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

In the Matter of the Accusation Against: Kenneth L. Lu, M.D. Physician's & Surgeon's Certificate No. A 62592 Respondent.	Case No. 800-2021-084230

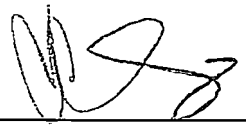
DECISION

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

This Decision shall become effective at 5:00 p.m. on May 24, 2024.

IT IS SO ORDERED: April 25, 2024.

MEDICAL BOARD OF CALIFORNIA



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

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
LATRICE R. HEMPHILL
Deputy Attorney General
State Bar No. 285973
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6198
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Accusation Against: **KENNETH L. LU, M.D.** **622 W. Duarte Road, Suite 101** **Arcadia, CA 91007-9266** **Physician's and Surgeon's Certificate No. A 62592,** Respondent.	Case No. 800-2021-084230 OAH No. 2023060349 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

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

2. Respondent Kenneth L. Lu, M.D. (Respondent) is represented in this proceeding by attorney Raymond L. Blessey, Esq., whose address is: 1230 Rosecrans Avenue, Suite 450, Manhattan Beach, CA 90266-2436.

3. On or about June 6, 1997, the Board issued Physician's and Surgeon's Certificate No. A 62592 to Kenneth L. Lu, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2021-084230, and will expire on June 30, 2025, unless renewed.

JURISDICTION

4. Accusation No. 800-2021-084230 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on May 1, 2023. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2021-084230 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2021-084230. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2021-084230, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2021-084230, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 62592 to disciplinary action.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

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

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

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

///

///

///

///

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 62592 issued to Respondent Kenneth L. Lu, M.D. is hereby Publicly Reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Accusation No. 800-2021-084230, is as follows:

> In 2016, you committed acts constituting negligence, resulting from your care and treatment of a single patient. During that time, you also maintained incomplete and inadequate medical records for that patient, as more fully described in Accusation No. 800-2021-084230.

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

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

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

2. CLINICIAN-PATIENT COMMUNICATION COURSE. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a course in a clinician-patient communication course approved in advance by the Board or its designee. Respondent

shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The clinician-patient communication course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

3. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement in the amount of $17,085.00 (seventeen thousand and eighty-five dollars and zero cents). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

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

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

///

///

ACCEPTANCE

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

DATED: 12.29.23

KENNETH L. LU, M.D.
Respondent

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

DATED: 12/29/23

RAYMOND L. BLESSEY, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

LATRICE R. HEMPHILL
Deputy Attorney General
Attorneys for Complainant

LA2023600807
66466762.docx

ACCEPTANCE

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

DATED: _____

KENNETH L. LU, M.D.
Respondent

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

DATED: _____

RAYMOND L. BLESSEY, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: January 3, 2024

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

LATRICE R. HEMPHILL
Deputy Attorney General
Attorneys for Complainant

LA2023600807
66466762.docx

Exhibit A
Accusation No. 800-2021-084230

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
State Bar No. 155307
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6453
Facsimile: (916) 731-2117
E-mail: Judith.Alvarado@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the Accusation Against: **KENNETH L. LU, M.D.** **622 W. Duarte Road, Suite 101** **Arcadia, CA 91007-9266** **Physician's and Surgeon's Certificate No. A 62592,** Respondent.	Case No. 800-2021-084230 **ACCUSATION**

PARTIES

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

2. On or about June 6, 1997, the Board issued Physician's and Surgeon's Certificate Number A 62592 to Kenneth L. Lu, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2025, unless renewed.

///

///

JURISDICTION

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

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

5. Section 2220 of the Code states:

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

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in

damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

6. Section 2227 of the Code states:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(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.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

STATUTORY PROVISIONS

7. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

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

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

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

8. Section 2266 of the Code states:

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

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTUAL ALLEGATIONS

10. Patient 1,[1] an 86-year-old female, was initially seen by Respondent on or about April 13, 2016 for a complaint of cataracts. Following an examination, Respondent rendered a diagnosis of primary senile cataracts, ptosis (drooping) of the eyelids, and dermatochalasis (loose and redundant eyelid skin). His plan was to perform a phacoemulsification/toric lens with low

[1] The patient is identified in this Accusation by number to protect her privacy.

power cylinder, possible I-Ring (iris ring), of the left eye. Patient 1 had a history of atrial fibrillation, hypertension, a pacemaker, and she was hard of hearing. Her visual acuity at this visit was 20/70.

