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

In the Matter of the Accusation Against: Stuart Nathan Graham, M.D. Physician's and Surgeon's Certificate No. G 70035 Respondent.	Case No.: 800-2021-080909

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 February 22, 2024.

IT IS SO ORDERED: January 23, 2024.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Accusation Against:

STUART NATHAN GRAHAM, M.D., Respondent

Agency Case No. 800-2021-080909

OAH No. 2022090176

PROPOSED DECISION

Debra D. Nye-Perkins, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter by videoconference and telephone on October 23 through 27, 2023.

Giovanni F. Mejia, Deputy Attorney General, represented complainant, William Prasifka, Executive Director of the Medical Board of California (board), Department of Consumer Affairs, State of California.

Keith W. Carlson and Kathy W. Nichols, Attorneys at Law, Carlson & Jayakumar, L.L.P., represented respondent Stuart Nathan Graham, M.D., who was present throughout the hearing.

Oral and documentary evidence was received. The record was closed, and the matter was submitted for decision on October 27, 2023.

PROTECTIVE SEALING ORDER

The names of patients in this matter are subject to a protective sealing order. No court reporter or transcription service shall transcribe the actual name of the patients but shall instead refer to the patients by their corresponding letters as set forth in the Confidential Names List marked and received into evidence under seal as Exhibit 24. To protect privacy and confidential personal and medical information from inappropriate disclosure, a written Protective Order Sealing Confidential Records was issued. The order lists the exhibits ordered sealed and governs the release of documents to the public. A reviewing court, parties to this matter, their attorneys, and a government agency decision maker or designee under Government Code section 11517 may review the documents subject to the order, provided that such documents are protected from release to the public.

MOTION IN LIMINE GRANTED AT HEARING

On October 9, 2023, complainant filed a Motion in Limine to exclude expert testimony and related expert documents of two individuals from whom respondent intended to solicit expert testimony, namely Rena Bravo, M.D. and Colette Grant, M.D. The basis for the motion was that respondent failed to timely disclose the identity of those experts, their opinions, and any related documents by the required deadline as set out in Business and Professions Code section 2334. On October 16, 2023, respondent filed his opposition to the Motion in Limine wherein he did not deny that he failed to meet the deadline as set forth in Business and Professions Code section 2334 but argued that his recent change of attorneys caused him to miss the deadline, that exclusion of the experts would be unduly prejudicial to him and would not be

prejudicial to complainant. The parties argued their positions at the beginning of the hearing. After consideration of the arguments, complainant's Motion in Limine was granted.

Jurisdictional Matters

1. On October 15, 1990, the board issued Physician's and Surgeon's Certificate Number G 70035 to respondent. The Certificate is set to expire on June 30, 2024, unless renewed. Respondent's certificate has no prior history of discipline.

2. On June 15, 2022, the board filed the accusation in this matter seeking revocation or suspension of respondent's certificate based upon three causes for discipline. Each cause for discipline related to respondent's care and treatment of four patients regarding the issuance of medical exemptions for vaccination and related record keeping for each of those four patients, namely: (1) gross negligence for his care and treatment of Patients A, B, C, and D; (2) repeated negligent acts for his care and treatment of Patients A, B, C, and D; and (3) failure to maintain adequate and accurate records with regard to Patients A, B, C, and D.

3. Respondent timely filed a notice of defense, and this hearing followed.

The New Medical Exemption from Immunization Process in California

4. Effective January 1, 2021, the State of California requires that any medical exemptions from immunization (exemptions) for entry to schools and child care facilities be issued pursuant to the California Immunization Registry Medical Exemption (CAIR-ME) website, which is run by the California Department of Public Health (CDPH). According to the CAIR-ME website, "[m]edical exemptions can only be issued by MDs or DOs licensed in California and must meet applicable Centers for

Disease Control and Prevention (CDC), Advisory Committee on Immunization Practices (ACIP), and American Academy of Pediatrics (AAP) criteria." CDPH is required to review exemptions in CAIR-ME when:

- A school's or child care facility's immunization rate falls below 95 percent or
- A school or child care facility fails to provide reports of vaccination rates to CDPH or
- A doctor writes five or more medical exemptions per year beginning January 1, 2020.

The CDPH may also review a medical exemption if CDPH determines it is necessary to protect public health.

5. As of January 1, 2016, personal belief exemptions, meaning exemptions from immunization based on the personal beliefs of the parents or individual without input from a health care provider, are no longer accepted in the State of California.

6. CDPH may revoke a medical exemption for immunization because the exemption did not meet applicable CDC, ACIP, and AAP criteria or the standard of medical care.

Complainant's Evidence

7. Complainant provided testimony from an expert witness and the board's investigator. Harpreet K. Hansra, M.D. provided expert testimony regarding respondent's issuance of vaccine exemptions and related record keeping for the four patients at issue. The board's investigator, Jillian Alexander, provided testimony regarding the board's investigation and efforts to obtain complete documentation of

respondent's care and treatment of the patients at issue. The following factual findings are based on the testimony of those two witnesses, as well as related documents received in evidence.

TESTIMONY OF HARPREET K. HANSRA, M.D.

8. Dr. Hansra is a pediatrician working at The Permanente Medical Group in northern California, a position she has held since July 2004. She has been licensed to practice medicine in California since 2003. Dr. Hansra completed her medical degree in May 2001 from New York Medical College, and she completed her pediatric internship and residency in June 2004 from Kaiser Los Angeles Medical Center. Dr. Hansra's duties in her current position as a private practice pediatrician consist mostly of outpatient pediatrics with some in-hospital work as a pediatrician. Dr. Hansra currently works four days per week in an outpatient pediatric clinic, which is a busy practice of urgent care patients and well-check visits. She also takes outpatient emergency call on the weekends about one weekend per month. Typically, she provides direct patient care for about 20 to 24 or more patients per day. In addition to her clinical work, Dr. Hansra has been a reviewer on the Pediatric Peer Review Committee for Kaiser Permanente, covering approximately 1,000 physicians, from 2011 to 2022, and she was the Chair of that committee from March 2017 to September 2021. In her role as a reviewer for that committee she reviewed cases involving outpatient care provided to determine if the quality or standard of care was met by the provider. Dr. Hansra is also board certified in pediatrics. Dr. Hansra evaluates patients for immunization purposes on a daily basis and in almost all of her patients.

9. Dr. Hansra was asked by the board to provide her expert opinion in this case with regard to the care provided by respondent to patients A, B, C, and D. As part of her evaluation of this matter, Dr. Hansra reviewed various documents, including the

medical exemptions for each of the four patients, medical records from respondent for each of the four patients, medical records for patient C from another provider, interview transcripts, and email correspondence. She summarized her opinions in this matter in a report dated March 7, 2022, which was received in evidence.

10. Dr. Hansra testified that she was asked by the board to give her opinion on whether respondent's issuance of the medical exemptions from immunization for patients A, B, C, and D, as well as respondent's care in relation to those patients deviated from the standard of care, which she stated meant the level of skill, care and knowledge in the diagnosis and treatment of a patient that an otherwise reasonable caregiver would provide under the same or similar circumstances. She further stated that the degree of departure from the standard of care is the determining factor on whether there was simple negligence or gross negligence.

Dr. Hansra opined that the standard of care for any physician when issuing a medical exemption from immunization is to follow the CDC, ACIP and AAP guidelines for routine childhood vaccinations, as well as to meet the CDPH requirements, which applies those standards. Dr. Hansra stated that the ACIP guidelines are the authority in the field of pediatrics and establish the practice guidelines for immunizations and provide a description of contraindications for vaccination. She explained that contraindications are conditions for which vaccines should not be administered by a physician. She explained that the ACIP also provides a list of conditions that constitute precautions for vaccination, meaning that for those listed conditions, the vaccination may have an increased risk for serious adverse reaction or that might compromise the vaccine effectiveness. Dr. Hansra stated that particularly with regard to precautions for vaccination, those conditions may not exist in the future for the patient and, as a result, the vaccination exemption based on a precaution must be reevaluated in time.

Dr. Hansra opined that the ACIP guidelines for vaccination reflect the standard of care for a physician in California in 2021 for the issuance of vaccine exemptions. She further opined that the CDC guidelines for vaccination and the AAP practice guidelines for pediatricians are also authoritative and reflect the standard of care in 2021 for the issuance of vaccine exemptions. She noted that these three sources, the ACIP, CDC, and AAP, essentially mirror each other. The CDC guidelines set forth that a child and adolescent immunization schedule is approved by the AAP.

11. Dr. Hansra testified that the board began its investigation into respondent's issuance of exemptions for immunization for the patients at issue after the CDPH notified the board that it had revoked the exemptions respondent issued for patients A, B, C, and D. Dr. Hansra also testified that patients A and B (both boys) are siblings with the same parents, and patients C and D (both girls) are siblings with the same parents.

PATIENT A

12. Patient A was 11 years of age at the time respondent issued the medical exemption for immunization at issue in this matter. The medical exemption submitted by respondent for Patient A on June 22, 2021, had an "exemption expiration date" of "temporary, expiring 6/21/2022" and was an exemption for the following vaccines: "DTaP, IPV, MMR, VAR/VZV[1]" and also provided that the medical condition for the exemption was "other condition," which is described as follows:

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[1] DTaP stands for diphtheria, tetanus, and acellular pertussis, and is a standard immunization. IPV stands for inactive polio vaccine. MMR stands for measles, mumps and rubella and this vaccination is a live virus vaccine. VAR/VZV are both vaccines for

> Patient has had seizures after vaccination First [*sic*] after chicken pox and Dtap vaccines, evaluated by Neurology for complex febrile seizures and preceding tremors; circa May of 2011 including admission to hospital. Have postponed all booster vaccines until before 7th grade at which time we will reevaluate. In addition he had significant diarrhea and was followed by GI who recommended delaying further live virus vaccines at the time. This has since resolved. He was fully vaccinated up to 2 years old, and the plan has been to revisit prior to seventh grade, when he is 12 years old, and consider final boosters at that time.

13. Dr. Hansra testified and wrote in her report that patient A's medical records indicate that patient A was fully vaccinated through 15 months of age and had normal development. At 15 months of age patient A received his first varicella (chickenpox) vaccine and his booster vaccine of Pentacel, which is a combination vaccine for DTaP, IPV, and Hib[2] on May 2, 2011, which was about two weeks prior to patient A's first complex febrile seizure. Dr. Hansra explained that the term febrile

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chickenpox and involve live virus. VAR stands for varicella meaning chickenpox. VZV stands for varicella-zoster-virus. Dr. Hansra explained that the only two vaccines typically administered to children that involve live viruses are for chicken pox and the MMR vaccine.

[2] Hib stands for the Haemophilus influenzae type b vaccine.

means associated with a fever. On May 16, 2011, patient A suffered his first episode of complex febrile seizures and was taken to Rady Children's Hospital (Rady).

Two days prior to the seizures, on May 14, 2011, patient A was noted to have viral gastroenteritis, and on May 9, 2011, patient A was noted to have some tremors, but was evaluated and was not thought to have seizures at that time. On May 16, 2011, patient A was admitted to Rady for evaluation and continued to have brief episodes of seizures with a total of five tonic/clonic seizures on May 16, 2011, as well as continued to have diarrhea. Patient A had a neurology evaluation with no significant findings. However, stool studies showed that patient A had a rotavirus infection. Dr. Hansra noted that on the admission note for patient A into Rady, patient A had a fever of 101 degrees Fahrenheit. Dr. Hansra explained that febrile seizures are common in young children under the age of five and are often triggered by viral infections, such as rotavirus. Notably, the medical records from the neurologist who evaluated patient A at Rady stated that "it is possible that his acute gastroenteritis, particularly if it is proven to be rotavirus, may have been the trigger for his seizures." Dr. Hansra also testified that there was nothing in the medical records for patient A that would indicate that his vaccinations on May 2, 2011, were related in any way to his seizures. Notably, she explained that two weeks of time passing between the administration of the vaccines and the seizures is a "big gap of time" indicating that the seizures were not related to the vaccinations. Moreover, there is strong indication that patient A had rotavirus causing fever, which likely caused the febrile seizures.

