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

In the Matter of the First Amended Accusation Against: MARTIN CHAN-HOI LEUNG, M.D. Physician's & Surgeon's Certificate No G 39648 Respondent.	Case No.: 800-2018-040046

DENIAL BY OPERATION OF LAW PETITION FOR RECONSIDERATION

No action having been taken on the petition for reconsideration, filed by February 27, 2024, and the time for action having expired at 5:00 p.m. on March 1, 2024, the petition is deemed denied by operation of law.

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
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STATE OF CALIFORNIA

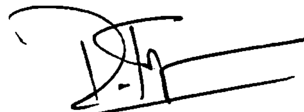
In the Matter of the First Amended Accusation Against: **MARTIN CHAN-HOI LEUNG, M.D.** **Physician's & Surgeon's Certificate No. G 39648** **Respondent.**	**Case No. 800-2018-040046** **ORDER GRANTING STAY** **(Government Code Section 11521)**

Jeffrey S. Kravitz, Esq. on behalf of Respondent, MARTIN CHAN-HOI LEUNG, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of February 20, 2024, at 5:00 p.m.

Execution is stayed until March 1, 2024, at 5:00 p.m.

This Stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: February 15, 2024



Reji Varghese
Executive Director
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
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In the Matter of the First Amended Accusation Against:

MARTIN CHAN-HOI LEUNG, M.D.,

Physician's and Surgeon's Certificate No. G 39648

Respondent.

Agency Case No. 800-2018-040046

OAH No. 2021090096

DECISION AFTER SUPERIOR COURT REMAND

This matter was originally heard by Administrative Law Judge (ALJ) Karen Reichmann, State of California, Office of Administrative Hearings, on March 15 through 17, 2022, by telephone and videoconference.

Deputy Attorney General Carolyne Evans represented Complainant William Prasifka, Executive Director of the Medical Board of California (Board) (Complainant).

Attorney Paul Chan represented Respondent Martin Chan-Hoi Leung, M.D., (Respondent) who was present.

The record closed and the matter was submitted for decision on March 17, 2022. The ALJ issued a proposed decision on April 14, 2022, which was adopted by Panel A of the Board as its own decision on May 26, 2022. In that decision, Respondent was found to have committed unprofessional conduct pursuant to three causes of action and failure to maintain adequate and accurate medical records as to Patient 1. Respondent was not found to have committed sexual misconduct against a second patient. He was placed on probation with various terms and conditions, including paying the Board's full fees and costs of $24,357.50.

On September 2, 2022, Respondent filed a Writ of Mandamus in the Superior Court of Sacramento County and the Honorable James Arguelles found that, since the second cause of action for sexual misconduct had been dismissed, the Board is required to reduce the amount of fees and costs awarded in this matter. Judge Arguelles also found that the evidence did not support two of the factors that the ALJ used to support a finding of gross negligence under the First Cause for Discipline. Consequently, the court remanded the action back to the Board for reconsideration and re-imposition of discipline consistent with the court's findings.

Following the court's remand, oral argument on the matter was heard by Panel A on November 29, 2023, with ALJ Wim van Rooyen presiding. Supervising Deputy Attorney General Machaela M. Mingardi represented Complainant. Respondent was present and was represented by Attorney Jeffrey S. Kravitz.

Panel A, having read and considered the entire record, including the transcript and the exhibits, the Superior Court's Order, and the written and oral arguments, hereby enters this Decision After Superior Court Remand.

FACTUAL FINDINGS

Introduction

1. On July 2, 1979, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. G 39648 (Certificate) to Respondent Martin Chan-Hoi Leung, M.D. The Certificate was in full force and effect at all times relevant to the charges in the First Amended Accusation. The Certificate will expire on May 31, 2025, unless renewed. This is the first disciplinary action against Respondent's Certificate.

2. On January 31, 2022, Complainant filed the First Amended Accusation solely in his official capacity as the Board's Executive Director. Complainant seeks to discipline Respondent based on incidents involving two patients.