11. Respondent performed the phacoemulsification of the cataract on or about May 2, 2016, at Specialty Surgery Center in Arcadia, California. In his operative note, Respondent charted:

> During the removal of the third and fourth quadrant, there was noted to be an accidental touch of the posterior capsule. At this time, viscoelastic material was used to tamponade the capsular break. A lens glide was used to tamponade the break as well. The remnant cataracts were then phacoemulsified and taken out of the eye. The lens glide was also removed from the eye. At this time since the posterior capsule was ruptured, the original implant toric intraocular lens was aborted since that requires a good capsular support in order to ensure centration of the lens. Therefore, a decision was made to place a three-piece intraocular lens which was then inserted into the capsular ciliary sulcus without any difficulty. Viscoelastic material was then removed.

Respondent did not tell Patient 1 or her son about the intraoperative complication, other than to report that the toric intraocular lens could not be used because it was too big to fit in the eye capsule. The procedures performed during surgery are identified in the operative report as: Phacoemulsification of the cataract; Anterior vitrectomy; and Insertion of a post chamber intraocular lens (AMO model Z9002, power 19.5 diopter).

12. Patient 1 returned for a postoperative visit with Respondent on May 3, 2016. Her visual acuity was counting fingers at two feet.[2] The cornea had 2+ edema. No inflammation was noted ("deep and quiet") and there was no cell or flare. The iris was normal (no documentation of vitreous strands to the corneal wound and no architectural changes to the iris). Corneal edema was managed with Muro drops (drops used to reduce swelling of the cornea). Respondent's plan was for Patient 1 to return in one week for dilation.

13. Patient 1 returned for her visit on May 11, 2016. Her vision had improved to 20/50-2, but the patient stated that her vision was still blurry and that the eye felt swollen. She also had discomfort in the left eye and complained of floaters. On examination, Respondent documented

[2] All examination descriptions are limited to the left eye unless otherwise stated.

that the patient's cornea was clear, the anterior chamber was deep and quiet, and that the iris was normal. A dilation examination was not performed.

14. Respondent saw Patient 1 on May 31, 2016. Her visual acuity was 20/60-2 and she complained of redness and pain for two days. Patient 1 reported that her vision fluctuated. The conjunctiva/sclera were reported as white and quiet, no redness, hyperemia, or injection was documented. The anterior chamber was noted to be deep and quiet (no inflammation, cell or flare was documented). The iris was normal (no irregular shape or vitreous to the wound was noted). Fundus exam was documented as normal, however, this was an undilated examination. Durezol (steroid drops to treat postoperative swelling and pain) were restarted, to be used twice a day. Patient 1 was to return in one month.

15. Patient 1's next visit with Respondent was on July 6, 2016. Her visual acuity was 10/60-2. Her son reported that her vision had not improved much since her surgery. The patient reported redness in both eyes, but no pain. On examination, the conjunctiva/sclera were still reported as white and quiet, no redness, hyperemia, or injection was documented. The anterior chamber was noted to be deep and quiet (no inflammation, cell or flare was documented). The iris was normal (no irregular shape or vitreous to the wound was noted). Fundus exam was documented as normal; this again, was an undilated examination. Respondent's assessment was of residual inflammation of the left eye with mild cells. Optical coherence tomography (OCT, an imaging technique that takes cross-section pictures of the retina), of the macula (the center of the retina) was noted to have no cystoid macular edema (CME), both eyes. Durezol was increased to four times per day.

16. Respondent next saw Patient 1 on July 26, 2016. It was noted that she still had inflammation, now with pain at a level of 2:10. She complained of a foreign body sensation in the eye and had the need to constantly blink. Patient 1 was using Durezol every two hours. Her visual acuity was 20/50 and she also had redness. The anterior chamber was noted to have trace cell. The macula was noted to be normal. Respondent discontinued the Muro drops and instructed Patient 1 to return in two weeks.

