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

In the Matter of the Accusation Against: JORDAN ISAAC ZIEGLER, M.D. Physician's and Surgeon's Certificate No. A 91470 Respondent.	Case No.: 800-2019-063212

DECISION

The attached 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 21, 2024.

IT IS SO ORDERED: January 22, 2024.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Accusation Against:

JORDAN ISAAC ZIEGLER, M.D., Respondent

Agency Case No. 800-2019-063212

OAH No. 2023020805

PROPOSED DECISION

Danette C. Brown, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter by video conference on October 16 to 20, and November 6 to 9, 2023, from Sacramento, California.

John S. Gatschet, Deputy Attorney General, represented complainant Reji Varghese, Executive Director, Medical Board of California (Board), Department of Consumer Affairs (DCA).

Nicholas D. Jurkowitz, Attorney at Law, Fenton Law Group, LLP, and Laura E. Ozak, Attorney at Law, represented Jordan Isaac Ziegler, M.D. (respondent), who was present at the hearing.

Evidence was received, the record closed, and the matter submitted on November 9, 2023.

FACTUAL FINDINGS

Jurisdictional Matters

1. On May 27, 2005, the Board issued to respondent Physician's and Surgeon's Certificate No. A 91470 (certificate). The certificate will expire on May 31, 2025, unless renewed or revoked.

2. On December 16, 2022, a former Board Executive Director filed an Accusation in his official capacity against respondent, alleging four causes for discipline constituting unprofessional conduct: (1) gross negligence; (2) repeated negligent acts; (3) dishonesty; and (4) general unprofessional conduct.

3. Specifically, complainant alleged respondent committed gross negligence by accessing 214 patient medical records from December 21 to December 31, 2019; improperly obtained in January 2020 the medical records of at least 12 patients from University of California, Davis Medical Center (UCD Med Center) radiology staff without disclosing that he was no longer on the medical staff and had relinquished his privileges; and provided unredacted UCD Med Center medical records of five patients to Mercy San Juan Hospital (MSJH), from February 4 and 24, 2020, without legal authority.

Complainant also realleged the acts of gross negligence as distinct and simple departures from the standard of care constituting repeated negligent acts. In addition, complainant alleged respondent committed repeated negligent acts when, on January 10, 2018, he performed a wrong site procedure on a confidential patient (Patient 1), resulting in a delay of care.

Complainant alleged respondent engaged in dishonesty or corruption by obtaining and disseminating patient medical records without legal authority. Lastly, complainant alleged general unprofessional conduct based on the factual allegations as a whole.

4. Respondent timely filed a Notice of Defense to the charges. The matter was set for an evidentiary hearing before an ALJ of the OAH, pursuant to Government Code section 11500 et seq. This hearing followed.

5. At hearing, complainant moved to amend the Accusation on page 9, lines 19 and 20, to read as follows: "On or about January 10, 2018, respondent performed a series of wrong side angiograms on Patient 1 that resulted in a delay of care." Respondent opposed, the objection was overruled, and the Accusation was amended.

Complainant's Evidence

JANUARY 10, 2018 WRONG SIDE ANGIOGRAMS ON PATIENT 1

6. On January 10, 2018, at 6:56 a.m., Patient 1, a 53-year-old male, was transported to the UCD Med Center Emergency Department (ED). Respondent and a nurse practitioner (NP) went to the ED to briefly evaluate Patient 1, whose admission diagnosis was "[c]erebral infarction due to embolism of left middle cerebral artery [(MCA)]." Patient 1 presented with symptoms of a stroke including aphasia (the inability to speak or understand others) and hemiplegia (one-sided paralysis) on the right side. Patient 1 was also noted to engage in methamphetamine and cocaine abuse, long term opiate use, and had a history of previous strokes.

7. Respondent noted Patient 1's preoperative diagnosis as "Left MCA thrombosis." Respondent further noted Patient 1 had an "altered mental status and

agitation and could not be consented," and that an "immediate family member was also described as somewhat altered and unable to provide circuit consent." A two-physician emergency consent "was obtained for patient's threatened left MCA circulation on an emergent basis with emergency note written by the neurology service." The consent was for a "full cerebral angiography and MCA thrombectomy." Patient 1 was brought to the "Room 27 biplane angiography suite on an emergent fashion."

8. Patient 1 had an "MCA Occlusion Left," meaning that a blood clot was located on the left side of the brain in the MCA. The MCA consists of four branches of blood vessels, M1, M2, M3, and M4, with the M1 branch being the larger branch, and the M4 the smallest. The blood clot was in the MCA M1 branch.

9. Intravenous tissue plasminogen activator (TPA) is medication given to break up a blood clot. Respondent noted Patient 1's clinical history of "MCA OCCCLUSION [*sic*] LEFT" and that Patient 1, a "meth user with acute stroke," was given intravenous TPA which improved, but did not resolve Patient 1's condition. He noted the patient had aphasia with "right hemiparesis," or one-sided muscle weakness. Respondent further noted:

> Patient was agitated and moving all extremities but CTA [computed tomography angiography] revealed left M1 MCA occlusion with threatened collaterals and a waxing and waning exam[.] No perfusion data obtained in an effort to reduce door-to-needle time. Plan full cerebral angiogram and MCA thrombectomy.

10. Respondent initially requested general anesthesia due to Patient 1's agitation and methamphetamine exposure. Respondent noted he decided to proceed with conscious sedation "to avoid procedural delay, as anesthesia was not immediately available." Both of Patient 1's "groins were sterilely prepped and draped and ultrasound guidance used to access the right common femoral artery with micropuncture access needle." The needle was replaced with a sheath "connected to pressurized heparinzed saline to flush" the sheath to prevent blood clotting. A "right common femoral arteriogram" was then performed. An arteriogram, also known as an angiogram, provides an image inside the arteries using x-rays and contrast dye.

ANGIOGRAM RUNS

11. Respondent accessed the right carotid femoral artery (RCFA) inserting a sheath catheter at 8:31 a.m. A front image was taken (Run 1). At 8:35 a.m., he inserted a glide catheter in the right common carotid artery (RCCA) and front and lateral images were taken (Run 2). At 8:40 a.m., the glide catheter was in the right internal carotid artery (RICA) and front and lateral images were taken (Run 3). At 8:42 a.m., the glide catheter was in the RICA and additional front and lateral images were taken (Run 4). At 8:52 a.m., the glide catheter was in the right vertebral artery (RVERT) and front and lateral images were taken (Run 5).

12. At 8:56 a.m., the glide catheter was in the left common carotid artery (LCCA) and front and lateral images were taken (Run 6). At 8:59 a.m., the glide catheter was in the left internal carotid artery (LICA) and front and lateral images were taken (Run 7). At 9:00 a.m., the glide catheter was in the LICA and front and lateral images were taken (Run 8).

13. Twenty minutes later, at 9:20 a.m., the glide catheter was in the LICA and front and lateral images were taken (Run 9). At 9:30 a.m., the glide catheter was in the LICA and front and lateral images were taken (Run 10). Lastly, at 9:32 a.m., the glide catheter was in the LICA and front and lateral images were taken (Run 11).

14. Respondent noted that the RICA was "selectively catheterized and biplane cerebral angiogram was done in multiple planes and projections." Respondent did not find a blood clot occlusion on Patient 1's right side. During Run 6, respondent noted that he exchanged the "angled glide" catheter for a "JB 1" catheter and "readvanced across the [subclavian] arch to select the [LCCA]." He performed a cervical LCCA angiogram. He advanced the catheter into the LICA and performed an angiogram "in multiple planes and directions." Accessing the blood clot in the left M1 MCA, respondent performed a "mechanical aspiration thrombectomy" to "retrieve the clot in near entirety." (A thrombectomy is a mechanical interventional procedure used to remove a blood clot using image guidance with endovascular devices such as a catheter. Endovascular devices are used for minimally invasive procedures done inside blood vessels.) Respondent removed all catheters and wires without complication and completed the thrombectomy procedure. On January 12, 2018, Patient 1 was discharged from the hospital.

NOTED COMPLICATIONS

15. Respondent added a section titled "COMPLICATIONS" in his notes. He wrote in pertinent part:

> There was a minor procedural delay as the initial full diagnostic cerebral angiogram was done including right carotid catheterization prior to definitive left MCA

mechanical thrombectomy. A full diagnostic cerebral angiogram is a routine/standard part of all stroke intervention but typically performed after the thrombectomy to avoid any delay in reperfusion. I reviewed the initial imaging and identified a left MCA thrombus but when I evaluated the patient in the hallway his speech and motor function had returned to some degree and he was non-lateralizing and highly agitated. I then mistakenly concluded that the patient had a right-sided, not left-sided thrombus based on the non-lateralizing exam and having just concurrently triaged and reviewed a patient with right sided ruptured aneurysm. Once the right side was declared patent, I continued the exam, identified the left MCA thrombus, and performed successful recanalization in 29 minutes (FT), which is still very expedient (exceeds guidelines) and well within community standards and he had an excellent outcome with no permanent complications.

805 Reports Filed by UCD Med Center

16. On December 16, 2019, UCD Med Center reported to the Board, pursuant to Business and Professions Code section 805.01, that it imposed a summary suspension of respondent's staff privileges on November 22, 2019, following peer review that identified deficiencies in respondent's patient care.

17. On January 3, 2020, UCD Med Center filed a supplemental 805 report informing the Board that respondent resigned from UCD Med Center medical staff on

December 2019, "following notification of a pending investigation initiated for a medical disciplinary cause or reason." The supplemental 805 report also informed the Board that the November 22, 2019 summary suspension of respondent's membership and privileges was lifted on December 16, 2019.

JULY 14, 2021, BOARD INTERVIEW OF RESPONDENT

18. On July 14, 2021, the Board interviewed respondent regarding his care and treatment of Patient 1. The Board's medical consultant, Howard Slyter, M.D., asked respondent if he understood the occlusion was on the left side. Respondent stated he discovered his error after starting his angiography and "announced to the room in a quite animated fashion, that, 'oh crap, I'm on the wrong side.'" Respondent "did consult with another one of [his] colleagues who was standing outside the room with crossed arms."

19. Respondent confirmed that he realized he was on the wrong side and corrected his error. He explained that there was a lot going on at the time such as the procedure being his first case at UCD Med Center, having to mix his own heparin bags because his protocol for 5,000 units "was somewhat different than they do for thrombectomies at Davis," getting called away several times to document his heparin preparation because the "nurses were not comfortable placing a heparin order in the EPIC chart," and respondent being "out of [his] element" in a new environment.

20. Respondent believed it was "absolutely appropriate" to perform angiograms on both sides due to the vasoactive effects of methamphetamine. Respondent asserted a full angiogram should always be performed on a methamphetamine patient, "particularly with collaterals" as they could have multiple clots. Collaterals are blood vessels that take over blood flow when an artery is blocked.

Respondent asserted he would have "done an angiogram on that right side regardless." Respondent admitted that he "stated to the room" that he meant to start on the left side but started on the right, and "admitted [his] error." Respondent asserted Patient 1 "had no deficit whatsoever."

TESTIMONY OF COMPLAINANT'S EXPERT, NICHOLAS A. TELISCHAK, M.D.

21. Dr. Telischak is board certified in Radiology and holds a subspecialty certification in Neuroradiology. Dr. Telischak received his medical degree from Dartmouth Medical School in 2008. He completed a one-year internship in 2009 at Hitchcock Medical Center's Department of Internal Medicine in West Lebanon, New Hampshire.

He completed a one-year Radiology residency in 2010 at Stanford University Medical Center. He completed a three-year Radiology residency in 2013 at Beth Israel Deaconess Medical Center in Boston, Massachusetts. He was a Clinical Fellow from 2010 to 2013, at Harvard Medical School's Department of Radiology. He completed fellowships in Neuroradiology in 2014, and Interventional Neuroradiology in 2016, at Stanford University Medical Center.

Dr. Telischak has, since June 1, 2019, held an academic appointment as Clinical Assistant Professor of Radiology, and by courtesy, Neurosurgery, at Stanford University School of Medicine. He supervises Neurointerventional Fellows, Diagnostic Neuroradiology Fellows, and Neurosurgical Interns, and is a Neurointerventional Clinic Preceptor.

22. The Board retained Dr. Telischak to review respondent's care and treatment of Patient 1. Dr. Telischak reviewed Patient 1's medical records, the transcript and recordings of respondent's July 14, 2021, Board interview, an

investigation report, the 805 and supplemental 805 Reports, and Patient 1's brain, head, and neck imaging. Dr. Telischak prepared a report of his opinions and testified consistently with his report.

23. Dr. Telischak addressed the issue of whether respondent's performance of a complete angiogram prior to proceeding with a mechanical thrombectomy on the left side, resulting in a 21-minute intra-procedural delay, was below the standard of care. Dr. Telischak opined that the standard of care is:

> To address the vessel occlusion first during the thrombectomy procedure in most cases. An exception may be a case where an assessment of collaterals is desired in order to make a decision regarding risk-benefit of thrombectomy. Some practitioners do complete a four-vessel angiogram following the mechanical thrombectomy but this practice is variable and is not the standard of care.

24. Dr. Telischak explained that an angiogram serves as a road map to a blood clot, and collaterals are a way for blood flow to get around the blockage to provide blood flow to an area of the brain at risk. The term "Time is brain" means the more quickly the blood vessel can be reopened, the better the patient's outcome.

