

[¶] . . . [¶]

(3) "Sexual contact" means sexual intercourse or the touching of an intimate part of a patient for the purpose of sexual arousal, gratification, or abuse.

(4) "Intimate part" and "touching" have the same meanings as defined in Section 234.4 of the Penal Code.

7. Penal Code section 234.4, subdivision (g)(1), defines "intimate part" to mean the sexual organ, anus, groin, or buttocks of any person, and the breast of a female." The statute defines "touching" as physical contact with the skin of another person whether accomplished directly or through the clothing of the person committing the offense or through the clothing of the victim. (Pen. Code, § 234.4, subd. (e)(2).)

8. Complainant did not prove by clear and convincing evidence that respondent touched an intimate part of Patient 1 or Patient 2 for sexual arousal, gratification, or abuse. (Factual Findings 17–87, 102–119, 124–131.) The evidence did not establish respondent sought or received sexual gratification from touching the breasts of Patient 1 or Patient 2. Complainant did not prove that the breast examinations were outside the scope of reasonable medical treatment. Cause therefore does not exist to discipline respondent's certificate under Business and Professions Code sections 729 and 2234, subdivision (a).

Second Cause for Discipline

9. The Second Amended Accusation alleges respondent is subject to disciplinary action for sexual misconduct under Business and Professions Code section 726 based on his treatment of Patient 1 and Patient 2.

10. Business and Professions Code section 726 states as follows:

> (a) The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this division or under any initiative act referred to in this division.
>
> (b) This section shall not apply to consensual sexual contact between a licensee and his or her spouse or person in an equivalent domestic relationship when that licensee provides medical treatment, other than psychotherapeutic treatment, to his or her spouse or person in an equivalent domestic relationship.

11. Complainant did not prove by clear and convincing evidence that respondent engaged in sexual misconduct in treating Patient 1 or Patient 2 or made sexualized comments during his examination of Patient 1. (Factual Findings 17–87, 102–119, 124–131; Legal Conclusion 9.) Cause therefore does not exist to discipline respondent's certificate under Business and Professions Code section 726.

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Third Cause for Discipline

12. The Second Amended Accusation alleges respondent's certificate is subject to discipline under Business and Professions Code section 2234, subdivision (b), because he was grossly negligent in his care and treatment of Patient 1, Patient 2, and Patient 3. Complainant alleges respondent committed extreme departures from the standard of care as follows: (a) in the treatment of Patients 1 and 2, he inappropriately touched their breasts without informing them, without explanation, and without obtaining consent; (b) he made inappropriate sexual comments to Patient 1; (c) his medical record keeping was inadequate and inaccurate for Patient 1 and Patient 2 in that the records were largely illegible, both patients' records lacked required information including elements of the breast and pelvic examinations, and with respect to Patient 2, the records lacked elements of the ultrasound examination; and (d) his medical record keeping was inadequate and inaccurate for Patient 3 because they were largely illegible and lacked required information, including elements of the breast exam, pelvic examinations, and ultrasound examinations (both pelvic and first trimester).

13. The Medical Practice Act does not define "negligence." Generally, negligence is conduct that falls below the standard established by law for the protection of others against unreasonable risk of harm. (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997, Rest.2d Torts, § 282.) It is well settled that the standard of care for physicians is the reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of the medical profession under similar circumstances." (*Avivi v. Centro Medico Urgente Medical Center* (2008) 159 Cal.App.4th 463, 470; *Brown v. Colm* (1974) 11 Cal.3d 639, 643.). Specialists are held to that standard of learning and skill normally possessed by such

specialists in the same or similar locality under the same or similar circumstances. (*Quintal v. Laurel Grove Hospital* (1964) 62 Cal.2d 154, 159.) Gross negligence includes "the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Van Meter v. Bent Cons. Co.* (1956) 46 Cal.2d 588, 594.)

14. Complainant did not prove by clear and convincing evidence that respondent inappropriately touched Patient 1 or Patient 2's breasts without informing them, without explanation, and without obtaining consent. (Factual Findings 17–87, 102–116, 124–131.) Complainant did not prove by clear and convincing evidence that respondent made inappropriate sexual comments to Patient 1. (Factual Findings 17–87, 117–119.)

