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

In the Matter of the Accusation Against: Andrew S. Hsu, M.D. Physician's and Surgeon's Certificate No. A 108956 Respondent.	Case No.: 800-2021-074865

DECISION

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

This Decision shall become effective at 5:00 p.m. on December 15, 2023.

IT IS SO ORDERED: November 16, 2023.

MEDICAL BOARD OF CALIFORNIA

Laurie Rose Lubiano, J.D., Chair
Panel A

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

In the Matter of the Accusation Against: **ANDREW S. HSU, M.D.** **480 4th Avenue, Suite 404** **Chula Vista, CA 91910-4413** **Physician's and Surgeon's Certificate No. A 108956** Respondent.	Case No. 800-2021-074865 OAH No. 2023030131 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Tessa L. Heunis, Deputy Attorney General.

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2. Respondent Andrew S. Hsu, M.D. (Respondent) is represented in this proceeding by attorney David Rosenberg, Esq., whose address is: 10815 Rancho Bernardo Road, Suite 260, San Diego, CA 92127.

3. On or about July 22, 2009, the Board issued Physician's and Surgeon's Certificate No. A 108956 to Andrew S. Hsu, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2021-074865 and will expire on March 31, 2025, unless renewed.

JURISDICTION

4. On January 13, 2023, Accusation No. 800-2021-074865 was filed before the Board and is currently pending against Respondent. A true and correct copy of the Accusation and all other statutorily required documents were properly served on Respondent on January 13, 2023. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2021-074865 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in Accusation No. 800-2021-074865. Respondent has also carefully read, fully discussed with his counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

8. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2021-074865 and that his Physician's and Surgeon's Certificate No. A 108956 is therefore subject to discipline.

9. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2021-074865 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California or elsewhere.

CONTINGENCY

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

11. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2021-074865 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 108956 issued to Respondent Andrew S. Hsu, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years from the effective date of the Decision on the following terms and conditions:

1. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

2. PROHIBITED PRACTICE. During probation, Respondent is prohibited from being on any on-call panel for general surgery. After the effective date of this Decision, all patients being treated by Respondent shall be notified that Respondent is prohibited from being on-call for

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general surgery. Any new patients must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

3. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

4. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

5. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

6. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert reviews, amended accusations, legal reviews, investigations, and subpoena enforcement, as applicable, in the agreed upon amount of $24,171.35 (twenty-four thousand one

hundred seventy-one and 35/100 dollars), being seventy percent of the Board's actual costs. Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by Respondent to the Board. Failure to comply with the payment plan shall be considered a violation of probation.

The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility to repay investigation and enforcement costs, including expert review costs.

7. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

8. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

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License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

9. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

10. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing..

11. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. This term does not include cost recovery, which is due within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board and timely satisfied. Upon successful completion of probation, Respondent's certificate shall be fully restored.

12. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license.

The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

15. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2021-074865 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, David Rosenberg, Esq. I fully understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate A 108956. Having the benefit of counsel, I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 10 / 11 / 2023

ANDREW S. HSU, M.D.
Respondent

I have read and fully discussed with Respondent Andrew S. Hsu, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 10/11/2023

DAVID ROSENBERG, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: October 11, 2023

Respectfully submitted,

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

TESSA L. HEUNIS
Deputy Attorney General
Attorneys for Complainant

ROB BONTA
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **Andrew S. Hsu, M.D.** **480 4th Ave., Ste. 404** **Chula Vista, CA 91910-4413** **Physician's and Surgeon's Certificate No. A 108956,** Respondent.	Case No. 800-2021-074865 **ACCUSATION**

PARTIES

1. Reji Varghese (Complainant) brings this Accusation solely in his official capacity as the Deputy Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 22, 2009, the Medical Board issued Physician's and Surgeon's Certificate No. A 108956 to Andrew S. Hsu, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2023, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

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

5. Section 2220 of the Code states:

> Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes ...

6. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

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

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

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STATUTORY PROVISIONS

7. Section 2234 of the Code, states:

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

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

...

(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.

...