25. Dr. Telischak opined that respondent mistakenly performed RICA and RVERT angiograms prior to addressing the known left MCA occlusion, adding 21 minutes to the procedure time. Despite this, "[emergency department] door to reperfusion time was still 120 minutes which is within one standard deviation of the mean for such procedures."

26. Dr. Telischak explained that a simple departure from the standard of care is the failure to use that skill and care physicians would use in same or similar circumstances. An extreme departure from the standard of care is want of even scant care. Dr. Telischak determined that respondent's decision-making was appropriate at each step. Respondent made a "sidedness error, realized his error, and corrected." Dr. Telischak concluded that respondent engaged in a simple departure from the standard of care when he "performed angiograms in other circulations other than the target circulation, causing delay." Dr. Telischak did not conclude that the series of wrong side angiograms on the right side, resulting in a delay of care, were separate and distinct departures from the standard of care.

TESTIMONY OF BRIAN DAHLIN, M.D.

27. Dr. Dahlin is a Senior Physician at Kaiser Permanente North Valley in Sacramento, California (Kaiser North Valley), Interventional and Diagnostic Neuroradiology Department. Prior to his current position, he was an Associate Physician at Kaiser North Valley in the same department. From July 2017 to February 2020, he was UCD Med Center Associate Clinical Professor in the Interventional and Diagnostic Neuroradiology Department. From July 2011 to June 2017, he was a UCD Med Center Assistant Clinical Professor in Interventional and Diagnostic Neuroradiology Department.

Dr. Dahlin received his medical degree in 2003 from the Saint Louis University School of Medicine. At UCD School of Medicine, he completed his residency in Diagnostic Radiology in 2008, his Diagnostic Neuroradiology Fellowship in 2009, and his Interventional Neuroradiology Fellowship in 2011. Dr. Dahlin worked at UCD Med Center for 16 years. Dr. Dahlin is board certified in Radiology and holds a subspecialty certification in Neuroradiology.

28. Dr. Dahlin met respondent several times before respondent joined the faculty at UCD in late 2016 or early 2017, and they began working together in approximately 2017, performing diagnostic and interventional radiology. In addition to his clinical duties, Dr. Dahlin served as Chair of the Continuous Quality Improvement (CQI) Committee at UCD Health's Vascular Center, and as member of UCD Med Center's Medical Review Committee for pending legal actions. (UCD Med Center is a part of UCD Health.) Dr. Dahlin was looking for some relief from the workload, and believed it would be "helpful that respondent was in the pool." Dr. Dahlin served as respondent's proctor for the first 18 months of respondent's tenure at UCD Med Center. Dr. Dahlin proctored respondent's medical treatment of Patient 1.

29. On January 10, 2018, Dr. Dahlin was present in the diagnostic and radiology reading room approximately 50 feet away while Patient 1 was in the angiography suite (angio suite) with respondent and other medical staff. Dr. Dahlin "had already seen the CT [computerized tomography] angiogram where the blockage was" on the left side.

An inventory specialist tapped Dr. Dahlin on the shoulder telling him that "something was not right" and asked Dr. Dahlin to help. He walked over to the angio suite and went into the control room containing computers and monitors. The control room is separated from the angio suite by a large glass window to prevent radiation exposure. In the control room, Dr. Dahlin could see real time fluoroscopic imaging of the blood vessels. Dr. Dahlin saw that there were no "pictures" of Patient 1's left side where the clot was. He was not expecting this and thought pictures of the right side were "odd." This was "somewhat puzzling" to Dr. Dahlin because "the clot was not on the right side to begin with." He testified, "the faster blood flow is restored, the better the chance of recovery."

30. Respondent walked out of the angio suite to talk to Dr. Dahlin. Dr. Dahlin told respondent that the blood clot was on the left side. A neurosurgery resident, "Jodi," stated that the "clot lysed," meaning that the clot dissolved with TPA. Respondent stated that the clot was gone and had lysed, implying he was on the correct side and the clot dissolved with TPA. Dr. Dahlin stated to respondent "the clot is on the left, Jordan." Respondent was "somewhat shocked and mentioned some expletive, something along the lines of 'fuck me.'" Dr. Dahlin also noticed that Angioseal, used to seal a hole in the artery wall at the termination of a case, was being prepared for deployment. Dr. Dahlin realized at that moment "something was not right." Respondent returned to the angio suite and "performed [a] left carotid angiogram and a left thrombectomy." "Respondent took responsibility for this."

31. Dr. Dahlin informed his superiors, Matthew Bobinsky, M.D., then Chief of Neuroradiology, and then Chief of Staff John Livoni, M.D., of the incident and documented it in UCD Med Center's Interventional Radiology Morbidity and Mortality Logbook for review of the problem and ways to prevent it in the future. Dr. Dahlin documented respondent's "Right/Left side misidentification for MCA thrombectomy" in pertinent part as follows:

> [Respondent was] [o]perating under a false assumption that the patient was presenting with a right middle cerebral artery occlusion, a right-sided common carotid and internal carotid angiogram was performed. This demonstrated no vessel occlusion, as expected, given that the patient was suffering from a left middle cerebral artery M1 occlusion. Additional physicians were contracted for consultation, and at this point in time, [respondent] realized that the left

middle cerebral artery was the vessel involved. The appropriate procedure was then performed.

Patient underwent subsequent left MCA thrombectomy, despite procedural delays.

There are [two] points of significant concern in this case. The first, a lack of a procedural pause to specify laterality. Second point of concern, lack of recognition of wrong laterality despite negative right common and internal carotid angiography. Given the negative right-sided angiogram, an experienced operator should be capable of evaluating the situation and promptly recognizing a potential error, without reliance on additional staff. It wasn't until additional help arrived that [respondent] was informed of/and realized that the stroke was occurring on the opposite side.

32. A root cause analysis (to identify the root cause of an event) was later performed by the medical review committee, which emphasized that a "procedural pause," or "timeout," pursuant to UCD's timeout policy, would be required prior to interventional neuroradiology procedures taking place.

33. Dr. Dahlin did not believe respondent is a good doctor. He had concerns with five cases as respondent's proctor for the first 18 months of respondent's tenure at UCD, including Patient 1's case. He refused to sign off on any more cases due to his reservations about respondent's medical practices.

TESTIMONY OF MATTHEW BOBINSKI, M.D.

34. Dr. Bobinsky is board certified in Radiology and holds a subspecialty certification in Neuroradiology. He received his medical degree in 1988 and his Ph.D. from the Medical University of Gdansk in Poland. He completed his residency in Radiology in 2001 at the SUNY Health Science Center in Brooklyn, New York, was a Chief Resident from 2001 to 2002 at Long Island College Hospital's Department of Radiology in Brooklyn, and completed his Neuroradiology Fellowship at New York University's Department of Radiology. His current job is UCD Med Center's Vice Chair of Clinical Operations in the Department of Radiology, and Director of Magnetic Resonance Imaging (MRI). In 2018, Dr. Bobinsky was UCD Med Center's Chief of Neuroradiology. Dr. Bobinsky has worked at UCD Med Center for the past 15 years.

35. Dr. Bobinsky has known respondent since 2016, though he met respondent a few times previously when respondent volunteered at UCD Med Center over a decade ago. Dr. Bobinsky was respondent's and Dr. Dahlin's supervisor and Chair of the Department of Radiology on January 10, 2018. That morning, Dr. Bobinsky learned from Dr. Dahlin aspects of respondent's procedure on Patient 1. He trusted Dr. Dahlin's account of the procedure, describing Dr. Dahlin as a colleague, collegial, and a "truthful person with great integrity."

36. After Dr. Bobinsky spoke with Dr. Dahlin, respondent went to Dr. Bobinsky and spoke to him "right after the procedure." Respondent did not mention to Dr. Bobinsky that he was corrected by anyone, in contrast to Dr. Dahlin's account asserting that it was he who informed respondent that he was on the wrong side. Dr. Bobinsky was "not really concerned who caught the mistake." His concern was that a procedural pause, or time out, did not occur, and there was a delay in the procedure. A technologist also informed Dr. Bobinsky that respondent performed an angiogram on

the wrong side and was concerned about the time that had elapsed. Dr. Bobinsky was confident that calling a time out would have prevented respondent's mistake. However, overall, Dr. Bobinski believed respondent provided the correct treatment on Patient 1.

37. Raymond Dougherty, M.D., former Chair of the Department of Radiology at UCD Med Center, made a decision to summarily suspend respondent after speaking with Dr. Bobinsky and several other leaders. They all supported the decision to summarily suspend respondent. When asked on direct examination, Dr. Bobinsky denied harassing Dr. Dahlin or spreading the rumor that Dr. Dahlin impregnated another female employee.

SUMMARY SUSPENSION AND SUBSEQUENT RESIGNATION

38. On November 22, 2019, Dr. Dougherty provided a written notice to respondent that he was summarily suspended from UCD Med Center medical staff effective the same date. The notice informed respondent of his "right to request a meeting with an ad hoc panel authorized to represent the Medical Staff Executive Committee."

39. On November 26, 2019, respondent requested a meeting with an ad hoc panel, and in advance of the meeting, he requested patient medical record numbers, dates of admission and discharge, and the "claimed questionable procedure (date and time), with description of allegedly deficient clinical judgment, technique, and/or management." On November 27, 2019, UCD Med Center Chief of Staff JoAnne Natale, M.D., Ph.D., wrote respondent informing him of names of the ad hoc panel members and provided the medical record numbers of the patients involved in the five cases reviewed.

40. On December 3, 2019, Drs. Dougherty and Bobinsky wrote to the ad hoc panel summarizing the reviews of the five cases, including Patient 1's case. (The four other cases are not at issue in the instant case; only the case involving Patient 1 is at issue here.) Dr. Dahlin and Stroke Neurologist Kwan Ng, M.D., reviewed each of the five cases.

41. On December 4, 2019, the ad hoc committee wrote to respondent informing him that based on their independent review of the cases and the discussion they had with respondent the previous day, they determined that continuance of the suspension from medical staff membership and privileges was "appropriate at this time."

42. On December 16, 2019, Dr. Doughtery wrote to respondent agreeing to end the summary suspension because respondent agreed not to engage in any clinical activities until the Medical Staff Executive Committee had an opportunity to meet on December 18, 2019, to determine whether a formal investigation would take place.

43. On the same day, December 16, 2019, respondent provided his letter of resignation from his employment as a Health Sciences Clinical Professor in the Department of Radiology at UCD School of Medicine, and as a physician on UCD Med Center medical staff, and his "relinquishment of privileges in [his] specialty of neurointerventional radiology." Respondent's resignation was to be effective December 31, 2019. The reason for respondent's resignation was to pursue a practice opportunity at another general acute care hospital and to facilitate his assumption of patient care responsibilities at the other facility.

ACCESS TO 214 PATIENT MEDICAL RECORDS DECEMBER 2019

Testimony of Raymond Dougherty, M.D.

44. Dr. Dougherty, UCD Med Center's Chair of the Department of Radiology, testified at hearing consistent with the contents of his November 22, 2019 letter to respondent informing him of the summary suspension, his (and Dr. Bobinski's) December 3, 2019, letter to the ad hoc panel, and his December 16, 2019, letter to respondent ending the summary suspension.

45. When respondent was summarily suspended on November 22, 2019, Dr. Dougherty "scripted" what he was going to tell respondent and had medical staff review the script. The script contained instructions to respondent. Dr. Dougherty verbally instructed respondent that he was to leave UCD Med Center premises immediately, ask for Dr. Dougherty's permission to come to UCD Med Center to retrieve his personal belongings, and cease performing medical care. He then provided the script/instructions to respondent.

46. At or around Thanksgiving 2019, respondent requested permission to retrieve his belongings. On Thanksgiving Day, November 28, 2019, Dr. Doughtery learned from Dr. Chang via email that respondent accessed UCD Med Center's electronic medical imaging technology, "PACS," (which stands for picture archiving and communication system), from home. Although respondent was not specifically instructed that that he could not access patient medical information, Dr. Dougherty "thought it was understood [respondent] would not access [the patient medical records]," after being summarily suspended, and found it "hard to believe with all that military training" respondent failed to understand "this is common sense."

47. Dr. Dougherty asserted it was not appropriate for respondent to access patient medical records (on November 28, 2019) because "it can be reasonably assumed and [it is] common knowledge that [the medical records] are the property of UCD." He did not specifically speak with respondent after learning of respondent's unauthorized access, but instead resent respondent a copy of the script/instructions "to remind respondent of his status." Dr. Dougherty did not dispute that respondent was entitled to access patient medical records. However, respondent needed to obtain patient permission and go "through the proper channels" by requesting the records from the medical office staff. Respondent was not to personally access patient medical records on his own.

48. Dr. Doughtery learned from other physicians that respondent again accessed PACS on December 29 and 30, 2019. PACS shows users who is online, as it is designed as a communication tool. The physicians provided Dr. Dougherty with "screen shots" of respondent's access on PACS, and Dr. Dougherty forwarded this information to UCD Med Center's Chief Compliance Officer.

49. Dr. Dougherty conceded that respondent's unauthorized access to patient medical records in EPIC (digital medical record software) and PACS could have been an oversight, in that UCD Med Center should have disconnected his access when he was summarily suspended. However, he explained the "normal process" is to disconnect access on the effective date resignation.