15. Complainant proved by clear and convincing evidence that respondent's medical records for Patient 1 and Patient 2 were illegible to others and therefore inadequate. (Factual Findings 120–123, 135–138.) Complainant also proved by clear and convincing evidence that respondent's medical records for Patient 3 were illegible and inadequate insofar as respondent failed to chart Patient 3's blood type. (Factual Findings 89–96, 139–148.)

16. Complainant, however, did not prove by clear and convincing evidence that respondent's failure to maintain adequate and accurate records for Patients 1, 2, and 3 constituted an extreme departure from the standard of care within the meaning of Business and Professions Code section 2234, subdivision (b). Although respondent deviated from the standard of practice for keeping records embodied in section 2266, complainant failed to demonstrate respondent's charting omissions were egregious or reflected a want of even scant care for his patients. The evidence did not establish respondent's deficient records compromised the care of any patient. Respondent

recorded what he believed was important for him and his staff to remember in treating his patients. The deficiencies were caused by respondent's poor handwriting, making them illegible to anyone other than the doctor, his staff, and the few people who could discern his writing. Respondent's recordkeeping therefore did not rise to the level of gross negligence.

17. Based on the foregoing, cause therefore does not exist to discipline respondent's certificate for gross negligence under Business and Professions Code section 2234, subdivision (b).

Fourth Cause for Discipline

18. The Second Amended Accusation alleges respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that he was repeatedly negligent in the care and treatment of Patient 1, Patient 2, and Patient 3. These acts included: (a) respondent's inappropriate touching of the breasts of Patients 1 and 2 without informing them, without explanation, and without obtaining consent; (b) making inappropriate sexual comments to Patient 1; (c) inadequate and inaccurate medical recordkeeping for Patient 1 and Patient 2; (d) inserting his fingers inside Patient 2's vagina without explanation; (e) inadequate and inaccurate medical recordkeeping for Patient 3; (f) failure to perform blood type testing for Patient 3 to ascertain Rh status (positive or negative); and (g) failure to conduct a breast examination that met clinical standards for Patient 3.

19. Complainant did not prove by clear and convincing evidence that respondent inappropriately touched the breasts of Patients 1 and 2 without informing them, without explanation, and without obtaining consent, or made inappropriate sexual comments to Patient 1. (Factual Findings 17–87, 102–119, 124–131.)

Complainant also did not prove respondent inserted his fingers inside Patient 2's vagina without explanation. (Factual Findings 57–87, 132–134.) Complainant additionally did not prove respondent's failure to perform blood testing to ascertain Patient 3's Rh status departed from the standard of care. (Factual Findings 89–93, 139-142.) Nor did complainant prove by clear and convincing evidence that respondent failed to conduct an appropriate breast exam for Patient 3.

20. Complainant established by clear and convincing evidence respondent maintained inadequate and inaccurate medical records for Patients 1, 2, and 3. (Factual Findings 120–123 135–138, 143–148.) Cause therefore exists based on respondent's inaccurate and inadequate medical record keeping to discipline respondent's certificate based on his violation of Business and Professions Code section 2234, subdivision (c).

Fifth Cause for Discipline

21. The Second Amended Accusation alleges respondent is subject to disciplinary action because he failed to maintain adequate and accurate medical records for Patient 1, Patient 2, and Patient 3.

22. 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. (Bus. & Prof. Code, § 2266.) The Medical Practice Act does not define "adequate" or "accurate." The language of a statute is given its plain and ordinary meaning while considering each provision of the statute in the context of the entire statutory scheme, avoiding any interpretation leading to absurd results. (*DuBois v. Workers' Comp. Appeals Bd.* (1993) 5 Cal.4th 382; *Hall v. Court Reporters Bd.* (2002) 98 Cal.App.4th 633.) "Adequate" is commonly defined as "enough or good enough for

what is required or needed . . . barely satisfactory, acceptable but not remarkable." (Webster's New World Dict. (3d College Ed, 1988) p. 16.) "Accurate" is commonly defined as "careful and exact . . . free from mistakes or errors." (*Id.* at p. 9.)

23. Accurate and adequate records promote a physician's skillful treatment of a patient, contain the essence of what the physician was told and what the physician observed, and trace the physician's medical decision-making process. Accurate and adequate records permit a review of the progression of an illness or disease and what treatment proved successful and what did not. A physician's memory does not constitute an adequate medical record. A patient may be seen by other physicians. Patients move, change health care plans, and seek second opinions. Poor charting practices may support claims of unprofessional conduct and provide patients, attorneys, expert witnesses, and others with a basis for asserting negligence when none exists. Accurate charting both protects a physician from false claims and promotes skillful patient treatment.