8. Section 2266 of the Code states:

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

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to 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, with failure of the licensee to comply subjecting the license to not being

renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTUAL ALLEGATIONS

10. At all relevant times, Respondent was practicing as a general surgeon.

Patient 1:[1]

11. Patient 1, an 88-year old female, was admitted to hospital on or about January 10, 2016, with end-stage renal disease on peritoneal dialysis.[2]

12. On or about January 18, 2016, a computed tomography (CT) scan of the abdomen and pelvis, with contrast, was done. The findings included a dilated small bowel filled with fecal-like material going to non-dilated small bowel.

13. On or about Tuesday, January 19, Respondent was consulted and diagnosed Patient 1 with "a high-grade small-bowel obstruction[3] from an incarcerated incisional hernia"[4] that had "spontaneously reduced by the time of [his] examination." Respondent recommended "repair with possibility of mesh. No urgency as contrast is passing through to the colon. Tentative schedule for Thursday."

14. Patient 1's bowel functioned worsened and she was taken to the operating room on or about Thursday, January 21. Respondent's intraoperative findings included healthy intestine with the hernia. The hernia was reduced and repaired with the implantation of mesh.

15. Postoperatively, Patient 1 remained in critical condition. Respondent did not see Patient 1 on Friday, January 22, or Saturday, January 23.

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[1] The identity of Patient 1 and others is known to all parties but not disclosed herein for privacy reasons.

[2] Peritoneal dialysis is a type of dialysis which uses the peritoneum in a person's abdomen as the membrane through which fluid and dissolved substances are exchanged with the blood. It is used to remove excess fluid, correct electrolyte problems, and remove toxins in those with kidney failure.

[3] A high-grade (or complete) obstruction indicates no fluid or gas passes beyond the site of obstruction.

[4] An incisional hernia, also called a ventral hernia, is a bulge or protrusion that occurs near or directly along a prior abdominal surgical incision. An incarcerated hernia is a hernia which is no longer reducible.

16. On or about January 24, at around 8:31 p.m., Patient 1 underwent a CT scan. CT findings included "persistent evidence of small bowel obstruction with transition immediately posterior to the surgical site at the level of the umbilicus." Patient 1 was noted to be unresponsive and obtunded.[5]

17. Respondent attended Patient 1 on January 24, at around 9:33 p.m. Per Respondent's progress note for this encounter, he reviewed the CT and found that it showed "overall improvement and bowel obstruction slowly improving."

18. On or about January 25, Respondent again attended Patient 1. Respondent's subjective impressions for this encounter are almost identical to his subject impressions for the previous day, and he reiterates "CT reviewed and shows overall improvement and bowel obstruction slowly improving."

19. On or about January 26, Respondent saw Patient 1 and documents the same subjective impressions as on his previous two visits. In his assessment, Respondent documents that Patient 1 is "critically ill, septic, status post incarcerated ventral hernia repair with slowly returning bowel function. [White blood cell count] back to normal."

20. On or about January 28, Respondent's assessment of Patient 1 included "critically ill … Concern for residual bowel obstruction and that hernia was not causing bowel obstruction." His plan included "repeat CT scan in near future."

21. Patient 1 developed coagulopathy and gastrointestinal bleeding requiring transfusion. She then developed multi-system organ failure, sepsis, and cardiac arrest. She was made "do not resuscitate" and expired on January 29.

Patient 2:

22. Patient 2, a 68-year old female, presented at the Emergency Room ("ER") shortly after midnight on or about September 10, 2018, with a history of lymphoma (on chemotherapy) and rectal and buttock pain.

23. A CT scan was performed at approximately 02:35 a.m. and showed severe proctitis with suspected necrotizing fasciitis.

[5] Obtunded is difficult to arouse, a dulled or reduced level of alertness or consciousness.

24. An ER physician concluded that Patient 2 had proctitis[6] and fasciitis and neutropenic sepsis.[7] In the Emergency Department Admission Documentation, created at or around 3:01 a.m. on September 10, 2018, the ER physician documents speaking with Respondent for possible debridement. A subsequent ICU note documents Patient 2's white blood cell count as 400 (cells per microliter of blood).[8]

25. Respondent clinically evaluated Patient 2 on September 10, and documented his evaluation in a progress note at approximately 2:47 p.m. ("the September 10 note").