14. On February 1, 2011, patient A received his first dose of Hep A[3] vaccine, which is a two-dose vaccination. There was no indication that patient A had any

[3] Hep A stands for Hepatitis A vaccination.

reaction or seizures from that dose. On August 8, 2011, patient A received the second (booster) dose of the Hep A vaccine. Approximately two weeks later, on August 23, 2011, patient A had a seizure in the morning and an ambulance took him to Rady where he was seen in the emergency room and thereafter admitted. The medical note from the emergency room physician at Rady stated, "Pt with past history of febrile seizure in 5/16/11 secondary to rotavirus." At the time of his visit to the emergency room of Rady, patient A had been suffering from diarrhea for four days. Dr. Hansra noted that the neurologist who evaluated patient A on August 23, 2011, in the emergency department provided his impression in the medical records as follows:

> [Patient A] is an 18-month-old boy with a past medical history for complex febrile seizures in [*sic*] May 8, 2011, in the context of fever and diarrhea now presents with seizures again in the context of diarrhea and fever. There is a document of a low-grade fever in the ED of 100.8, so likely complex febrile seizure secondary to acute gastroenteritis. He well be admitted for further evaluation and monitoring.

Dr. Hansra further testified that she saw nothing in the medical records for patient A for the August 23, 2011, seizures to indicate that those seizures were caused by or related to the August 8, 2011, Hep A booster vaccine. Instead, it appears that the cause of the seizures on August 23, 2011, was gastroenteritis caused by a viral illness resulting in fever and then seizures. Dr. Hansra noted that the August 8, 2011, Hep A vaccination was the last documented vaccination for patient A in any of his medical records reviewed.

15. On May 24, 2020, patient A was again admitted to Rady for seizures. Dr. Hansra noted that patient A had not had any vaccines in the time period before this admission to Rady and none since August 2018. At the time of his admission to Rady on March 24, 2020, patient A did not have a fever or any other precipitating symptoms showing viral illness. Patient A was evaluated by a neurologist.

16. Dr. Hansra testified that the standard of care for pediatricians is to follow the CDC, ACIP and AAP guidelines for routine childhood vaccinations, as well as the CDPH requirements and to provide the vaccine when recommended unless there is a medical contraindication or precaution to doing so. The majority of contraindications or precautions are temporary and must be reevaluated. It is important for pediatricians to adhere to those guidelines to provide those vaccines when required to prevent routine infections that can be fatal or lead to serious complications for children. With regard to patient A, Dr. Hansra compared the medical exemption provided by respondent for patient A to those CDC, ACIP and AAP guidelines, including the listed contraindications and precautions for each of the four listed vaccines on the exemption. Her analysis for each of those four listed vaccines is provided below.

With regard to DTaP, the ACIP provides a list of contraindications for when this vaccine should not be given. Those contraindications include severe allergic reaction or encephalopathy (including prolonged seizures) not attributable to another cause within seven days of a prior DTaP vaccination. However, in the case of patient A, the first febrile seizures occurred two weeks after the DTaP (Pentacel) vaccine administration, not within seven days, and the seizures were most likely triggered by concomitant viral gastroenteritis.

With regard to IPV, the ACIP provides that the main contraindication is a history of severe allergic reaction to a prior dose or vaccine component. Dr. Hansra testified

and wrote in her report that there is no applicable contraindication or precaution for this IPV vaccine for patient A.

With regard to MMR, the ACIP provides that the main contraindications are severe allergic reaction, known severe immunodeficiency, or family history of altered immunocompetence. Dr. Hansra explained that patient A had diarrhea, but it was attributed to gastroenteritis and not immunocompetence. Accordingly, there were no contraindications or precautions for patient A to receive the MMR vaccine.

With regard to VZV, the ACIP provides the main contraindications are severe allergic reaction, pregnancy, known severe immunodeficiency, or family history of altered immunocompetence. Accordingly, there were no contraindications or precautions for patient A to receive the VZV vaccine.

Dr. Hansra further testified and wrote in her report that respondent deviated from the standard of care to an extreme degree, constituting gross negligence, for providing a medical exemption for the listed vaccines above for patient A because there were no contraindications or precautions provided in the ACIP, CDC, or AAP guidelines for those vaccines for patient A at all.

17. With regard to respondent's documentation in patient A's medical records of his discussions with patient A's parents related to vaccination, as well as the documentation regarding the parent's position regarding the vaccinations, Dr. Hansra testified and wrote in her report that the standard of care for a physician related to documentation of these vaccine discussions is that the physician needs to document both the discussion and outcome of the discussion regarding any vaccine hesitancy from the patient's parents or refusal to vaccinate from the patient's parents at every visit with the physician, including why the vaccines are important, their risks versus

benefits, along with providing the parents with a vaccine information statement for each vaccine. Dr. Hansra stated that while it is not mandatory to meet the standard of care for documentation, it is recommended by the AAP that the physician obtain a signed refusal to vaccinate form from the parents and place it in the patient's chart. If the parents refuse to sign the form, then this refusal should also be documented in the chart. Dr. Hansra stressed that for unvaccinated or partially vaccinated children, the physician needs to revisit the immunization issue at each patient visit and document that discussion accordingly in the patient's chart. At a minimum to meet the standard of care, a physician needs to document in the patient's chart that at each visit he discussed the need for vaccination, the risks and benefits of vaccination, and that the parents refused the vaccination and why.

With regard to respondent's documentation in patient A's medical records of discussion of vaccination and refusal of vaccination, Dr. Hansra testified that she could not find any documentation in the records showing that respondent discussed the need for vaccinations for patient A with his parents, respondent did not document the substance of any such discussions and did not document that the parents refused any vaccinations or their reasons for refusal. Notably, Dr. Hansra reviewed the transcript of the board's interview of respondent on this topic and noted that respondent testified that he discussed these issues with patient A's mother. However, no documentation of those discussions was provided in patient A's records for any of his visits. Dr. Hansra opined that respondent's failure to document those discussions over the period of several years for multiple visits constitutes an extreme departure from the standard of care, and thus constitutes gross negligence.

PATIENT B

18. Patient B was six years of age at the time respondent issued the medical exemption for immunization at issue in this matter. The medical exemption submitted by respondent for Patient B on June 22, 2021, had an "exemption expiration date" of "temporary, expiring 6/22/2022" and was an exemption for the following vaccines: "DTaP, MMR" and also provided that the medical condition for the exemption was "other condition," which was described as follows:

> Patient had possible febrile seizure shortly after MMR vaccine. He has a brother with a history of twice having seizures after different vaccines.

19. Dr. Hansra testified and wrote in her report that patient B's medical records indicate that patient B was fully vaccinated to 12 months of age, and he had his first MMR and booster pneumococcal vaccine on July 27, 2015, at the age of one year, which was his last vaccination shown in the medical records reviewed. On August 5, 2015, patient B had his first febrile seizure when he had a fever, runny nose, and upper respiratory infection. Patient B was seen in the Rady emergency room on August 5, 2015, and medical records from that visit show that patient B had a viral infection of his airway with no evidence of a bacterial infection, and his neurological examination was normal. Dr. Hansra explained that for children under the age of five, seizures caused by fever, also known as febrile seizures, are common and occur in about five percent of the population. She stated that febrile seizures are most commonly caused by a viral infection. She stated that febrile seizures can be caused by certain vaccinations, but that there was no evidence that patient B's febrile seizure on August 5, 2015, was caused by his July 27, 2015, immunizations. Instead, the fever causing the febrile seizure was more likely from patient B's underling viral infection of his airway.

Patient B had a second seizure, which was afebrile (or not associated with a fever) and not associated with any viral symptoms, on December 23, 2015. Dr. Hansra noted that patient B did not have any vaccinations after the July 27, 2015, vaccinations, and certainly none near the time of the December 23, 2015, seizure. Patient B was evaluated at Rady emergency room on December 23, 2015, and admitted to the hospital for evaluation. Patient B had no further seizures while hospitalized and was evaluated by neurologists with no significant findings.

Dr. Hansra reviewed the transcript of respondent's interview with the board regarding his issuance of the medical exemption for immunization for patient B. According to that transcript, the family of patient B was fearful that his seizures were secondary to his recent immunizations, respondent and the family made the shared decision to wait on future vaccinations until patient B was 10 to 12 years of age. Accordingly, respondent wrote two temporary medical exemption letters for patient B dated February 10, 2020, and February 25, 2020,[4] for his admission to kindergarten, which cited a possible febrile seizure after MMR vaccine, and recommended deferral of DTaP (fourth booster), Hep A, MMR (second booster), IPV (fourth booster) and Varicella vaccines with a plan to re-evaluate yearly. Notably, there was no documentation of respondent's discussion with patient B's parents in this regard or documentation of the parent's refusal to vaccinate contained in patient B's medical records from respondent.

20. With regard to patient B, Dr. Hansra compared the medical exemption provided by respondent for patient B to the CDC, ACIP and AAP guidelines, including

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[4] It is noted that these medical exemption letters pre-dated the creation of the CAIR-ME website and related regulations and statutes.

the listed contraindications and precautions for each of the two listed vaccines on the exemption. Her analysis for each of those four listed vaccines is provided below.

With regard to the MMR vaccination exemption, Dr. Hansra notes that the first seizure of patient B occurred nine days after his MMR vaccination, but also occurred with the presence of fever and viral infection. There were no vaccinations given prior to his second seizure. Dr. Hansra testified, and wrote in her report, that the ACIP guidelines do not provide that a seizure post MMR vaccination is considered a contraindication or a precaution for future MMR vaccinations.

With regard to the DTaP vaccination exemption, Dr. Hansra noted that the ACIP provides that having a prolonged seizure within seven days of a prior DTaP vaccine with no other identifiable cause would qualify as a contraindication for a future DTaP vaccination. However, in the case of patient B, he did not receive the DTaP vaccine prior to either of his two seizures and therefore, that contraindication scenario is not applicable to patient B. She opined that there are no ACIP guideline contraindications or precautions appliable to patient B for the DTaP vaccine exemption provided by respondent.

Dr. Hansra further testified and wrote in her report that respondent deviated from the standard of care to an extreme degree, constituting gross negligence, for providing a medical exemption for the listed vaccines above for patient B because there were no contraindications or precautions provided in the ACIP, CDC, or AAP guidelines for those vaccines for patient B at all.

21. With regard to respondent's documentation in patient B's medical records of discussion of vaccination and refusal of vaccination, Dr. Hansra testified that she could not find any documentation in the records showing that respondent

discussed the need for vaccinations for patient B with his parents, nor did he document the substance of any such discussions, and he did not document that the parents refused any vaccinations or their reasons for refusal. While patient B's records did show that respondent wrote vaccine exemption letters on February 10 and 25, 2020, those letters did not suffice as documentation of vaccination discussions, were not part of patient B's medical record, and did not provide any substance on discussions with the parents. Furthermore, documentation of telephone conversations between respondent's staff and the parents of patients A and B where the parents requested medical exemptions are also insufficient for documentation purposes.