3. As to Patient 1, Complainant alleges that Respondent did not obtain and/or document the patient's medical history prior to prescribing controlled substances, did not document treatment goals regarding the controlled substances, prescribed narcotics without informed consent or failed to document informed consent, did not adequately monitor the patient by reviewing CURES data or urine toxicology screens, and failed to maintain adequate and accurate medical records.[1] Complainant does not allege that Respondent's decision to prescribe controlled substances to Patient 1 was improper or that he prescribed an excessive quantity. Respondent concedes that his recordkeeping was deficient but disputes the remaining allegations.

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[1] The First Amended Accusation also alleged that Respondent prescribed controlled substances without a legitimate indication, but this allegation was withdrawn at hearing.

4. As to Patient 2, Complainant alleges that Respondent engaged in sexual misconduct by calling her beautiful, groping her breast while listening to her heart with a stethoscope (cardiac auscultation), asking to administer a vaccine into her buttock, and repeatedly touching her knee with his knee while administering a vaccine in her arm; and that Respondent engaged in gross negligence in the administration of the vaccine because he was not wearing gloves and used his bare finger on the injection site to stop the bleeding. Respondent denies any misconduct relating to Patient 2.

5. Complainant also seeks to discipline Respondent for failing to participate in an investigative interview regarding both patients. Respondent contends that his refusal to be interviewed was justifiable because he feared criminal prosecution.

Respondent's Background

6. Respondent graduated from medical school in Canada in 1978. He completed a one-year internship in family medicine in Bakersfield. He worked briefly for Kaiser Permanente in Los Angeles and San Francisco and in a private practice in Arizona before opening his own solo practice in San Francisco's Chinatown in 1983, providing primary care to adults only. In 2004, he moved his practice to the Glen Park neighborhood of San Francisco. He employed two medical assistants and had three examining rooms. Respondent saw patients four days a week, from 1:00 p.m. to 5:00 p.m. and usually saw 30 patients per day. Respondent retired in late 2021. He "shadowed" the physician who took over his practice for two months and stopped seeing patients completely as of February 26, 2022.

Patient 1

7. Patient 1 had more than 60 medical appointments with Respondent between December 2014 and March 2019. Respondent maintained handwritten

records for the patient and in November 2015 he also began making parallel entries in an electronic recordkeeping program. Records from six clinic visits between December 2014 and May 2015 mention that Patient 1 reported pain, that an x-ray had been reviewed with negative findings, that the patient was being treated by a psychiatrist, and that Respondent had recommended Motrin. During the course of treatment, Respondent referred the patient to specialists for consultations.

8. Respondent first prescribed Norco 5/325[2] to Patient 1 on June 20, 2015. Respondent documented that the patient reported back and neck pain. There is no examination recorded in the chart note and no explanation of the rationale for prescribing Norco. There is no documentation that Respondent explained the risks and benefits of Norco to the patient and there is no written, signed pain contract in the patient's record. Respondent continued to prescribe Norco to Patient 1 until the patient stopped seeing him in 2019. The patient was maintained on the same dose, two tablets per day. Respondent's notes do not reflect why Respondent continued to prescribe Norco and do not reflect a tapering plan.

9. Respondent never performed a urine toxicology screening of Patient 1 to confirm the patient's medication compliance. There is no CURES[3] report in Patient 1's

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[2] Norco 5/325 consists of 5 mg of hydrocodone and 325 mg of acetaminophen. Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(1) and a dangerous drug pursuant to Business and Professions Code 4022.

[3] CURES is a database of controlled substance prescriptions dispensed in the state. It is useful for determining whether patients are obtaining multiple prescriptions from different providers. Use of CURES for physicians prescribing controlled substances became mandatory by state law as of October 2, 2018.

chart until October 2018, more than three years after Respondent began prescribing him Norco.

Patient 2

10. Patient 2 was 30 years old when she had her first and only appointment with Respondent on January 3, 2019. Patient 2 had been a lifelong Kaiser Permanente patient, but had recently switched to a lower-cost health insurance plan to save money. She was seeking to establish care with a primary care provider with a practice near her residence. After calling several physicians who were not accepting new patients or who had no appointments available for months, she scheduled an appointment with Respondent. She wanted to have a routine check-up and a flu shot.

11. Patient 2 formed a negative impression of Respondent's practice before encountering him. She observed open patient files at the reception desk and was concerned about the practice's attention to patient privacy. She was required to pay a copayment upfront before seeing Respondent. Patient 2 waited for 30 minutes in the waiting room and 10 minutes in the examination room before Respondent came into the room. This differed from her experiences at Kaiser, where she was never made to wait.