26. At an interview with the Board during the investigation of this matter ("the Board interview"), Respondent said his actual evaluation of Patient 2 was earlier than 2:47 p.m. and possibly around 9:00 a.m. on September 10. He did not document the encounter at that time and/or at any time prior to 2:47 p.m. on the same day. Respondent explained that he did not re-examine Patient 2 at the time of creating the September 10 note but dictated his consult note based off of reviewing the records and his recollection of that morning's visit.

27. When asked about the delay in documenting his evaluation of Patient 2 on September 10, Respondent stated that he was "just busy attending to other matters at the office."

28. In the September 10 note, Respondent noted "large ecchymotic patch of the perineum and rectal area. Extreme tenderness with mild drainage." Respondent's plan included "surgical debridement of the perineum for necrotizing infection ... followed by colostomy creation with the possibility of a feeding tube or cholecystectomy."

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[6] Proctitis is inflammation of the lining of the rectum.

[7] Neutropenic sepsis is a life-threatening whole-body reaction to an infection. It is a complication of a very low white blood cell count that predisposes to a severe infection.

[8] The normal number of white blood cells ("WBC") in the blood is 4,500 to 11,000 WBCs per microliter (4,500 to 11.0 × 10^9/L). Leukopenia (WBC of less than 4,500) can interfere with the ability to fight infection. Leukocytosis (WBC of more than 11,000) can indicate the presence of (and the body's attempts to counteract) infection or inflammation, among other causes.

29. Patient 2's potassium on admission to the ER was 3.7.[9] By approximately 9:07 a.m., her potassium was noted to be 7; at 2:37 p.m. it was 7.5, and at 9:55 p.m. it was 8.3. The emergent debridement required by Patient 2 was delayed several hours by Respondent's delay in seeing her and also by the increase in her potassium levels, which then necessitated dialysis.

30. Patient 2 was taken to the operating room at about 8:40 p.m. on September 10, for debridement of the skin, subcutaneous tissue, muscle, and fascia. Postoperatively, Patient 2 had progressive acidosis[10] and developed shock. She developed asystole and expired on September 11, 2018.

Patient 3:

31. Patient 3 is an 87-year old male who presented at the ER by ambulance around 9:00 p.m. on or about September 21, 2018, with a history of abdominal pain that developed when he was bearing down to try and have a bowel movement.

32. On exam, Patient 3 was found to have a distended, tender abdomen. His lactic acid was elevated[11] to 5.5, his white blood cell count was 25,000 with a left shift[12]; he was tachycardic and tachypneic.[13]

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[9] The normal potassium level for an adult ranges from 3.5 to 5.2 mEq/L (3.5 to 5.2 mmol/L). Hyperkalemia is an elevated level of potassium in your blood that can cause an abnormal heart rhythm which can result in cardiac arrest and death. Potassium levels between 5.1 mEq/L to 6.0 mEq/L are considered to be mild hyperkalemia; potassium levels of 6.1 mEq/L to 7.0 mEq/L are moderate hyperkalemia; and levels above 7 mEq/L reflect severe hyperkalemia. Potassium levels between 3 and 3.5 mEq/L (3 to 3.5 mmol/L) are considered mild hypokalemia (low potassium).

[10] Acidosis is a condition in which there is too much acid in the body fluids.

[11] Elevated lactic acid indicates that body tissues are not getting enough oxygen. Conditions that can increase lactic acid levels include heart failure and liver disease. Normal lactate levels are less than two mmol/L, with hyperlactatemia defined as lactate levels between 2 mmol/L and 4 mmol/L. Severe levels of lactate are 4 mmol/L or higher.

[12] Left shift is an increase in the number of immature cell types among the blood cells in a sample of blood. It indicates an infection in progress.

[13] Tachycardia is a rapid heartbeat that may be regular or irregular, but is out of proportion to age and level of exertion or activity. Tachypnea refers to fast, shallow breathing that results from a lack of oxygen or too much carbon dioxide in the body.

33. A CT scan of Patient 3's abdomen/pelvis at approximately 11:15 p.m. on September 21, showed a "large volume of retained colonic stool suggestive of fecal impaction or significant constipation."

34. Patient 3 was attended by Dr. A-Q, at approximately 2:30 a.m. on September 22, who ordered a chest CT and subsequently also performed a history and physical examination and documented his findings.

