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

In the Matter of the Second Amended Accusation Against: Andrew Jay Ross, M.D. Physician's and Surgeon's Certificate No. G 74867 Respondent.	Case No. 800-2020-063511

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 25, 2023.

IT IS SO ORDERED August 24, 2023.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Second Amended Accusation Against:

ANDREW JAY ROSS, M.D.,

Physician's and Surgeon's Certificate No. G 74867

Respondent.

Agency Case No. 800-2020-063511

OAH No. 2022110749

PROPOSED DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on May 15, 16, and 17, 2023, by videoconference.

Deputy Attorney General Hamsa M. Murthy represented complainant Reji Varghese, Executive Director of the Medical Board of California.

Attorney Thomas E. Still represented respondent Andrew Jay Ross, M.D., who was present for the hearing.

The matter was submitted for decision on May 17, 2023.

FACTUAL FINDINGS

1. The Medical Board of California issued Physician's and Surgeon's Certificate No. G 74867 to respondent Andrew Jay Ross, M.D., on August 4, 1992. At the time of the hearing, this certificate was active and was scheduled to expire April 30, 2024.

2. Acting in his official capacity as the former Executive Director of the Board, William Prasifka filed an accusation against respondent in August 2021. Respondent returned a timely notice of defense. Prasifka filed a first amended accusation in March 2022, and a second amended accusation in August 2022. Prasifka later left employment with the Board, and complainant Reji Varghese assumed responsibility for this matter in his official capacity as the Board's Interim Executive Director.

3. Complainant alleges cause for discipline against respondent stemming from respondent's treatment, and treatment documentation, of two patients, one in 2018 and another in 2019. In both cases, complainant alleges that respondent spoke unprofessionally to the patients by mentioning sexual topics without cause and by employing sexual innuendo. In addition, complainant alleges that respondent maintained inadequate medical records regarding both patients, that he documented more complete physical examinations for both patients than he actually conducted, and that the physical examinations he documented for the patients were unwarranted given the patients' reasons for consulting him.

Respondent's Education and Medical Practice

4. Respondent graduated from medical school in 1990, and completed a residency in internal medicine in 1993. He has been board-certified in internal medicine since 1993.

5. After residency, respondent joined a private internal medicine practice in San Francisco. In March 1995, respondent moved to a nine-physician private internal medicine practice in Berkeley. When that practice disbanded in 2004, respondent continued in private practice with a single physician business partner. Respondent's former business partner left their practice in early 2019, and a new partner joined the practice later that year.

6. Respondent provides outpatient primary care to adults, many of whom address him as "Dr. Andy." He has saved hundreds of notes and cards he has received over the years from patients, praising his care and compassion.

7. Three staff members support respondent and his partner in their medical practice. Two of them testified about their experience working with him.

a. The practice's business manager, Timika Lipscomb, has worked in the practice since 2009 and has served as the administrative business manager since 2016. Lipscomb is not aware of any complaints by patients or other staff members about respondent's communication style, and believes she would not have tolerated working for so many years for a physician who was disrespectful to women.

b. The practice's medical assistant, Tanisha Jacobs, also has worked in the practice for more than 10 years. Jacobs has received patient complaints about having to wait too long for their appointments, but never a complaint that respondent's

words or acts have made any patient feel uncomfortable or unsafe. She thinks respondent is "a great doctor to work for."

8. Many other physicians and health care providers in the East Bay use respondent as their primary care physician. He offered reference letters from several such patients, as well as testimony from two. Respondent also offered reference letters and testimony from numerous specialist physicians and other health care providers with whom he has shared patients over his 30 years in private practice. All these witnesses and character references have great respect for respondent's medical knowledge and patient-care skills, and none has ever witnessed or heard about any impolite or unprofessional communication by respondent toward a patient. The physicians with whom respondent has shared patients also have uniform respect for his medical record-keeping practices.

Events Alleged as Cause for Discipline

9. Complainant alleges that respondent committed unprofessional conduct regarding two patients, both adult women who are younger than he is. His alleged misconduct with Patient 2 occurred before his alleged misconduct with Patient 1.

PATIENT 2

10. Patient 2 saw respondent for primary medical care over a period of about 10 years. Her parents, sister, and husband also were respondent's patients. No medical records regarding Patient 2 were in evidence except respondent's records regarding her visit to him on July 9, 2018. Neither respondent nor Patient 2 described their prior relationship or her prior medical care with respondent in any detail.

11. On July 8, 2018, Patient 2 requested an appointment with respondent because of what she believed to be a skin infection on a finger. Respondent's scheduling staff member was able to offer Patient 2 an appointment on July 9.

12. Respondent's medical record for Patient 2's visit on July 9, 2018, lists "dermatitis" among her ongoing "Active Problems." Both respondent and Patient 2 recall that respondent had seen Patient 2 several times over the preceding six or eight months for persistent skin irritation on the external portion of one of her ears.

13. A medical assistant showed Patient 2 to an examination room on July 9. She waited alone a short time for respondent, and believes that she sat on an examination table.