12. Patient 2 was wearing a long-sleeve shirt over a tank top. The shirt was tucked into her pants. Patient 2 remained dressed and the door to the examination room remained open during the appointment. Respondent's staff members entered the room at different times during the appointment.

Patient 2 testified that Respondent called her "beautiful" several times during the appointment, and that this made her uncomfortable. During the check-up, Respondent took Patient 2's blood pressure over her shirt. Patient 2 testified that Respondent grabbed and untucked her shirt without warning in order to place his

stethoscope on her back to listen to her breathing; that he then abruptly moved his hand with the stethoscope underneath her shirt around to her chest; and that he "cupped" her left breast with his hand for several minutes while listening to her heart with the stethoscope. Patient 2 did not state that Respondent's hand touched her bare breast; her testimony is interpreted as alleging that Respondent's hand was over the tank top. Patient 2 stated that she was very uncomfortable while this happened and that it "did not feel normal." She acknowledged that Respondent's staff came in and out of the room during her appointment, but stated that no one was in the room when Respondent touched her breast.

13. Patient 2 asked Respondent for a flu shot. Respondent left the room to get a syringe and flu vaccine. He did not wear gloves during the administration of the vaccine. Respondent asked the patient whether she wanted the shot administered in her arm or her buttock. This surprised Patient 2 because she had never been asked if she wanted a shot in her buttock before. She asked for the shot in her arm. According to Patient 2, Respondent did not prepare the vaccination site with alcohol, and when she asked him to do so told her it "didn't matter." Patient 2 further testified that Respondent touched her knee with his knee while giving her the vaccine, and that when she tried to move her knee away he moved his forward to rest against her knee again. She stated that Respondent's knee was touching her knee as he administered the vaccine for a period of five minutes. Finally, she testified that Respondent used his bare finger to stop the bleeding after removing the syringe.

14. Patient 2 felt that the appointment with Respondent was not normal and that she had been sexually assaulted. Shortly after she left, she contacted friends and posted a message on social media, stating, "you think you can trust people and you can't," and using the hashtag, "#MeToo." She did not identify Respondent by name. She spoke with a friend who is a lawyer who recommended that she write down what

happened as soon as possible, while her recollection was fresh. A friend who is a dentist sent her a link to use to file a complaint with the Board.

15. Patient 2 wrote down her recollection of the appointment and submitted an online complaint that evening, a few hours after her afternoon appointment with Respondent. In the online complaint, Patient 2 did not accuse Respondent of calling her "beautiful" and in her description of the incident she wrote that Respondent "groped" her breast under her shirt without noting that she was wearing a tank top.

16. Patient 2 explained at the hearing that she wanted to stand up for other women and be a voice to prevent similar incidents. She also stated that she had looked Respondent up on "Yelp" and had read a review from another patient who reported a similar incident.

Patient 2 explained that she hoped that by sharing her experience she would feel less alone and help others feel less alone. Submitting a complaint to the Board and testifying at the hearing helped Patient 2 feel validated.

Patient 2 did not contact the police. She testified that she did not think it would help, noting that she had heard stories that the police do not do anything for women who report sexual assaults. Patient 2 did not sue Respondent and did not ask for a refund of her copayment.

17. Although Respondent gave her an order for lab work, Patient 2 chose not to go to the lab for the tests because she did not want to be associated with Respondent anymore. Patient 2 switched back to Kaiser for her health care.

Interview Request

18. In February and April 2020, Division of Investigation investigator Rebecca

Sernett contacted Respondent's counsel in order to schedule an interview of Respondent. Respondent was notified of the identities of the two patients at issue in the investigation. In a letter to Sernett dated May 1, 2020, Respondent's attorney wrote that Respondent "has advised that he declines to be interviewed regarding this investigation."

19. In a letter to Respondent dated May 19, 2020, Sernett wrote that the Health Quality Investigation Unit is "charged with investigating criminal and/or administrative misconduct involving licensed physicians in the state of California on behalf of the Medical Board of California." Sernett advised Respondent of his obligation under Business and Professions Code section 2234, subdivision (g), to participate in the Board's investigative interviews. Sernett requested that an interview be scheduled within 7 days and be completed within 30 days, and warned Respondent that the matter would be sent for review to an expert without his input should he decline to participate in an interview. He was also warned that he could be charged with violating section 2234, subdivision (g). Respondent refused to be interviewed.