Dr. Hansra testified that the parents of patient B, who are the same parents of patient A, were understandably hesitant to provide vaccines to those children because of the older brother's (patient A) history with febrile seizures and because of patient B's history with febrile and afebrile seizures. However, it falls on respondent as their primary caregiver to explain to the parents that the seizures were not related to the vaccines and to take the time to address the parent's concerns. Documentation of those discussions is required pursuant to the standard of care. Respondent did not document any of those discussions in the medical record, did not obtain a refusal to vaccinate form for the records, and failed to document those discussions over a period of several years. Accordingly, respondent's failure to do so constitutes an extreme departure from the standard of care and gross negligence.

PATIENT C

22. Patient C was five years of age at the time respondent issued the medical exemption for immunization at issue in this matter. The medical exemption submitted by respondent for Patient C on July 26, 2021, had an "exemption expiration date" of "permanent, expiring at the end of the selected grade span" and was an exemption for

the following vaccines: "DTaP, HepB, Hib, IPV, MMR, Tdap, VAR/VZV" and also provided that the medical condition for the exemption is "other condition," with the further specification of "Family History of at risk disease," which is described as follows:

> The Father of the patient has MS; Immune Cancer and a genetic mutation which may be in the children. He has provided me two letters from different Physicians he sees which both state they should not have immunizations; particularly live virus immunizations, until further notice. [Patient C] is a carrier for Gaucher disease.

23. Dr. Hansra testified that with regard to the medical exemption issued by respondent above, the term "immune cancer" is not a medical term. She stated that while there are autoimmune disorders or leukemia that can affect the immune system, she is unaware of any medical definition of the phrase "immune cancer" and is unsure what that means. Dr. Hansra reviewed medical records for patient C, which indicate that patient C has a history of psoriasis and is developmentally normal but behind on routine childhood vaccinations. The medical records also show that patient C's father has a history of Gaucher disease and irritable bowel syndrome (IBS), the maternal uncle has a history of multiple sclerosis (MS), and the paternal grandfather has a history of testicular cancer. Nowhere in patient C's history (or patient D's history, who is patient C's sibling) does the medical record reflect that the father has MS, and nowhere does it reflect that the father has immune cancer or any other kind of cancer. Dr. Hansra further noted that a genetic mutation is not a disease in and of itself, but is instead simply an alteration in the DNA, which may be silent with no significance whatsoever.

Dr. Hansra explained that respondent noted that patient C is a carrier of Gaucher disease, which she stated is a rare lysosomal storage disease and not a disease about which Dr. Hansra is particularly familiar. She stated that in order to care for any patient with Gaucher disease, she would need to refer the patient to a geneticist. Dr. Hansra further noted that there was no record of any lab work or genetic testing of patient C to confirm that patient C is actually a carrier for Gaucher disease, and no record of any visits to a geneticist.

Dr. Hansra also noted that respondent wrote that patient C's father provided him with two letters from physicians who see the father of patient C and those physicians recommended no vaccinations, particularly live virus immunizations. Dr. Hansra stated that she reviewed those two letters from the records. The first letter dated October 14, 2020,[5] is from Dr. Barry E. Rosenbloom, whose medical specialty is not indicated in the very short letter. Dr. Rosenbloom simply wrote, "The above-named children [patient C and patient D] are both Gaucher disease carriers. It is not advisable to give them the live virus vaccine." No genetic testing was provided, and no other evidence was provided to show that patient C or patient D were carriers of Gaucher disease.

[5] Dr. Rosenbloom wrote two letters both dated October 14, 2020, with one of the letters for patient C and the other for patient D. Both letters were identical in their substance for both patients.

The second letter is dated May 5, 2021.[6] from Dr. Brian P. First, whose specialty is listed as internal medicine and endocrinology. Dr. Hansra noted that endocrinology is a specialty not related to genetics. Again, no genetic testing was provided, and no other evidence was provided to show that patient C or patient D were carriers of Gaucher disease. Dr. First wrote in both of the letters for patient C and patient D as follows:

> [Patient C and patient D] has a strong family history of autoimmune diseases such as Multiple Sclerosis, Immune cancer and a genetic mutation that makes severe vaccine reactions more likely. If there is imminent medical threat in the community we can consider a single vaccine in a controlled medical environment; however, the benefits to her and the community must greatly outweigh her very real personal risk. This medical exemption for vaccines should remain in effect until more complete immunological testing can be completed. It includes, but not limited to, DTap, polio, MMR, Varicella, Hep B and A, HPV, Influenza and Meningitis and includes all current vaccines on the CDC recommended vaccine list and any vaccines placed on the list in the future.

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[6] Dr. First wrote two letters both dated May 5, 2021, with one of the letters for patient C and the other for patient D. Both letters were identical in their substance for both patients.

Dr. Hansra testified that a reasonable pediatrician would not have relied on either of the two letters, from Dr. Rosenbloom or Dr. First, to determine if patient C or patient D were carriers of Gaucher disease or to rely on them to make a determination that patient C or patient D should be exempt from vaccination. Neither of those physicians are pediatricians, and they provided no evidence or further explanation of how they came to the conclusion that the children should not receive vaccinations. Notably, Dr. Hansra stressed that even having Gaucher disease, which neither patient C or patient D actually had, would not be a contraindication for receiving vaccinations as set out in the ACIP, CDC, and AAP guidelines. Dr. Hansra wrote in her report as follows:

> Gaucher disease is a lysosomal storage disorder. Patients with Gaucher disease are not generally considered immunocompromised and have no clinical signs of autoimmune disorders. Therefore, routine vaccines are recommended for patients with Gaucher disease.
>
> The standard is that unless a patient has been excluded from live viruses due to a genetic condition that significantly affects immunocompetence, it is not considered a contraindication or precaution.
>
> [¶] . . . [¶]
>
> Even if [patient C] were a carrier for Gaucher disease, it would not affect clinical immunocompetence as even a diagnosis of full Gaucher's disease does not exempt an individual from routine vaccinations. Live viruses such as MMR and VZV do carry a contraindication for family history

of immunocompetence, but Gaucher disease does not qualify as a recognized major immunodeficiency.

[Patient C] does not meet any of the contraindications or precautions to exclude her from the non-live viruses requested, i.e. DTaP, HepB, Hib, IPV, and Tdap.

[¶] . . . [¶]

Given that [patient C] did not have a condition that qualified her as immunodeficient, there was no family history of altered immunocompetence, and she did not have any severe allergic reactions to vaccines in the past, she did not meet the CDC/ACIP/AAP guidelines for medical exemptions for routine childhood live or non-live vaccinations.

24. Dr. Hansra concluded that with regard to patient C, respondent's actions in granting a permanent medical exemption for the listed vaccines was an extreme departure from the standard of care because patient C did not meet any of the medical exemption criteria.

25. With regard to respondent's documentation in patient C's medical records of discussing vaccination with the parents and the parent's refusal of vaccination, Dr. Hansra testified that her review of patient C's medical records show that respondent did have some documentation in the chart regarding the parents of patient C and D refusing vaccination during their initial visits with respondent, and the chart shows that respondent did speak to the parents about vaccinations on August 28, 2020, October 21, 2020, and January 29, 2021, by making the generic note of

"discuss vaccines." However, there was no documentation regarding the substance of those discussions and there was no assessment or plan regarding vaccinations in the medical records for patient C. Dr. Hansra noted that during the board's interview of respondent, respondent stated that he had discussions with the family regarding the vaccine schedule, and that the parents refused all vaccines for patient C on January 29, 2021. However, that discussion, and the parent's refusal or why they refused, was not recorded in the medical records. Dr. Hansra noted that there are some notes from respondent's staff regarding the parents calling respondent's office asking for the status of vaccine exemptions, but those telephone call notes are not part of the medical record and do not constitute proper documentation that would meet the standard of care she set forth above.

Accordingly, with regard to patient C, Dr. Hansra opined that respondent deviated from the standard of care for the documentation of his discussion of vaccines and the parent's refusal of the vaccines. She opined that the departure was a simple departure from the standard of care because there was some documentation showing that vaccines were discussed during multiple visits, but that documentation was insufficient. Accordingly, respondent's lack of documentation with regard to patient C constitutes negligence.

PATIENT D

26. Patient D was 8 years of age at the time respondent issued the medical exemption for immunization at issue in this matter. The medical exemption submitted by respondent for Patient D on July 26, 2021, had an "exemption expiration date" of "permanent, expiring at the end of the selected grade span" and was an exemption for the following vaccines: "DTaP, HepB, Hib, IPV, MMR, Tdap, VAR/VZV" and also provided that the medical condition for the exemption was "other condition," with the

further specification of "Family Hx of precluding disease," which was described as follows:

> The Father of the patient has MS; Immune Cancer and a genetic mutation which may be in the children. He has provided me two letters from different Physicians he sees which both state they should not have immunizations; particularly live virus immunizations, until further notice. [Patient D] is a carrier for Gaucher disease.

27. Dr. Hansra testified that patient D and patient C are siblings with the same parents, and that the medical exemption provided for both patient D and patient C are the same. Accordingly, the analysis for both patient C and patient D with regard to the medical exemption provided by respondent is the same. As in the medical records of patient C, the medical records for patient D also did not show any genetic testing or results of genetic testing to confirm that patient D was a carrier of Gaucher disease.

For the same reasons discussed above for patient C, Dr. Hansra concluded that with regard to patient D, respondent's actions in granting a permanent medical exemption for the listed vaccines was an extreme departure from the standard of care because patient D did not meet any of the medical exemption criteria listed in the CDC, ACIP, or AAP guidelines.

28. With regard to respondent's documentation in patient D's medical records of discussion of vaccination with the parents and the parent's refusal of vaccination, Dr. Hansra testified that her review of patient D's medical records showed that there was no documentation of any discussion of vaccination or vaccine refusal by

the parents of patient D around the time the medical exemption was submitted to CAIR-ME by respondent. The only recordation of any discussion of vaccination in patient D's chart was at her three-year-old check up with a note that alluded to prior discussions of vaccine refusal, but those discussions were not in the record. While patient D's records do contain two AAP Refusal to Vaccinate forms dated March 28, 2015 and December 17, 2015, those two forms were obtained by respondent's colleague and not respondent during a time prior to when respondent took over the care of patient D. There is no documentation in the record for multiple visits over several years for patient D of any discussion of vaccination or vaccine refusal or the parent's reasons for vaccine refusal. Dr. Hansra noted that during the board's interview of respondent, respondent stated that he had discussions with the family (which is the same family as patient C) regarding the vaccine schedule, and that the parents refused all vaccines. However, those discussions, and the parent's refusal or why they refused, were not recorded in the medical records.

Accordingly, with regard to patient D, Dr. Hansra opined that respondent deviated from the standard of care for the documentation of his discussion of vaccines and the parent's refusal of the vaccines. She opined that the departure was an extreme departure from the standard of care because there was no documentation showing that vaccines were discussed during multiple visits over several years. Dr. Hansra opined that with regard to patient D, respondent's failure to document those discussions and the parent's refusal to vaccinate, constituted gross negligence.

THE BOARD'S INVESTIGATION

29. Jillian Alexander is currently employed by the board as a special investigator, a position she has held since June 2020. Prior to this position she worked from July 2019 to June 2020 as an investigative analyst for the Division of

Investigation, Department of Consumer Affairs, where she conducted investigations related to licensees of the board and podiatric doctors. Ms. Alexander has had over 160 hours of training related to investigations, including report writing and investigative techniques. Her duties as a special investigator include conducting administrative investigations of licensees for the board, writing reports summarizing her findings, drafting medical record requests and obtaining those records, and cooperating with arresting agencies and courts in criminal matters. Ms. Alexander has conducted about 215 investigations for the board. Ms. Alexander was assigned to investigate this matter for the board on September 2, 2021, and summarized her findings in a report, which was received in evidence.