///

17. Patient 1 returned to see Respondent on August 2, 2016. Her visual acuity is noted as 20/80-2, with pinhole of 20/50-3. She was complaining of pain in the left eye at a level of 2-3:10 and was still using Durezol every two hours. Respondent performed a dilation examination of the patient's eyes and noted that the conjunctiva/sclera were white and quiet, the cornea was clear, and the anterior chamber had trace cell. The iris was normal and the left posterior chamber with intraocular lens. The vitreous was normal, the macula was normal, and the vessels were normal. Respondent made an assessment of Pseudophakia (implanting of an intraocular lens to replace a natural lens) of the left eye. He documented that the inflammation had improved. Respondent instructed Patient 1 to decrease the Durezol to four times a day. She was told to return in one month.

18. On August 3, 2016, Patient 1 was seen by retina and vitreous specialist Dr. PW. Patient 1's visual acuity of the left eye was 20/50. On examination vitreous strand to corneal wound with slight disc edema was noted. Hemorrhage and macular edema were also encountered. The following assessment was rendered (1) Retinal hemorrhage/macular edema/disc edema left eye, possibly due to hypertensive retinopathy (however, cannot rule out cerebral etiology. Please see primary care physician and obtain blood laboratory testing and a CT scan of the head/orbit); (2) Dry eyes, both eyes; (3) Pseudophakia, left eye; and (4) Cataract, right eye. Macular OCT left eye was conducted and showed macular edema of the left eye. Patient 1 was to return in one month.

19. Patient 1 returned to Respondent on September 2, 2016. She complained of blurred vision, redness and tearing of the left eye, along with pain and occasional sharp pain. Her visual acuity was 20/60-1. She was using Durezol as needed. On examination, the conjunctiva/sclera were white and quiet. The cornea was clear. The anterior chamber had trace cell. The iris was normal, the posterior chamber had an intraocular lens. The vitreous was normal, macula was normal, and the vessels were normal. Respondent instructed Patient 1 to continue Durezol twice a day and to return in two months. This was the last time Patient 1 treated with Respondent.

20. Patient 1 continued to treat with Dr. PW. She saw him on August 9, 2016, September 7, 2016, and September 20, 2016. Patient 1's condition continued to deteriorate. By the time of

her September 30, 2016 visit, she was unable to read handwritten documents. She had acute optic disc edema and Dr. PW recommended a neuro-ophthalmology consultation as soon as possible.

21. Patient 1 began treatment at USC Roski Eye Institute on October 3, 2016. She was seen by neurologist, Dr. DW, for complaints of vision loss since September 29, 2016. She was seen in the emergency department at Methodist Hospital at that time and underwent a head CT scan with normal results. Dr. DW performed an incomplete dilated examination of Patient 1's eyes and noted macular edema of the left eye, fundus disc with 360 edema, splinter hemorrhage off disc, notably at 3 o'clock and 9 o'clock. The left vessels had splinter hemorrhage. An assessment of scleral injection, and a left peaked pupil with optic disc edema, macular edema, and retinal hemorrhages, was rendered. Dr. DW was concerned about a panuveitis (generalized inflammation of the uveal tract, including the retina and the vitreous humor). She referred Patient 1 to uveitis specialist, Dr. DR.

22. Patient 1 began treatment with Dr. DR at USC Roski Eye Institute on October 7, 2016. Following examination, Dr. DR rendered an impression of retinal vasculitis/panuveitis and optic nerve head edema/macular edema following complicated cataract extraction with implant of intraocular lens. No retained lens on imaging, positive vitreous strand to wound, no signs of P. acnes infection (bacterial infection). The plan was to attempt a YAG vitreolysis of strand to wound. Patient 1 was to restart Durezol every two hours, atropine drops and was referred to rheumatology for lupus.

23. The YAG laser capsulotomy performed by Dr. DR on October 7, 2016, minimally improved Patient 1's vision.

24. Patient 1 continued to treat with Drs. DR, DW, VP, and Dr. S at USC Roski Eye Institute until at least July 12, 2017. Patient 1's working diagnosis at that time was retinal vasculitis/severe Irvine-Gass Syndrome (a cystoid macular edema that develops following uneventful cataract surgery). Neuro-ophthalmologist, Dr. VP, noted on March 1, 2017, that in his opinion, Patient 1 may have experienced a limited central retinal vein occlusion secondary to a vasculitis as positive inflammation was noted. Patient 1 had no pain or inflammation as of March 1, 2017. Dr. VP did not believe that the patient's autoimmune condition contributed, but the

inflammation could have been from an infectious etiology, as there were no intracameral antibiotics given at the time.