14. When respondent entered the examination room, one of Patient 2's hands was near her head. She recalls that she was rubbing her neck with one hand because her neck felt stiff. Respondent believed that Patient 2 was using her hand to touch or scratch her irritated ear.

15. Although respondent and Patient 2 remember respondent's exact words differently, they agree that respondent told Patient 2 that touching her ear was contributing to her ongoing dermatitis, and that she needed urgently to break the habit of touching or scratching it.

a. Patient 2 recalls that respondent first told her that he found it "frustrating" to see her "in that little sundress . . . touching yourself." Respondent believes he might have told Patient 2 that he was "frustrated" to see her touching her ear, because they had discussed the importance of not touching it on earlier visits

relating to her ear dermatitis. He denies having referred in any way to Patient 2's clothing, however.[1]

b. Patient 2 recalls that respondent then advised her that to break her ear-touching habit, she should "Touch yourself somewhere else. . . . When you want to touch your ear, masturbate. Go upstairs and masturbate." Respondent believes he suggested that when Patient 2 found one of her hands at or moving toward her ear she should redirect it, but denies having told her to masturbate.

c. Patient 2 recalls that respondent told her to imagine a "force field" around her head, preventing her hand from reaching her ear. Respondent does not recall using that metaphor, but Patient 2's testimony that he did is credible. Respondent dictated a note in Patient 2's presence stating that she should "not be constantly touching her ear like a caged spider monkey." For her part, Patient 2 does not recall respondent's comparing her to a monkey, but respondent's testimony that he used these words in front of her is credible.

16. As Finding 15.c illustrates, neither Patient 2 nor respondent perfectly recalls their conversation on July 9, 2018, even though they both recall its general content. Regardless of respondent's precise words, however, Patient 2 inferred reasonably that respondent intended sexual innuendo by telling her that seeing her touch herself was "frustrating" to him, and that she should touch her body somewhere other than her ear. Moreover, although respondent's testimony that he did not specifically mention Patient 2's clothing or advise her to masturbate is not less credible

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[1] Neither respondent nor Patient 2 testified about what clothing Patient 2 actually wore to respondent's office on July 9, 2018.

than Patient 2's testimony that he did, respondent's denial that he intended a sexual meaning is not credible. Respondent either stated or deliberately implied to Patient 2 on July 9, 2018, that her appearance was sexually provocative and that she should touch her body sexually as a substitute for touching her ear dermatitis. He also stated in Patient 2's presence that her ear-touching habit made her resemble a monkey.

17. Respondent examined Patient 2's finger, and prescribed medications to treat both the finger infection and the ear dermatitis.

18. Patient 2 remained clothed throughout the appointment, and does not believe that respondent examined any other parts of her body aside from her ear and finger. Respondent testified credibly, however, that he performed a brief physical examination of Patient 2 on July 9, 2018, which included observing her movement and conversation; looking in her eyes, ears, and mouth; listening to her heart, lungs, and abdomen with a stethoscope; and palpating her upper abdomen, neck, and ankles.

19. Respondent's record of his interaction with Patient 2 on July 9, 2018, covers two printed pages. It says that respondent completed it at 1:53 p.m.

a. The medical record begins with lists of "Active Problems," "Allergies," and "Current Meds."

b. The record shows Patient 2's height, weight, and blood pressure, as recorded at 1:49 p.m. on that date.

c. It describes a physical examination, noting some components (breast, pelvic, and rectal) that respondent did not perform; noting "SKIN: seborrheic

dermatitis on ear, also par[o]nychia[2] on finger"; and noting essentially unremarkable observations regarding the remaining components (general, HEENT [head, ears, eyes, nose, and throat], neck, lymph nodes, chest, CV [cardiovascular], ABD [abdomen], extremities, and neurologic).

d. Respondent's brief physical examination was insufficient to support the detail he recorded in some of the physical examination observations. For example, respondent acknowledged in testimony that he palpated Patient 2's neck, but not her armpits or groin, for enlarged lymph nodes; yet the record states simply, "LYMPH NODES: There is no palpable lymphadenopathy." Similarly, the record states "NEUROLOGIC: Gait WNL, CN [cranial nerves] II-XII intact, DTR's [deep tendon reflexes] 2+ and symmetric throughout, Strength 5/5 throughout," despite no evidence that respondent used any instrument or technique to assess either Patient 2's reflexes or her strength, and despite his testimony that he assessed Patient 2's gait and cranial nerves simply by observing her as they conversed.

e. Under "Assessment," the record lists "Paronychia, finger," "Seborrheic dermatitis," "Insomnia," and "Depression, recurrent." Under "Plan," it states that Patient 2 will start taking doxycycline (an antibiotic) for the paronychia, and terbinafine (an anti-fungal drug) for the seborrheic dermatitis.

f. Finally, the record has a narrative section labeled "Discussion/Summary." Respondent created this portion of the record by dictating it in Patient 2's presence. In addition to the statement quoted in Finding 15.c regarding Patient 2's touching her ear, this section says,

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[2] A paronychia is a subcutaneous infection at the margin of a finger- or toenail.