35. At approximately 2:34 a.m. on September 22, a chest CT of Patient 3 showed "a large hiatal hernia ... containing essentially the entire stomach. The stomach is distended with fluid and some air..." The radiologist's interpretation includes a "large hiatal hernia with organoaxial volvulus[14] and persistent distention of the stomach, similar in appearance to the CT scan of September 21... Correlation for symptoms of partial gastric outlet obstruction is suggested."

36. An Emergency Department note made at approximately 3:12 a.m. on September 22, indicates that Respondent was contacted and was agreeable to evaluate Patient 3 for possible exploratory laparotomy in the operating room.

37. At approximately 3:42 a.m. on September 22, Dr. A-Q noted that Patient 3's lactate had worsened.[15] His history and physical documents that he has "discussed the case with the surgeon on-call, [Respondent], who will evaluate the patient." At approximately 6:27 a.m., Dr. A-Q notes "updated [Respondent] regarding patient condition. The patient has a rise in lactate and temp of 38C. [Respondent] recommends close clinical monitoring for now in hopes that re-perfusion occurs spontaneously. He recommends NG tube for decompression of the stomach. He will continue to follow [Patient 3]. [Dr. A-Q] will defer decision on surgical intervention to [Respondent]."

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[14] Gastric Volvulus is an uncommon medical condition that occurs when the stomach rotates on its axis more than 180°. If not diagnosed and treated early, gastric volvulus may lead to severe complications including gastric ischemia and necrosis, perforation of the stomach, omental avulsion, pancreatic gangrene, and in a few cases splenic rupture. This medical condition's high mortality rate (30%-50%) indicates an emergent accurate diagnosis followed by appropriate intervention to avoid aforementioned complications. (https://www.sciencedirect.com/science/article/pii/S2210261217305916) Organoaxial volvulus occurs when the stomach rotates 180 degrees around the long axis (as opposed to around the axis perpendicular to this, which is mesenteroaxial volvulus).

[15] Patient 3's chart shows his lactic acid to be 7.3 at 3:48 a.m. on September 22.

38. Patient 3's chart at 7:45 a.m. on September 22 reflects his lactic acid as 7.7.

39. Respondent evaluated Patient 3 at approximately 8:57 a.m. on September 22. In his documentation of this consultation, Respondent's abdominal exam noted, "Nondistended. Nontender. There is no palpable mass. There is no peritonitis." In his assessment, Respondent noted an "acute surgical abdomen without specific findings on CT scan." Respondent's plan was to do an exploratory laparotomy with possible bowel resection and a possible ostomy.

40. Patient 3 was taken to the operating room at approximately 1:51 p.m. on September 22 and Respondent started surgery at 2:54 p.m. Respondent performed a total abdominal colectomy,[16] cholecystectomy, omentectomy,[17] and placed a feeding tube.

41. Intraoperative findings were notable for diffuse patches of ischemia throughout the colon and evidence of cholecystitis. The hiatal hernia was identified and "from what [Respondent] could examine of the stomach ... it was benign."

42. Since a portion of Patient 3's stomach was known to be intrathoracic, it was not accessible or visualizable without further mobilization. The portion of Patient 3's stomach that was not visualized was also critically important.

43. During Respondent's intraoperative exploration, he reportedly considered returning the stomach to the abdomen but decided against it because "that would've been a fairly lengthy additive portion to the procedure, and when [he] examined the stomach, it was benign."

44. Respondent reportedly also considered untwisting the volvulized stomach but did not do so because "there was a nasogastric tube decompressing that..."

45. Surgical pathology was notable for diffuse mucosal and submucosal hemorrhagic ischemia throughout the entire colon.

46. Respondent did not do a progress note for Patient 3 on September 24.

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[16] Total abdominal colectomy is the removal of the large intestine from the lowest part of the small intestine (ileum) to the rectum.

[17] An omentectomy is the surgical removal of all or part of the omentum. The omentum is a fold of fatty tissue inside the abdomen that surrounds the stomach, large intestine and other abdominal organs.

47. Postoperatively, Patient 3 had persistent leukocytosis and pain. A chest X-ray on or about September 28 showed "presence of bowel gas overlying the heart suggest[ing] a hiatal hernia." A kidney, ureter, and bladder X-ray ("KUB")[18] on September 29 demonstrated "gaseous distention of small bowel loops in the midabdomen."