24. Complainant established by clear and convincing evidence that respondent's medical recordkeeping was inadequate for Patients 1, 2, and 3. (Factual Findings 120–123, 135–138, 143–148.) While respondent's Progress Notes may have been understandable to respondent and at times Dr. Rakhshani, the notes are illegible to those unfamiliar with reading handwritten gynecological records. They would be of little use to other doctors treating respondent's patients and could not ensure his patients' continuity of care. Respondent also acknowledged the Progress Notes failed to reflect his conversation with Patient 3 regarding her blood type and Rh status. Cause therefore exists to discipline respondent's license for inadequate and inaccurate medical record keeping under Business and Professions Code section 2266.

Sixth Cause for Discipline

25. The Second Amended Accusation alleges respondent is subject to disciplinary action under Code section 2234 in that he engaged in unprofessional conduct in the care and treatment of Patient 1, Patient 2, and Patient 3.

26. Complainant proved by clear and convincing evidence respondent repeatedly and negligently failed to maintain adequate and accurate medical records in violation of Business and Professions Code sections 2266 and 2234, subdivision (c). (Factual Findings 120–123, 135–138, 143–148; Legal Conclusions 20, 24.) Cause therefore exists to discipline respondent's license under Business and Professions Code section 2334 for unprofessional conduct.

Disposition

27. Under the Board's Disciplinary Guidelines, a finding of repeated acts of negligence, unprofessional conduct, or inadequate medical record keeping warrants license probation to monitor a physician's activities. The evidence here demonstrates that a deviation from the Guidelines' recommended discipline is warranted because probation is not necessary to safeguard the public. The evidence does not indicate a need for monitoring of respondent's practice at work. Complainant did not demonstrate any deficiency in respondent's clinical skills. His peers vouched for those skills, and the size and the return rate of his practice underscore the community's confidence in his services. Respondent also acknowledged the Board's concerns and made changes in his practice to satisfy those concerns. Shortly after the Board's interview, respondent instituted a formal consent process, which he still employs, informing his patients of the components of his exams and requiring they document their consent to such exams in writing, even though he knows of no other ob/gyn

physician who does so. He also has begun the long and expensive process of switching from handwritten to electronic records so that his records will be legible to others and complete. (Factual Findings 149–156.)

28. Respondent's inadequate record keeping practices however must be addressed to protect his patients and others. The Board must be certain that respondent's electronic records capture the information essential to ensure not only respondent's safe practice but also the safe practice of any other doctor who must rely on respondent's records to safely treat their patients. In addition, the records must include information necessary to satisfy legal and other needs.

29. Thus, taking into account respondent's lack of prior discipline, the changes he has already made in his practice, his respect for the Board and its investigative process, and his standing in the Koreatown and medical community, a public reprimand is warranted with the condition that respondent takes and successfully completes a medical record keeping course. A public reprimand will serve to remind respondent that the same or similar misconduct will likely result in a far more serious disciplinary action. It also provides notice to the public and others of the nature and extent of respondent's misconduct.

Costs

30. Effective January 1, 2022, the ALJ may direct a Board license found to have committed a violation or violations of the Medical Practice Act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. (Bus. & Prof. Code, § 125.3, subd. (a).) In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32 (*Zuckerman*), the Supreme Court set forth factors to be considered in determining the reasonableness of the costs sought. These factors

include: 1) the licentiate's success in getting the charges dismissed or the severity of the discipline imposed reduced; 2) the licentiate's subjective good faith belief in the merits of his or her position; 3) whether the licentiate raised a colorable challenge to the proposed discipline; 4) the licentiate's financial ability to pay; and 5) whether the scope of the investigation was appropriate in light of the alleged misconduct. (*Zuckerman*, supra, 29 Cal.4th at p. 45.)

31. Complainant requests reimbursement of $69,557.13 in actual costs of prosecution and enforcement and $8,935 in estimated costs. (Factual Findings 157–158.) Complainant's request for reimbursement for estimated costs is denied because the request did not meet the standards set forth in California Code of Regulations, title 1, section 1042. Additionally, the request for estimated expert costs lacks the proper documentation.