> Patient comes in with a couple of dermatological issues. First of all, she has a paronychia on her finger and we prescribed antibiotics to her pharmacy of choice. Don't pick at the area.
>
> The patient has seborrheic dermatitis now with cracking by her ear. This is because she touches her ear incessantly. . . . Also [] going to give the patient some terbinafine in order to decrease her yeast.
>
> The patient's depression seems to be under reasonable control at today's visit.
>
> The patient needs a refill of Ambien as she is traveling and gets travel insomnia.

20. Patient 2 did not object aloud to respondent's sexual innuendo during the discussion about her ear described above in Findings 15 and 16. She also did not communicate any objection, to respondent or to any other practice staff member, immediately after her appointment or in the next few weeks. Instead, over the next few weeks Patient 2 exchanged email with respondent to follow up on the treatment and prescriptions she had received on July 9, 2018.

21. At the beginning of August 2018, Patient 2 received a bill from respondent's practice for his service to her on July 9.[3] She testified credibly that she

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[3] Respondent did not accept Patient 2's insurance coverage. She knew before she went to see him on July 9, 2018, that he would bill her for the service.

resented receiving a bill, believing instead that respondent owed her an apology for making sexually charged remarks to her during her appointment that day. When she received the bill, Patient 2 emailed respondent to complain about his conduct.

> I've been coming to you for years and you've always been a trusted family doctor. That's why i'm so conflicted about how to address the way I feel about some things you said to me last time I was in your office on July 9th, 2018. You made comments of a sexual nature which had nothing to do with my condition and reason for my visit. These comments were completely inappropriate, made me feel extremely uncomfortable, and something I would not expect from someone I trust with my health and well-being.
>
> I also received a bill for more than twice the amount that I'm usually charged, and after thinking about how this has impacted me for weeks, I dont feel that it is fair that I have to pay for a visit which has effected me in such a negative way. I would like you to remove the charges on my account for this visit.

22. Respondent replied tersely to this message: "ok we will remove the charges. thanks for letting me know. always[,] dr. andy." The next day, respondent sent a letter to Patient 2 notifying her that he would no longer act as her primary care physician. The letter provided information about how to find a new primary care physician, and said that respondent would remain "available to you for 30 days of this letter to assist you with urgent care matters only."

23. Although Patient 2 was already contemplating a search for a new primary care provider, she experienced her abrupt dismissal from respondent's medical practice as adding injury to the insult she had experienced on July 9. About six weeks after receiving the letter described in Finding 22, Patient 2 complained to the Board about respondent's conduct.

PATIENT 1

24. Patient 1 received primary care from respondent's former business partner for about 20 years. Over these years, Patient 1 received treatment for several significant medical problems, including cancer and major depressive disorder. No medical records regarding Patient 1 were in evidence except respondent's records regarding her visits to him in May, July, and September 2019.

25. When Patient 1's former primary care physician (a woman) left the practice in early 2019, respondent (a man) offered to become his former partner's patients' new primary care physician. Patient 1 believed she would prefer to receive primary medical care from a woman rather than from a man, and considered leaving the practice for this reason. She chose to continue as respondent's patient, however, on the theory that continuing in the same practice would benefit her more than switching practices to have a woman serve as her primary care provider.

May 31, 2019, Office Visit

26. In late 2018, Patient 1's former primary care physician had prescribed Lexapro, an anti-depressant drug, to Patient 1. Patient 1 previously had used other similar medications, but not Lexapro.

27. About six months later, Patient 1 made an appointment to see respondent, to meet him in a non-urgent context[4] and also to consult him about her experience so far using Lexapro. The appointment was for May 31, 2019.

28. When Patient 1 arrived, a medical assistant escorted Patient 1 to an examination room. She waited there for respondent, sitting in a chair.

29. Respondent entered the examination room, alone. Patient 1 remained seated in the chair as they exchanged greetings. Respondent asked Patient 1 the reason for her visit, and she explained that despite taking Lexapro for about six months, she still felt listless and unhappy. She phrased her concern about the medication's effectiveness only by saying that it seemed not to have given her much if any benefit, not by describing any harm she believed the medication to have caused.

30. Respondent asked Patient 1 a few questions to assess her mood. Although he did not note specifically in his medical record that he asked Patient 1 whether she had considered suicide or other self-harm, he testified credibly that he did ask and that she denied any such thoughts. Respondent suggested that a medication change might be appropriate.

31. Respondent then asked Patient 1 to move from the chair to the examination table, but did not ask her to remove any of her clothing. Respondent began a physical examination while Patient 1 sat on the table. As he examined

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[4] Both Patient 1 and respondent believe that respondent had provided medical care to Patient 1 on one prior occasion in approximately 2010, when Patient 1 urgently needed care but respondent's former partner was unavailable.

Patient 1, respondent resumed conversing with her about her experience using Lexapro.