48. Clinical notes in Patient 3's chart demonstrate that Respondent was aware of the symptoms but that he "doubts any [small bowel obstruction] as the ileostomy is functional."

49. Patient 3 subsequently developed respiratory failure and was noted to have massive aspiration of gastric contents, leading to cardiac arrest. He expired on October 2, 2018.

Patient 4:

50. Patient 4 is a 68-year old female with a history of right breast mass discovered on mammography.

51. A mammogram performed on or about August 21, 2018, demonstrated "increasing calcifications posterior upper outer quadrant." After magnifications views, this was later assessed to be BI-RADS 4 suspicious[19] and a biopsy was recommended. A biopsy performed on or about November 6, 2018 confirmed a benign lesion.

52. There were several treatment options open to Patient 4 for dealing with the benign lesion, including continued observation and surveillance, or resection.

53. Respondent saw Patient 4 at his outpatient clinic on or about February 4, 2019. He documented a plan to perform a needle-localized excision of the right breast mass, which was subsequently done in hospital on or about March 12, 2019.

54. Respondent prepared an office note for Patient 4's visit on or about February 4 ("the February note"). Respondent used the contents of this February note to populate his note for the March 12 visit in Patient 4's hospital chart.

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[18] A KUB may be performed to assess the abdominal area for causes of abdominal pain, or to assess the organs and structures of the urinary and/or gastrointestinal (GI) system.

[19] A BI-RADS 4 lesion under the breast imaging-reporting and data system refers to a suspicious abnormality. BI-RADS 4 lesions may not have the characteristic morphology of breast cancer but have a definite probability of being malignant.

55. Respondent did not include in his note any indication of how he arrived at his plan to perform the excision. His note contains no documentation of an in-depth discussion with Patient 4 and/or her wishes and/or that she had chosen surgical removal of an asymptomatic benign mass over continued surveillance and/or her reasons for doing so. Respondent's note provides no indication that Patient 4 understood the nature of her disease and options available to her.

Patient 5:

56. Patient 5 is a 71-year old female with a history of diabetes and morbid obesity (with a body mass index of 50).[20] After a CT and an ultrasound showed hepatomegaly,[21] a gallstone in the gallbladder and gallbladder wall thickening, Patient 5 was diagnosed with acute cholecystitis.

57. Respondent evaluated Patient 5 on or about February 16, 2017, and recommended a laparoscopic cholecystectomy.

58. On or about February 16, 2017, Respondent started the cholecystectomy laparoscopically but "due to [Patient 5's] morbid obesity, the working space was very limited" so Respondent "switched to the open procedure."

59. Once open, Respondent noted purulence in the gallbladder and portions of the gallbladder were friable and disintegrated upon manipulation.

60. During the procedure, Respondent "identified a vascular structure, which was likely the cystic artery" at the base of the gallbladder. "Also at the base of the gallbladder, [Respondent] identified [another] structure, which may have been the cystic duct. Identification of the structures could not be performed with confidence due to poor exposure."

61. This lack of confidence in identification notwithstanding, Respondent proceeded to divide and ligate these putative structures.

62. At the Board interview, Respondent explained that he "had sufficient identification to proceed with the surgery." This was achieved through a "process of elimination," where he

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[20] Body mass index (BMI) is a value derived from the mass and height of a person. Normal weight falls into the BMI range of 18.5-24.9. Obesity is a BMI of 30 or greater.

[21] An enlarged liver.

"eliminated anything that could be dangerous like the cystic – like the common bile duct or any of the hepatic arteries."

63. After a period of postoperative monitoring, an additional procedure, and recovery, Patient 5 was eventually discharged on or about February 25.

Patient 6:

64. Patient 6 is a 35-year old male with a history of one year of pain in the right lower extremity.

65. Patient 6 presented to the ER on or about July 17, 2017, where he was diagnosed with an infection and underwent incision and drainage, and was given antibiotics.

66. Patient 6 returned to the ER on or about July 20, 2017, with continued drainage and pain. The ER physician noted a mass with associated hematoma and loculations[22] on the right lower extremity that would "likely need debridement in the OR setting." Patient 6 was evaluated by Respondent on or about July 20, 2017.