32. Complainant's request for reimbursement of $69,557.13 for actual costs is unreasonable under the *Zuckerman* factors. Although the scope of the Board's investigation was appropriate and there was no evidence showing respondent lacked the financial resources to pay the Board's costs, respondent succeeded in getting the most significant charges dismissed and reduced the severity of the discipline imposed. He raised a colorable challenge to the proposed discipline. He also had a subjective good faith belief in the merits of his position. It is therefore appropriate to reduce the costs sought by 70 percent, for a total of $20,867.14.

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ORDER

1. Peter Haeyong Park, M.D., holder of Physician's and Surgeon's Certificate No. G 67513 is hereby publicly reproved pursuant to Business and Professions Code sections 495 and 227.

2. Respondent shall enroll in a Board-approved medical recordkeeping course within 60 days of the effective date of this decision.

3. Respondent shall pay $20,867.14 to the Board in reimbursement for its costs of investigation and enforcement based on a payment plan approved by the Board.

DATE: 07/11/2022

CINDY F. FORMAN
Administrative Law Judge
Office of Administrative Hearings

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

In the Matter of the Second Amended Accusation Against: **PETER HAEYOUNG PARK, M.D.** **3456 West Olympic Boulevard** **Los Angeles, California 90019-2124** **Physician's and Surgeon's Certificate G 67513,** Respondent.	Case No. 800-2018-048067 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. William Prasifka ("Complainant") brings this Second Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On November 13, 1989, the Board issued Physician's and Surgeon's Certificate Number G 67513 to Peter Haeyoung Park, M.D. ("Respondent"). That certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2023, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code 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.

STATUTORY PROVISIONS

5. Section 2234, subdivisions (a)-(c), of the Code state in pertinent part:

> 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.
>
> (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.
>
> . . . .

6. Section 2246 of the Code provides that any proposed decision or decision issued under this article that contains any finding of fact that the licensee engaged in any act of sexual exploitation, as described in paragraphs (3) to (5), inclusive, of subdivision (b) of Section 729, with a patient shall contain an order of revocation. The revocation shall not be stayed by the administrative law judge.

7. 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.

8. Section 729 of the Code states:

(a) Any physician and surgeon, psychotherapist, alcohol and drug abuse counselor or any person holding himself or herself out to be a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor, who engages in an act of sexual intercourse, sodomy, oral copulation, or sexual contact with a patient or client, or with a former patient or client when the relationship was terminated primarily for the purpose of engaging in those acts, unless the physician and surgeon, psychotherapist, or alcohol and drug abuse counselor has referred the patient or client to an independent and objective physician and surgeon, psychotherapist, or alcohol and drug abuse counselor recommended by a third-party physician and surgeon, psychotherapist, or alcohol and drug abuse counselor for treatment, is guilty of sexual exploitation by a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor.

(b) Sexual exploitation by a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor is a public offense:

(1) An act in violation of subdivision (a) shall be punishable by imprisonment in a county jail for a period of not more than six months, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(2) Multiple acts in violation of subdivision (a) with a single victim, when the offender has no prior conviction for sexual exploitation, shall be punishable by imprisonment in a county jail for a period of not more than six months, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(3) An act or acts in violation of subdivision (a) with two or more victims shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for a period of 16 months, two years, or three years, and a fine not exceeding ten thousand dollars ($10,000); or the act or acts shall be punishable by imprisonment in a county jail for a period of not more than one year, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(4) Two or more acts in violation of subdivision (a) with a single victim, when the offender has at least one prior conviction for sexual exploitation, shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for a period of 16 months, two years, or three years, and a fine not exceeding ten thousand dollars ($10,000); or the act or acts shall be punishable by imprisonment in a county jail for a period of not more than one year, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(5) An act or acts in violation of subdivision (a) with two or more victims, and the offender has at least one prior conviction for sexual exploitation, shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for a period of 16 months, two years, or three years, and a fine not exceeding ten thousand dollars ($10,000).

For purposes of subdivision (a), in no instance shall consent of the patient or

client be a defense. However, physicians and surgeons shall not be guilty of sexual exploitation for touching any intimate part of a patient or client unless the touching is outside the scope of medical examination and treatment, or the touching is done for sexual gratification.

(c) For purposes of this section:

(1) "Psychotherapist" has the same meaning as defined in Section 728.

(2) "Alcohol and drug abuse counselor" means an individual who holds himself or herself out to be an alcohol or drug abuse professional or paraprofessional.

(3) "Sexual contact" means sexual intercourse or the touching of an intimate part of a patient for the purpose of sexual arousal, gratification, or abuse.