Respondent's Testimony

PATIENT 1

20. Respondent defended his treatment of Patient 1. He stated that he was very cautious when prescribing Norco to this patient and made sure not to overprescribe. Respondent has prescribed Norco to very few patients, and Patient 1 was the only patient for whom he prescribed Norco for long-term use. He noted that he did not give large quantities, did not increase the dose, and did not give early refills.

Respondent asserted that he provided information about the risks of taking Norco to Patient 1, obtained informed consent, and had a verbal pain contract. This testimony was credible. He acknowledged that these things were not documented in the patient's medical record. He also agreed that he should have documented a full medical history before prescribing controlled substances to Patient 1. He asserted that his practice is to take a full history, including asking the patient about prior drug use, but that he only documents pertinent responses. Respondent admitted that he did not request records from Patient 1's treating psychiatrist prior to prescribing him Norco.

Respondent admitted that he did not check CURES for Patient 1 until late 2018, when it became mandatory. He added that he believed Patient 1 was compliant and he never suspected him of abuse.

Although Respondent admitted that his recordkeeping was deficient (consistent with the opinion of his expert witness), during his testimony he defended his records and did not seem to appreciate the necessity of accurate, complete medical records. He blamed "time limitations" for his failure to be more comprehensive in his documentation. Respondent stated that he wrote enough information so that he would understand what he did at the next patient visit. He minimized the importance of another physician being able to understand his notes, stating that in his practice he does not generally refer to the notes of other physicians. He added that emergency room physicians are able to treat patients without the benefit of prior providers' records.

PATIENT 2

21. Respondent does not remember his appointment with Patient 2 and did not recognize her when she testified at the hearing. Accordingly, he testified as to his

general practices and could not testify specifically regarding his one encounter with Patient 2.

Respondent denied that he called Patient 2 "beautiful," saying that he would not make such a comment to a patient, especially on a first appointment. Respondent does not generally comment on patients' appearances, although he might comment approvingly on a patient's weight loss or on the general appearance of a long-time patient.

Respondent adamantly denied groping Patient 2's breast, stating that he would never do such a thing. He explained that his general practice was to keep the door open during patient appointments, unless performing a breast exam or other more intimate procedure, in which case he would have a medical assistant present as a chaperone. Respondent acknowledged that he might help a patient move their shirt out of the way to place the stethoscope. He holds the stethoscope with three fingers and tries to avoid any contact with a patient's breast when listening to the heart. This testimony was credible.

Respondent acknowledged that it is not his practice to wear gloves while administering injections, because he has a latex allergy. He uses a "no touch" technique instead. Respondent stated that his practice is to wash his hands at a sink which is located outside the patient examining rooms. He retrieves the individually sealed sterile syringe and vaccine and returns to the examining room, where he has glass jars with alcohol-soaked cotton balls. He cleans the injection site with the cotton ball and administers the injection without touching the patient's skin. He uses another cotton ball to stop the bleeding before putting on a band-aid. He denies ever administering a shot without first cleaning the site or using his bare finger to stop the bleeding, commenting that he has ample supplies of alcohol and cotton balls, no

reason not to use them, and no interest in coming into contact with patients' blood. This testimony was credible.

Respondent acknowledged that he frequently administers vaccines, including the flu vaccine, in the upper hip/buttock region. He stated that it is less painful for the patient than administering the shot in the arm, and that many of his patients prefer it. He stated that his knee might have bumped into Patient 2's knee while he gave her the flu vaccine, but that if so, it was unintentional. This testimony was also credible.

INTERVIEW REFUSAL

22. Respondent admitted that he declined to be interviewed by the Board's investigator. He stated that he was scared that he would say the wrong thing and did not want to go to jail. He noted that the letter from the Board's investigator described in Finding 19 referenced the Board's authority to conduct a criminal investigation.

