BEFORE THE
MEDICALBOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Scott Evan Powell, M.D. Physician's and Surgeon's Certificate No. G 73757 Respondent.	Case No.: 800-2019-062698

ORDER NUNC PRO TUNC

With the concurrence and agreement of the Complainant and the Respondent, through counsel, the Decision is modified to add the following probationary condition as paragraph 15 on page 11 of the Decision, which was originally left out in error:

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

This Decision shall become effective at 5:00 p.m. on May 3, 2024.

IT IS SO ORDERED: April 26, 2024.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp MD

Richard E. Thorp
Chair, Panel B

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

In the Matter of the Accusation Against: Scott Evan Powell, M.D. Physician's and Surgeon's Certificate No. G 73757 Respondent.	Case No.: 800-2019-062698

DECISION

The attached Stipulated Settlement and Disciplinary 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 3, 2024.

IT IS SO ORDERED: April 4, 2024.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, Chair
Panel B

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

In the Matter of the Accusation Against: SCOTT EVAN POWELL, M.D. 2701 W. Alameda Avenue, Suite 200 Burbank, CA 91505-4406 Physician's and Surgeon's Certificate No. G 73757, Respondent.	Case No. 800-2019-062698 OAH No. 2023040425 **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). This matter was initiated by his predecessor in office solely in his official capacity. The Complainant is represented in this matter by Rob Bonta, Attorney General of the State of California, by Wendy Widlus, Deputy Attorney General.

2. Respondent Scott Evan Powell, M.D. (Respondent) is represented in this proceeding by attorney Derek F. O'Reilly-Jones, whose address is: 355 South Grand Avenue, Suite 1750, Los Angeles, CA 90071.

3. On or about March 31, 1992, the Board issued Physician's and Surgeon's Certificate No. G 73757 to Scott Evan Powell, 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. 800-2019-062698, and will expire on August 31, 2025, unless renewed.

JURISDICTION

4. Accusation No. 800-2019-062698 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 December 6, 2022. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2019-062698 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. 800-2019-062698. 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.

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2019-062698, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a prima facie case or factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. 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. 800-2019-062698, 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. G 73757 to disciplinary action.

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

CIRCUMSTANCES IN MITIGATION

13. Respondent Scott Evan Powell, M.D. has never been the subject of any disciplinary action.

CONTINGENCY

14. 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.

15. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2019-062698 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

17. 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. G 73757 issued to Respondent Scott Evan Powell, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions:

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. 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 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

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

3. MONITORING - PRACTICE/BILLING. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice and billing monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or

personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

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

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

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

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of

such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

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

4. 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.

5. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena enforcement, as applicable, in the amount of $35,000.00 (thirty five thousand dollars). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

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

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

6. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations

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

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

7. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

8. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be

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

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

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

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

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

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

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

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

12. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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

14. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2019-062698 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Peter R. Osinoff. 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: 12/11/23

SCOTT EVAN POWELL, M.D.
Respondent

I have read and fully discussed with Respondent Scott Evan Powell, 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: 12/11/2023

DEREK F. O'REILLY-JONES
Attorney for Respondent

ENDORSEMENT

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

DATED: December 11, 2023

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

WENDY WIDLUS
Deputy Attorney General
Attorneys for Complainant

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Attorneys for Complainant

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

In the Matter of the Accusation Against: SCOTT EVAN POWELL, M.D. 2701 West Alameda Avenue, Ste 200 Burbank California 91505-4406 Physician's and Surgeon's Certificate G 73757, Respondent.	Case No. 800-2019-062698 **ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California (Board).

2. On March 31, 1992, the Board issued Physician's and Surgeon's Certificate Number G 73757 to Scott Evan Powell, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2023, unless renewed.

JURISDICTION

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

(Code).

4. Section 2001.1 of the Code states:

Protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

5. 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.

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.

7. Section 2228 of the Code states:

The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(d) Providing the option of alternative community service in cases other than violations relating to quality of care.

STATUTORY PROVISIONS

8. 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 practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

(h) The repeated 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

9. Section 2261 of the Code states:

Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

10. Section 2262 of the Code states:

Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

In addition to any other disciplinary action, the Division of Medical Quality or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section.

11. 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

12. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may 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.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one year for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in

that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

DEFINITIONS

13. MRI – This is an abbreviation for "magnetic resonance imaging" defined as a medical imaging technique that uses a magnetic field and computer-generated radio waves to create detailed images of the organs and tissues in the body. The technique is a noninvasive way for a physician to examine body organs, tissues, and skeletal system. The technique produces high-resolution images of the inside of the body that help diagnose a variety of problems. This technique gives better images of organs and soft tissues than other scanning technologies.