(4) "Intimate part" and "touching" have the same meanings as defined in Section 243.4 of the Penal Code.

(d) In the investigation and prosecution of a violation of this section, no person shall seek to obtain disclosure of any confidential files of other patients, clients, or former patients or clients of the physician and surgeon, psychotherapist, or alcohol and drug abuse counselor.

(e) This section does not apply to sexual contact between a physician and surgeon and his or her spouse or person in an equivalent domestic relationship when that physician and surgeon provides medical treatment, other than psychotherapeutic treatment, to his or her spouse or person in an equivalent domestic relationship.

(f) If a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor in a professional partnership or similar group has sexual contact with a patient in violation of this section, another physician and surgeon, psychotherapist, or alcohol and drug abuse counselor in the partnership or group shall not be subject to action under this section solely because of the occurrence of that sexual contact.

9. Section 726 of the Code states:

(a) The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this or under any initiative act referred to in this division.

(b) This section shall not apply to consensual sexual contact between a licensee and his or her spouse or person in an equivalent domestic relationship when that licensee provides medical treatment, to his or her spouse or person in an equivalent domestic relationship.

10. Section 243.4 of the Penal Code states:

. . .

(f) As used in subdivisions (a), (b), (c), and (d), "touches" means physical contact with the skin of another person whether accomplished directly or through the clothing of the person committing the offense.

(g) As used in this section, the following terms have the following meanings:

(1) "Intimate part" means the sexual organ, anus, groin, or buttocks of any person, and the breast of a female.

. . . .

11. Section 2228.1 of the Code states:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to

the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

COST RECOVERY

12. Effective on January 1, 2022, section 125.3 of the Code was amended to provide as follows:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the

proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.[1]

FIRST CAUSE FOR DISCIPLINE

(Sexual Exploitation - Patient 1 and Patient 2)

13. Respondent is subject to disciplinary action under Code sections 2234, subdivision (a), and 729 in that he is guilty of sexual exploitation by a physician with respect to Patient 1 and Patient 2[2] in that he engaged in sexual contact with the two patients. The circumstances are as follows:

Patient 1

14. On January 5, 2019, Patient 1, who at the time was a 31-year-old female, went to see Respondent in his office for a pap smear (vaginal exam). She was directed to an exam room.

[1] Effective January 1, 2022, subdivision (k) of Section 125.3, which exempted physicians and surgeons from paying recovery of the costs of investigation and prosecution by the Board, was repealed.

[2] The patients' names are reduced to Patient 1 and Patient 2 to protect their right of privacy.

After performing the vaginal exam, Respondent took off his gloves and, without advance notice, explanation, or consent, slid his hands underneath the paper gown Patient 1 was wearing and her unhooked bra, touched her breasts, and groped them. He groped the left breast, then moved to the right breast, then moved back to the left breast. Respondent used a swiping motion. His bare hands contacted her breasts and nipples. Patient 1 was then directed to meet Respondent in his office.

15. While Patient 1 was in Respondent's office, Respondent told her, "I didn't get to see the full you." When Respondent informed her of potential cancer risks and Patient 1 informed Respondent that her boyfriend is an oncologist, Respondent asked: "Will you do anything to make your boyfriend happy?" Patient 1 interpreted Respondent's statements as being of a sexual nature and not a clinical one. Patient 1 felt uncomfortable by the breast exam and encounter. She reported the incident to several people and entities, including the police and the Board.

16. Patient 1 felt that the reason why Respondent grasped and touched her breasts was sexually motivated conduct without any clinical justification. Based on Patient 1's report of the breast exam, the exam met nearly none of the clinical requirements of a breast exam. Respondent's documentation of the components of the breast exam in Patient 1's medical record is deficient because the components are not documented. If any of the components of a breast exam are present in the medical documentation, they are not legible.

Patient 2

17. On August 25, 2018, Patient 2, who at the time was a 38-year old female, presented herself to Respondent's office, complaining of lower abdomen pain. When Patient 2 was on the examination table, Respondent reached up from under her clothing and fondled her breasts without warning, explanation, or consent. He rubbed the front of her breasts and touched her nipples, swiping from one breast to the other. When she exclaimed, "What are you doing?" Respondent stated, "An exam," and repeated it one more time. After he was finished touching her breasts, he said, "You don't have breast cancer; you are OK."

18. Patient 2 was shocked and felt horrible. The purported breast exam was inconsistent

with breast examinations that Patient 2 had previously received from other healthcare providers.