32. According to respondent, he asked Patient 1 whether she had experienced any unpleasant effects from taking Lexapro. He described several common patient concerns about Lexapro, including sleep disturbance, digestive discomfort, and dry mouth, all of which Patient 1 denied having experienced. He also mentioned that Lexapro sometimes causes sexual dysfunction, specifically anorgasmia (an inability to experience orgasm). Finally, respondent testified that he told Patient 1 that he personally had experienced this sexual side effect from Lexapro, but that discontinuing the medication had resolved it.

33. According to Patient 1, respondent neither asked nor told her about any non-sexual Lexapro side effects. Instead, she testified that while examining her, respondent asked her only whether she had been able to experience orgasm since beginning to take Lexapro. The question surprised Patient 1, and respondent explained in response to her objection that anorgasmia is a relatively common negative side effect for women taking Lexapro. Patient 1 also testified that respondent told her that he personally had experienced this sexual side effect from Lexapro, but that discontinuing the medication had resolved it.

34. Patient 1 felt very "uncomfortable and unsafe" discussing Lexapro's potential sexual side effects with respondent while he examined her body. Respondent's disclosure of his personal experience with this medication increased Patient 1's discomfort. Patient 1 testified credibly that if respondent had raised the possibility of Lexapro-induced anorgasmia to her in the context of a fuller discussion of Lexapro's potential side effects, while sitting across from her in a chair without touching her, and without discussing his own sexual experience, she would have

believed the discussion to be professionally appropriate, though perhaps still personally distressing.

35. Respondent did not introduce the topic of Lexapro-induced anorgasmia to Patient 1 for his personal sexual gratification. Rather, he introduced it because he believed reasonably, based in part on his own experience, that Lexapro's sexual side effect might be an obstacle to some patients' successful treatment with it. Moreover, respondent mentioned anorgasmia even though Patient 1 had not described any negative effects from Lexapro because he believed reasonably, based on his experience with other patients, that if she were experiencing this problem she might not link it to Lexapro, or might be too modest to mention it spontaneously.

36. Patient 1's testimony describing her conversation with respondent on May 31, 2019, is more credible than respondent's testimony, however. Respondent did not discuss Lexapro-induced anorgasmia in the context of describing, or asking about, any other common Lexapro side effects. Instead, he mentioned only this sexual side effect. Furthermore, respondent conducted this conversation while touching Patient 1 in the course of performing a physical examination. Finally, and as Patient 1 and respondent agree, respondent personalized this aspect of their conversation by recounting his own experience. Regardless of respondent's intentions, Patient 1's concern that respondent had begun a discussion about sexual matters on May 31, 2019, as a precursor to sexual misconduct was reasonable.

37. Patient 1 does not recall ever lying down on the examination table during her office visit on May 31, 2019, and believes that respondent did not touch her abdomen, neck, or ankles. Respondent testified credibly, however, that he did conduct a brief but complete physical examination of Patient 1 that day, similar to the examination of Patient 2 described above in Finding 18.

38. Respondent's record of his interaction with Patient 1 on May 31, 2019, covers two printed pages. It says that respondent completed it at 2:45 p.m.

a. The medical record begins with lists of "Active Problems," "Allergies," and "Current Meds."

b. The record shows Patient 1's height, weight, and blood pressure, as recorded at 2:35 p.m. on that date.

c. It describes a physical examination, noting some components (breast, pelvic, and rectal) that respondent did not perform and noting essentially unremarkable observations regarding the remaining components. Even if respondent examined Patient 1 in the manner to which he testified, rather than as minimally as she testified he did, the physical examination notes describe observations that respondent's examination would not have supported.

d. Under "Assessment," the record lists depression, acne,[5] and insomnia. Under "Plan," it states that the patient will start taking duloxetine (an anti-depressant drug) for recurrent depression.

e. Finally, the record has a narrative section labeled "Discussion/Summary." Respondent created this portion of the record by dictating it in Patient 1's presence. It says,

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[5] Respondent testified credibly that he did not believe Patient 1's acne to be as severe as she did, but that he documented it in her medical record to facilitate the dermatology referral she requested.

> I have a brand-new patient. Her previous doctor has retired. The patient has a chronic depression. We[']re going to add duloxetine to her Lexapro 20 mg to see if we can activate the patient and make her less sad and anxious. The patient will go on duloxetine very modest dose of 20 mg and see me in a month.
>
> The patient seems to be doing well with trazodone for her insomnia. The patient has recalcitrant acne and would like to follow-up with her excellent dermatologist, Dr. Dunn.

39. Patient 1 left her appointment on May 31, 2019, with a prescription for duloxetine and a referral to the dermatologist. She does not recall having spoken to any office staff members on her way out. Patient 1 decided after this experience to seek a new primary care physician, because even though her appointment with respondent had ended without any further unusual incident she did not believe she would feel safe in his presence in the future.

July 8, 2019, Office Visit

40. Patient 1 was unable immediately to find a new primary care physician who was within her insurance plan's provider network and whose practice was open to new patients. For this reason, she scheduled a follow-up appointment with respondent for July 8, 2019, to confer with him about the effects of her medication change.