Expert Opinions

23. Brian Chan, M.D., testified as an expert witness on behalf of Complainant. He has been licensed as a physician in California since 1997. Dr. Chan is board certified in internal medicine. He has worked in an outpatient clinic at Kaiser Permanente in Richmond since 1999. Dr. Chan has served as an expert reviewer for the Board for about 18 years, reviewing approximately 30 cases during this time. Dr. Chan reviewed documents including the patients' medical records and the investigation report,[4] and wrote a report with his findings.[5] Dr. Chan also reviewed the report of Respondent's expert prior to testifying at the hearing.

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[4] The investigation report was not offered into evidence.

[5] In his report, Dr. Chan uses the opposite designations for the patients than is used in the First Amended Accusation and in this decision - the patient designated as Patient 1 in his report is the patient designated Patient 2 in this decision and vice versa.

24. Dean J. Nickles, M.D., testified as an expert witness on behalf of Respondent. Dr. Nickles is board certified in internal medicine and has practiced in the bay area for more than 40 years. Dr. Nickles is currently affiliated with Stanford Medicine Partners in Emeryville. Dr. Nickles reviewed the patients' medical records and other documents and wrote a report with his findings. Dr. Nickles reviewed Dr. Chan's expert report prior to testifying at the hearing.

PATIENT 1

25. Dr. Chan identified several departures from the standard of care regarding Patient 1. He testified that the standard of care requires a physician to take a thorough social and psychological history prior to prescribing controlled substances, in order to assess the patient's risk. Because of the high association with morbidity and mortality associated with Norco, the physician must make sure it is safe for the patient prior to prescribing it. A physician should obtain past records and any imaging of the areas in pain. The physician must also explain the serious risks, obtain patient consent, and document informed consent. Dr. Chan believes that by 2015, the standard of care required a written pain management contract for patients being prescribed Norco for a prescriber to satisfy the informed consent requirement.

Dr. Chan believes that Respondent departed from the standard of care by failing to perform testing, failing to perform and/or document a thorough history and physical examination, failing to review prior medical records, and failing to document his rationale for prescribing Norco prior to starting the patient on this medication. He characterized this pre-prescription group of departures as extreme.

26. Dr. Chan noted that the standard of care for prescribing Norco requires a physician to have a treatment plan and objectives and to have the patient take Norco for as short a period of time as possible. He noted that Respondent continued to

prescribe Norco without documenting his rationale. Dr. Chan could not discern Respondent's treatment plan from reviewing the records. He concluded that Respondent committed a simple departure from the standard of care by failing to explain his treatment plan in the patient's medical record.

27. Dr. Chan opined that the standard of care requires a physician prescribing controlled substances to monitor patient compliance by performing urine toxicology screening and checking CURES at least annually. Dr. Chan was aware that CURES was not mandatory until 2018, but believes that reasonably prudent physicians were consulting it between 2015 and 2018 and that Respondent's failure to do so and failure to perform urine toxicology screening at least annually were extreme departures from the standard of care.

28. Dr. Chan explained that the standard of care for patient records is for the physician to provide adequate information that is thorough, legible, and complete, in order that another physician can understand what has taken place. Failure to do so can have a negative impact on subsequent care. Dr Chan found Respondent's records for Patient 1 to be sparse and difficult to interpret and noted that he had to make inferences to reach an understanding of the course of treatment and that he was never able to figure out Respondent's rationale. Dr. Chan believes that the records were so deficient as to constitute an extreme departure from the standard of care. Dr. Chan does not believe that there is a different standard of care for patient records for physicians who are older or who are in a solo practice setting.

29. Dr. Nickles agreed that Respondent's documentation fell below the standard of care. He characterized the departure as simple rather than extreme, and not unusual for "older" physicians. He stated that he felt that he could understand what Respondent did and Respondent's line of thinking in the

treatment of Patient 1, but that it was "difficult" and he had to "read between the lines." Dr. Nickles did not disagree with Dr. Chan's opinion that a thorough evaluation, history, and physical examination must be performed prior to prescribing controlled substances, but did not find Respondent to have been negligent in failing to do so, instead concluding that Respondent merely failed to document doing so.

30. Dr. Nickles agreed that a physician prescribing controlled substances must communicate the risks to the patient, but stated that the standard of care in 2015, when Respondent began prescribing Norco to Patient 1, did not require a written pain contract in the patient's file. In his experience, most physicians still do not use a written pain contract. He acknowledged that Respondent should have documented informed consent in Patient 1's records.