67. In his consultation report dated July 20, 2017, Respondent noted Patient 6 to have "a 10 cm lesion that is protruding from his right calf..." Respondent noted that Patient 6's pain was constant, had been getting worse over time, and worsened with movement. Respondent noted, further, that the mass was "nontraumatic in etiology" and that a preoperative x-ray confirmed "soft tissue mass versus abscess." Finally, Respondent recorded Patient 6's initial laboratories as showing a hemoglobin of 14.9 and white blood cell count of 12.2 (12,200 cells per microliter).

68. Patient 6's clinical scenario raises alarm bells for malignancy and prompts a proper workup including an MRI and biopsy.

69. Patient 6 was clinically stable and was neither septic nor acutely exsanguinating.

70. Respondent did not get an MRI nor did he do a core needle biopsy of the lesion.

71. After evaluation, Respondent recommended surgical resection.

72. Patient 6 was taken to the operating room on or about July 20, 2017, for excisional debridement. Intraoperative findings were notable for a ten by ten (10 x 10) centimeter area of

[22] A loculation is the localized failure of a region to drain fluids, resulting in an enlarged mass.

tissue down to the level of muscle as well as a five (5) centimeter subfascial soft tissue mass which was excised.

73. Postoperative pathology was notable for a high-grade malignant spindle-cell sarcoma.

74. After the diagnosis of sarcoma was established, Respondent did not obtain an MRI to identify the extent of tumor invasion and its relationship to vascular or nervous structures.

75. On or about July 26, 2017, Patient 6 underwent radical resection of the right lower extremity tumor. The gastrocnemius muscle was completely isolated and divided at its insertion and resected.

76. Respondent did not place surgical clips at the margins of resection to mark the periphery of the surgical field and other relevant structures to help guide potential future radiation therapy.

77. On or about August 2, 2017, Respondent placed a tunneled intravenous catheter for chemotherapy and Patient 6 went home that day.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

78. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient 1, Patient 2, Patient 3, Patient 4, Patient 5, and Patient 6, as more fully set out in paragraphs 10 through 77 above, which are hereby realleged and incorporated by this reference as if fully set forth herein, and that include, but are not limited to:

79. Between on or about January 21, 2016, and January 24, 2016, Respondent failed to clinically evaluate the critically-ill post-operative Patient 1, and/or document his findings and care recommendations for the clinical care team.

80. On or about September 10, 2018, Respondent delayed evaluating Patient 2, a critically ill patient with necrotizing fasciitis, for more than six hours.

81. On or about September 10, 2018, Respondent failed to document and/or unacceptably delayed documenting his clinical evaluation and medical decision-making in his care and treatment of Patient 2, who was critically ill.

82. On or about September 22, 2018, Respondent failed to visualize and/or treat the entirety of Patient 3's stomach during an exploratory laparotomy.

83. On or about February 4, 2019, and/or March 12, 2019, Respondent excised a benign asymptomatic breast lesion without documenting any discussion with Patient 4 regarding, and/or her understanding of, the nature of her disease and/or the options available to her for treatment.

84. On or about February 16, 2017, during an open cholecystectomy on Patient 5, Respondent divided critical structures in the patient's inflamed gallbladder bed when visualization was poor and without reasonable confidence in their identification.

85. On or about July 20, 2017, Respondent improperly diagnosed and worked up Patient 6's soft tissue sarcoma.

86. On or about July 26, 2017, Respondent failed to fully characterize Patient 6's soft tissue sarcoma to guide further surgical therapy, including but not limited to, his failure to obtain preoperative imaging and/or place surgical clips at the margins of resection.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

87. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records in his care and treatment of Patient 1, Patient 2, Patient 3 and/or Patient 4, as more particularly alleged in paragraphs 10 through 55 above, which are hereby realleged and incorporated by this reference as if fully set forth herein.

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 No. A 108956, issued to Respondent Andrew S. Hsu, M.D.;

2. Revoking, suspending or denying approval of Respondent Andrew S. Hsu, M.D.'s authority to supervise physician assistants and advanced practice nurses;

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3. Ordering Respondent Andrew S. Hsu, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: JAN 13 2023

REJI VARGHESE
Deputy Director
Medical Board of California
Department of Consumer
Affairs State of California
Complainant