30. Ms. Alexander testified that the board received a notification from CAIR-ME on August 20, 2021, that CDPH had rejected some medical exemptions filed by respondent. Upon receiving the notification and after Ms. Alexander was assigned to this matter on September 2, 2021, she printed the exemptions from CAIR-ME, along with documents attached to those exemptions as filed by respondent including the letters from Dr. Rosenbloom and Dr. First, and mailed requests for authorization for medical records to the parents of the patients at issue. After receiving the authorizations from the parents, Ms. Alexander requested the medical records for patients A, B, C, and D from respondent, and also requested medical records for patients C and D from Dr. First.

After sending the request for medical records for patients C and D to Dr. First, Ms. Alexander received a certification that he had no medical records for patients C and D. Ms. Alexander made contact with Dr. First by telephone and on October 21, 2021, and during that telephone call Dr. First acknowledged to Ms. Alexander that patients C and D were never his patients, and that he is a close family friend of the

father of patients C and D and wrote the letter at issue as a favor to the father. According to Ms. Alexander's report, Dr. First told her that he should never have written the letter as a favor to the father. Ms. Alexander testified that she did not reach out to Dr. Rosenbloom to obtain medical records for patients C and D.

Respondent's Evidence

31. Respondent testified at the hearing and also provided testimony from five other witnesses. Two of those witnesses are parents of the patients at issue, and three of those witnesses are character witnesses for respondent. The following factual findings are based upon the testimony of respondent and the additional five witnesses, as well as related documents received in evidence.

TESTIMONY OF THE MOTHER OF PATIENTS A AND B

32. The mother of patients A and B works as an independent nutrition coach but does not have any medical training. She and her husband share four children together, and patients A and B are her youngest children. As of the date of the hearing, all of her children are fully vaccinated, and her three sons all use respondent as their pediatrician.

33. The mother testified that patient A first started seeing respondent as his physician around the time of his birth but initially saw respondent's colleague, Neil Goldfinger, M.D., in the same private practice. Patient A received all of his recommended and scheduled vaccinations up to the age of 18 months. At the age of 15 months, Dr. Goldfinger gave patient A his chicken pox (varicella) vaccination and Pentacel vaccinations on May 2, 2011. Within 24 hours of receiving those vaccinations patient A began to have blue lips and was shaking. The mother called the "nurse line" to discuss those symptoms and to see if she needed to bring patient A into the

physician to be seen. Patient A's medical records reflect that the mother called Dr. Goldfinger on May 11, 2011, about patient A having blue lips and shaking. The mother recalls making multiple telephone calls to Dr. Goldfinger's office prior to that date, but no such calls were reflected in the medical record. On May 13, 2011, the mother took patient A to see Dr. Goldfinger because he was still getting blue lips every morning, shaking, and having diarrhea. Dr. Goldfinger evaluated patient A and sent him home.

On May 15, 2011, the mother's husband took patient A to an urgent care office located in the same office building as respondent's practice. Patient A still was getting blue lips, was shaking, was not eating, and was getting worse. During that visit, the physician who evaluated patient A "could not figure out what was going on" and advised the parents to take patient A to the emergency room.

On the morning of May 16, 2011, patient A had a seizure and the mother called 911 and patient A was transported by ambulance to Rady's emergency room for evaluation. The physicians at Rady called it a febrile seizure and patient A had about four to five more seizures during the time he was at the emergency room. The mother stated that when 911 arrived to take patient A to the hospital, patient A had a fever of only 99 degrees Fahrenheit. Patient A was admitted to Rady hospital at that time and stayed for four or five days for evaluation. Patient A saw multiple neurologists for evaluation at Rady while he was there. According to the mother, she asked the neurologists if the symptoms could be connected to the immunizations patient A received two weeks earlier. In response she was told "no" but that "there is a strong correlation between them," and that "there was a stream of events in between" the vaccinations and the symptoms. The mother stated that she took those answers to mean that patient A's seizures were connected to the vaccinations he had two weeks earlier. She asked the neurologists if patient A getting his next scheduled vaccination

would be a problem, and they told her that they did not think it would be a problem but to talk to patient A's pediatrician. On cross-examination, the mother admitted that she understands that a rotavirus infection was connected to patient A's seizures in May 2011.

34. On May 20, 2011, patient A saw respondent for an office visit as a follow up from his hospitalization. The mother was concerned because the next scheduled vaccination for patient A was in July or August of 2011. According to her, during that visit respondent discussed with her "what immunizations are and what they do." The mother was concerned that patient A was "still not healthy," and she did not want him to get vaccinated again "to put him through that." According to her, respondent did not feel that there was any reason to delay patient A's next scheduled vaccination and attempted to reassure her.

35. On August 8, 2011, patient A made an office visit to Dr. Goldfinger of respondent's practice and during that visit received his next scheduled vaccinations. The mother stated that during this appointment she had the same conversations with Dr. Goldfinger that she had had with respondent on May 20, 2011, regarding the risks and benefits of vaccination. Dr. Goldfinger gave her "almost the same answers" to her questions regarding her concerns related to vaccinations. She "was fine" with giving patient A his vaccinations on that visit, but "was still a bit leery."

According to the mother, the day after his August 8, 2011, vaccinations, patient A again had the same symptoms of blue lips, shaking, decreased appetite, and diarrhea. She did not recall calling respondent's pediatric office on August 9, 2011, but she did call on August 10, 2011, and spoke to office staff. According to her, the office staff told her to watch patient A's symptoms and make sure he did not have a fever.

She told the office staff that she was afraid that seizures would happen, but they informed her that there was nothing that could be done to prevent that.

On August 23, 2011, patient A again had a seizure and "stopped breathing." The mother called 911, and patient A was taken to Rady emergency room by ambulance. She stated that the paramedics did not perform cardiopulmonary resuscitation (CPR) but only gave patient A oxygen because "his lips were blue, and his face turned blue." After arriving at Rady, a neurologist named Mark Nespeca, M.D. evaluated patient A at her request. She stated that she was familiar with Dr. Nespeca because he had treated her older daughter, who suffered from seizures. According to the mother, Dr. Nespeca told her that patient A was suffering from febrile seizures, which is common for children under the age of five years. She stated that typically the children "grow out of it." Dr. Nespeca did not want to put patient A on medications to treat his seizures because he did not believe that the patient A was epileptic. However, patient A was given seizures medications while at Rady and was sent home with the medication just in case he suffered another seizure that lasted more than two minutes.

The mother stated that patient A was referred to a gastroenterologist to treat patient A's diarrhea, but she did not recall him having any diagnosis of an infection. During the time patient A was in the hospital at Rady after the August 23, 2011, seizure, the mother had the same conversation with the physicians at Rady regarding whether the seizure was related to the vaccinations patient A had on August 8, 2011. According to her, the physicians at Rady told her, "There is a strong correlation between the vaccines and the seizures," but that she should talk to her pediatrician regarding further vaccines.

36. Thereafter she followed up with respondent after patient A's August 2011 hospitalization, and she understood that there were no further vaccinations scheduled

until kindergarten for patient A. She requested that no further vaccinations be provided to patient A "to allow him time to heal." She recalled that this was a lengthy office appointment with respondent because "we talked about vaccinations and what they do." She was very hesitant to give patient A any further vaccines, but respondent reassured her and told her that immunization is necessary, but that he also understood her fear. According to her, respondent told her that he did not believe that the vaccinations caused patient A 's seizures. She stated that she and her husband came to the conclusion that they did not want to vaccinate patient A "for some time."

37. On November 7, 2011, she and her husband took patient A to Rady emergency room because he "was never getting better, was continuing to wake up in the morning with blue lips and shakiness, and the diarrhea was not getting better." Patient A had not received any vaccine since August 8, 2011, and did not have a seizure that day. The mother stated that she was concerned because patient A "had not gotten any better" since May 2011 when he was immunized. She stated that in November 2011 patient A stayed at Rady overnight, and the physicians there told her that patient A was "an unusual case" but gave her no reasons for the seizures or other symptoms.

38. The mother testified that she discussed with respondent a plan to revisit vaccinations at the time of kindergarten for patient A. Patient A only received scheduled vaccines up to the age of 18 months and not thereafter. Respondent provided patient A with a letter dated April 15, 2015, when patient A was five years old and going into kindergarten, providing a vaccine exemption for patient A to allow him to go to kindergarten because he did not receive the required vaccinations. The mother stated that during each well check with respondent that patient A had from the age of 18 months onward, respondent discussed starting immunizations again and

the mother requested that he not do so. She stated that patient A went in for a well-check visit once per year. Respondent provided her another letter dated November 2015 for patient A to attend kindergarten because the school needed additional information, so she requested that letter and respondent provided it. At the time she obtained the exemption letter for patient A to attend kindergarten, she and respondent discussed the plan to revisit his vaccinations when patient A enters the seventh grade and to "catch up" on his missed vaccinations at that time. The mother stated that she and her husband requested that patient A not be vaccinated until he was older and entering the seventh grade. She stated that she and respondent had these conversations in 2015 when patient A received his kindergarten exemption letter from respondent.

39. On May 24, 2020, when patient A was ten years old, the mother called 911 because patient A had another seizure, and his lips were blue. The firemen arrived and gave him oxygen, took his temperature, and transported him to Rady emergency room. Patient A did not have any seizures from 2011 to May 24, 2020. The mother stated that she thought patient A was done with seizures and was contemplating having him catch up with his vaccinations, but this event happened, and she became fearful again. Notably, patient A had not had any vaccines since 2011. The mother noted that on May 24, 2020, patient A did not have a fever and was not ill. The physicians at Rady suggested that this was a "random seizure" and recommended patient A follow up with a neurologist.

40. After the May 2020 visit to Rady emergency room, patient A had a follow-up appointment with respondent. On that appointment, respondent told the mother that "immunizations should be done," and assured her that it was safe to immunize patient A after the May 2020 seizure. She and her husband did not want

patient A to re-start his vaccinations until the seventh grade "to let his body grow and mature more." The mother again requested a vaccine exemption from respondent. Patient A was scheduled to start the seventh grade in 2021. Patient A had another well-check visit with respondent after this follow-up appointment where respondent discussed vaccination again, and she requested that patient A not receive his vaccinations yet.

41. In a June 21, 2021, well-check visit for patient A with respondent, when patient A was 11 years old, the mother requested a medical exemption from vaccination for patient A from respondent in order for him to attend seventh grade. Respondent discussed vaccinations with her and told her that "it was fine to start back with vaccinations now," but she again requested an exemption "for a few months to do them sometime during his seventh-grade year." At the time of her request, she was not familiar with the CAIR-ME website or the requirements for requesting a vaccine exemption. She stated that respondent told her about the risks of not getting patient A vaccinated, but she requested the exemption because of her fears.

42. With regard to patient B, the mother stated that patient B is her youngest child and had the same pediatricians as patient A. When patient B was born, he received his vaccinations at the hospital at birth. On patient B's first well-check visit at nine weeks of age on September 23, 2014, with Dr. Goldfinger, the mother requested that patient B receive his vaccines on a slower schedule because of what happened with patient A. She explained that Dr. Goldfinger was near retirement at that time and after his retirement, respondent would be taking patients A and B as his patients. At that appointment, Dr. Goldfinger discussed the risks of delaying the vaccinations.