41. Respondent's record of his interaction with Patient 1 on July 8, 2019, covers three printed pages. It says that respondent completed it at 9:15 a.m.

a. The medical record again begins with lists of "Active Problems," "Allergies," and "Current Meds." It also includes a section for "PMH" (previous medical history), into which respondent had moved several items that were on the "Active Problems" list at Patient 1's previous appointment.

b. The record shows Patient 1's height, weight, and blood pressure, as recorded at 9:03 a.m. on that date. It describes a physical examination, essentially identically to the description on May 31, 2019.

c. Under "Assessment," the record lists acne, depression, insomnia, and breast cancer. Under "Plan," it states that the patient will increase her daily dose of duloxetine.

d. Finally, the record has a "Discussion/Summary" section, which respondent again dictated in Patient 1's presence. It says, in pertinent part,

> My patient comes in for follow-up. . . . The patient is feeling somewhat better the last couple of weeks. I highly recommend that the patient increase her duloxetine from 20 mg to 30 mg for the next month or so. At any point, she can double the dose to go up to the usual cruising altitude of 60 mg. The goal is that the patient has more spring in her step.
>
> The patient can see me for follow-up in about six weeks because I'm going to be away the first two weeks of August seeing my mother on the East Coast.
>
> [¶]

> The patient has a pending appointment with her dermatologist this week. The trazodone seems to be working for her insomnia. The patient's cancer of the breast seems to be under control and the patient is following up with oncology.

42. Patient 1 recalls discussing her medication adjustment with respondent on July 8, 2019. She testified that despite the notes described above in Finding 41.b, respondent did not look in her eyes, ears, or mouth; did not listen to her chest or abdomen with a stethoscope; and did not palpate her neck, abdomen, or ankles. She believes that after her experience on May 31, 2019, she would have been surprised and distressed if respondent had attempted to touch her during this July 8, 2019, appointment.

43. Respondent is confident that he included a description of a brief but complete physical examination in Patient 1's chart for this visit because he performed one. He also testified, however, that until he learned later (in late 2019 or early 2020) about Patient 1's complaint, he did not realize that their discussion of anorgasmia on May 31 had made Patient 1 wary about him. For this reason, Patient 1's testimony that respondent did not touch her at this July 2019 visit is more credible than respondent's testimony that he did.

September 17, 2019, Office Visit

44. By September 2019, Patient 1 still had not established a primary care relationship with a new physician. She made another appointment to see respondent on September 17, 2019, for further follow-up regarding her anti-depressant medication and to get an influenza vaccine.

45. Respondent and Patient 1 recall most details about this appointment differently. Many of these differences are not material to complainant's allegations, however.[6]

46. Patient 1 was apprehensive about seeing respondent again. She became more apprehensive when she realized that respondent, rather than a medical assistant, would administer her influenza vaccine, by injection, because she knew that he would need to be physically close to her to do so. As she waited for respondent to prepare the injection, Patient 1 showed her discomfort by looking away from him and by fidgeting.

47. Respondent observed Patient 1's restless behavior, but believed her to be apprehensive about receiving an injection rather than about his moving close to her to administer it. As he approached her to inject the vaccine, he commented to the effect that either she or her behavior was "cute."

48. Respondent's record of his interaction with Patient 1 on September 17, 2019, covers three printed pages. It says that respondent completed it at 4:14 p.m.

a. The medical record again begins with lists of "Active Problems," "Allergies," "Current Meds," and "PMH."

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[6] One of the details respondent and Patient 1 remember differently concerns a remark that Patient 1 recalls, and found offensive because she perceived it as sexual innuendo, but that respondent denies having made. Although the parties presented evidence and argument about this remark, complainant does not identify it as cause for discipline.

b. The record shows Patient 1's height, weight, and blood pressure, as recorded at 4:04 p.m. on that date. It describes a physical examination, essentially identically to the descriptions on May 31, 2019, and July 8, 2019.

c. Under "Assessment," the record lists depression, insomnia, breast cancer, and "Restless legs syndrome." Under "Plan," it states that the patient will alter her anti-depressant medication regimen.

d. The final "Discussion/Summary" section includes short narrative statements about Patient 1's depression, insomnia, restless legs at night, and cancer follow-up. It also states that Patient 1 received "her annual flu vaccine."

49. Patient 1 testified that on September 17, as on July 8, respondent did not look in her eyes, ears, or mouth; did not listen to her chest or abdomen with a stethoscope; and did not palpate her neck, abdomen, or ankles. In light of the matters stated in Findings 43 and 47, her testimony that respondent touched her on September 17 only to administer an injectable influenza vaccine is more credible than respondent's testimony that he performed a physical examination sufficient to support the observations in Patient 1's medical record from that date.

50. Patient 1 found a new primary care physician in fall 2019. After establishing care with her new provider, Patient 1 made a complaint to respondent's medical group and to the Board about his behavior toward her on May 31, July 8, and September 17.