25. Patient 1 never underwent cataract extraction surgery with intraocular lens placement of her right eye. Her visual acuity of the right eye in 2017 was 20/50.

STANDARD OF CARE

26. The standard of care requires an ophthalmologist to document positive findings that are revealed on the corresponding examination.

27. The standard of care in the postoperative management of a posterior capsular rupture complication of cataract extraction surgery with intraocular lens placement which results in the vitreous strands to the corneal wound accompanied by iris corectopia (displacement of the pupil from its normal position), persistent inflammation, and lack of visual acuity improvement, along with the patient's complaints of eye redness and pain, should prompt an appropriate work-up and treatment. Use of an iris ring (I-Ring) is a known risk factor for post-surgical inflammation. However, a complication of a posterior capsular rupture and the presence of vitreous wick to the corneal wound requires the surgeon to rule out such vision threatening conditions as endophthalmitis, toxic anterior segment syndrome, or residual lens fragments in the vitreous. Recurrent or recalcitrant inflammation after cataract surgery also warrants early referral by the surgeon to a retina specialist for further evaluation. Topical NSAIDs should be prescribed to treat postoperative inflammation as they are steroid-sparing agents. YAG laser anterior vitreolysis can release vitreous incarceration in the cataract incision wounds that can cause persistent intraocular inflammation.

28. The standard of care is to consider and outline a differential diagnosis in an assessment and plan. A differential diagnosis in the case of persistent post-operative inflammation without visual acuity improvement should include uveitis due to systemic inflammatory syndrome, retained lens or nuclear fragments, infectious endophthalmitis, Irvine-Gass Syndrome, refractive error, ocular tumors, toxic anterior segment syndrome, and occlusive retinal vasculitis. Refraction, dilated fundus examination, B-scan ultrasonography, fluorescein

angiography, scleral depressed extended ophthalmoscopy, blood and laboratory work-up, and referral to subspecialists may be warranted based on the differential diagnosis.

29. During postoperative examinations of a patient, the standard of care is to perform a dilated funduscopic examination with either 1.0% Mydriacyl, 2.5% Phenylephrine or 1% Tropicamide and 2.5% Phenylephrine. Dilated funduscopic examinations with the pharmacologic agents described are necessary, especially after a complicated cataract surgery with posterior capsular rupture and vitreous strand to the cornea wound. Dilated funduscopic examination is performed to rule out retained lens or nuclear fragments, retinal tears, retinal tumors, retinal detachment, and to evaluate the extent of inflammation in the vitreous.

30. The standard of care is to treat the patient in order to obtain resolution of the signs and symptoms as well as improvement in visual acuity postoperatively. It is imperative to make a diagnosis for the cause of lack of visual acuity improvement. Once the diagnosis is made, a treatment plan can be established with a proposed timeline for visual recovery. If an anterior segment surgeon is unable to successfully treat a patient or if there is difficulty in establishing a correct diagnosis and causation of visual acuity loss or lack of recovery, referral to a subspecialist is necessary. Referral to a retina-vitreous specialist is also necessary given lack of visual recovery in the setting of complicated cataract extraction surgery with posterior capsular rupture.

31. According to the American Medical Association Principles of Medical Ethics, physicians should hold themselves accountable to patients, families, and fellow health care professionals for communicating effectively and coordinating care appropriately.

The standard of care is to tell patients and their family in a timely manner when complications or incidents occur. All complications should be addressed and should include an appropriate explanation, along with information for further treatment options, and ongoing support for the patient and their family. Effective communication ensures the patient's and their family's understanding of their health care.

///

///

///

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

32. Respondent Kenneth L. Lu, M.D. is subject to disciplinary action under section 2234, subdivision (c) of the Code in that he was negligent in the care and treatment of Patient 1. The circumstances are as follows:

33. The facts and allegations set forth in paragraphs 10 through 31 are incorporated herein by reference as if fully set forth.