43. At his well-check visit with Dr. Goldfinger on February 16, 2015, when patient B was six months of age, he received his flu vaccination but no other

vaccinations. During this visit, the mother discussed with Dr. Goldfinger the plan to vaccinate slower than the recommended schedule. The mother testified that on this visit she specifically asked if patient B could get the MMR vaccine on that date because the measles "were going around" and she was concerned. She also stated she was concerned about giving patient B the MMR vaccine and others, particularly because the MMR is a live virus vaccine, and she had more concerns about that given patient A's history. Regardless, patient B could not get the MMR vaccine on this visit because he was not yet one year of age, and Dr. Goldfinger discussed "catching up" patient B with his vaccines.

44. At his well-check visit with respondent on April 28, 2015, when patient B was nine months of age, patient B received two vaccinations, namely the Hep B and pneumococcal vaccinations. Then at his well-check visit with respondent on July 27, 2015, when patient B was 12 months old, patient B received his MMR and pneumococcal vaccinations. The mother stated that she understood the risk of contracting measles outweighed the risk of immunization, and she and her husband wanted patient B to have the MMR vaccination at one year of age. The mother testified that as of this visit, she knew that patient B was behind on his other vaccinations, such as chicken pox, but she and her husband decided to get the MMR and pneumococcal booster vaccinations.

45. On August 5, 2015, patient B had seizures in the afternoon and 911 was called. The mother stated that patient B's lips were blue, and he was shaking, just like the symptoms of patient A discussed above. After the paramedics arrived, patient B was transported to Rady emergency room. Patient B had another seizure and vomited in the ambulance on the way to the hospital. She stated that she did not recall if patient B had a fever at that time. At the hospital, patient B received fluids and was

released from the hospital after an overnight stay and instructed to follow-up with a neurologist. The mother testified that the physicians at Rady told her this was a febrile seizure event.

46. Soon after the August 5, 2015, seizure of patient B, the mother took patient B to respondent's office for a follow-up visit, but she does not recall if she saw Dr. Goldfinger or respondent for that visit. Regardless, she and her husband had already made up their minds that patient B would not receive any further vaccines because of the similarities in symptoms and events after patient A and B each received vaccines. She and her husband felt that the vaccines were causing the seizures. The mother testified that the pediatrician she met with during that visit tried to reassure her that the vaccines did not cause the seizures, and she was informed of the risks of her decision to stop vaccinations. However, she and her husband decided to stop vaccinations for both patient A and patient B at this point.

47. On December 23, 2015, patient B had another seizure in the afternoon and the mother called 911. The paramedics transported patient B by ambulance to Rady emergency room. Patient B was evaluated, given fluids, and released from the hospital that night. Later in the evening on December 23, 2015, patient B had another seizure and the mother took him back to Rady emergency room and he was admitted to the hospital. The last vaccination patient B had prior to his December 2015 hospital admission was on July 27, 2015. In December 2015 the physicians at Rady told her that they did not know a cause of his seizures in December 2015 and that the seizures were "unprovoked" and recommended placing him on anti-seizure medication.

48. The mother thereafter took patient B for a follow-up appointment with either respondent or Dr. Goldfinger (she did not recall which physician saw patient B at that visit). She stated that she discussed her concerns regarding the vaccination being

a cause of patient B's seizure, but that whoever the pediatrician was did not give her a reason for the seizure. She was still following up with a neurologist for patient B at that time. Thereafter, in each well-check visit with respondent, she discussed vaccination for both patient A and patient B because she and her husband had decided to stop all vaccinations. According to her, during each of those visits, respondent told her that he believed that both patient A and patient B could be safely immunized, and the vaccines would do no harm, but she and her husband "were not ok with it."

49. On December 8, 2016, when patient B was two years of age, respondent wrote an exemption to vaccination letter for patient B to be used for his admission into day care. In February 2020, the mother had a discussion with respondent because she was requesting an exemption from vaccination letter from him for patient B because patient B was about to enter kindergarten. On February 25, 2020, respondent provided an exemption to vaccine letter for patient B. According to her, respondent told her at that time that patient B could safely receive immunizations but provided her with the letter because she requested it.

50. On June 21, 2021, patient B had a well-check visit with respondent when he was six years and ten months old. During this visit, the mother again requested vaccine exemptions for both patient A and B with respondent. She recalls this visit because during this time the CAIR-ME website required an online submission for vaccine exemption. She testified that at this visit, respondent communicated to her that he believed that both patients A and B could get immunized with no issues. However, she requested the exemptions for both patients A and B so that they could attend school. Respondent provided those through the CAIR-ME website for both patients A and B.

51. Patients A and B started school in August 2021. About one week into the school year, the mother was notified by email from CAIR-ME that the submitted exemptions by respondent for patients A and B were denied. The email instructed that she had one week to get the children vaccinated, or alternatively she could appeal the denial. The mother chose to appeal the denial. The appeal process lasted until December 2021, and she lost that appeal, meaning that the medical exemptions provided for both patients A and B were revoked. The mother stated that she was given ten days to get immunizations up to date, but that could not be done because some immunizations cannot be given at the same time, and some immunizations had to be given four months apart. The mother stated that both patient A and patient B were up to date on their vaccinations by July 2022.

52. The mother wrote a letter of support for respondent for this matter, which was received in evidence. She believes that respondent listened to her concerns about vaccinations, and he continues to be a pediatrician to her children. Overall, she is very satisfied with the care respondent has provided to her children.

TESTIMONY OF THE FATHER OF PATIENTS C AND D

53. The father of both patients C and D, who are sisters, testified. He and his wife are the biological parents of patients C and D. The father has a doctorate degree in Chinese Medicine and is licensed in California as an acupuncturist, but currently works as a real estate agent in Texas. He lived in California with his wife and children from 1989 to 2022. He and his wife and children all moved to Texas in 2022 for "a job." Respondent was the pediatrician for both patients C and D for most of their life until they moved to Texas.

54. Patient C is currently eight years old, and patient D is currently 11 years old. Respondent was patient C's pediatrician since she was born and was patient D's pediatrician after Dr. Goldfinger retired. The father testified that both patient C and D attended all well-check visits with respondent (or Dr. Goldfinger initially for patient D), which occurred annually or more often when the children were younger. He stated that he is familiar with the CDC guidelines for vaccination scheduling for children because that was given to him at the first well-check visit with his children, and also because he has learned about it "through his own training and research." He and his wife both discussed the vaccination schedule with respondent with regard to both of their children, and respondent encouraged them to start the vaccinations for both patient C and D. He and his wife were concerned about vaccinations because of the father's medical history, family history, and Patient C's autoimmune condition of psoriasis, which she was diagnosed with at the age of two. The father also stated that "more recently" patient C was also diagnosed with an autoimmune condition of Crohn's disease.

55. The father explained his disease, which caused him concerns regarding the vaccination of his children. Specifically, he has a condition called type I Gaucher's disease, which is a very rare genetic condition he has lived with his entire life. As a result of this disease, he lacks an enzyme that breaks down a lipid in his body causing Gaucher cells to develop, which get stored in the liver and spleen, causing symptoms of enlarged liver, enlarged spleen, anemia, low blood counts, bone weakness, and other problems. He explained that patients C and D are carriers of Gaucher disease, but because his wife is not a carrier of the gene, patients C and D do not have Gaucher disease. The father was one of the first patients to ever receive treatment for Gaucher disease when he was 10 years of age and is very familiar with the disease.

56. The father's primary concerns regarding vaccination for patients C and D is that because they are both carriers for Gaucher disease, this may cause them to be at a higher risk of adverse reactions from vaccinations. Additionally, with regard to patient C, who has the autoimmune condition of psoriasis diagnosed at age two, this additional condition may put her at a higher risk of adverse reaction to vaccination. The father testified that patients C and D also have other family members with autoimmune diseases that caused him to have concern regarding immunizations, but that his primary concerns were the fact that patients C and D are carriers for Gaucher disease, as well as patient C's psoriasis diagnosis.

57. The father testified that during the time both patients C and D were under the care of respondent, and Dr. Goldfinger, neither of them received any vaccinations. He stated that he and his wife made the joint decision to not vaccinate either of their children. He stated that this decision was based on "information from other providers" and on his "own research and medical history." The father denied having a generalized hesitation toward immunization and stated, "I have no problem with other people vaccinating their kids." With regard to other providers, he stated that he relied on Dr. Rosenbloom and Dr. First. The father was under Dr. Rosenbloom's care for about 20 years for his Gaucher disease. He stated that Dr. First cared for him when he was a child and is familiar with his disease.

58. The father testified that for both patients C and D, he used the personal belief exemption to immunization to enroll his children in school until 2016 when he was no longer allowed to do so. Thereafter, he first requested an immunization exemption for both patients C and D from respondent in 2020 or 2021 when the new CAIR-ME system required them to be submitted online in order for patients C and D to be enrolled in school. Between 2016 and 2020 or 2021, he obtained medical

exemption from vaccine letters from other physicians for patients C and D in order to enroll them in school, but he claimed he did not recall who those physicians were. However, once the law changed and the CAIR-ME system required online submission of the medical exemptions, the letter exemptions previously obtained were no longer valid or accepted.

Medical records for patients C and D show that in the years up to 2016, he and/or his wife signed documents titled "Personal Beliefs Exemption to Required Immunization," which was also signed by either Dr. Goldfinger or respondent. The father testified that at every well-check visit for both patient C and patient D, either respondent or Dr. Goldfinger discussed the need for vaccination for the children, which the father stated was a total of about 12 times. On all the occasions respondent discussed vaccination with him or his wife, respondent told them that vaccination of patients C and D was safe for them and recommended for them.

59. Beginning at a well-check visit for both patients C and D on August 28, 2020, the father asked respondent for a vaccine exemption for both children through the new CAIR-ME online site so that the children could enroll in the upcoming school year. The father had a few online consultations with respondent thereafter to discuss vaccination and to request a medical exemption for both children. On June 28, 2021, he again called respondent's office requesting the medical exemption because he had started the process on the CAIR-ME website and needed respondent to complete his part. During each of these conversations with respondent, respondent told him that he did not believe that the genetic condition of being a carrier for Gaucher disease prohibited patients C and D from being vaccinated. The father stated that even so, respondent is not an expert in Gaucher disease or "his genetic condition", and respondent indicated that if the father provided further evidence for the need for a

medical exemption, then respondent "would consider that in his decision." The father then reached out to Dr. Rosenbloom, who had treated him from 2000 to 2022, although he was not his primary care physician. According to the father, Dr. Rosenbloom told him patients with Gaucher disease, as well as patients who are genetic carriers of Gaucher disease, should not get a live-virus vaccine. He asked Dr. Rosenbloom to write a letter for each child reflecting that opinion, which he did, and which was received by respondent and attached to the medical exemptions at issue in this matter. The father admitted that Dr. Rosenbloom had never examined patients C or D.

After receiving the letter from Dr. Rosenbloom, respondent told the father that the letter only addressed live-virus vaccines and not the other vaccines and recommended that the children receive the other vaccines. Thereafter, the father contacted Dr. Brian First, an endocrinologist who had treated him from 1989 to 1999. Dr. First had never treated patients C or D. The father testified that based on his own medical history, Dr. First agreed that his concerns regarding vaccination of patients C and D were valid and that they were at a higher risk of adverse reactions from vaccines. As a result, Dr. First wrote the letter that was given to respondent and also attached to the medical exemptions at issue in this matter. The letter from Dr. First states that the father has MS, however he stated that he does not have MS, but his wife's brother does. The letter also states that the father has "immune cancer." He testified that one of his grandparents had that, but he admitted he does not know what immune cancer is. The father admitted that he expressed concerns to Dr. First about patient C's psoriasis diagnosis and the weakened immune system related to the father's condition, all of which was reflected in that letter.