Testimony of Alessia Shahrokh

50. Ms. Shahrokh was a Senior Privacy and Compliance Investigator at UCD Health's Compliance Office beginning in 2014. In December 2018, she became the Compliance Manager for the Compliance Office. One of the Compliance Office's goals

is to ensure members of UCD Med Center and the UCD workforce who perform activities for UCD Med Center comply with the UCD Health's policy titled "Employee Access to Protected Health Information and Personal Information." (Employee Access Policy.) The Employee Access Policy was in effect in December 2019 and January 2020.

51. The Employee Access Policy sets forth, in pertinent part: (1) accessing or viewing patient information is confidential and shall not be viewed or accessed other than for the sole purpose of performing employment duties and responsibilities; (2) access to protected health information (PHI) or personal information (PI) shall be limited to accomplish the intended purpose of such use or disclosure to fulfill employment duties; (3) any UCD Med Center member who discovers or suspects a breach must notify the Compliance Department; and (4) copies of personal medical records should be obtained from Health Information Management in accordance with the Policy 2358: Accessing/Requesting Medical Records.

52. Ms. Shahrokh testified that Employee Access Policy is "more stringent" than access allowed under state and federal law. Patient consent is needed, and the access or viewing of the patient medical records must be for the purpose of performing job tasks. An individual cannot access PHI to check the work of his peers, or to access the records of random patients. An individual needs authority to access PHI based on the scope of his job.

53. Ms. Shahrokh explained that EPIC is the electronic health record used by UCD Health. EPIC is the predominant source of medical records and is the core system used by UCD Med Center staff. PACS is an auxiliary imaging system used largely by the Department of Radiology to view or interpret medical imaging. As of a few months ago, PACS is no longer used. However, PACS was used by UCD Med Center in November and December 2019, and January through March 2020.

54. UCD Health's Chief Compliance Officer assigned Ms. Shahrokh to determine whether respondent's access of patient medical records was appropriate under UCD Health's policies, state, and federal law. (Ms. Sharokh's testimony regarding any legal conclusions regarding state or federal law was not considered and no findings will be made in this regard.)

55. Ms. Shahrokh's assignment began after Dr. Dougherty reported to the Compliance Office respondent's access activities on or about Thanksgiving 2019, (November 28, 2019), while he was on summary suspension. Although respondent arguably had no clinical or medical justification to access patient medical records at that time, Ms. Shahrokh focused on respondent's access to patient medical records for the period December 15, 2019, to January 1, 2020, because respondent agreed to no longer perform clinical duties when the summary suspension was lifted on December 16, 2019. Ms. Shahrokh was able to determine each time respondent accessed EPIC and/or PACS through his unique username and password. Respondent created an activity log each time he used his username and password to access the medical records system. Ms. Shahrokh found that during the period of December 21 to 31, 2019, respondent accessed PACS for the medical records of 214 patients for whom he had no medical purpose.

56. On February 18, 2020, Ms. Shahrokh emailed respondent requesting a meeting to discuss his access of the patient medical records for which she could not find a work purpose. On February 28, 2020, Shara Rasmussen, UCD Health's Chief Compliance and Privacy Officer, followed up with Ms. Shahrokh's email requesting a meeting. On March 3, 2020, respondent wrote Ms. Shahrokh and Ms. Rasmussen, stating in pertinent part:

> I fully understand why your Department would not apparently be aware that my review of the records of the care I have provided to a few of my patients toward the end of last year was part of a Medical Staff quality assurance and peer review activity. Should more explanation be required, I am sure that the Chief of Staff could confirm what you describe as a "work purpose."

Ms. Shahrokh asserted at hearing that respondent's explanation for accessing records did not comply with the Employee Access Policy.

57. On June 30, 2020, Ms. Rasmussen reported to the Department of Public Health, pursuant to Health and Safety Code section 1280.15, subdivision (b)(1), respondent's access to 214 patients' Electronic Medical Records (EMR) without a work purpose from December 21 to 31, 2019. Ms. Rasmussen wrote that respondent "was reviewing records in an unauthorized review of the quality of patient care, including the records of individuals who were not his patients."

58. On February 26, 2021, Ms. Shahrokh filed a breach notification via the website of the Office for Civil Rights (OCR) at the Department of Health and Human Services. She informed OCR that the breach occurred from December 21 to 31, 2019, and involved the EMR of 214 individuals.

ACCESS TO PATIENT IMAGING FROM RADIOLOGY JANUARY 2020

59. On January 6, 2020, UCD Med Center Chief of Staff JoAnne Natale, M.D., Ph.D., wrote to respondent informing him of his right to a hearing because of his summary suspension of his Medical Staff membership and privileges on November 22, 2019. Dr. Natale further informed respondent that by January 15, 2020, he was to be

sent written notification of the cases, including the medical record numbers, considered by Dr. Dougherty in his decision to suspend respondent, as well as the initial list of witnesses UCD Med Center expects to call at hearing. In the coming weeks, respondent was to be informed of the date of the hearing.

Testimony of Yasamin Mohammad

60. In late December 2019 or early January 2020, respondent called Yasamin Mohammad, a UCD Med Center Weekend ER Radiology Clerk, asking her to make a few compact discs for the five patients and make them anonymized. On January 4, 2020, Ms. Mohammad texted respondent that the anonymized compact discs he requested were ready for pickup. Ms. Mohammad also made a key identifying a patient to a specific compact disc. Respondent thanked Ms. Mohammad and picked up the compact discs that night. He also requested imaging of seven more patients. He provided the patient initials and numbers to Ms. Mohammad. On January 5, 2020, Ms. Mohammad texted respondent that the imaging for the seven additional patients was completed and ready for pickup. To her knowledge there was no record of respondent picking up the CDs on or after January 5, 2020.

61. On January 24, 2020, respondent texted Ms. Mohammad and re-requested imaging for five patients which he previously received. Respondent was applying for privileges at MSJH at this time, and the credentialing coordinator there requested the records of the five patients involved in his summary suspension. Respondent informed Ms. Mohammad that he would pick up the five patient records that evening, Sunday, January 26, 2020.

62. Ms. Mohammad testified that it was "not super common" for radiologists to request patient medical records from her. If they did, the records would be used for

training or presentation purposes. She believed respondent was still on the faculty at UCD Med Center when he requested the 12 patient medical records. Ms. Mohammad would not have provided the records to respondent had she known he was no longer on the faculty. Respondent did not inform her that he was no longer on the UCD Med Center Medical Staff when he requested the 12 patient medical records.

63. Ms. Mohammad did not verify a physician's authority when they requested records. A common practice was to see the physician's identification badge before gathering the records. The computer system did not notify her that respondent was no longer employed by UCD Med Center. Ms. Mohammad never asked respondent why he needed the records, and respondent did not tell her the reason for his requests.

CONFIDENTIALITY ATTESTATION

64. On January 31, 2020, respondent signed an Attestation stating he was employed by UCD Health from November 16, 2016, to December 31, 2019. He understood UCD Health is a Covered Entity under the Health Insurance Portability and Accountability Act (HIPAA) and acknowledged UCD Health is responsible for ensuring patient medical information, defined under California law and HIPAA, is protected and treated in a confidential manner.

65. Respondent further acknowledged UCD Health provided him with the medical records of five patients for the purpose of a UCD Medical Staff hearing, and understood and agreed that all documents provided to him "shall be used exclusively for this purpose."

66. Respondent understood and agreed that it was his responsibility to keep the documents in a secure location and protect the documents from re-disclosure to any third party not directly involved with the Medical Staff hearing.

67. Respondent understood and agreed that no copies of the documents were to be made, and he would promptly return the documents to UCD Health at the close of the hearing. He further understood and agreed that he would be reported to state and federal agencies as required by law if he failed to timely return the medical records.

DISCLOSURE OF PATIENT MEDICAL RECORDS TO MERCY SAN JUAN HOSPITAL

Testimony of Barbara Selby

68. Ms. Selby was the Director of Medical Staff Administration at MSJH from October 2015, to June 2023. In June 2023, she became the Director of Medical and Regulatory Affairs at UCD Med Center. On November 21, 2019, respondent applied for temporary privileges at MSJH. Ms. Selby testified that temporary privileges are issued on rare occasions, in that an emergency patient care need must be established. Further, if respondent did not have active staff privileges at UCD Med Center, he was not eligible for active staff privileges at MSJH.

69. On December 6, 2019, respondent received an email from Leslie Towns Navarra, UCD Med Center's Director of Medical and Regulatory Affairs, informing him of the meaning of "good standing" as defined in the Medical Staff Bylaws:

> **In Good Standing** means a member is currently not under suspension or serving with any limitation of voting or other

prerogatives imposed by operation of the Bylaws, Rules and Regulations or Policies of the Medical Staff.

Ms. Towns Navarra informed respondent that if the Medical Staff Office received a query from another peer review body inquiring about respondent's Medical Staff status, her office "would have to say that [respondent is] not in good standing" based on the summary suspension.

70. On December 9, 2019, Ms. Selby queried UCD Med Center about respondent's standing after respondent came to her office accompanied by a senior radiologist seeking to obtain temporary privileges. After talking to Ms. Selby about his expertise, he took the temporary privileges application packet with him. UCD Med Center responded to Ms. Selby's query with a letter informing her that respondent was no longer in good standing.

71. On December 13, 2019, respondent submitted an application for full privileges to MSJH, updated on December 17, 2019, to include his summary suspension which was not previously disclosed in his initial application. Ms. Selby then received an updated letter from UCD Med Center stating he was in good standing because the summary suspension had been lifted on December 16, 2019. Respondent then updated his full application on December 19, 2019, indicating he was in good standing. Ms. Selby characterized respondent's update as "very unusual" and "raise[d] questions."

72. On December 26, 2019, Ms. Selby sent a letter to respondent informing him that his application was incomplete. Ms. Selby asked respondent for information on his summary suspension. On January 7, 2020, respondent provided a summary of

the five patients whose cases were peer reviewed. Respondent told Ms. Selby that the summary suspension was "purely political."

73. On January 24, 2020, MSJH Chief of Staff Jennifer Osborn, M.D., sent a letter to respondent requesting documents regarding UCD Med Center's Medical Staff Executive Committee discussion and action and complete copies of the UCD Med Center medical records of the five patients referenced in Dr. Natale's November 27, 2019, letter. She informed respondent that the records were to be sent for independent peer review as part of the application process. She requested respondent "please make arrangements to have those submitted via CD to Barbara Selby, in the Medical Staff Office."

74. On February 4, 2020, respondent arrived at Ms. Selby's office to hand-deliver compact discs (CDs) containing the medical records and/or imaging for the five patients. Ms. Selby was "very shocked," and "never expected that." She anticipated that respondent would follow the process to request patient medical records from UCD Med Center, and that UCD Med Center, not respondent, would send the records to MSJH. Patient names and other identifiers were printed on the CDs. Ms. Selby believed respondent's submission of the CDs violated HIPAA. Ms. Shelby believed she fulfilled her obligations under HIPAA by notifying UCD Med Center of the perceived breach.

75. Upon receiving the CDs, Ms. Selby spoke to a medical staff attorney and locked the CDs in a cabinet. No one viewed the contents of the CDs. She contacted Ms. Towns Navarra about respondent providing the CDs to MSJH. On February 11, 2020, Ms. Towns Navarra emailed Ms. Selby, informing her that the contents on the CDs were the UCD Med Center property. Ms. Towns Navarra picked up the CDs from Ms. Selby's office the following day and the CDs were returned to UCD Med Center.

76. On February 13, 2020, Dr. Osborn wrote to respondent reiterating her request to make arrangements to have the medical records for the five patient cases submitted to MSJH's Medical Staff Office in order for them to conduct the independent peer review in connection with his application for full privileges. She wrote: "If you are able to obtain those records through the appropriate channels, you may resubmit them for our external review process." Respondent's application remained incomplete.

77. On February 24, 2020, respondent delivered to Ms. Selby's office a second set of CDs for the five patients. Ms. Selby observed that "they appeared different," in that the CDs had "Radiology Department" printed on the front of the CDs. Respondent wrote a letter to Dr. Osborn on the same date stating, among other things, that he delivered a second set of CDs to MSJH's Medical Staff Services Office. He did not provide authorization from UCD Med Center that he could provide the CDs to Ms. Selby. Ms. Selby kept the CDs locked and secure, notified Ms. Towns Navarra at UCD Med Center about the second set of CDs, and planned for Ms. Towns Navarra to pick them up. Ms. Towns Navarra picked up the CDs from Ms. Selby on March 5, 2020, and returned them to UCD Med Center.

78. Ms. Selby conceded that having respondent make arrangements to provide the five patient medical records was "totally new territory." She further stated "[MSJH] was not exactly sure how to address this," meaning that she had never had the issue of an applicant needing to provide patient medical records to MSJH to get privileges.

Testimony of Leslie Towns Navarra

79. Ms. Towns Navarra was the Director of Medical and Regulatory Affairs at UCD Med Center for approximately 10 years until she retired on July 21, 2023. Prior to becoming the Director of Medical and Regulatory Affairs, Ms. Towns Navarra served as UCD Med Center's Manager of Medical Staff Administration, a job she held for 28 years. Her job responsibilities in both positions included licensure and accreditation of UCD Med Center, Medical Staff administration overseeing physician credentialing, peer review, and quality and safety activities.

80. Ms. Towns Navarra testified that UCD Health and Medical Staff have policies regarding PHI, and that patient medical records can only be accessed if there is a work need. If unauthorized access of patient medical records occurs, there are "Medical Staff remedies." Ms. Towns Navarra is familiar with UCD Health's Employee Access Policy, stating the policy was in place in 2019 to March 2020. Medical Staff members receive annual training on the policy, and if they violate the policy, they can lose their job. Violations are reported to the Chief Medical Officer who reviews the circumstances underlying the violation. The policies regarding PHI only apply to people on staff, not individuals who are no longer working at UCD Med Center.