19. Respondent then performed a vaginal examination. He did not give a warning nor ask for her approval when he inserted his fingers into her vagina. Respondent did this two times, without even explaining what he was doing. He then performed an internal ultrasound. Respondent then told Patient 2 that she had uterine lumps (fibroids) or polyps and further tests may be required.

20. Respondent questioned if Patient 2 had a boyfriend and stated that her "Boyfriend must be sleeping with other women." Respondent told Patient 2 that polyps from a virus or bacteria caused the lumps. These statements made Patient 2 believe that her medical condition was a sexually transmitted disease (STD). Patient 2 felt ashamed and embarrassed by Respondent's comments about her boyfriend and possible STD.

21. Patient 2 felt mistreated and sexually violated by Respondent. As a result, she reported the incident to the Board. She also obtained a second opinion from another physician, who advised her that she did not have uterine lumps and that she was clean of any virus or bacteria.

22. Patient 2 also felt that the reason why Respondent grasped and touched her breasts was sexually motivated and was not clinical in nature. Based on Patient 2's report of the breast exam, the exam met nearly none of the clinical requirements of a breast exam. Respondent's documentation of the components of the breast exam in Patient 2's medical record is deficient because the components are not documented. If any of the components of a breast exam are present in the medical documentation, they are not legible.

23. Respondent's acts and/or omissions as set forth in Paragraphs 14 through 22, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute sexual exploitation pursuant to Code sections 2234, subdivision (a), and 729. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Sexual Misconduct - Patient 1 and Patient 2)

24. Respondent is subject to disciplinary action under Code section 726 in that he

committed acts of sexual abuse and misconduct with two patients, Patient 1 and Patient 2. The circumstances are as follows:

25. The acts and allegations in Paragraph 14 through 22, above, are incorporated by reference and re-alleged as if fully set forth herein.

26. Respondent's acts and/or omissions as set forth in Paragraphs 14 through 22, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute sexual misconduct pursuant to Code section 726. Therefore, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence - Patient 1, Patient 2, and Patient 3)

27. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he was grossly negligent in his care and treatment of Patient 1, Patient 2, and Patient 3. The circumstances are as follows:

28. The acts and allegations in Paragraph 14 through 22, above, are incorporated by reference and re-alleged as if fully set forth herein.

Patient 3

29. On March 11, 2017, Patient 3,[3] who at the time was a 31-year old female, presented to Respondent's office for an abortion procedure. Respondent performed a pelvic exam and pelvic ultrasound on her. He also performed a dilation and curettage, a procedure to remove tissue from inside the uterus. However, he did not perform any blood type testing to ascertain Rh status (positive or negative). Women who are Rh negative require a shot of Rh immunoglobulin as a precaution against a situation called Rh incompatibility, which could affect future pregnancies and cause hemolytic disease (a blood disorder) in the newborn.

30. Two weeks later, on March 25, 2017, Patient 3 saw Respondent for a post-abortion pelvic examination. He performed a pelvic exam, pap smear, transvaginal ultrasound, and breast exam. The breast exam did not meet clinical standards. Patient 3 was wearing a dress and was instructed to remove her underwear for the exam. When Patient 3 was on the examination table, Respondent reached up from under her dress and touched the upper half of her body without

[3] The patient's name is reduced to Patient 3 to protect her right of privacy.

warning, explanation, or consent. Respondent touched only one of her breasts. He did not look at her breasts. Her breasts were not exposed.

31. Respondent's medical records for Patient 3 lack required information, including elements of the breast exam, pelvic examinations, and ultrasound examinations. If any of the components of the breast and pelvic exams are present in the medical documentation, they are not legible. Respondent's evaluation of the pelvic ultrasound report is not legible or complete. There are insufficient elements of the first-trimester ultrasound examination documented in the patient's medical record. Even if the elements are recorded, they were not placed in the medical record in a manner that meets the standard for billing, coding, or professional documentation.

32. Respondent committed extreme departures from the standard of care as follows:

A. Respondent committed extreme departures from the standard of care in the care and treatment of Patients 1 and Patient 2 by inappropriately touching their breasts without informing them, without explanation, and without obtaining consent.

B. Respondent committed extreme departures from the standard of care when he made inappropriate sexual comments to Patient 1.