Expert Opinions

51. Complainant presented expert testimony from board-certified internal medicine specialist Sarah Hooks, M.D. Dr. Hooks has practiced medicine for about 20

years, mostly in adult primary care. She has never trained physicians, however, or served on a formal peer review or quality control committee.

52. Respondent presented expert testimony from board-certified family medicine specialist Robert Norman, M.D. Dr. Norman also has practiced chiefly in adult primary care, for about 40 years. He served for about 30 years as director of a family medicine residency program, and also has served on hospital peer review and quality control committees.

SEXUAL SELF-DISCLOSURE TO PATIENT 1

53. Dr. Hooks testified that the standard of care for an adult primary care physician is to avoid making "sexually suggestive" comments to patients. In particular, she testified that a physician must never share personal sexual information with a patient, and that doing so would constitute an extreme departure from the standard of care in every context she can imagine.

54. Dr. Norman agrees with Dr. Hooks that flirtatious or "sexually suggestive" statements by physicians to their patients depart from the standard of care. He believes, however, that a physician who speaks "with forethought, good judgment and without any intent to cause harm to the patient" may describe the physician's personal experience, to illustrate or normalize a problem the patient also may have experienced. He testified that in his opinion, even sexual self-disclosures may meet this standard.

55. As to self-disclosure regarding sexual experience or dysfunction, Dr. Hooks's opinion is more persuasive than Dr. Norman's opinion. Although a physician may conform to the standard of care by discussing or broaching sexual health with a patient, or by reassuring the patient that successful medical treatment exists for a

sexual problem, a physician who uses his or her own experience to illustrate such a problem or its treatment commits an extreme departure from the standard of care.

56. Both respondent and Dr. Norman emphasized in testimony that Lexapro causes anorgasmia often enough to justify respondent's having introduced this topic into his conversation with Patient 1 on May 31, 2019. This testimony, while credible and persuasive, does not address complainant's allegation that respondent acted unprofessionally by telling Patient 1—as he admits he did—that he had personal experience with Lexapro-induced anorgasmia. As summarized in Findings 26 through 36, respondent committed an extreme departure from the standard of care not by discussing Lexapro's potential impact on sexual health with Patient 1 but by sharing information with her about his own sexual response to this medication.

57. Dr. Hooks also believes that the standard of care requires a physician to avoid belittling or demeaning patients. She believes for this reason that calling Patient 1 or her behavior "cute," as described in Finding 47, was a departure from the standard of care, and she holds this opinion even though she understands that respondent may have used this word not to compliment Patient 1's appearance but to relieve what he understood to be Patient 1's anxiety over receiving a vaccine injection. Her opinion on this word is more persuasive than Dr. Norman's opinion that calling an adult patient "cute" in a non-flirtatious manner would not depart from the standard of care.

58. Dr. Hooks viewed respondent's use of the word "cute" to Patient 1 as an extreme departure from the standard of care. In light of all evidence, this aspect of her opinion is not persuasive; respondent's remark on September 17, 2019, was a simple departure from the standard of care.

UNNECESSARY AND INCOMPETENT PHYSICAL EXAMINATIONS OF PATIENT 1

59. Because Patient 1 visited respondent in July and September 2019 chiefly to follow up on her prescriptions for anti-depressant medication, Dr. Hooks does not believe that respondent should have performed complete physical examinations of Patient 1 at these visits. The matters stated in Findings 42, 43, and 49 do not establish that he did so, however.[7] In any event, Dr. Hooks's opinion that physical examinations as complete as respondent's records describe on these dates would have departed from the standard of care is not persuasive.

60. Dr. Hooks also opined that respondent departed from the standard of care by examining Patient 1 without having her remove any clothing. Dr. Norman, in contrast, opined that a primary care physician often can examine a patient adequately without asking the patient to remove ordinary clothing, and that without specific evidence that respondent had purported to examine Patient 1 over or through unsuitable clothing he would not consider respondent's failure to have asked Patient 1 to undress to be a departure from the standard of care.

61. Dr. Norman's opinion is more persuasive than Dr. Hooks's opinion on this issue. The matters stated in Findings 31 and 37 do not show respondent to have departed from the standard of care by examining Patient 1 while she continued to wear the clothing she had worn into the office.

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[7] Complainant does not allege with respect to Patient 1 that respondent departed from the standard of care by recording physical examination observations that he did not actually make.

INADEQUATE MEDICAL RECORDS REGARDING PATIENT 1

62. Dr. Hooks criticized respondent's medical record-keeping regarding Patient 1 for failing to describe Patient 1's subjective complaints clearly. She viewed these omissions as significant enough to qualify as extreme departures from the standard of care for medical record-keeping.

63. Dr. Norman testified that the standard of care for primary care physicians is to ensure that medical records provide an explanation of what problems the physician evaluated, how the physician evaluated those problems, and what interventions the physician undertakes or prescribes. In his view, respondent's records regarding Patient 1 satisfy this standard.