31. Dr. Nickles does not believe that the failure to document a treatment plan constituted a departure from the standard of care, because he believes that although the plan was not documented, the actual treatment provided was within the standard of care.

32. Dr. Nickles testified that urine toxicology screening "should be done" but he does not believe that Respondent deviated from the standard of care by failing to do so because, in his experience, many other doctors never perform any urine toxicology screening of patients taking controlled substances. He believes that Respondent did not deviate from the standard of care by not performing urine toxicology screening of Patient 1 because there were no "red flags" and the patient was on a low dose of Norco.

33. Dr. Nickles testified that between 2015 and 2018, the standard of care did not require physicians to check CURES when prescribing controlled substances. He

described the CURES interface prior to 2016 as "clunky" and emphasized the fact that it was not mandated by law that prescribers check CURES until 2018.

34. Consistent with the Superior Court's remand in this case, there was insufficient evidence to prove the charge of gross negligence or repeated negligent acts regarding Patient 1.

PATIENT 2

35. Both experts agreed that a physician must treat patients in a non-sexual manner, and that it is a departure from the standard of care for a physician to touch a patient's breast while performing a cardiac auscultation. Both acknowledged that brief incidental contact with a patient's breast during this procedure can occur and would not constitute a departure from the standard of care.

36. Dr. Chan stated that it is "unusual" to administer a flu shot in a patient's buttocks and that he has not seen it done. As a physician working at Kaiser, Dr. Chan does not often administer injections, which are usually performed by other medical staff.

Dr. Chan stated that it is not always wrong to compliment a patient's appearance, but that a physician must be careful when making complimentary statements and not do so in a threatening manner.

Dr. Chan concluded that the conduct alleged by Patient 2 - touching of her breast, calling her beautiful, and asking to administer the vaccine in her buttock - would likely make a patient uncomfortable. He opined that the conduct, if true, would constitute an extreme departure from the standard of care. He added that incidental contact between a physician's knee and a patient's knee during the administration of

an injection may be unavoidable, but that when viewed in context of the other allegations by Patient 2, it seems "suspect."

Dr. Chan explained that the standard of care for administering a vaccine requires that the administration be safe and sterile. The standard of care requires sterilizing the injection site and using gauze to stop the bleeding. He conceded that if the physician washes his hands before administering a shot and drew the vaccine into the syringe without making physical contact, wearing gloves is not necessary. Dr. Nickles testified that he does not wear gloves when administering injections and agreed that the standard of care requires cleaning the injection site with an alcohol swab and avoiding any skin to skin contact.

Dr. Nickles does not think that it is unusual to administer a flu shot in a patient's buttock. Dr. Nickles does not wear gloves when giving injections, and agreed with Dr. Chan that gloves are not necessary if the physician is careful to avoid skin to skin contact and sterilizes the injection site.

Other Evidence

37. Respondent submitted three letters from patients, two of whom also testified at the hearing.

a. Elizabeth Ko is a schoolteacher who became Respondent's patient in 2013. For a period of time, she had monthly appointments with Respondent. Ko testified that Respondent is like a grandfather figure to her, and she feels safe and comfortable with him. Ko is grateful for Respondent's care, which has helped her live a happy, healthy, and productive life, and is sorry that he has retired.

Respondent has never complimented her appearance or made her feel uncomfortable. Ko trusts Respondent and believes he is an ethical physician. She was

shocked and puzzled when she learned that he was accused of groping a patient. She would not tolerate misconduct of that sort.

Ko has received injections from Respondent and she believes Respondent always disinfected her skin with a cotton ball prior to administering an injection. She recalled having a shot administered in her hip at least once. She remembered lowering one side of her pants slightly so that Respondent could give her the shot.

b. Selina Chen became Respondent's patient 25 years ago, after feeling quite ill at church one Sunday. Chen's mother-in-law was a patient of Respondent's and called him for help. He agreed to see Chen even though his office was closed on Sunday. Respondent diagnosed Chen with shingles and treated her. Chen did not have health insurance and Respondent told her that it did not matter to him. Chen believes Respondent saved her life. She stayed as his patient ever since because she believes he is "a doctor with a heart." Respondent has also treated several of Chen's family members. Chen has had appointments with Respondent approximately 10 times a year for approximately 25 years. She has never felt uncomfortable in Respondent's presence.