81. Ms. Towns Navarra further testified that UCD Med Center Medical Staff are the owner of the patient medical records. "When you are not on staff, you do not have an ownership interest in the records."

82. As UCD Med Center's Director of Medical and Regulatory Affairs, Ms. Towns Navarra knew of respondent's November 22, 2019, summary suspension. She also knew that the summary suspension was lifted on December 16, 2019, based on respondent no longer providing clinical care until the date of his resignation on

December 31, 2019. She also knew that respondent submitted an email requesting UCD Med Center to accept a withdrawal of his resignation, and that UCD Med Center denied his request. Upon his termination, respondent no longer had privileges to access PHI because he did not have a work-related need for obtaining records. Ms. Towns Navarra prepared and submitted the 805 and 805 Supplemental Reports to the Board concerning respondent's summary suspension, the lifting of the summary suspension, and respondent's resignation from UCD Med Center.

83. Ms. Towns Navarra was unaware that respondent provided the CDs, previously provided to him pursuant to the Attestation for the sole purpose of his Medical Staff hearing, to MSJH. She was further unaware that when respondent re-requested medical imaging for the five patients from Ms. Mohammad on January 24, 2020, he was doing so because MSJH requested those records for their independent review.

84. Ms. Towns Navarra was present when respondent read and signed the Attestation on January 31, 2020. He agreed that he would use the patient medical records for the Medical Staff hearing, would not make copies, would not give the records to others, and would return the records to UCD Health after the hearing. Respondent did not protest when he signed the Attestation. After signing it, he received the CDs. Respondent did not have permission or authority to provide the CDs to MSJH.

85. On February 28, 2020, respondent sent an email with an attached letter to Ms. Towns Navarra, requesting medical records for the five patients to prepare for the Medical Staff hearing. He also informed her that MSJH requested the patient records/images and he wanted to give the records to MSJH. This was the first time respondent asked that the patient records/images be transferred to MSJH.

86. On March 2, 2020, Ms. Selby called Ms. Towns Navarra informing her that respondent provided a second set of CDs for the five patients. The CDs for respondent's February 28, 2020 request had not yet been created by March 2, 2020, and Ms. Towns Navarra had not yet given them to respondent. Ms. Towns Navarra told Ms. Selby that respondent was not authorized to have the CDs, and if he received those CDs through "normal channels," Ms. Towns Navarra would have been part of the communication stream. Ms. Towns Navarra retrieved the CDs from Ms. Selby's office on March 5, 2020.

87. Looking at the second set of CDs, Ms. Towns Navarra noticed that they had different labels with "Radiology Department" and "PACS" on them. The CDs had been prepared on January 25 and 26, 2020. She took the CDs to the UCD Med Center's Director of Imaging Services and he determined that Ms. Mohammad made some, but was not sure she made all of them.

88. On March 2, 2020, Chief of Staff Dr. Natale wrote to respondent informing him that he violated the agreement to use the medical records solely for the purposes of preparing for the Medical Staff hearing. She informed respondent that he would not be provided with the medical records a second time, but would provide the medical records to respondent's counsel, upon receiving a confidentiality statement signed by him, or provide electronic access to respondent at UCD Health by appointment.

COMPLAINANT'S EXPERT SUZANNE A. FIDLER, M.D., F.A.C.P.

89. Dr. Fidler is board certified in Internal Medicine. She received her medical degree from the Medical College of Pennsylvania, completed her Internship and Residency in Internal Medicine from the University of California, Davis, and is a Fellow

of the American College of Physicians. She holds a Juris Doctor degree from Chapman University School of Law. She is a Certified Professional in Healthcare Risk Management. She has held numerous jobs as a physician in Southern California and is currently the Medical Director at Optum Med-Surg in the Clinical Care Department.

90. Dr. Fidler performs peer review for the Optum network. Peer review is a confidential process, and she ensures that all members who participate sign confidentiality agreements and conflict of interest statements. All members are trained on how to access medical records and are warned not to share medical records. Members are instructed to delete the records after peer review. The peer review process is to ensure quality of care, and it is not punitive. Peer review is a fair, educational, and training process. Dr. Fidler is a voting member of the credentialing committee. She reviews credential files and makes a detailed review of all documents submitted before making a determination on whether to accept a provider in the network.

91. As a practicing physician, Dr. Fidler always understands that access to patient medical records is restricted. She has access to records of the patients she treats. When conducting a peer review, patient record access is restricted to the minimum necessary under HIPAA. Access is provided only to the number of records needed to perform the review.

92. Dr. Fidler opined that the general standard of care is that "level of training, skill, and knowledge that one would recognize for a provider in that healthcare specialty." A simple departure from the standard of care is "a minor or less substantial deviation from the applicable standard of care." An extreme departure from the standard of care is a "more substantial deviation from the applicable

standard of care." Gross negligence is an extreme departure from the standard of care, and simple negligence is a minor departure from the standard of care.

93. Dr. Fidler was retained by the Board to provide her expert opinion whether respondent engaged in unprofessional conduct "if he accessed patients' records and imaging without following appropriate processes." (The other issue on which she opined was not relevant to the charges in the Accusation.) Dr. Fidler testified at hearing consistent with her initial and supplemental expert reports.

Initial Expert Report of November 13, 2022

94. In her initial expert report dated November 13, 2022, Dr. Fidler opined that "the standard of care is that physicians must follow all laws and regulations." They must adhere to all patient privacy and confidentiality laws. Dr. Fidler cited HIPAA, a federal law requiring the "minimum necessary standard" restricting the use and disclosure of PHI "to the minimum amount necessary to achieve the purpose for which it is being used, requested, or disclosed. State laws also provide privacy protection for patients."

95. Dr. Fidler opined that once respondent was no longer on staff at UCD Med Center, he was required to adhere to UCD Med Center's process for obtaining medical records he was permitted to have. Dr. Fidler did not identify this process or whether he followed it.

96. Dr. Fidler then opined that if respondent improperly accessed patient's records and images without following all federal and state privacy rules and the established polices and processes at UCD Med Center, "then this represents a violation of patient privacy protections and constitutes unprofessional conduct" constituting an extreme departure from the standard of care.

Supplemental Expert Report of December 13, 2022

97. Dr. Fidler's more detailed supplemental expert report dated December 13, 2022, addressed whether respondent engaged in unprofessional conduct: (1) when he accessed patients' records between December 21, 2019, and December 31, 2019; (2) when he obtained patients' images from UCD Med Center employees after he no longer held Medical Staff privileges at UCD Med Center; and (3) when he provided MSJH with patients' imaging records belonging to UCD Med Center. Dr. Fidler also opined on whether respondent violated ethical principles.

Records Access from December 21 to 31, 2019

98. Dr. Fidler provided a more robust standard of care than that provided above. She opined that "physicians must follow all laws, regulations, and policies including all patient privacy and confidentiality laws." She then explained that HIPAA is a federal law protecting PHI and cited the "minimum necessary" standard.

99. She then explained in depth that California has several laws on health information privacy, including the Confidentiality of Medical Records Act under Civil Code section 56 et seq., the Patient Access to Health Records Act under Health and Safety Code section 123110 et seq., the Insurance Information and Privacy Protection Act under Insurance Code section 791 et seq., and the Information Practices Act under Civil Code section 1798 et seq. She also provided a link to the Office of the Attorney General's website for information on medical privacy.

100. Here, respondent was required to adhere to UCD Med Center's Employee Access Policy, which allowed access to PHI and PI only for a legitimate work purpose. Respondent did not comply with the policy, accessing the medical records of over 200 patients from December 21 to 31, 2019, without a legitimate work purpose, in that Dr.

Fidler noted no documentation indicating respondent was treating all of these patients during that time period. In addition, respondent's medical privileges were ending, and he would not have been involved in research, quality of care reviews, or peer review activities that would have required him to review the records.

101. Dr. Fidler determined that respondent improperly accessed patients' records and images without following all federal and state privacy rules and the established policies and processes at UCD Med Center. This was a violation of patient privacy protections and constituted unprofessional conduct and an extreme departure from the standard of care.

Obtaining Patient Images from Radiology Employees

102. Dr. Fidler opined that the standard of care is that physicians must follow approved processes to obtain PHI. Physicians who no longer hold Medical Staff privileges at a facility are not authorized to obtain PHI and/or remove patients' records without approved authorization.

103. When respondent sent text messages to Ms. Mohammad to request patient imaging records, Ms. Mohammad did not know that respondent was no longer on the Medical Staff at UCD Med Center and continued to assist respondent. Dr. Fidler determined that respondent violated patient privacy and confidentiality protections that all physicians must follow. Because respondent was no longer on staff and not providing medical care, he had no work or medical treatment purpose to access the records. Moreover, in order to safeguard patient privacy, UCD Med Center was required to notify regulatory agencies, including the Department of Public Health and the Office of Civil Rights, of respondent's inappropriate access to the patient medical records. Dr. Fidler concluded that respondent "deceptively obtain[ed] unauthorized

access to PHI multiple times from UCD Med Center employees after his medical staff privileges were terminated" representing an extreme departure from the standard of care. Dr. Fidler added at hearing that respondent's conduct was an "unacceptable approach to obtain medical records this way," and "this was dishonest." Dr. Fidler's opinion that respondent was deceptive and dishonest are questions of fact not under her purview as an expert.

Providing MSJH with Images Owned by UCD Med Center

104. Dr. Fidler opined that the standard of care is to abide by the Attestation and follow established processes physicians are required to follow. Here, respondent signed the Attestation acknowledging that UCD Health is a Covered Entity under HIPAA and is responsible for ensuring all patient information is protected and treated in a confidential manner. Respondent agreed to safeguard the medical records of the five patients and use them solely for his UCD Medical Staff hearing. He agreed to protect the records from re-disclosure and to return them after the hearing. Instead, respondent provided the records, contained in CDs, to MSJH on February 4, 2020. After being instructed by UCD Med Center to obtain the records through proper channels, respondent again "disregarded the established process he a was advised to follow and violated his signed attestation" by submitting a second set of CDs on February 24, 2020.

105. Dr. Fidler determined that respondent's disregard of the Attestation and established processes which physicians are required to follow was an extreme departure from the standard of care.

Violation of Ethical Principles

106. Dr. Fidler opined that the standard of care is that physicians must follow ethical principles which include maintaining the trust of the medical profession by respecting patients' rights, demonstrating trust, honesty and integrity, and following all laws, regulations, and hospital policies. Here, respondent "deceptively obtained unapproved access to confidential health information," disregarding patient trust in the healthcare team and UCD Med Center to safeguard their PHI.

107. Respondent also solicited the help of other employees to aid him in gathering medical records for his application for privileges at MSJH. The employees unknowingly assisted respondent in a potential privacy breach. Respondent's conduct was "deceptive and unethical to use others to obtain inappropriate access to patient records." Ms. Mohammad felt she had no right to question respondent because he was a faculty member and she was just the weekend clerk.

108. Respondent's disregard of the Attestation demonstrated another example of unethical behavior for failure to abide by UCD Med Center safeguards to protect patient privacy. Dr. Fidler concluded that respondent's failure to abide by the Attestation, his deceit in procuring PHI, inappropriately removing medical records belonging to UCD Med Center, and using his professional status to gain access to a medical facility where he was no longer employed, represented unethical behavior and constituted an extreme departure from the standard of care.

Respondent's Evidence

RESPONDENT'S TESTIMONY

109. Respondent is board certified in Neuroradiology and Diagnostic Radiology and holds a subspecialty certification in Neuroradiology. He received his Bachelor of Science degree in Psychobiology from the University of Southern California (USC) in 1993. He began medical school at USC in July 1993, and in August 1994 he completed a six-week program at the United States Naval Officer Indoctrination School in Newport, Rhode Island. He received his medical degree from the USC Keck School of Medicine in 1998 and completed his residency in Radiology at Maine Medical Center in 2005. He completed fellowships in Diagnostic Radiology and Interventional Neuroradiology at the University of California, Los Angeles in 2006 and 2007, respectively.

Respondent has performed consulting services since 2007. His work history includes: Academic Chief of Neuroradiology at the Naval Medical Center in San Diego from 2007 to 2011; Division Head of Neurovascular Surgery at the Southern California Permanente Medical Group in San Diego from 2009 to 2015; Neurointerventional Surgeon and Radiologist at UCD Med Center from 2016 to 2017; and Clinical Professor at UCD Med Center from 2017 to 2019.

Respondent currently works as a Teleradiologist for Alta Vista Radiology, LLC, located in Paradise Valley, Arizona, and Pinnacle Radiology located in Los Angeles. He has worked as a Teleradiologist for both companies since September 1, 2020. Respondent is licensed to practice medicine in 13 states.

110. Respondent explained that an interventional radiologist is a neuroscience physician that uses guidance to treat problems in the brain, head, neck, and eyes.

Interventional radiologists treat a large number of conditions, including brain aneurysms, stroke, cancer, vascular tumors, and venous conditions in the eyes.

He further explained that a thrombectomy is an endovascular procedure used to treat large vessel strokes. A blood clot is removed by sucking the clot through a large aspiration catheter, putting a wire through the clot and opening a stent on a stick which seeps into the clot and removes it, or injecting TPA.