60. The father testified that after he gave respondent the letters from Dr. Rosenbloom and Dr. First, respondent "thought that those letters would be sufficient to obtain a medical exemption," but in respondent's opinion it was fine for patients C and D to get the vaccinations. He stated that because he provided those letters to respondent, respondent "was willing to submit that to CAIR-ME" to see if it would go through. The father testified that on multiple occasions he told respondent that he wanted a permanent exemption from vaccinations for both of his daughters.

61. Soon after the medical exemptions were submitted to CAIR-ME for patients C and D, those medical exemptions were revoked by CDPH. The father thereafter spoke with respondent about a possible appeal of the revocation, and in August 2021 respondent referred patients C and D to an immunologist for a further opinion regarding his concerns about vaccinating his children. The father admitted that throughout the time patients C and D saw respondent for care, respondent always expressed that it was his medical opinion that patients C and D could safely receive vaccinations and should do so. A medical record from Rady dated October 13, 2021, from an immunologist shows that the immunologist opined regarding both patients C and D that "I do not see any reason [these] child[ren] should not be able to proceed on with receiving the usual pediatric vaccines. [They] are not at any risk higher than usual, for an adverse reaction to live and non-live vaccines."

62. After the revocation of the medical exemptions for patients C and D, respondent advised the father that based on that revocation, he needed to discuss a schedule to catch-up the children on their vaccines because they can't all be given at once.

63. On September 14, 2021, the father wrote a letter to the board investigator regarding respondent after he learned that respondent was being

investigated for writing vaccine exemptions. The father's letter mirrored his testimony at hearing. He stated that he wrote the letter "to let them know that this was not just me asking for an exemption and getting one."

64. On August 23, 2023, the father wrote another letter "to whom it may concern," regarding respondent's issuance of medical exemptions from vaccination for patients C and D. He wrote this letter after he learned that the accusation against respondent had been filed and wanted to share his experience with respondent as the pediatrician for patients C and D. In this letter, the father wrote that he made the request to respondent for the medical exemptions and that in response "Dr. Graham was clear that he did not believe this precluded my daughters from the vaccination requirements, but he was willing to make the request so long as I could provide further supporting evidence by speaking with other specialist providers familiar with immunology and genetics." The father further praised respondent's professionalism, compassion, and competence.

RESPONDENT'S TESTIMONY

65. Respondent is 60 years old and currently in private practice as a pediatrician in Poway, California. He has been married for 38 years, has six grown children, and is about to have his tenth grandchild. He is board certified in pediatrics from the American Board of Pediatrics. He received his M.D. degree in 1989 from University of California Irvine (UC Irvine) College of Medicine. He completed his internship and residency in pediatrics at Long Beach Memorial Hospital and Miller Children's Hospital at Children's Hospital of Orange County, part of UC Irvine. He has been licensed to practice medicine in California since 1990 and currently holds hospital privileges at Palomar Medical Center. Respondent has practiced as a pediatrician for 33 years. He has been part of his current private practice group, currently called

Palomar Health Medical Group, which has had a number of other names over the years. When respondent started with the group, it consisted of 30 doctors and now has about 150 doctors. In 2000, respondent served as a board member for the group, and in 2003 or 2004 he became president of the group and served in that capacity for 14 years. During his presidency, and about 14 years ago, the group sold off their management service organization and practice management association to Arch Health Partners. Additionally, he was the head of the Utilization and Quality Management Committee of his group and was a member of the peer review committee for his group. During the last 33 years of his practice, respondent has seen over 100,000 pediatric patients.

In addition to his work as a pediatrician, respondent has worked since 1983 with a Christian ministry he helped form. The ministry helps homeless people in downtown San Diego, which initially had a church but has now grown to be an international ministry for orphans and children with churches in Nepal, Kashmir, Armenia, and Oregon. Respondent spends a significant amount of time, about one and one-half days per week, managing this ministry. He stated that he retired from the administrative and management duties from his private practice group so that he could spend more time managing the ministry.

66. Respondent explained that pediatric care consists of well-check visits, which look at the growth and development of the child, general health measures, and provides vaccinations on the required schedule. Respondent stressed that immunizations are the most important medical advancement for children. Respondent stated that when he was in medical school, he and his wife had their first child. When that child was almost one year of age, the child almost died from pneumococcal meningitis because at that time there was no vaccine for it. Respondent's practice, and

the practice of all the three to four pediatricians in his group, is general primary care pediatrics. According to respondent, immunization discussion is the most dominant discussion in all well-check visits for children and is the "biggest part" of a well-check. Respondent's practice is to sit and talk to the parents about what is important to them for their children. Many parents have questions about vaccines, and respondent repeats the same information about vaccines over an over throughout the day. In the case of the four patients at issue in this matter, and the two sets of parents who were worried about their children and vaccinations, respondent was "trying to deal with those concerns." Respondent spends a lot of time talking to his patients and his appointments are usually scheduled for 15-minute time intervals. However, because he spends a lot of time talking to parents, he is typically running behind on his appointments. Respondent deals with vaccine-hesitant parents weekly.

Respondent further explained that when an infant is born, he sees them post hospital and that can consist of more than one visit depending on any issues with the child. Thereafter, the children come for well-visits and the primary series of vaccinations at two, four, and six months of age, which are meant to protect the child until the age of two. The child is given booster vaccines at nine, 12, 15, 18, and 24 months of age. He explained that there are also a few new vaccines given at those later appointments, as well. He also explained that if a child is behind on vaccinations, you must reassess the schedule to create a "catch-up" schedule.

67. Respondent testified that he documents all visits with his patients in the medical record, and he documents what he believes is pertinent to their care. With regard to immunizations, he stated that the most pertinent information is what immunizations were given, along with the lot number and expiration date of the immunization given. Respondent stated that it is secondary to document details of

vaccination discussions with parents. He stated that frequently when parents are vaccination-hesitant, parents are scared to tell you what they actually think for fear of "looking stupid." Accordingly, respondent tells parents that he is not taking notes, but is instead "just talking to them." He stated that his job is to persuade the parents to give the required vaccinations. Respondent stated that this can be a very stressful event for parents because there is so much misinformation out there. Respondent explains the vaccinations to the parents and how they work. Some parents "have a certain amount of knowledge that is dangerous," but "you have to work with those people." Respondent testified that some of his colleagues simply "kick those patients out of their office," but he does not do that simply because the parents don't agree with him. Respondent testified that the parent's reasons that the child was not vaccinated or was vaccinated is not important to put in the medical record. He believes the only time the parent's reason for refusing vaccination is important is during his discussion with them in his efforts to persuade them to vaccinate. Respondent's goal is to get the parents to trust him and to be a resource for them.

Respondent uses electronic medical records in his practice, and he finds it "clunky." He said that the electronic medical records were designed to be a billing system rather than a medical record. He does not enter the medical record when he is meeting with the patient, and he goes patient to patient with only a "piece of paper" with him to write down any "unusual discussion." When he is finished seeing patients in the morning or afternoon, then he will enter all the information into the electronic medical record for the patients. He enters the information in the electronic medical record the same day, sometimes late in the evening when he is at home. He stated that "referrals are documented right away." With regard to patients A and B, respondent stated that theirs were not cases of "vaccine refusal." With regard to patients C and D, theirs were both "refusal to vaccinate from the get-go." Respondent

stated that the reasons why the parents of each of these four children did not vaccinate was not important, but that he documented that vaccinations were recommended but the parents refused.

68. Respondent stated that the recommended vaccination schedule from the CDC is available to parents in his practice, and he provides all parents with a more narrative version of the immunization schedule. He stated that he begins the first discussions about immunization with parents often before the child is born. The first recommended vaccination is Hep B and is given at birth. He stated that this is not a requirement but is primarily designed for children born to Hepatitis B positive mothers, which is a rare occurrence in his practice. Many parents refuse that vaccination at birth and for those patients he gives the vaccination a bit later. At the age of two months the child gets their first vaccination for rotavirus, DTaP, and others. Respondent stated that some vaccine schedules have changed over time and used the example of MMR. He stated that in 1989 or 1990 when he was entering his residency, Los Angeles had a measles outbreak focused on the University of Southern California college campus. The quarterback of the football team missed a game because he had measles. That outbreak affected lots of children, and at that time the recommended time to give the first MMR vaccine was at 15 months. Unfortunately, many children under the age of 15 months contracted measles and some died. Respondent watched two infants die of the measles during this time, and he never forgot that experience. As a result of that outbreak the recommended schedule to administer the first MMR vaccine was moved from 15 months to 12 months, and in India it is given at nine months. Also, a booster of MMR vaccine was recommended at 10 to 12 years of age. Later, that booster recommendation was changed to be given at five years of age to correspond to kindergarten.

Respondent further explained that parents will frequently know the difference between a live virus vaccine (such as MMR) and a non-live virus vaccine. A live virus vaccine uses a live virus that has been attenuated to prevent it from being as infectious as the wild type of live virus. The live virus vaccines used today are MMR, varicella (chicken pox), and rotavirus. A non-live virus vaccine tends to elicit a reaction relatively quickly, whereas a live virus vaccine tends to get its reaction later. Respondent explained that giving the live virus vaccine of MMR can have the reaction of eliciting a mild measles-like illness, such as fever and rash. However, that is nothing like the real measles, and many of his own colleagues have never seen a real measles infection. One of respondent's sons had a significant reaction to the MMR vaccine at the age of one and seven days after the vaccine developed a fever and measles rash that reminded respondent of those children in 1989 and 1990 who died from measles but was significantly more attenuated. It lasted 36 hours and went away. Respondent often uses his son as an example of the worst MMR reaction he has ever seen when he explains the vaccine to his patients. The longest MMR reaction he has ever seen lasted ten days. These examples he provides during his discussion with them "scare the crap" out of parents but provides them with a better understanding of the risks of not vaccinating.

69. In a typical year respondent sees about 3,000 pediatric patients. In 2021 he wrote about 12 or 13 medical exemptions for vaccinations for his patients. Prior to 2021 and CAIR-ME medical exemptions for vaccinations were not "tracked." Prior to 2016, parents could simply provide a personal belief waiver to vaccination. After 2016, parents would ask the physician for a waiver letter, which respondent stated he was not in the habit of giving. In situations where a child needed to "catch-up" on vaccines because they were behind, he would provide a letter to the school stating that they are

actively on a catch-up schedule and will be caught up by a named date. Some vaccines require at least six months to provide.

Respondent stated that with regard to general waiver from vaccine letters, many of his anti-vaccination parents would "buy" a letter from some doctor who would simply fill out the exemption letter for a fee, but that was not done by his practice. After the CAIR-ME site was in use after 2021, respondent "suddenly had about a dozen families, some with multiple children, caught in a difficult situation," namely that they wanted their children in school and had previously "bought" an exemption from a physician that is no longer valid, and they came to respondent seeing a medical exemption. Respondent told those patients that if they would agree to start a vaccine schedule to catch-up their children on the vaccinations, then he would write a medical exemption to vaccination for one year to allow that catch-up to happen. Respondent admitted that patients C and D "were outliers" and he admitted that "maybe" those fell outside of the standard of care with regard to the issuance of an exemption to vaccination. However, later in his testimony respondent stated that he believed he met the standard of care for the issuance of the exemptions for patients C and D.