Chen reported that she gets a flu shot from Respondent every year, and that Respondent asks where to administer it. Chen prefers having the shot in her buttock because she does not want her arm to be sore.

Chen does not believe that Respondent groped a patient's breast. She described him as a professional who does not look at her body. She added that Respondent's female assistant is always present during more intimate procedures.

c. Tsui Fung Mo wrote that she become Respondent's patient in 2010. Her father-in-law was already a patient of Respondent's. Mo had suffered from stomachaches for several years and had sought treatment from other physicians

without success. Respondent diagnosed her with gallbladder disease. Respondent has taken care of several of Mo's family members from newborn to elderly.

Mo wrote that Respondent is hardworking, honest, ethical, professional, knowledgeable, and compassionate. Mo added that she is aware that Respondent has been accused of groping a patient and does not believe that Respondent would have done such a thing. Mo has never felt violated by Respondent in any way.

Ultimate Findings

38. In compliance with the Superior Court's remand in this case, the Board finds that there was insufficient evidence to prove the charge of gross negligence or repeated negligent acts regarding Patient 1 relating to prescribing Norco.

39. Both experts agreed that Respondent's recordkeeping regarding Patient 1 was deficient; they disagreed as to whether it constituted a simple or extreme departure from the standard of care. Both testified that it was difficult to understand Respondent's treatment decisions by reviewing the records. For this reason, Dr. Chan's opinion that the departure was extreme was more persuasive than the opinion of Dr. Nickles that the departure was merely simple.

40. It was not established by clear and convincing evidence that Respondent committed sexual misconduct. Although Patient 2 was credible in her belief that Respondent called her "beautiful," touched her breast during cardiac auscultation, had salacious intent when offering to inject the flu vaccine in her buttock, and intentionally touched her knee with his knee, Respondent was equally credible in his denial of engaging in this type of behavior. The evidence suggested the possibility that

Respondent had inadvertent contact with the patient's breast and knee, but did not establish intentional touching or a sexual motive.

41. Respondent did not depart from the standard of care by asking Patient 2 whether she preferred to be vaccinated in the arm or buttock. Although Dr. Chan opined that it is uncommon to administer a flu vaccine in the buttock, it was not established that offering to do so is a departure from the standard of care. Nor was it established by clear and convincing evidence that Respondent departed from the standard of care by not wearing gloves or failing use sterile practices in administering the vaccine.

42. It is undisputed that Respondent refused to be interviewed by the Board's investigator regarding either Patient 1 or Patient 2.

Costs

43. Complainant seeks to recover $1,350 for expert reviewer costs and $23,007.50 for legal services provided by the Department of Justice, all billed in the year 2022, for a total of $24,357.50. These costs are supported by declarations in compliance with the requirements of California Code of Regulations, title 1, section 1042, and are reasonable. As discussed below, however, cost recovery must be reduced in this case.

LEGAL CONCLUSIONS

1. It is Complainant's burden to demonstrate the truth of the allegations by "clear and convincing evidence to a reasonable certainty," and that the true allegations constitute cause for discipline of Respondent's Certificate. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

2. Business and Professions Code section 2227 authorizes the Board to take disciplinary action against licensees who have been found to have committed violations of the Medical Practice Act. Business and Professions Code section 2234, included in the Medical Practice Act, provides that a licensee may be subject to discipline for unprofessional conduct, which includes gross negligence (§ 2234, subd. (b)), repeated negligent acts (§ 2234, subd. (c)), sexual abuse or misconduct (§ 726), inadequate or inaccurate records (§ 2266), and failure, in the absence of good cause, to attend and participate in an interview by the Board (§ 2234, subd. (g)).

First Cause for Discipline - Gross Negligence/Repeated Negligent Acts (Patient 1)

3. The evidence did not establish that Respondent committed gross negligence by prescribing Norco to Patient 1 without a thorough evaluation, history, physical examination, informed consent, and regular monitoring with CURES and urine toxicology screening, nor that he committed an act of simple negligence by failing to document a treatment plan for the prescription of Norco.