A cerebral angiogram is a minimally invasive test where the patient has a small sheath placed in the groin and a catheter is guided through the heart and advanced to the common carotid artery in the neck. A radioactive liquid is injected to show movement of the liquid dye across the blood vessels to see if the brain is getting its blood supply.

An angio suite, also known as a "cath lab," is an operating room environment with imaging equipment and space for the anesthesiologist and charting nurse. There is also space for the circulating nurse, the patient table, other tables, and the "Pyxis" machine which dispenses medications.

111. Respondent moved to Northern California in early 2016. He began his position at UCD Med Center's Department of Radiology as clinical academic faculty on January 9, 2018. His job was to train residents and fellows. Prior to that, he was a medical service provider under contract with UCD Med Center. Respondent joined neurointerventional radiology providers Drs. Ben Waldau and Brian Dahlin. Their supervisor was Dr. Bobinsky. Above Dr. Bobinsky was Radiology Department Chair Dr. Dougherty. Respondent was not provided with onboarding materials or given an orientation prior to starting work on January 9, 2018.

Calling a Timeout

112. Respondent acknowledged that calling timeouts was a part of his job and his medical training. A nurse would call a timeout to confirm consent, the right patient, anesthesia comments, then the procedure would commence. Respondent was not aware of a timeout policy at UCD Med Center and did not recall being handed the policy or seeing it. He acknowledged that that "anything that happens in the room during the procedure ultimately falls on the doctor who is doing the procedure." He took responsibility for failing to call a timeout prior to Patient 1's procedure.

Root Cause Analysis

113. After Patient 1's procedure, respondent "wrote [him]self up" and participated in the root cause analysis. Present during the meeting were several nurses, administrators, physicians including Dr. Dahlin and respondent. They listed factors that contributed to the timeout not being called and asked for input to ensure timeouts could be more widely adopted. Respondent made the suggestion to use a white board with a check box. The white board was incorporated as a result of the root cause analysis.

Dr. Dahlin

114. Respondent's working relationship with Dr. Dahlin "was not great." Dr. Dahlin "did not want [respondent] there" because he was concerned respondent's presence "would dilute his operative volume and it would stress the system." During the series of angiograms performed on Patient 1, respondent denied that Dr. Dahlin told him he was on the wrong side. Well before respondent was summarily suspended, he authored and submitted a 25-page document expressing his concerns about Dr. Dahlin ordering MRIs without patient consent or respondent's input, and not always

being accountable or productive. Respondent also expressed concern about Dr. Dahlin and/or other practitioners avoiding certain complex cases and engaging in referral patterns that did not ensure patients received appropriate care at the appropriate time. Respondent also reported physician misconduct.

Dr. Bobinsky

115. In contrast to his strained relationship with Dr. Dahlin, respondent's relationship with Dr. Bobinsky was "quite good," but there were a "series of events that soured our relationship." Respondent recounted where Dr. Bobinsky would be "quite upset" and would "pull" respondent out of the reading room to perform procedures while Dr. Waldau was on call. Respondent and Dr. Dahlin would "help each other to get through that." Dr. Bobinsky would make anti-semitic and homophobic comments and used the "N-word" on several occasions. He made comments about the military residents having no academic value and were "useless and stupid." Respondent described Dr. Bobinsky as having a "locker room mentality." Public conflicts occurred between respondent and Dr. Bobinsky. Their relationship deteriorated. Respondent did not report Dr. Bobinsky's behavior because he did not believe Dr. Bobinsky's conduct "rose to the level of reporting." He regrets that now. On October 31, 2019, respondent was removed from providing neurointerventional radiology services. On November 22, 2019, he was summarily suspended.

116. Respondent denied that he told Dr. Bobinsky that he was going to look up medical records to "get dirt on [Dr.] Dahlin." After his summary suspension on November 22, 2019, respondent acknowledged he was not allowed to be on the UCD Med Center campus.

Angio Suite Activity

117. Respondent described the frantic nature of the environment in the angio suite at the time he performed the angiogram on Patient 1. He had to mix his own heparin bags because UCD Med Center's standard was to use 2,000 units per liter of hepranized saline and he was trained to use 5,000 units. He asked a nurse to make the heparin bags at 5,000 units and she said respondent "would need to do that if he wanted to." Respondent broke scrub, grabbed vials of heparin, and showed the nurse how he mixed the bags. While dealing with the heparin bags, respondent called for anesthesia because Patient 1 was agitated and unable to understand what was going on, and respondent was worried Patient 1 would move during the procedure, perforating or tearing blood vessels, and his blood pressure was unstable. Learning anesthesia was not available, respondent put Patient 1 under conscious sedation which added to the complexity of the case. Respondent was "managing multiple things" including the team and Patient 1. He did not call for a timeout, no one else in the room initiated a timeout, and no one reminded him of calling a timeout.

Right Side Angiogram on Patient 1

118. Respondent disagreed with complainant's expert testimony that there was no reason to perform a right-side angiogram. Respondent claimed a right-side angiogram was warranted because Patient 1 displayed "deficits on both sides." Patient 1's "conjugate gaze was somewhat confusing," he had "meth and cocaine exposure use," and there were "bilateral findings on his CTA."

119. Respondent asserted that the CTA is "not adequate to exclude small clots or narrowing with patients [that have] predisposing risks like drug use." TPA can "melt the periphery of the clot" and move further downstream into an M2 vessel or beyond.

It was incumbent to confirm the clot location and determine how he could get there safely. Respondent asserted that one does not "rely on just CTA in that setting." He started on the right side but planned to do a left side thrombectomy. Respondent admitted that he "forgot the patient's clot was on the left side." He "made a mistake," and starting on the right side was "not [his] intention."

120. As respondent advanced the catheter on Run 3 at 8:40 a.m., he took pictures looking for the clot. Run 4 occurred at 8:42 a.m. and he repositioned the camera to get a different view to see if the blood clot was "hiding" or overlapped with another vessel. When he did not see the clot, Dan Jones, a radiology technician, asked, "Do you think the clot lysed?" (Clot lysis is a breakdown of the blood clot.) At that moment, respondent stated "Oh shit I'm on the wrong side." Respondent made the discovery sometime between 8:42 a.m. and 8:52 a.m. Crystal Starbuck, another technician, Mr. Jones, and respondent looked at the images on the monitor. Respondent at that time had no communication with Dr. Dahlin. Respondent then stated that he was "going to get the clot on the left."

Respondent was going to advance the catheter on the left side when he noticed Dr. Dahlin "standing in the control room with crossed arms." He described Dr. Dahlin as "looking in the room through the glass and glaring at me. He looked angry." Instead of performing a run at that moment, respondent took his gloves off, stepped out, and felt extremely embarrassed. He stated to Dr. Dahlin that he "fucked up" and was "going to fix it." Respondent was "mortified" and "could not believe [he] made such a stupid mistake. Respondent did not recall what Dr. Dahlin said because he was too focused on what he was saying. The conversation was brief, "not more than a sentence or two."

121. Respondent asserted that Dr. Dahlin's claim that he told respondent he was on the wrong side "is false." Respondent discovered the wrong side by reviewing images, Patient 1's presentation, and Mr. Jones's comment about the clot being lysed.

122. Respondent found the clot on the left side and was able to remove it. Patient 1 "ended up doing great." Patient 1 left the hospital within two days.

"Complications" Section on Notes

123. Respondent felt it was incumbent upon him as an ethical physician and within the standard of care to document complications for transparency. After the procedure, either later in the morning or that afternoon, respondent wrote an incident report on himself for failing to perform a timeout and performing a wrong side angiogram on Patient 1 when he intended to address the left sided clot first. Respondent's intent on reporting himself was to improve the process which led to his mistake. Respondent asserted he did not hide that he made a mistake.

Access to 214 Patient Medical Records

124. When respondent was summarily suspended, Dr. Dougherty told respondent he was not welcome to set foot on campus and unless he intended to clean out his office and, if so, respondent had to inform Dr. Dougherty before doing so. Respondent was not to talk to anyone or discuss his suspension with any UCD Med Center providers. Respondent "was not told anything about accessing medical records."

125. UCD Med Center did not "cut off" respondent's access to EPIC or PACS until December 31, 2019. Respondent still talked to his patients even though he was not to provide patient care. He felt it was his duty to ensure patients were safe after

undergoing risky procedures "in spite of the suspension." Respondent acknowledged he would not provide patient care after his summary suspension.

126. Respondent admitted accessing patient medical records after his summary suspension on November 22, 2019, and before he left UCD Med Center on December 31, 2019. Of the 214 patient records he accessed, respondent claimed he was "around the department and on call when many of these cases occurred." He "poked his head in the room and [others] asked what he [thought]." Respondent conceded he was not involved in every case but was familiar with a large proportion of the cases. He accessed the records after discussing with an attorney (not representing him in this matter) his right to the records in order to prepare his defense to the charges for his Medical Staff hearing. Respondent produced emails between him and the attorney. Respondent denied that he "look[ed] up the 200 [plus] cases to dig up dirt on [Dr.] Dahlin."

Application for Medical Staff Privileges at MSJH

127. Respondent filed an application requesting temporary privileges at MSJH on November 21, 2019. In late January 2020, MSJH requested complete imaging and charts for the five patients at issue. Believing he had a right to the records, respondent informally requested anonymized imaging for the five patients from Ms. Mohammad. However, respondent was no longer an employee at UCD Med Center and no charges were pending.

128. On January 24, 2020, respondent requested the five patient records from Anna Orlowski, Chief Counsel of UCD Health's Legal Affairs Office, and Ms. Towns Navarra. On January 31, 2020, Ms. Towns Navarra provided the records but "they were not complete." Respondent was then asked to sign the Attestation, which he did. His

attorney told respondent that his sharing of the medical records with MSJH as part of the credentialing process "is protected," and respondent had a right to do so. However, the attorney did not instruct respondent on how to get the medical records. Wanting complete records, respondent requested them from Ms. Mohammad on January 24, 2020.

129. When respondent gave the CDs to MSJH, his "understanding was these institutions were talking to each other." He believed MSJH "was to return the [CDs] back to UCD Med Center to ensure the loop was closed," meaning that MSJH would return the CDs once their independent peer review was complete. When respondent provided the CDs to MSJH the first time on February 4, 2020, he believed doing so was "legal and proper," and according to the attorney, respondent would risk "adverse reporting" to the Board if he did not provide the CDs.

130. In reliance on the attorney's representations (again, not the attorney representing respondent in this matter), respondent submitted in evidence an email dated February 24, 2020, from the attorney acknowledging that respondent desired to "promptly pursue the [MSJH] credentialing process," and sensed that UCD Med Center would refuse to return the CDs to respondent unless he promised not to forward them to MSJH. The attorney further stated "it would be logical to deliver the copy you made of the medical records to the [MSJH] Staff Services Office" and to "get a promise that the CDs will be returned to [respondent] (and not UC Davis) once [MSJH] is through with [its review]." The attorney was going to prepare a letter for respondent to send to MSJH at the time the second set of CDs were going to be delivered to explain that respondent now hoped the review scheduled for February 27, 2020, would go forward.

131. When respondent provided the CDs to MSJH a second time on February 24, 2020, Ms. Selby took the CDs and did not tell respondent she could not accept

them. Respondent was confused after he learned that MSJH returned the CDs to UCD Med Center without performing the independent review. He was anxious to "move things along" with his credentialing application. He still believed it was "legal and necessary" to share the CDs with MSJH "to ensure they conducted the independent review so I could get credentialing." Respondent was "scared and frustrated."

132. Respondent attempted to rescind his resignation which was to be effective on December 31, 2019. He eventually resigned on that date. MSJH did not grant staff privileges to respondent.

Obtaining CDs from Radiology Department

133. Respondent admitted that he did not tell Ms. Mohammad that he was no longer on the Medical Staff at UCD Med Center when he requested the medical records of 12 patients total. Respondent acknowledged he did not request the records from the appropriate department at UCD Med Center. Respondent claimed that he was not trying to deceive or lie to radiology staff. He was acting under the attorney's counsel. He was only trying to ensure his patients were safe. Respondent asserted he operated on all the patients for whom he requested records. With regard to the seven additional patients, he requested their records for his review and to ensure that these seven patients received appropriate follow up with another provider and were kept safe. He did not want these seven patients to think he was abandoning them.

RESPONDENT'S EXPERT, MARY ELIZABETH JENSEN, M.D.

134. Dr. Jensen is board certified in Diagnostic Radiology and serves as Chair of the Federal Drug Administration's Neurological Devices Panel. She has been licensed by the Virginia Board of Medicine since 1983. Her California medical license was issued on August 7, 1989, and is on a "cancelled" status, meaning the license was

voluntarily cancelled, or has not been renewed. Dr. Jensen has not been licensed in California as a physician and surgeon since June 30, 2001.

135. Dr. Jensen received her medical degree in 1982 from the Medical College of Virginia. While there, she also completed an internship in Neurology in 1983, residency in Neurology in 1984, residency in Diagnostic Radiology in 1987, and a fellowship in Diagnostic Neuroradiology in 1989. Dr. Jensen completed a fellowship in Interventional Neuroradiology at the University of California, Los Angeles, in 1990.

Dr. Jensen has many years of medical experience with the Virginia Air National Guard, starting as a Second Lieutenant with the Medical Services Corps in 1982, and retiring as a Lieutenant Colonel with the Medical Services Corps in 1996.

Dr. Jensen's most recent clinical appointment was as Director of Interventional Neuroradiology at the University of Virginia's Department of Radiology. She served in that capacity from June 30, 1998, to June 30, 2019.