70. Otherwise, he believes that all of the exemptions he provided were within the standard of care. For patients A and B, respondent believes his issuance of an exemption for those two patients was within the standard of care because he did discuss with the parents the need to "catch-up" the patients on vaccinations when patient B had a second seizure. Respondent stated that it is possible that patients A and B had febrile seizures related to the fever they got as a result of being vaccinated. However, that alone is not a contraindication to the vaccines, which is why he was working hard to get those children vaccinated. He stated that he believes it was within the standard of care to get those vaccines done "over a period of time." Respondent

testified that in 2021 he did have an understanding that CDPH could revoke a medical exemption for vaccine that he issued, and that if a physician had five or more revocations of exemptions that the physician would be reported to the board. However, he had no idea of the criteria that CDPH would use to revoke a medical exemption. He did not believe that the exemptions he provided "would be an issue, except for patients C and D." Respondent stated that there are legitimate reasons to delay vaccinations, including if the child is actively ill, has a fever, or is hospitalized. However, he admitted that it would "not be proper" for a parent to delay vaccination for several years.

71. With regard to when a medical exemption to vaccination is appropriate, respondent testified that he follows the CDC guidelines for all children, which is what he recommends. However, sometimes you "run up against situations where you need to catch-up" the patients in their vaccines and it is difficult to meet the administrative deadlines (like enrolling in school) right away, so you give some time and usually the "catch-up" can almost always get done within a year. This is why the exemptions he provided were temporary for one year. Respondent stated that 2021 was an unusual year because of the number of people who had prior medical exemptions to vaccination that were no longer valid and had to "catch-up" on vaccines. Additionally, the COVID-19 pandemic prevented some patients from coming into the office for vaccinations. Respondent stated that while he follows the CDC, ACIP, and AAP guidelines for vaccinations, he did not believe that he was required to rigidly follow those guidelines to meet the standard of care.

72. Respondent stated that with regard to patients A and B, patient A went without vaccinations from age 15 months and respondent intended to vaccinate him at the age of five or six years. During that time the parents of patient A had the ability

to have a personal belief waiver to vaccinations. Also, when patient A turned five or six years old, patient B then had his second seizure, which set the parents back again on their willingness to vaccinate either child. The parents of patients A and B "were very resistant to vaccination," and respondent "was working with them." According to respondent, both patients A and B were scheduled to be fully immunized during the 2021-2022 school year and he issued the exemption to make that happen. Respondent stated that a febrile seizure is a "relative contraindication" to further vaccination, but that for both patients he believed that the vaccines could be safely administered and that the benefits of vaccination outweighed the risks. On cross-examination, respondent admitted that neither patient A nor patient B had any contraindication to vaccination. Respondent believed that it was in his clinical judgment to issue the exemptions for patients A and B in order to consider the parent's concerns regarding vaccination and the heightened concerns of an adverse reaction of a febrile seizure.

73. Regarding patients C and D, respondent stated that he did not have a good understanding of the rare disease of Gaucher disease or how the fact that patients C and D were carriers of that disease would impact their response to vaccines. Respondent requested that patients C's and D's father provide him with information from specialists on this issue. When respondent received the letters from Dr. Rosenbloom, which stated that patients C and D could not get live virus vaccines, respondent recommended starting with the non-live vaccines "while I figure out if I agree with this or not." Respondent stated that "at this point" he recommended that the father take patients C and D to a pediatric immunologist to evaluate if patient C and D have any contraindications to vaccination. According to respondent, "that did not go anywhere for a while." Respondent then received the letter from Dr. First recommending that patient C and D not get any vaccine. Respondent stated, "I did not think that was right, but I did not know." Notably, respondent admitted that he made

no effort to contact Dr. First or Dr. Rosenbloom by telephone to discuss the letters. Respondent testified that the basis for his issuance of the medical exemptions for patients C and D was to "put down what Dr. First wrote," even though he was not certain of whether that was correct. Respondent admitted that on July 26, 2021, when he issued the medical exemption to vaccination for both patients C and D, that he did not believe there were any contraindications to vaccinations for either child, and that the benefit of vaccination outweighed any risks. Respondent testified that he told the father that he would issue the medical exemption through CAIR-ME only if the father would take the children to a pediatric immunologist for evaluation. Respondent admitted that even though he submitted the exemption to CAIR-ME for patients C and D, he felt that the exemption "would be denied" because respondent believed that patients C and D did not have a contraindication to vaccination "but he did not know." He made the exemptions permanent for both patients C and D because it was based on a genetic condition that would not change.

74. Respondent testified that he did not believe that medical contraindications are the only reason to issue a medical exemption to vaccination. Specifically, he stated that "there are situations of timing" and that children need to go to school. He believes that a physician should be able to use his clinical judgment, which includes taking into account the parents' concerns about vaccination.

TESTIMONY OF CHARACTER WITNESSES

75. Respondent provided testimony from three witnesses related to respondent's character in this matter. The following factual findings are made based on their testimony.

76. The first character witness was Louis Maletz, M.D. Dr. Maletz is a family practice physician licensed to practice medicine in California. He works in a multi-specialty group practice in Poway, which is also the same private practice group where respondent works. Dr. Maletz is a primary care provider for both adults and for some pediatric patients. Dr. Maletz is the Chief Medical Officer for Palomar Health Population and has known respondent since 1993 when Dr. Maletz was the Medical Director of University of California San Diego (UCSD) hospital and respondent joined a practice near Alvarado Hospital where Dr. Maletz worked with him. Dr. Maletz has known respondent for 30 years. Dr. Maletz testified that respondent was the president of their group from 2003 to about 2017 and improved the group substantially. Dr. Maletz stated that respondent has the best clinical practice and is devoted to his patients. Dr. Maletz testified that respondent would always help him with his patients when he asked and that he "stayed late and came early." He described their group as very busy with three to four pediatricians. Dr. Maletz stated that respondent put together practice guidelines for vaccinations, particularly the HPV vaccine, because he was the "most experienced and understood what we were trying to do." Respondent is not anti-vaccination and has never "handed out" vaccine exemptions. He described respondent as excellent and a leader in the area of vaccination.

Dr. Maletz wrote a letter received in evidence where he praised respondent's medical knowledge, clinical skills, ethics and professionalism.

77. The second character witness was Colette Louise Grant, M.D. Dr. Grant is a pediatrician licensed in California. She has practiced as a pediatrician for 33 years. She met respondent when they were in their pediatrics residency together at UC Irvine. Dr. Colette testified that over the past few years she has had discussions with respondent regarding immunizations, and respondent tries to immunize all of his

patients and follow the CDC guidelines to the best of his abilities. Dr. Grant stated that she knows respondent addresses the concerns of the parents and patients in his practice and that he listens to parents. She is not aware of any situation where respondent acted improperly regarding medical exemptions for immunization. However, Dr. Grant admitted that she has not practiced with respondent since their residency and has not observed his practice since that time.

78. The third character witness was Rene H. Bravo, M.D. Dr. Bravo is a primary care pediatrician in San Luis Obispo, California and licensed to practice medicine in California. He has practiced as a pediatrician for almost 40 years. Dr. Bravo first met respondent about 40 years ago and is related to respondent by marriage. Respondent is Dr. Bravo's brother-in-law. Dr. Bravo often discusses pediatric practice with respondent and sometimes asks his advice regarding pediatrics. They also refer patients to each other. Dr. Bravo and respondent speak frequently at family events and on phone calls. Dr. Bravo has discussed with respondent how respondent deals with parents who are vaccine-hesitant because the issue is extremely challenging for pediatricians and has increased over the last five or ten years. Dr. Bravo stated that it is a "real art to try to guide people away from misinformation." Some pediatricians will "kick people out" of their practice if they refuse to vaccinate and tell them that they need to find a new doctor. Respondent tries really hard not to do that, and his approach is to talk to the parents to try to understand why they have a fear of vaccines.

Dr. Bravo has discussed the new requirements for medical exemptions for vaccination with respondent. He stated that before 2016 parents could simply use a personal belief exemption, but when that was taken away in 2016 then parents sought letters from physicians giving exemptions vaccinations, which led to a market of some

physicians "selling" the exemptions. That "sale" of exemptions led to the new law creating the CAIR-ME website and CDPH review. Dr. Bravo stated that this "led to another slew of issues" and he is concerned about "entrapment of doctors." Dr. Bravo stated that respondent told him that he felt entrapped by the CAIR-ME website and the accusation in this matter because he finds himself involved with discipline for trying to help his patients deal with vaccinations. Dr. Bravo believes that the CAIR-ME website causes distress for pediatricians.

Dr. Bravo believes respondent is a vaccine supporter and promotes safe vaccinations. Dr. Bravo believes that respondent exercises reasonable judgment when issuing vaccine exemptions. Dr. Bravo wrote a letter of support for respondent mirroring his testimony that was received in evidence.

Cost of Investigation and Enforcement

79. Complainant seeks recovery of enforcement costs of $41,380 pursuant to Business and Professions Code section 125.3. In support of the request, the Deputy Attorney General who prosecuted the case signed a declaration requesting costs for legal work of 189.25 hours billed through October 13, 2023, totaling $41,380. Attached to the declaration was a document entitled "Costs of Suit Summary." This document identified the tasks performed, the dates legal services were provided, who provided the services, the time spent on each task, and the hourly rate of the individuals who performed the work.

80. Complainant submitted two declarations of investigative costs in this matter, one was signed by Rashya Henderson, supervising special investigator for the board, certifying that she is the board's designee for certifying costs of investigation,

and certifying that Jillian Medeiros[7] was the special investigator assigned to this matter. Ms. Henderson also provided an attachment to her certification that gives a general description of the tasks performed by the special investigator in this matter, the time spent on each of the tasks. The certification provided that the hourly rate charged for the work of Jillian Alexander was $104 per hour and she spent 5.5 hours on this investigation, totaling $572.

The second declaration was signed by Charles Shartle, an Associate Government Program Analyst for the board, certifying that he is the designated representative for the board to certify costs incurred. Mr. Shartle's certification provided that he has reviewed the pertinent records regarding expert costs in this matter and he certified that Dr. Hansra incurred 15 hours of work at a rate of $150 per hour for review and evaluation of case-related records, report writing, and hearing preparation in this matter totaling $2,250.

The two certifications of investigative costs submitted in this matter established that the board billed $2,822 for 20.5 hours expended on this case for investigation.

81. California Code of Regulations, title 1, section 1042, subdivision (b), requires that any declaration seeking costs include "specific and sufficient facts to support findings regarding actual costs incurred and the reasonableness of the costs." The certifications of enforcement and investigation satisfied the requirements of California Code of Regulations, title 1, section 1042, subdivision (b), and the certification regarding enforcement costs supports a finding that costs in the amount

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[7] It is noted that the special investigator in this matter now goes by the name of Jillian Alexander but presumably was previously known as Jillian Medeiros.

of $41,380 are reasonable in both the nature and extent of the work performed. The certification regarding investigation costs supports a finding that costs in the amount of $2,822 are reasonable in both the nature and extent of the work performed. Accordingly, the reasonable cost of enforcement and investigation of this matter is $44,202.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. Complainant bears the burden of proof of establishing that the charges in the accusation are true. (Evid. Code, § 115; 500.) The standard of proof required is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The obligation to establish charges by clear and convincing evidence is a heavy burden. It requires a finding of high probability; it is evidence so clear as to leave no substantial doubt, or sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

Applicable Statutes

2. The primary purpose of disciplinary action is to protect the public. (Bus. & Prof. Code, § 2229, subd. (a).) The Medical Practice Act emphasizes that the board should "seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies." (Bus. & Prof. Code, § 2229, subd. (c).) However, "[w]here

rehabilitation and protection are inconsistent, protection shall be paramount." (Bus. & Prof. Code, § 2229, subd. (c).)