64. On this issue, Dr. Norman's opinion is more persuasive than Dr. Hooks's opinion, particularly in combination with the matters stated in Finding 8. Although respondent did not organize his records regarding Patient 1 in the manner Dr. Hooks prefers, the weight of evidence did not show that these records depart from the standard of care.

SEXUALLY SUGGESTIVE STATEMENTS TO PATIENT 2

65. In evaluating respondent's statements to Patient 2, Dr. Hooks assumed that Patient 2 remembered accurately that respondent had commented specifically on her skimpy clothing and told her explicitly to masturbate. Dr. Hooks believes that neither statement had any "medical context" and that together they constituted an extreme departure from the standard of care. She did not address whether these statements would have constituted a simple or extreme departure from the standard of care if respondent had implied them rather than stating them expressly. Dr. Norman agreed with Dr. Hooks that if respondent had spoken to Patient 2 about her ear in

exactly the manner Patient 2 recalls, his remarks would have been "inappropriate and unprofessional behavior."

66. Although the matters stated in Findings 14 through 16 do not establish that respondent's statements to Patient 2 on July 9, 2018, were expressly rather than implicitly sexual, they do establish that respondent intended and conveyed a sexual innuendo to Patient 2 while discussing her ear dermatitis. This sexual meaning, regardless of respondent's precise words, was an extreme departure from the standard of care for a primary care physician.

INACCURATE AND INADEQUATE MEDICAL RECORDS REGARDING PATIENT 2

67. As for Patient 1, Dr. Hooks believes that respondent would have departed from the standard of care by examining Patient 2 on July 9, 2018, as completely as his records indicate that he did. This opinion, again as for Patient 1, is not persuasive.

68. Similarly, Dr. Hooks criticizes the overall organization and content of respondent's records for Patient 2 in similar terms as for Patient 1, summarized above in Finding 62. As for Patient 1, this criticism is less persuasive than Dr. Norman's opinion that respondent's records meet the standard of care.

69. Dr. Hooks notes specifically her belief that respondent committed a simple departure from the standard of care by including a statement in Patient 2's record comparing her to a "spider monkey." On this specific point as well, in light of Patient 2's testimony (summarized in Finding 15.c) that she did not recall hearing or reacting to this statement, Dr. Norman's testimony that the statement did not depart from the standard of care is also persuasive.

70. Finally, Dr. Hooks also notes that if respondent did not perform a physical examination of Patient 2 that was as thorough as his notes suggest, he committed a simple departure from the standard of care. Dr. Norman did not address this opinion, because he assumed that respondent had examined Patient 2 fully in accordance with the examination notes. In light of the matters stated in Findings 18 and 19, Dr. Hooks's opinion that respondent's examination notes are a simple departure from the standard of care is persuasive.

Continuing Medical Education

71. In August 2020, after learning about Patient 1's and Patient 2's complaints but before receiving the original accusation in this matter, respondent completed a three-day, 40-hour course through the University of California, San Diego, School of Medicine, regarding appropriate professional boundaries for physicians. In May 2022, respondent also completed a one-day, eight-hour course regarding effective clinician-patient communication.

72. Respondent testified credibly that he has changed his communication style since taking these courses; in particular, he has stopped disclosing personal information about his own health to patients, and he pauses more frequently during examinations and conversations to confirm patients' consent and emotional comfort. He also has begun asking patients explicitly whether they would like a medical assistant present during examinations as a chaperon(e), rather than relying on patients to express any such preference.

73. In January 2022, respondent completed a two-day, 19-hour course in medical record-keeping through the Western Institute of Legal Medicine and the University of California, Irvine, School of Medicine. He also has changed electronic

medical record-keeping systems since 2019, and believes the new system allows him more easily to record pertinent observations without repetition or inaccuracy.

74. Respondent participates regularly in continuing medical education on a wide variety of topics, consistent with his practice as a primary care physician.

Costs

75. Since January 1, 2022, the Board has incurred $37,792.50 in costs for legal services provided to complainant by the California Department of Justice in this matter. Complainant's claim for reimbursement of these costs is supported by a declaration that complies with California Code of Regulations, title 1, section 1042, subdivision (b)(2). These costs are reasonable.

LEGAL CONCLUSIONS

1. The Board may take disciplinary action against respondent only if clear and convincing evidence establishes cause for such action. The factual findings above rest on clear and convincing evidence.

2. The Board may suspend or revoke respondent's physician's and surgeon's certificate if he has engaged in unprofessional conduct. (Bus. & Prof. Code, §§ 2227, 2234.) Unprofessional conduct includes medical practice reflecting gross negligence or repeated negligence. (*Id.*, § 2234, subds. (b), (c).) It also includes failure to maintain adequate and accurate medical records. (*Id.*, § 2266.)

First Cause for Discipline

3. In light of the matters stated in Findings 53 through 58, the matters stated in Findings 26 through 36, 46, and 47 constitute cause for discipline against respondent for unprofessional conduct under Business and Professions Code sections 2234, subdivisions (b) and (c), for making an inappropriate sexual self-disclosure to Patient 1 on one occasion and for calling her "cute" on another.