Dr. Jensen retired as a Professor Emerita at the University of Virginia but maintains a clinical appointment there. She treats pediatric patients with vascular malformations of the head, neck, and face. She also started a private practice group called Blue Ridge Area Interventional Neuroradiology in Charlottesville, Virginia, to provide University-level endovascular services in a private hospital system. She performs these services in Charlottesville and Lynchburg, Virginia.

136. Dr. Jensen has evaluated interventional cases for the Virginia Board of Medicine, did not charge a fee for her testimony, and does not have a personal relationship with respondent. Respondent is a "respected professional colleague."

137. Dr. Jensen reviewed a number of materials, including Patient 1's medical records and imaging studies, and Dr. Telischak's expert report. Dr. Jensen reviewed respondent's diagnostic angiogram and thrombectomy performed on Patient 1 to determine whether he met the standard of care. Dr. Jensen wrote an expert report dated September 15, 2023, and testified consistent with her report.

138. Dr. Jensen opined that the standard of care is to perform left side angiograms and a left side thrombectomy. The standard of care did not require respondent "to go to that vessel first," meaning the vessel on the left side. She opined that "you access the vessel in which the thrombus is located in order to extract it." She conceded, "I would go after the clot first, yes," rather than performing the angiogram on the right side first. However, she further opined that it is not below the standard of care "to shoot the right side if you feel something is there." Moreover it was not below the standard of care to look at the right side "to explore deficits." However, once respondent "realized the clot was not in the right MCA, he catheterized the left carotid artery and extracted the thrombus."

139. Dr. Jensen did not believe it was an egregious mistake in failing to call a timeout "given the flurry of tasks that occur when getting a stroke patient quickly onto the table so as to minimize the amount of infarcted brain."

140. Regarding the time delay of 21 minutes, Dr. Jensen opined that "the time from puncture to restoration of flow was well within the expected time from puncture to reperfusion." Dr. Jensen concluded:

> This is NOT wrong-sided surgery as no thrombectomy was attempted or performed. This was simply an angiographic

run on the contralateral side, and if anything, showed there were no other emboli located in the opposite hemisphere.

Dr. Jensen did not opine on what is a simple or extreme departure from the standard of care in California, or whether respondent engaged in unprofessional conduct based on such departures.

RESPONDENT'S EXPERT, RYAN BROOKS VIETS, M.D.

141. Dr. Viets is board certified in Radiology and holds a subspecialty certification in Neuroradiology. He received his medical degree from USC Keck School of Medicine in 2006. He completed an internship in Internal Medicine in 2007 at While Memorial Medical Center in Los Angeles, and his residency in Radiology in 2010 at Beth Israel Medical Center (Beth Israel) in New York City. He was Chief Radiology Resident at Beth Israel from 2010 to 2011. He has been a Neuroradiology Fellow in Diagnostic Neuroradiology and Endovascular Surgery at Mallinckrodt Institute of Radiology in St. Louis, Missouri since July 1, 2011. He is currently an Interventional Neuroradiologist at the California Center for Neurointerventional Surgery in La Jolla, California, a job he has held since July 1, 2019.

142. Like Dr. Jensen, Dr. Viets did not charge a fee for his testimony. Dr. Viets socialized with respondent when he lived in San Diego but has not seen respondent for four years. He described respondent as a respected colleague.

143. Dr. Viets reviewed the same materials as Dr. Jensen. He described Interventional Neuroradiology as a young and rapidly evolving specialty dedicated to treating blood vessel disorders in the central nervous system, using image-guided minimally invasive catheters. This minimally invasive approach eliminates many risks of open surgical procedures. Dr. Viets described a thrombectomy as an endovascular

procedure employed to remove a blood clot (embolus or thrombus) occluding one of the brain's arteries and causing ischemia, or stroke.

144. Dr. Viets addressed the issue of whether respondent departed from the standard of care in his treatment of Patient 1 related to a bilateral angiogram and successful thrombectomy. Dr. Viets opined that the standard of care is "the level of skill, knowledge and care in diagnosis and treatment that other reasonably careful practitioners would use in the same of similar circumstances." He testified that the standard of care is to perform an angiogram prior to the thrombectomy regardless of the location of the clot.

145. Dr. Viets did not view respondent's mistaken initial access of Patient 1's right cerebral vasculature as simple departure from the standard of care. It was not a "wrong site" procedure, in that respondent "did not perform a 'procedure' in the right sided vasculature." Respondent performed his intended diagnostic angiogram "out of sequence." This was an "inadvertent mistake in a non-elective, emergency interventional procedure performed under challenging circumstances." At hearing, Dr. Viets concluded that there was no deviation from the standard of care, but rather a "small error" occurred due to respondent performing the angiogram out of order.

CHARACTER WITNESSES

Nathan Deis, M.D.

146. Dr. Deis is a neurosurgeon and neurointerventionalist at Community Regional Medical Center in Fresno. He received his medical degree in 2006 and completed his residency in 2012 at the University of Alberta Faculty of Medicine. He completed a Critical Care Fellowship in 2014, and a Spinal Fellowship in 2015.

147. Dr. Deis met respondent in the summer of 2022, when they both worked together at Community Neurosciences Institute, a medical group practice in Fresno specializing in Neuroradiology and Neurosurgery. Respondent was under a one-year contract which he completed. Dr. Deis did not know whether there was an offer to extend respondent's contract.

148. Dr. Deis and respondent frequently interacted when performing rounds every morning at 7:00 a.m. He observed respondent as "present, on time, and eager to share insights on cases." He was always happy and satisfied with respondent's performance of procedures and did not have concerns with respondent's work. Dr. Deis had no concerns with respondent's honesty and integrity. Dr. Deis did not read the instant Accusation and only heard a brief summary of the charges prior to his testimony. He knew the angiogram was performed on the opposite side of the clot, and respondent's access of medical records after his UCD Med Center privileges were removed. He did not know respondent accessed the medical records of over 200 patients, or the Attestation wherein respondent agreed he would not divulge medical records yet provided them to MSJH.

Mark Krel, D.O.

149. Dr. Krel is a neurosurgeon at Community Health Partners in Fresno. Community Health Partners is affiliated with all of the regional medical centers. He received his medical degree in 2014 from Western University of Health Sciences in Pomona. He received a masters degree in Cognitive Neuroscience in 2007 from University of California, Irvine, and his Master of Public Health degree in 2008 from USC. He completed his residency in 2021 at Arrowhead Regional Medical Center in Colton, California. He completed a fellowship in Functional Neurosurgery and Epilepsy in 2022.

150. Dr. Krel and respondent worked together in the same medical group. Respondent worked as an interventionalist and Dr. Krel is a surgeon. They took simultaneous calls and spent a lot of professional time together. Their typical day consisted of making rounds with a neuro-hospitalist and others, and the team reviewed cases for the day.

151. Dr. Krel described respondent as "incredibly knowledgeable," "eager to teach," and had "ideas for treatment and workup that would not have otherwise come up." Respondent's performance was "top notch" with regard to his level of responsiveness and thoroughness. Dr. Krel had no concerns with respondent's care and treatment of patients. Respondent was willing to treat the sickest of patients and his "outcomes were spectacular." Dr. Krel interacted with respondent on a personal level, like going out to eat. He described respondent's personality as someone "who gets excited but not in a malignant way." Respondent was kind, and Dr. Deis never found respondent to be dishonest or lacking in integrity. Dr. Krel got to know respondent over a year and month.

152. Dr. Krel did not know of respondent's summary suspension at UCD Med Center, or that respondent accessed the medical records of 214 patients while on suspension, or that he obtained medical imaging of the 12 patients after the suspension was lifted. He was not aware of the Attestation. Knowing now of the charges in this case, Dr. Krel would not change his opinion of respondent "because [he] never witnessed the charges."

William Lakosky, M.D.

153. Dr. Likosky is a neuro-hospitalist and stroke specialist at Community Regional Medical Center in Fresno. He received his medical degree from the University

of Vermont College of Medicine and completed his residency in Neurology and Internal Medicine at Yale New Haven Hospital. He is board certified in Neurology.

154. Dr. Likosky met respondent in April 2023 and still works with respondent at Community Regional Medical Center. He described respondent as a specialist in neuroradiology, and respondent's interpretation of imaging "is right up there with the best of them." Dr. Likosky places a great deal of trust in [respondent's] interpretations. He is satisfied with respondent's practice in "managing the stroke." Respondent's reports are "very thorough and descriptive," and he has "properly informed patients and families of the consequences of procedures." Dr. Likosky has no concerns about respondent's medical care, honesty, or integrity.

155. Dr. Likosky is not aware of the Board's allegations in this case, but opined that "angiograms are not always performed perfectly," as physicians are under a lot of stress and anxiety. He also stated "sometimes [physicians] access records and other things that at another time . . . they would not normally do."

Daniel Hawley, M.D.

156. Dr. Hawley is a Professor of Neuroradiology at the University of California, San Diego. He has held his present position for over a year. He retired last year from the United States Navy and has practiced medicine in the Navy for most of his naval career.

Dr. Hawley received his medical degree from the University of Kansas School of Medicine. He completed his residency in Diagnostic Radiology in 2008 at the Naval Medical Center in San Diego and a fellowship in Neuroradiology in 2010 at Johns Hopkins University. He then returned to San Diego and remained at the Naval Medical

Center in the Neuroradiology Department. In four years, he became the Chair of the Radiology Department.

In his last four years of military service, Dr. Hawley became a specialty leader to the Surgeon General of the Navy. He retired from the U.S. Navy after 23 years of military service. Dr. Hawley is board certified in Diagnostic Radiology and Neuroradiology.

157. Dr. Hawley was a chief resident in 2007 when respondent arrived on active duty at the Naval Medical Center as head of the Interventional Neuroradiology and Diagnostic Radiology Departments. He began working with respondent as a neuroradiologist. He interacted with respondent frequently, on a daily basis. He described respondent as a "positive influence" and a "motivating faculty member." Respondent was excited about teaching and neuroradiology. His excitement "generated enthusiasm among the trainees." Respondent was supportive of the trainees at the Naval Medical Center, and respondent wrote a letter of recommendation for Dr. Hawley in support of his fellowship.

158. Dr. Hawley described respondent as a "forward type of person." Respondent was "knowledgeable about current techniques and advances in neurointerventional care." Respondent's expertise was "enlightening" for Dr. Hawley as a chief resident. Respondent was "professional, fast, and wanted the best outcome for his patients." Dr. Hawley found respondent to be honest and trustworthy.

159. Dr. Hawley did not read the instant Accusation, and only spoke to respondent briefly about it. He knew there was an interventional procedure that "became a point of contention," and understood there was an allegation related to HIPAA regarding credentialing at another hospital. Respondent never mentioned

accessing the medical records of over 200 patients or obtaining imaging from a clerk without authorization. He was not aware of respondent's summary suspension at UCD Med Center. Despite the allegations, Dr. Hawley's opinion of respondent has not changed.

Kurt Hildebrandt, M.D.

160. Dr. Hildebrandt is board certified in Diagnostic Radiology. He is a Diagnostic Radiologist at Community Medical Centers in Fresno. He received his medical degree in 1995 from the Uniformed Services University of Health Sciences. He completed an internship in 1996 and his residency in 2003 in Diagnostic Radiology at the Naval Medical Center. He completed a fellowship in Body Imaging in 2023 at the Naval Medical Center.

161. Dr. Hildebrandt and respondent served together as United States Naval personnel at the Naval Medical Center from 2007 to 2009. Dr. Hildebrandt was an attending physician performing body imaging, and respondent was Chief of cross-sectional imaging and later became Vice Chair of Radiology. During their two years working together in the U.S. Navy, Dr. Hildebrandt came to know respondent and was very impressed with respondent's professionalism and keen intellect. He did not observe respondent act in a dishonest or unprofessional manner. He described respondent as "bright and capable," "his intentions are always true," and "he calls things as he sees them."

162. Dr. Hildebrandt explained that cases would come to the Naval Medical Center from across the Pacific Fleet. During the war sailors and soldiers would come from the theater to receive treatment for their recovery. Dr. Hildebrandt consulted respondent about a patient who was developing catastrophic stroke symptoms and

could potentially lose half of his brain. Respondent looked at the studies and performed a neurointerventional procedure confirming the blockage. Respondent performed a thrombectomy on the patient and he had a full recovery. Dr. Hildebrandt found that respondent was committed to excellence in patient care.

163. Dr. Hildebrandt and respondent kept in touch after their work at the Naval Medical Center. Two years ago, respondent applied for staff privileges at Community Medical Centers in Fresno, where Dr. Hildebrandt is Vice President of the Medical Staff. Dr. Hildebrandt had to present respondent's application file to two different committees, peer review physicians, and the medical executive committee.

164. Dr. Hildebrandt supported respondent's application because he knew of respondent's character and "his explanation of events [about his summary suspension] ring true to me." Dr. Hildebrandt put his reputation on the line in support of respondent. Since then, respondent has "served the hospital well." Dr. Hildebrandt was not disappointed in hiring respondent. Dr. Hildebrandt asserted that respondent has honesty and credibility. Dr. Hildebrandt did not read the Accusation in the instant case, and only knew that UCD Med Center reviewed five cases and there were issues about HIPAA compliance.

Paul Dong, M.D.