Second Cause for Discipline - Failure to Maintain Accurate and Adequate Medical Records (Patient 1)

4. Cause for discipline under Business and Professions Code section 2266 for failing to maintain accurate and adequate medical records for Patient 1 was established, in light of the matters set forth in Finding 39.

Third Cause for Discipline - Failure to Participate in Investigative Interview (Patient 1)

5. Cause for discipline pursuant to Business and Professions Code section

2234, subdivision (g), for failing to participate in the investigative interview regarding Patient 1, was established in light of the matters set forth in Findings 18, 19, and 42. Respondent's fear of the consequences of participating in an investigative interview does not constitute good cause.

Fourth Cause for Discipline - Gross Negligence/Unprofessional Conduct/Sexual Misconduct (Patient 2)

6. As set forth in Findings 40 and 41, cause for discipline for sexual misconduct was not established.

Fifth Cause for Discipline - Gross Negligence/Repeated Negligent Acts (Patient 2)

7. Complainant seeks to discipline Respondent for failing to wear gloves while administering the flu vaccine to Patient 2 and using his bare finger to stop the bleeding. As set forth in Findings 36 and 41, the evidence failed to establish that a physician must wear gloves while administering a vaccine or that Respondent used his bare finger to stop the bleeding. Cause for discipline pertaining to the administration of the flu vaccine to Patient 2 was not established.

Sixth Cause for Discipline - Failure to Participate in Investigative Interview (Patient 2)

8. Cause for discipline pursuant to Business and Professions Code section 2234, subdivision (g), for failing to participate in the investigative interview regarding Patient 2, was established in light of the matters set forth in Factual Findings 18, 19, and 42. Respondent's fear of the consequences of participating in the investigation does not constitute good cause.

Discussion

9. Cause for discipline having been established, the appropriate level of discipline must be determined. The Board's Guidelines recommend a minimum discipline of five years' probation with appropriate conditions for inadequate recordkeeping, and general unprofessional conduct. There is no specific recommendation in the Guidelines for failing to participate in a Board interview.

The evidence established inadequate recordkeeping relating to a single patient, as well as Respondent's unreasonable refusal to participate in the Board's investigation of the allegations against him pertaining to two patients. Patient harm was not alleged and was not established by the evidence. This is the first disciplinary action against Respondent, who has been licensed by the Board for more than 40 years.

Although Respondent has recently retired, imposition of discipline within the Guidelines is still warranted for the protection of the public, especially if Respondent chooses to resume practicing in the future.

The appropriate discipline in this matter is a five-year period of probation. Respondent's grossly inadequate recordkeeping and his failure to participate in the Board's investigation warrant that he be ordered to complete recordkeeping and professionalism courses.

10. Business and Professions Code section 125.3 authorizes the Board to recover its reasonable costs of investigation and enforcement if the licensee is found to have committed a violation of the licensing act. In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth standards by which a licensing board must exercise its discretion to reduce or eliminate cost awards to ensure that licensees with potentially meritorious claims are

not deterred from exercising their right to an administrative hearing. Those standards include whether the licensee has been successful at hearing in getting the charges dismissed or reduced, the licensee's 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 to the alleged misconduct. Because the Respondent was successful in getting some of the allegations dismissed, and consistent with the Superior Court's remand, the Board is ordering a reduction of costs from $24,357.50 to $12,178.75.

ORDER

Physician's and Surgeon's Certificate No. G 39648, issued to Respondent Martin Chan-Hoi Leung, M.D., is revoked; however, revocation is stayed, and Respondent is placed on probation for five years under the following terms and conditions.

1. 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.

2. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

3. Obey All Laws

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

4. Quarterly Declarations

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

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

5. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

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.

6. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

7. Non-Practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California 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 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; and Quarterly Declarations.

8. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's Certificate shall be fully restored.

9. Violation of Probation

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

10. License Surrender

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

11. Probation Monitoring Costs

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

12. Medical Record Keeping Course

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

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

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

13. 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 Title 16, California Code of Regulations (CCR) 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 (6) 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 (1) 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 First Amended 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.

14. Cost Recovery

Respondent shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code Section 125.3 in the amount of $12,178.75.

The Decision shall become effective at 5:00 p.m. on February 20, 2024

IT IS SO ORDERED this 18th day of January, 2024.

Laurie Rose Lubiano, J.D.
Chair, Panel A
Medical Board of California