34. Additionally, Respondent was negligent in his care and treatment of Patient 1 as follows:

35. When Patient 1 was seen by outside consulting physicians (e.g., Drs. PW, DW, DR), a number of findings were documented in the consulting physicians' notes that were not documented in Respondent's chart notes. Specifically, Respondent did not chart that he identified conjunctival injection, anterior chamber cell and flare, vitreous strand to cataract wound, or iris peaked at 5 o'clock of the left eye. Respondent's failure to appropriately document his examination findings is a simple departure from the standard of care.

36. Respondent treated Patient 1's intraocular inflammation with Durezol, a topical steroid. No consideration was given to a trial of topical NSAIDs. Respondent did not consider performing Neodymium:YAG laser anterior vitreolysis to release vitreous incarceration in the cataract incision wounds to treat persistent post-operative intraocular inflammation. Respondent did not consider a bacterial infection or toxic anterior segment syndrome as the cause of Patient 1's persistent inflammation. Respondent did not refer Patient 1 to a retina specialist at any time. Respondent's post-operative management of Patient 1's complication is a simple departure from the standard of care.

37. Respondent failed to form a complete differential diagnosis for Patient 1. Respondent's failure to form a complete differential diagnosis for Patient 1 is a simple departure from the standard of care.

38. Respondent did not perform a dilated funduscopic examination of Patient 1 when he saw her for her first post-operative visit on May 3, 2016, due to corneal swelling and reduced

vision (counting fingers). On May 3, 2016, Respondent documented that he will dilate the patient in one week. However, Patient 1 was not dilated at the next visit of May 11, 2016. Respondent did not conduct a dilated funduscopic examination of Patient 1 until her visit of August 2, 2016, her second to last visit with him. Respondent's failure to conduct a dilated funduscopic examination of Patient 1 as part of her postoperative follow-up care is a simple departure from the standard of care.

39. Respondent failed to make any specific diagnosis that would support Patient 1's persistent intraocular inflammation with lack of visual acuity improvement. Respondent's treatment plan did not lead to significant improvement in visual acuity and did not provide an explanation, diagnosis or timeline for visual acuity improvement in Patient 1's left eye. Yet, Respondent failed to refer Patient 1 to a subspecialist or retina-vitreous specialist. Respondent's failure to refer Patient 1 to a subspecialist or retina-vitreous specialist is a simple departure from the standard of care.

40. Respondent encountered a complication during Patient 1's cataract extraction surgery with intraocular lens placement. During Patient 1's surgery, Respondent ruptured the posterior capsule. Due to the ruptured posterior capsule, Respondent was unable to implant the planned toric intraocular lens. Although Respondent told Patient 1 and her son that he could not place the toric intraocular lens, he stated that he did not place it because it was too big. Respondent did not disclose that the procedure was aborted due to the lack of good capsular support due to the rupture of the posterior capsule. Over the four month course of Patient 1's care, Respondent never told her or her son of the intraoperative complication. Respondent's failure to advise Patient 1 and her son of the intraoperative complication (ruptured posterior capsule) during her cataract extraction surgery with intraocular lens placement and the actual reason why the toric lens could not be placed is a simple departure from the standard of care.

41. Respondent's acts and/or omissions as set forth in paragraphs 33 through 40, inclusive, above, whether proven jointly, or in any combination thereof, constitute repeated negligent acts pursuant to section 2234, subdivision (c) of the Code. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

42. Respondent Kenneth L. Lu, M.D. is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate medical records for Patient 1. The circumstances are as follows:

43. The facts and allegations set forth in the First Cause for Discipline are incorporated herein by reference as if fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

44. Respondent Kenneth L. Lu, M.D. is subject to disciplinary action under section 2234 of the Code in that he engaged in unprofessional conduct in his care and treatment of Patient 1. The circumstances are as follows:

45. The facts and allegations set forth in the First Cause for Discipline are incorporated herein by reference as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 62592, issued to Respondent Kenneth L. Lu, M.D.;

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

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

///

///

///

///

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

DATED: MAY 0 1 2023

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

LA2023600807
LU ACCUSATION-MBC EDITS.docx