C. Respondent committed extreme departures from the standard of care in that his medical record keeping was inadequate and inaccurate for Patient 1 and Patient 2. The records of both patients were largely illegible. Both patients' records lacked required information including elements of the breast and pelvic examinations. With respect to Patient 2, the records also lacked elements of the ultrasound examination.

D. Respondent committed extreme departures from the standard of care in that his medical record keeping was inadequate and inaccurate for Patient 3. Her records were largely illegible. Her records lacked required information, including elements of the breast exam, pelvic examinations, and ultrasound examinations (pelvic and first trimester).

33. Respondent's acts and/or omissions as set forth in Paragraphs 28 through 32, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute grossly negligent acts pursuant to Code section 2234, subdivision (b). Therefore, cause for discipline exists.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence - Patient 1, Patient 2, and Patient 3)

34. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he was repeatedly negligent in the care and treatment of Patient 1, Patient 2, and Patient 3. The circumstances are as follows:

35. The acts and allegations in Paragraphs 14 through 22 and Paragraphs 28 through 32, above, are incorporated by reference and re-alleged as if fully set forth herein.

36. Respondent departed from the standard of care as follows:

A. Respondent departed from the standard of care in the care and treatment of Patients 1 and Patient 2 by inappropriately touching their breasts without informing them, without explanation, and without obtaining consent.

B. Respondent departed from the standard of care when he made inappropriate sexual comments to Patient 1.

C. Respondent departed from the standard of care in that his medical record keeping was inadequate and inaccurate for Patient 1 and Patient 2. The records of both patients were largely illegible. Both patients' records lacked required information including elements of the breast and pelvic examinations. With respect to Patient 2, the records also lacked elements of the ultrasound examination.

D. Respondent departed from the standard of care when, without warning or consent, inserted his fingers inside Patient 2's vagina without explanation. The vaginal exam covered little to none of the standard procedures when performing a vaginal exam, nor did Respondent's documentation cover the majority of the information required for a vaginal exam. The patient perceived the vaginal exam as being a violation of her consent.

E. Respondent departed from the standard of care in that his medical record-keeping for Patient 3 is inadequate and inaccurate. Her records were largely illegible. Her records lacked required information, including elements of the breast exam, pelvic examinations, and ultrasound examinations (pelvic and first trimester).

F. Respondent departed from the standard of care when he failed to perform blood

type testing for Patient 3 to ascertain Rh status (positive or negative).

G. Respondent departed from the standard of care when he conducted a breast exam of Patient 3 that did not meet clinical standards. He did not ask for consent; his exam could not have accurately visualized the breast; and his exam might not have palpated a lesion, if one were to exist in the breast tissue.

37. Respondent's acts and/or omissions as set forth in Paragraphs 35 through 36, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts pursuant to Code section 2234, subdivision (c). Therefore, cause for discipline exists.

FIFTH CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Records - Patient 1, Patient 2, and Patient 3)

38. Respondent is subject to disciplinary action under Code section 2266 in that Respondent failed to maintain adequate and accurate records relating to provision of services to Patient 1, Patient 2, and Patient 3. The circumstances are as follows:

39. The acts and allegations in Paragraphs 13 through 37, above, are incorporated by reference and re-alleged as if fully set forth herein.

40. Respondent's acts and/or omissions as set forth in Paragraphs 13 through 37, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute inadequate record-keeping pursuant to Code section 2266. Therefore, cause for discipline exists.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Patient 1, Patient 2, and Patient 3)

41. Respondent is subject to disciplinary action under Code section 2234 in that he engaged in unprofessional conduct in the care and treatment of Patient 1, Patient 2, and Patient 3. The circumstances are as follows:

42. The acts and allegations in Paragraphs 13 through 40, above, are incorporated by reference and re-alleged as if fully set forth herein.

43. Respondent's acts and/or omissions as set forth in Paragraphs 13 through 40, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute

unprofessional conduct pursuant to Code section 2234. Therefore, cause for discipline exists.

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 67513, issued to Respondent Peter Haeyoung Park, M.D.;

2. Revoking, suspending, or denying approval of Peter Haeyoung Park, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Peter Haeyoung Park, M.D. to pay the Board reasonable costs of investigation and prosecution incurred after January 1, 2022;

4. If placed on probation, ordering Peter Haeyoung Park, M.D. to pay the Board the costs of probation monitoring;

5. Ordering Peter Haeyoung Park, M.D., if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and

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

DATED: FEB 15 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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