3. Business and Professions Code section 2227 provides that a licensee who is found to have violated the Medical Practices Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay costs of probation monitoring, be publicly reprimanded, or such other action taken in relation to the discipline as the board deems proper.

4. Business and Professions Code section 2234, provides in part:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> [¶] . . . [¶]
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

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

5. It is also unprofessional conduct for a physician and surgeon to fail to maintain adequate and accurate records relating to the provision of services to his or her patients. (Bus. & Prof. Code, § 2266.)

The Standard of Care, Gross Negligence, Simple Negligence

6. Medical providers must exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances. (*Powell v. Kleinman* (2007) 151 Cal.App.4th 112, 122.) Because the standard of care is a matter peculiarly within the knowledge of experts, expert testimony is required to prove or disprove that a medical practitioner acted within the standard of care unless negligence is obvious to a layperson. (*Johnson v. Superior Court* (2006) 143 Cal.App.4th 297, 305.)

7. "Gross negligence" long has been defined in California as either a "want of even scant care" or "an extreme departure from the ordinary standard of conduct." (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 195-198; *City of Santa Barbara v. Superior Court* (2007) 41 Cal.4th 747, 753-754.)

8. Ordinary or simple negligence has been defined as a departure from the standard of care. It is a "remissness in discharging known duties." (*Keen v. Prisinzano*

(1972) 23 Cal.App.3d 275, 279; *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1055-1056.)

9. Repeated negligent acts mean one or more negligent acts; it does not require a "pattern" of negligent acts or similar negligent acts to be considered repeated. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468.)

10. A physician's failure to complete or maintain patient records can constitute gross or simple negligence, depending on the circumstances. (*Kearl v. Board of Medical Quality Assurance, supra, at pp.* 1054.)

Disciplinary Guidelines

11. California Code of Regulations, title 16, section 1361, provides that when reaching a decision on a disciplinary action, the board must consider and apply the "Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th Edition/2016)." Under the Guidelines, the board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the board and proposed settlements submitted to the board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

12. Under the Disciplinary Guidelines, the minimum discipline for gross negligence, repeated negligence, and failure to maintain adequate medical records is a stayed revocation for five years. The maximum discipline is revocation. Among the conditions of probation, the guidelines recommend an education course, medical

record keeping course, professionalism program (ethics course), clinical competence assessment program, a practice monitor, and solo practice prohibition.

Evaluation

13. Complainant alleged that respondent committed gross negligence for the issuance of the four vaccine exemptions for patients A, B, C, and D. Complainant also alleged that respondent committed repeated negligent acts for issuing those exemptions and for failing to properly document discussions of vaccinations and parental vaccine refusal. Complainant provided the expert testimony of Dr. Hansra to establish those allegations. In determining the weight of each expert's testimony, the expert's qualifications, credibility, and bases for the opinions were considered. California courts repeatedly underscore that an expert's opinion is only as good as the facts and reason upon which that opinion is based: "Like a house built on sand, the expert's opinion is no better than the facts on which it is based." (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923.) Dr. Hansra is qualified in her field of pediatrics, testified credibly and in a forthright manner with sound reasoning underlying her opinions, and had extensive knowledge of the standard of care applicable based on years of experience. While respondent does have many years of experience and training in his field, given that respondent has an obvious bias to protect his license, respondent's opinions are found less reliable than those of Dr. Hansra. Notably, Dr. Hansra testified, and common-sense dictates, that a medical exemption for vaccination should only be provided by a physician for a legitimate medical condition that qualifies for the exemption with reference to the CDC, ACIP, and AAP guidelines, which are well-regarded sources known to pediatricians as well as lay people. Respondent admitted repeatedly during his testimony that he knew that patients A, B, C and D did not legitimately qualify for a medical exemption from

vaccination based on those guidelines and his own medical opinions. However, he issued the exemptions for vaccination for each of those four patients anyway. Essentially, respondent admitted that he used the exemptions as a bargaining tool to convince the parents to later catch-up on their vaccinations. Use of medical exemptions in this manner is completely inappropriate and, as established by Dr. Hansra's testimony, an extreme departure from the standard of care.

With regard to patients C and D, respondent simply took the letter of Dr. First and used it to create the medical exemption submitted, even though he testified that he did not believe that patients C and D had a legitimate contraindication to vaccination. However, respondent made no effort to even contact Dr. First or Dr. Rosenbloom by phone to discuss those letters. This was particularly disturbing considering that respondent testified that he knew parents would purchase exemption letters from less than scrupulous physicians willing to sell them. Respondent claimed he wanted the children to be evaluated by a pediatric immunologist, which was reasonable. However, he issued the medical exemptions to vaccination before he obtained that immunology consult. Respondent admitted that he believed that each of the four patients at issue could safely receive their vaccinations and that the risks of vaccination for each was outweighed by the benefit of vaccination. Even so, he still issued those exemptions as a mechanism to appease the parents in order to convince them to later vaccinate their children. While his motivation may have been well-intended, his actions in issuing those medical exemptions was an extreme departure from the standard of care constituting both gross negligence and repeated negligent acts.

14. With regard to the allegations that respondent failed to properly document his discussions regarding vaccination and the parental refusal of

vaccination, respondent admitted that he did not believe that documentation of the specifics of his discussion of vaccination with parents is necessary and that the reason for a parent's refusal of vaccination did not need to be documented in the medical records because it was irrelevant. However, Dr. Hansra credibly testified that the standard of care of a reasonable physician requires this documentation and to do so at every well-check visit. Dr. Hansra's opinion regarding the documentation of vaccine discussion and parent refusal of vaccines was simply more persuasive and soundly reasoned that the testimony of respondent. For patients A, B, and D respondent simply failed to document the substance of his discussions with the parents regarding vaccinations and failed to document any information regarding the parent's vaccine hesitancy or refusal. He did so over the course of many years. While there was some evidence in the record regarding discussions with Dr. Goldfinger, the medical records were simply devoid of any substantive information regarding the discussions respondent had with those parents. Dr. Hansra's testimony established that with regard to patients A, B, and D, respondent's failure to document constituted an extreme departure from the standard of care. With regard to patient C, respondent had only "vaccines discussed" in the medical record, which as established by Dr. Hansra's testimony, was insufficient documentation but at least set forth that there was a discussion and was therefore a simple departure from the standard of care.

Cause Exists to Discipline Respondent's License

15. Cause exists under Business and Professions Code section 2234, subdivision (b), to impose discipline. Complainant established by clear and convincing evidence that respondent engaged in gross negligence with respect to his care and treatment of Patients A, B, C, and D by issuing medical exemptions from vaccination for each of those four patients without a proper contraindication or precaution for the

immunizations listed in each of the four medical exemptions. Respondent further committed gross negligence for failing to adequately document discussions with the parents of Patient A, B, and D regrading recommended routine immunizations and any reasons for refusal or concern by those parents or whether those patients met the criteria for medical exemption to vaccination.

16. Cause exists under Business and Professions Code section 2234, subdivision (c), to impose discipline. Complainant established by clear and convincing evidence that respondent engaged in repeated acts of negligence with respect to his issuance of medical exemptions for vaccination for Patients A, B, C, and D, as noted above, and failed to maintain adequate and accurate records for patients A, B, C, and D as noted above.

17. Cause exists under Business and Professions Code section 2266 to impose discipline. Complainant established by clear and convincing evidence that respondent maintained inadequate or inaccurate medical records with respect to Patients A, B, C, and D by failing to adequately document discussions with the parents of Patient A, B, and D regrading recommended routine immunizations and any reasons for refusal or concern by those parents or whether those patients met the criteria for medical exemption to vaccination.

Application of Disciplinary Guidelines

18. Because cause for discipline exists, a determination of the degree of discipline necessary must be made with application of the Disciplinary Guidelines. Respondent has long history of providing pediatric medical care for over 30 years. Respondent provided testimony of two of the parents of his patients at issue in the matter, as well as three medical doctors and character witnesses, all of whom praised

respondent's care, treatment, knowledge, and character as a physician. The evidence established that respondent is a professional, skilled pediatrician, who cares deeply for his patients. He has had no prior license discipline over the 30 years of his practice and has successfully treated over 100,000 patients in his career. Respondent admitted during his testimony that with regard to patients C and D, that his issuance of the exemptions may have been outside of the standard of care. Given that the new laws establishing the CAIR-ME website created new requirements regarding vaccine exemptions he was not familiar with, it is understandable that some issues may arise during its initial implementation resulting from a learning curve for practitioners. Respondent is well versed and knowledgeable regarding vaccine requirements, but he is less knowledgeable of the requirements of CAIR-ME and its implementation. Taking all these factors into consideration and under these circumstances, public protection will be provided by placing respondent's license on probation for a period of three years with appropriate terms and conditions.

Cost of Investigation and Enforcement

19. Under Business and Professions Code section 125.3, complainant may request that an administrative law judge "direct a licentiate 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." "A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case." (Bus. & Prof. Code, § 125.3, subd. (c).) The reasonable costs in this matter were $44,202.

20. The Office of Administrative Hearings has enacted a regulation for use when evaluating an agency's request for costs under Business and Professions Code

section 125.3. (Cal. Code Regs., tit. 1, § 1042.) Under the regulation, a cost request must be accompanied by a declaration or certification of costs. For services provided by persons who are not agency employees, the declaration must be executed by the person providing the service and describe the general tasks performed, the time spent on each task, and the hourly rate. In lieu of the declaration, the agency may attach copies of the time and billing records submitted by the service provider. (Cal. Code Regs., tit. 1, § 1042, subd. (b)(2).)

21. Another consideration in determining costs is *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32. In *Zuckerman*, the California Supreme Court decided, in part, that in order to determine whether the reasonable costs of investigation and enforcement should be awarded or reduced, the Administrative Law Judge must decide: (a) whether the licensee has been successful at hearing in getting charges dismissed or reduced; (b) the licensee's subjective good faith belief in the merits of his or her position; (c) whether the licensee has raised a colorable challenge to the proposed discipline; (d) the financial ability of the licensee to pay; and (e) whether the scope of the investigation was appropriate to the alleged misconduct.

22. Considering the *Zuckerman* factors, the scope of the investigation was appropriate to the allegations and the deputy attorney general who tried the matter was very well prepared. Respondent was successful in getting the charges reduced but not dismissed; respondent did appear to assert a good faith belief in the merits of his position; respondent did raise a colorable challenge to the proposed discipline; and respondent failed to present any evidence that he is financially unable to pay costs. After consideration of those factors, a reduction in the reasonable costs of $44,202 are appropriate. Respondent shall pay $22,101 to the board and may do so under a payment plan approved by the board.

ORDER

Certificate number G 70035 issued to respondent Stuart Nathan Graham, M.D. is revoked. However, revocation is stayed, and respondent is placed on probation for three years upon the following terms and conditions.

1. 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.

2. Supervision of Physician Assistants and Advanced Practice Nurses - During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

3. 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.

4. 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.

5. 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.

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.

6. 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.

7. 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.

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 Board's 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.

8. 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. Upon successful completion of probation, respondent's certificate shall be fully restored.

9. 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.

10. 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 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.

11. 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.

12. Costs Recovery – Respondent shall pay to the board costs associated with its enforcement pursuant to Business and Professions Code section 125.3 in the amount of $22,101. Respondent shall be permitted to pay these costs in a payment plan approved by the board, with payments to be completed no later than three months prior to the end of the probation term.

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

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

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

DATE: November 28, 2023

Debra D. Nye-Perkins

DEBRA D. NYE-PERKINS
Administrative Law Judge
Office of Administrative Hearings