165. Dr. Dong is an interventional radiologist who performs procedures on the body other than the head and spine. He is not a neurointerventional radiologist. He received his medical degree from Rush Medical College and completed his residency in Radiology at the University of California, Los Angeles (UCLA). He completed his fellowship in Interventional Radiology at UCD Med Center. He taught there for 12

years. He left for Sutter Medical Group, then returned to UCD Med Center for another 12 years.

166. Dr. Dong interacted with respondent at UCLA and UCD Med Center. He observed respondent to be cordial, honest, trustworthy, and very knowledgeable. Dr. Dong knew of the Board's Accusation but "did not review it that well." He knew that respondent started on Patient 1's right side during the procedure, but did provide anything more.

Anna Nidecker, M.D.

167. Dr. Nidecker is an interventional radiologist. She is board certified in Radiology with a subspecialty certification in Neuroradiology. She received her medical degree in 2003 from Albany Medical College in New York, completed her residency in Radiology at the State University of New York and Stony Brook, and completed a fellowship in Neuroradiology at John Hopkins University in Baltimore, Maryland.

168. Dr. Nidecker was called as a witness to impeach the veracity of Dr. Bobinski's testimony in this case. However, Dr. Bobinsky testified favorably about respondent in that he believed respondent provided the correct treatment on Patient 1. Further, although Dr. Bobinsky believed Dr. Dahlin's account of the event with Patient 1, Dr. Bobinsky was not concerned who caught the mistake. Nevertheless, Dr. Bobinski recommended the summary suspension of respondent.

169. Dr. Nidecker testified about her interactions with Dr. Bobinsky when she worked in the Neuroradiology Department at UCD Med Center in the early to mid 2010's. She observed Dr. Bobinsky's inappropriate behavior and language in the reading room. He used unnecessarily sexual and sexist language, "a lot of F-bombs

were floating around the reading room," and he used the "N-word." Dr. Bobinsky was insensitive and Dr. Nidecker felt sexually harassed by Dr. Bobinsky.

170. Dr. Nidecker described many other instances where Dr. Bobinsky was offensive, insensitive, and made her feel humiliated and embarrassed. She did not report Dr. Bobinsky's behavior to Human Resources because she believed she would be "blackballed," and her career would be compromised.

Analysis

CREDIBILITY DETERMINATIONS

171. The credibility of witnesses is evaluated under Government Code section 11425.50, subdivision (b):

> If the factual basis for the decision includes a determination based substantially on the credibility of a witness, the statement shall identify any specific evidence of the observed demeanor, manner, or attitude of witness that supports the determination, and on judicial review the court shall give great weight to the determination to the extent the determination identifies the observed demeanor, manner, or attitude of the witness that supports it.

Dr. Dahlin

172. Dr. Dahlin presented at hearing with a calm, humble demeanor. He was not argumentative or loud. He spoke clearly and explained his observations in a detailed, balanced, intelligent, and credible manner. He was cooperative and respectful. During Patient 1's procedure, Dr. Dahlin was not caught up in the many

distractions occurring in the angio suite and could observe what was going on in an objective, composed manner. His account that he told respondent that he was on the wrong side during the angiogram of Patient 1 was credible.

Dr. Bobinski

173. Dr. Bobinski testified in a fair, credible, and balanced manner and was not hostile to respondents' counsel. He answered all questions and was cooperative and respectful. He did not speak in a demeaning way about respondent. He did not appear to be biased against respondent. He was asked numerous questions about his education and background by respondent's counsel even though he was not an expert in this case. He answered all of counsel's questions without reservation. His frustration with the many questions on his background became evident, but he did not raise his voice or get angry. His testimony that he believed Dr. Dahlin's account of the event in the angio suite on January 10, 2018, was credible. He was also credible when he testified that respondent provided the correct treatment on Patient 1.

Dr. Dougherty

174. Dr. Dougherty also testified in a calm, balanced, respectful manner. He credibly gave his account of respondent's summary suspension and what he told respondent on the day of the suspension. He even conceded that UCD Med Center could have made an oversight in not disconnecting respondent's access to patient medical records on the date of the suspension. He demonstrated his willingness to be open, honest, and forthcoming about what UCD Med Center should have done on the date of the suspension.

Respondent

175. Respondent's demeanor was excitable, and he spoke extremely fast such that he was often difficult to understand. He was respectful, cooperative, and attentive throughout the nine days of hearing. He testified in a direct and candid fashion. He took responsibility for making a mistake with Patient 1, and was firm in his conviction that he did nothing wrong in accessing and disclosing patient medical records. Respondent's accuracy of his account of what occurred in the angio suite during Patient 1's procedure may have been compromised due to the distracting high activity in the angio suite and the amount of multi-tasking that had to be performed, which undermined his version of events. Moreover, respondent presented the attitude that he did nothing wrong. However, respondent was forthcoming during his testimony, but did not appear to be as credible as the other witnesses in this case who testified regarding the clinical and medical records issues.

Dr. Neidecker

176. Dr. Neidecker was a calm, cooperative, and credible witness. She had no reason to fabricate her observations of Dr. Bobinski's offensive behavior. She was reasonable and prudent for refraining from reporting him to Human Resources, and doing so could have undermined her career goals. In this regard, her testimony regarding Dr. Bobinski's character was given some, but not substantial weight. The factual finding above that Dr. Bobinski was credible in believing Dr. Dahlin over respondent, and the factual finding that Dr. Bobinski credibly testified that respondent provided the correct treatment on Patient 1, will not be impeached.

GROSS NEGLIGENCE

177. The evidence established that from December 21 to 31, 2019, respondent accessed the medical record of 214 patients at UCD Med Center without a legitimate medical purpose. Although respondent admitted that he did so in preparation for the UCD Medical Staff hearing and asserted he did so under the advice of an attorney, he conceded he was not involved in every case, but was only familiar with a large portion of them. Even if respondent treated those 214 patients, he would have had to request their medical records through proper channels with UCD Health's Health Information Management Office in accordance with the Employee Access Policy.

178. The evidence did not establish that on or between January 1, 2020, and January 31, 2020, respondent improperly obtained the medical records of at least 12 patients from UCD Med Center radiology staff without disclosing he was no longer on the medical staff and had relinquished his privileges. Ms. Mohammad credibly testified that she had no documentation that respondent picked up and therefore obtained the seven patient medical records he requested from Ms. Mohammad via text on January 4, 2020.

However, the evidence did establish that on January 4, 2020, respondent improperly obtained the medical records of at least five patients without disclosing he was no longer on the medical staff and had relinquished his privileges.

179. Lastly, the evidence established that on February 4, 2020, and February 24, 2020, respondent provided unredacted UCD Med Center records of five patients on CDs to MSJH without legal authority to disclose the records. Respondent signed the Attestation on January 31, 2020, agreeing he would use the records for the five patients solely for his UCD Medical Staff hearing. In violation of the Attestation,

respondent provided the CDs to Ms. Selby at MSJH and they were promptly picked up by Ms. Towns Navarra at UCD Med Center.

180. Respondent's contentions that he did nothing wrong, that he understood that the "institutions were talking to each other," and that MSJH was to return the CDs back to UCD Med Center, were not persuasive and unsupported by the evidence. Respondent's contention that he relied on the attorney's advice is a mitigating factor, in that the attorney suggested in a February 24, 2020, email that respondent deliver the copy he made of the medical records to MSJH.

181. The Board's expert Dr. Fidler opined on whether respondent committed gross negligence by accessing the 214 patient medical records and providing CDs with five patient medical records to MSJH on two occasions. Dr. Fidler cited as the standard of care that "physicians must follow all laws, regulations, and policies including all patient privacy and confidentiality laws." Dr. Fidler's expert opinion was given little weight for a number of reasons.

First, Dr. Fidler provided a deficient definition of what constitutes an extreme departure from the standard. She opined that an extreme departure is a "more substantial deviation from the applicable standard of care" but did not explain what this meant. She then defined gross negligence as an extreme departure from the standard of care, without more clearly defining what is an extreme departure. She did not, in the alternative, define gross negligence as a "want of even scant care."

Second, Dr. Fidler based her expert opinion on her interpretation of HIPAA and California statutes she identified as the Confidentiality of Medical Records Act under Civil Code section 56 et seq., the Patient Access to Health Records Act under Health and Safety Code section 123110 et seq., the Insurance Information and Privacy

Protection Act under Insurance Code section 791 et seq., and the Information Practices Act under Civil Code section 1798 et seq. None of these laws are cited in the Accusation, nor was sufficient evidence presented to support factual findings or legal conclusions that respondent violated the statutes referenced by Dr. Fidler. Moreover, it is unlikely that this court has jurisdiction to interpret or impose discipline based upon the federal statutes referenced by Dr. Fidler.

Third, Dr. Fidler determined that respondent violated patient privacy and confidentiality protections that all physicians must follow but did not reference any laws or hospital policy to support this determination.

Fourth, Dr. Fidler concluded that respondent "deceptively obtain[ed] unauthorized access to PHI multiple times . . . " representing an extreme departure from the standard of care, and added that respondent's conduct was an "unacceptable approach to obtain medical records this way," and "this was dishonest." Dr. Fidler's conclusions that respondent acted with intent to deceive are factual questions not within the province of expert opinion.

Fifth, Dr. Fidler's conclusion that respondent's "disregard of the Attestation and established processes which physicians are required to follow" was an extreme departure from the standard of care again confronts the flaw in her definition of what constitutes an extreme departure and, by extension, gross negligence. The most that can be said is that respondent breached the Attestation to use the five patient medical records for the limited purpose of his Medical Staff hearing. There is not sufficient evidence or expert analysis by Dr. Fidler that respondent violated any laws, regulations, and/or policies including all patient privacy and confidentiality laws when he breached the Attestation.

Sixth, regarding her opinion on whether respondent violated ethical principles, Dr. Fidler improperly concluded respondent "deceptively" obtained unapproved access to confidential health information, which is a question of fact not under her purview, as she did not have any advantage over a lay person in making a factual determination about respondent's alleged deception or dishonesty. Based on the foregoing, Dr. Fidler's expert opinion on whether respondent committed gross negligence is given little weight. Cause was not established that respondent engaged in gross negligence.

REPEATED NEGLIGENT ACTS

182. The evidence established that on January 10, 2018, respondent performed a series of wrong side angiograms on Patient 1 that resulted in a delay of care. The Board's expert, Dr. Telischak, persuasively opined that the standard of care was to address the vessel occlusion first. He further opined some practitioners do a complete angiogram following the mechanical thrombectomy, which is not the standard of care, whereas here, respondent performed a complete angiogram prior to the mechanical thrombectomy.

183. Dr. Telischak correctly articulated the definitions that a simple departure from the standard of care is the failure to use that skill and care physicians would use in same or similar circumstances. An extreme departure from the standard of care is want of even scant care. Dr. Telischak's expert opinion that respondent's "sidedness error" which he realized and corrected was a simple departure from the standard of care, was persuasive and given great weight. He did not conclude that the series of wrong side angiograms on the right side, resulting in a delay of care, were separate and distinct departures from the standard of care that would constitute repeated negligent acts.

184. In order to establish repeated negligent acts, there must be two or more negligent acts or omissions. Dr. Telischak found only one simple departure. Therefore, respondent's conduct was insufficient to establish repeated negligent acts.

185. However, Dr. Fidler's opinion supports repeated negligent acts in that respondent engaged in simple departures from the standard of care based on his access to patient medical records in violation of hospital policy. Thus, respondent engaged in repeated negligent acts.

186. Respondent's expert, Dr. Jensen, has not practiced medicine in California since June 30, 2001. This, however, did not detract from the depth and breadth of her vast medical experience and knowledge. She is well-regarded in her field and her expert opinion explaining angiograms and thrombectomies was helpful. Dr. Jensen did not believe it was below the standard of care to explore any right-side deficits. However, the standard of care was to perform the left side angiograms and left side thrombectomy first. This, respondent did not do. Dr. Jensen simply characterized respondent's mistake as an angiographic run on the contralateral side. Dr. Jensen's opinion was afforded less weight because she did not opine on what is a simple or extreme departure from the standard of care, what constituted gross negligence or repeated negligent acts, or whether respondent engaged in unprofessional conduct.

187. Respondent's second expert, Dr. Viets, opined that the standard of care is to perform an angiogram prior to the thrombectomy regardless of the location of the clot. He concluded that respondent performed his intended diagnostic angiogram "out of sequence," which was an inadvertent mistake during an emergency under challenging circumstances. Dr. Viets described respondent's conduct as a "small error" that did not deviate from the standard of care. The weight of the evidence favors

addressing the vessel occlusion first. Drs. Telischak and Jensen were more persuasive in this regard.

DISHONESTY

188. "'Dishonesty' denotes an absence of integrity; a disposition to cheat, deceive, or defraud; deceive and betray." (*Hogg v. Real Estate Commissioner* (1942) 54 Cal.App.2d 712, 717.) Complainant alleged that respondent engaged in dishonesty or corruption by obtaining and/or disseminating patient medical records without legal authority. When respondent was summarily suspended, Dr. Dougherty provided respondent with a "script" of instructions. Dr. Dougherty did not explicitly state in the instructions that respondent was to refrain from accessing EPIC and PACS, and respondent's access was to be cut off on the date of his resignation, or December 31, 2019. Respondent mistakenly believed he had a right to the records to prepare for his Medical Staff hearing. Not every patient was his, but he was familiar most of the cases. This mistaken but good faith belief in his right to the records, even when he was no longer on UCD Med Center's medical staff, was careless and ignorant. Respondent was not dishonest or corrupt.