Second Cause for Discipline

4. In light of the matters stated in Findings 59 through 61, the matters stated in Findings 31, 37, 41 through 43, and 46 through 49 do not constitute cause for discipline against respondent for unprofessional conduct under Business and Professions Code sections 2234, subdivisions (b) and (c), with respect to respondent's physical examinations of Patient 1.

Third Cause for Discipline

5. In light of the matters stated in Findings 62 through 64, the matters stated in Findings 26 through 38, 41 through 43, and 46 through 49 do not constitute cause for discipline against respondent for unprofessional conduct under Business and Professions Code sections 2234, subdivision (b), and 2266, with respect to respondent's medical records for Patient 1.

Fourth Cause for Discipline

6. In light of the matters stated in Findings 65 and 66, the matters stated in Findings 11 through 16 constitute cause for discipline against respondent for unprofessional conduct under Business and Professions Code sections 2234, subdivision (b), based on respondent's sexual innuendo directed at Patient 2.

Fifth Cause for Discipline

7. In light of the matters stated in Finding 70, the matters stated in Findings 11 through 13, 18, and 19 constitute cause for discipline against respondent for unprofessional conduct under Business and Professions Code sections 2234, subdivision (c), and 2266, for documenting a more thorough physical examination of Patient 2 than he performed.

Disciplinary Considerations

8. As summarized in Findings 11 through 16, 26 through 36, 53 through 56, 65, and 66, and in Legal Conclusions 3 and 6, respondent committed acts of gross negligence with respect to two patients. Although both of these events involved an adult patient's reasonable perception of sexual innuendo (as summarized in Findings 16, 34, and 36), neither involved any actual effort or intent by respondent to pursue sexual activity with the patient. These events reflected extremely poor professional judgment, but not sexual misconduct. As summarized in Findings 71 and 72, respondent has taken courses and altered his routine practices to avoid making similar judgment errors in the future.

9. As summarized in Findings 11 through 13, 18, 19, and 70, and in Legal Conclusion 7, respondent also committed an act of simple negligence in medical record-keeping regarding one patient. As summarized in Finding 73, respondent has taken a course and changed his medical record-keeping practices to improve his records' accuracy.

10. As summarized in Findings 6 through 8, respondent enjoys a strong reputation in the medical community in which he practices. Many physicians, other

health care providers, and patients have trusted him for many years to provide competent and compassionate primary medical care.

11. Complainant advocates for an order placing respondent on five years' probation, with conditions including requirements to take remedial courses and to use a chaperone in all encounters with women patients. Probationary orders are common in matters involving multiple acts of gross negligence. (See Manual of Model Disciplinary Orders and Disciplinary Guidelines [12th ed. 2016]; Cal. Code Regs., tit. 16, § 1361.) In this matter, however, in light of all evidence, such an order would impose burdens on respondent, the Board, and his patients that are not necessary to achieve the Board's critical public welfare mission (Bus. & Prof. Code, § 2229.)

12. The Board may issue a public reprimand to respondent, on terms including requirements that he take courses and reimburse the Board for its reasonable enforcement costs. (Bus. & Prof. Code, §§ 125.3, subd. (a), 495, 2227, subd. (a)(4).) The matters stated in Findings 71 through 74 show respondent to have taken appropriate courses, but an order for cost reimbursement should accompany the Board's public reprimand to him.

Costs

13. A physician who has committed a violation of the laws governing medical practice in California may be required to pay the Board the reasonable costs of the investigation and enforcement of the case, but only as incurred on and after January 1, 2022. (Bus. & Prof. Code, § 125.3.) The matters stated in Finding 75 establish that these costs for this matter total $37,792.50.

14. In *Zuckerman v. State Bd. of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth the standards by which a licensing board or

bureau must exercise its discretion to reduce or eliminate cost awards to ensure that the board or bureau does not deter licensees with potentially meritorious claims from exercising their administrative hearing rights. The court held that a licensing board requesting reimbursement for costs relating to a hearing must consider the licensee's "subjective good faith belief" in the merits of his position and whether the licensee has raised a "colorable challenge" to the proposed discipline. (*Id.*, at p. 45.) The board also must consider whether the licensee will be "financially able to make later payments." (*Ibid.*) Last, the board may not assess full costs of investigation and enforcement when it has conducted a "disproportionately large investigation." (*Ibid.*)

15. All these matters have been considered. Respondent's successful challenge to some of the allegations against him justifies reduction of his reimbursement obligation to $15,000.

ORDER

1. Physician's and Surgeon's Certificate No. G 74867, held by respondent Andrew Jay Ross, M.D., is hereby publicly reprimanded.

2. Respondent must pay $15,000 to the Board, to reimburse the Board for its enforcement costs in this matter, within 30 days after the effective date of this order.

DATE: 06/12/2023

Juliet E. Cox

JULIET E. COX
Administrative Law Judge
Office of Administrative Hearings