189. Similarly, respondent obtained the CDs because he believed he had a right to them, and completely ignored the Employee Access Policy. He was scared and frustrated at the slow pace of getting the medical records of the five patients to MSJH, so he took matters into his own hands and contacted Ms. Mohammad, a weekend radiology clerk, to obtain the records on his own, bypassing the Employee Access Policy's requirement that respondent contact UCD Health's Health Information Management Office. Respondent's intent was to provide the CDs to MSJH as soon as possible, to speed up his credentialing application approval. The weight of the

evidence did not demonstrate that respondent intended to deceive the Radiology Department.

190. Respondent is astute, resourceful, experienced, accomplished, and highly intelligent. Yet he ignored the Employee Access Policy and his obligations under the Attestation because of an attitude of entitlement and hubris rather than his reliance on his attorney's advice. Regardless, the February 24, 2020 email to respondent from his attorney does support his claim that his attorney suggested he deliver a copy he made of the medical records to MSJH. Respondent knew or should have known what he was doing was improper, but he was so blinded by his concentrated efforts to get privileges at MSJH that he ignored the requests of compliance and medical staff at UCD Med Center and MSJH. Although it was not established here that respondent engaged in dishonesty, his conduct was nonetheless unprofessional.

GENERAL UNPROFESSIONAL CONDUCT

191. In order to impose discipline for general unprofessional conduct, one must breach the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine.

192. Respondent's violation of the Attestation is serious breach of the agreement and UCD Health's Employee Access Policy and constitutes unethical and conduct unbecoming a member in good standing of the medical profession.

193. By accessing the 214 patient medical records, after respondent agreed not to perform any clinical work, he undermined the trust of the medical profession and respondent's honesty and integrity. Such conduct is unethical and is unbecoming of a member in good standing of the medical profession. Similarly, respondent's

conduct in obtaining the CDs from the Radiology Department without telling them he was no longer an employee shows that he lacked judgement in that particular instance in ensuring that no other employees were subject to violations of UCD Med Center's Employee Access Policy, which could have subjected them to employee discipline. This conduct was unethical and unbecoming of a member in good standing of the medical profession.

194. Lastly, respondent's disclosure of the CDs containing the medical records of the five patients to MSJH was careless, self-serving, and showed a lack of regard of the Attestation, medical staff, and UCD Med Center's Employee Access Policy. Such conduct was also unethical and unbecoming of a member in good standing of the medical profession. Respondent's overall conduct in this regard constitutes general unprofessional conduct.

REHABILITATION CRITERIA

195. The Board has established rehabilitation criteria for a licensee that has been convicted of a crime or has been disciplined in another state. (Cal. Code Regs., tit. 16, § 1360.1.) Respondent has not been convicted of a crime nor disciplined in another state. However, the rehabilitation criteria are helpful in evaluating respondent's rehabilitation. The applicable criteria are: (1) the nature and gravity of the professional misconduct; (2) total record of misconduct; (3) time that has elapsed since the professional misconduct; and (4) evidence of rehabilitation submitted by the licensee.

196. The nature and gravity of respondent's conduct are serious. He compromised the privacy of patient medical records with his unauthorized access of 214 patient records and by providing the CDs containing five patient medical records to MSJH on two occasions while agreeing not to share the information to third parties.

197. It was not established that respondent has a history of discipline with the Board. However, his misconduct in the instant case was not what would be expected from a former U.S. Naval Officer and Neurointerventional Radiologist with a distinguished educational background and medical career. The incidents at issue occurred primarily in 2018 to 2020, within the past five years.

198. Respondent presented very little evidence of rehabilitation. Rehabilitation is a state of mind, and the law looks with favor upon rewarding with the opportunity to serve, one who has achieved reformation and regeneration. (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.) The mere expression of remorse does not demonstrate rehabilitation. Rather, a truer indication of rehabilitation is the demonstration of sustained conduct over an extended period of time that the licensee is rehabilitated and fit to practice. (*In re Menna* (1995) 11 Cal.4th 975, 987, 991.) The evidentiary significance of an applicant's misconduct is greatly diminished by the passage of time and by the absence of similar, more recent misconduct. (*Kwasnik v. State Bar* (1990) 50 Cal.3d 1061, 1070.)

199. Respondent expressed remorse for his conduct and while the mere expression of remorse does not demonstrate rehabilitation, sustained good conduct over a period of time does. Respondent did not demonstrate taking proactive measures to gain insight into his conduct. Respondent did not provide performance evaluations reflecting his current work performance. He did not take courses addressing confidentiality of patient records and the laws and regulations that provide protections for patient privacy. He did not take an ethics course to gain insight.

200. Respondent's colleagues, who are accomplished in their own right, credibly testified about respondent's professionalism, competency, medical knowledge, and his exceptional abilities as a clinician, teacher, mentor. Despite

respondent's lapse in judgment, none of them have any concerns about respondent's professional conduct or moral integrity. However, most, if not all of respondent's witnesses barely knew of the allegations in the Accusation. (See, *Seide v. Committee of Bar Examiners of the State Bar of California* (1989) 49 Cal.3d 933, 940 [a character witness's opinion is entitled to less weight when they are unaware of the reason for which discipline was imposed.])

201. Respondent has not demonstrated that he understands and has learned from his errors with respect to access to patient medical records. As he stated throughout his testimony regarding the accessing and providing of records to MSJH, he did nothing wrong and was acting upon the advice of an attorney. While this is a mitigating factor in this case, it does not demonstrate insight into rules that must be followed to get the records through proper channels. Respondent completely disregarded the admonitions in the Attestation, a legal document. Respondent has not provided adequate assurances to the Board that he is a safe and trustworthy medical practitioner. While it is doubtful that respondent will repeat the conduct addressed in the instant case, a period of probation is necessary to provide the Board with assurances that respondent has gained insight into his conduct, and to protect the public safety. Based on the evidence as a whole, probation is the appropriate discipline.

Costs

202. Pursuant to Business and Professions Code section 125.3, complainant requested that respondent be ordered to reimburse the Board for the reasonable costs of the investigation and adjudication of the case. Complainant submitted a Declaration of the Deputy Attorney General with an attached computer printout that lists the amounts charged by the Attorney General's Office by time, date, and task. The

Declaration and computer printout show that the Attorney General's Office billed the Board $43,515 for prosecuting the case. A Declaration and chart showing expert review services, the dates, hours performed, rate and total cost show the Board incurred expert review services of $9,260. Similarly, complainant submitted a Declaration of Investigative Activity by the Department of Consumer Affairs (DCA) with an attached Investigator Log that lists the amounts charged by time, date, and task. The declaration shows that DCA billed the Board $7,149.50 for investigating the case. The total costs of $59,924.50 appear reasonable in light of the allegations and issues this matter.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The Medical Practice Act is set forth in Business and Professions Code section 2000 et seq. The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea v. Bd. of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.)

Burden and Standard of Proof

2. Complainant bears the burden of proving each of the grounds for discipline alleged in the Accusation, and must do so by clear and convincing evidence. (*Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence is evidence that leaves no substantial doubt and is sufficiently strong to command the unhesitating assent of every reasonable mind. (*In re Marriage of Weaver* (1990) 224 Cal.App.3d 478, 487.) The higher standard of proof is justified

where vested rights are at stake – the revocation or suspension of a physician's and surgeon's certificate in this case.

License Discipline

3. Business and Professions Code section 2227, subdivision (a) provides, in pertinent part, that a licensee who has been found "guilty" of violations of the Medical Practice Act (Bus. & Prof. Code, § 2000 et seq.), shall:

> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

Unprofessional Conduct

4. Business and Professions Code section 2234 provides that the Board shall take action against any licensee found to have engaged in unprofessional conduct, which includes but is not limited to the following:

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

(b) Gross negligence.

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

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

(2) When the standard of care requires a change in the diagnosis, act, or omission that constituted 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.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the

qualifications, functions, or duties of a physician and surgeon.

5. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Bd. of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

Negligence

6. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care applicable to a medical professional must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal.App.4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280.) The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care. A single instance of negligent treatment is not grounds for discipline of a physician. (*Gromis v. Medical Board* (1992) 8 Cal.App.4th 589, 600). Repeated negligent acts consist of two or more negligent acts. (*Zabetian v. Medical Bd. of Cal.* (2000) 80 Cal.App.4th 462, 468.)

Dishonesty

7. Under Business and Professions Code section 2234, subdivision (e), unprofessional conduct includes "the commission of an act involving dishonesty or

corruption that is substantially related to the qualifications, functions, or duties of a physician or surgeon."

Causes for Discipline

8. Complainant did not establish by clear and convincing evidence that respondent engaged in unprofessional conduct by engaging in gross negligence pursuant to Business and Professions Code section 2234, subdivision (b), as set forth in the Factual Findings as a whole.

9. Complainant established by clear and convincing evidence that respondent engaged in unprofessional conduct by committing repeated negligent acts pursuant to Business and Professions Code section 2234, subdivision (c), as set forth in the Factual Findings as a whole.

10. Complainant did not establish by clear and convincing evidence that respondent engaged in unprofessional conduct by committing dishonesty pursuant to Business and Professions Code section 2234, subdivision (e), as set forth in the Factual Findings as a whole.

11. Complainant established by clear and convincing evidence that respondent engaged in general unprofessional conduct pursuant to Business and Professions Code section 2234, as set forth in the Factual Findings as a whole.

Disciplinary Guidelines

12. The Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (Guidelines) provides recommended ranges of penalties for specified violations of the Medical Practice Act. For violation of Business and Professions Code section 2234 (general unprofessional conduct), and section 2234, subdivision (c)

(repeated negligent acts), the recommended minimum penalty is stayed revocation and five years' probation with standard probation conditions and optional conditions 13 (education course), 14 (prescribing practices course), 15 (medical record keeping course), 18 (clinical competence assessment program), 23 (monitoring-practice/billing), 24 (solo practice prohibition), and 26 (prohibited practice). The maximum penalty is revocation.

13. Respondent has not taken responsibility for his privacy breaches and violation of UCD's Employee Access Policy. It is reasonable for a client to follow the instructions of his lawyer, however, there was very little evidence to show that respondent had an absolute right to patient medical records with unfettered discretion to obtain them. Respondent did not follow the policy and demonstrated general unprofessional conduct in this regard. Respondent has not established that he is a safe and trustworthy medical practitioner. The Board does not have adequate assurances that respondent can practice without the imposition of probation.

14. Based on the evidence as a whole, the public safety will be protected with the recommended minimum discipline of five years of probation with applicable standard and optional terms. The optional terms of a prescribing practices course, medical recordkeeping course, clinical competence assessment program, and prohibited practice will not be ordered. The standard terms of prohibition of supervision of physician assistants and advance practice nurses, and practice monitoring, will not be ordered. An ethics course, education course, and solo practice prohibition will be ordered. A downward departure from the Board's Disciplinary Guidelines is not warranted.

Conclusion

15. The objective of an administrative proceeding relating to licensing is to protect the public. Such proceedings are not for the primary purpose of punishment. (*Fahmy v. Medical Bd. of California* (1995) 38 Cal.App.4th 810, 817.) When all of the evidence is considered, the public safety is ensured by placing respondent on probation, with terms and conditions set forth below.

Cost Recovery

16. Pursuant to Business and Professions Code section 125.3, a licensee found to have violated a licensing act may be ordered to pay the reasonable costs of investigation and prosecution of a case. In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth factors to be considered in determining the reasonableness of costs sought pursuant to statutory provisions like Business and Professions Code section 125.3. These factors include whether the licensee has been successful at hearing in getting charges dismissed or reduced, the licensee's subjective good faith belief in the merits of his or her position, whether the licensee has raised a colorable challenge to the proposed discipline, the financial ability of the licensee to pay, and whether the scope of the investigation was appropriate in light of the alleged misconduct.

17. Here, the scope of the investigation was appropriate to the alleged misconduct. Respondent was successful in getting some charges dismissed or reduced. He presented a colorable challenge to license revocation. Respondent established a basis to reduce the costs in this matter. Total costs are reduced to $30,000. Respondent may make payments in installments as directed by the Board.

ORDER

Physician's and Surgeon's Certificate No. A 91470, issued to respondent JORDAN ISAAC ZIEGLER, M.D., is REVOKED. However, the revocation is stayed and respondent is placed on probation for five years upon the following terms and conditions related to his repeated negligent acts and general unprofessional conduct.

Optional Conditions

1. EDUCATION COURSE

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. PROFESSIONALISM PROGRAM (ETHICS COURSE)

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of California Code of Regulations, title 16, section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents

that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program 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 program would have been approved by the Board or its designee had the program 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 program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. SOLO PRACTICE PROHIBITION

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective

date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the respondent's practice setting changes and the respondent is no longer practicing in a setting in compliance with this Decision, the respondent shall notify the Board or its designee within five calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

Standard Conditions

4. NOTIFICATION

Within seven days of the effective date of this Decision, 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.

5. Obey All Laws

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

6. 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.

7. 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(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 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.

8. 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.

9. 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 years.

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

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

10. 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.

11. 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.

12. 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 license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of

probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

13. 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.

14. Enforcement Costs

Respondent shall pay the costs associated with the enforcement of this matter in the reduced amount of $30,000. Respondent may negotiate a payment plan with the Board and the costs may be adjusted. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee not later than January 31 of each calendar year.

DATE: November 22, 2023

Danette C. Brown

DANETTE C. BROWN
Administrative Law Judge
Office of Administrative Hearings