14. The Lachman test is a specific clinical exam technique used to evaluate patients with a suspected anterior cruciate ligament (ACL) injury. The test relies on proper positioning and technique and is regarded as the most sensitive and specific test for diagnosing acute ACL injuries. The test is conducted with the knee flexed 20-30 degrees; the tibia is displaced anteriorly relative to the femur; a soft endpoint of greater than 4 mm displacement is positive, i.e., abnormal.

15. The anterior drawer test is a knee assessment used by a doctor, physical therapist, or sports therapist to check for an ACL injury. If the tibia, or shinbone, has more movement or the ligament is loose compared with the other knee, the anterior drawer test is considered positive. This test is often used along with a Lachman test, a pivot shift test, and an MRI.

16. The McMurray test is usually part of a preliminary exam when you visit your provider with knee pain or after an injury. The McMurray test is a series of knee and leg movements healthcare providers use during a physical examination to diagnose a torn meniscus. The provider physically moves the patient's leg and knee joint to identify any pain or other symptoms during the movements. The McMurray test uses the movements to check the patient's symptoms and range of motion. The patient lays on their back and the provider bends the patient's knee to 90 degrees perpendicular to the rest of the body, and rotates the bent knee in toward the patient's body and out. The McMurray test's different positions apply mild stress to the meniscus as the movements are close to the kind of tension that's applied to the knee during

the patient's daily routine. While moving the patient's leg, the provider asks the patient if they are feeling any pain and listens and feels for a popping in the knee. Some studies show that the McMurray test may not be very accurate at verifying whether or not the patient's meniscus is torn. The test is usually only the first step the provider will take to diagnose an injury. Imaging tests give a more conclusive answer.

17. Tendinosis occurs when tendons [tendons are the tough, fibrous cords that attach muscles to bones made of straight, parallel fibers of collagen] degenerate with small tears or disorganized collagen fibers instead of straight collagen fibers.

18. Arthroscopic surgery, also known as arthroscopy, is a minimally invasive orthopedic procedure used to diagnose and treat joint problems. It involves the use of a narrow scope, called an arthroscope, and specialized surgical tools to access a joint through tiny "keyhole" incisions. Because arthroscopic surgery requires smaller incisions than open surgery, recovery times tend to be shorter.

19. ACL reconstruction surgery is a repair of the anterior cruciate ligament [ACL]. The ACL is an important soft-tissue structure in the knee that connects the femur to the tibia. ACL tears treated with an ACL reconstruction surgery allows the torn ligament to be replaced with a tissue graft from either the patient or a donor which mimics the natural ACL.

20. The medial collateral ligament [MCL] is a tough band of tissue that stabilizes the knee joint and connects the bones that form the knee similar to the anterior cruciate ligament; however, the MCL runs along the inside of the knee and connects the femur [thigh bone] and tibia [shin bone]. The MCL allows the knee to rotate and is often referred to as the primary stabilizer of the knee because it prevents the knee from bending inward excessively. MCL reconstruction is a minimally invasive surgical treatment to replace the existing, torn MCL.

21. The lateral collateral ligament [LCL] is a thin band of tissue found on the outer side of the knee. The LCL is one of the four major ligaments involved in stabilizing the knee joint. The LCL allows for controlled sideways movement of the knee and helps prevent excessive bowing of the knee when stress is placed on the knee.

Lateral collateral ligament [LCL] reconstruction is an open surgical procedure performed to

repair a stretched or torn LCL. The surgical treatment cannot be performed arthroscopically due to the position of the ligament which exists outside of the knee joint.

22. Cruciate and collateral ligaments – Ligaments [a band of fibrous tissue connecting bones or cartilages, serving to support and strengthen joints] of the knee are classified as cruciate and collateral ligaments. The major ligaments of the knee consist of the ACL (anterior cruciate ligament, PCL (posterior cruciate ligament), MCL (medial collateral ligament) and LCL (lateral collateral ligament). Cruciate ligaments are within the knee joint. They prevent anterior (forward) and posterior (backward) translation of the femur from the tibia. Collateral ligaments are outside the knee joint and prevent medial (inside) and lateral (outside) instability.

23. Meniscus – The medial meniscus of the knee is a thickened crescent-shaped cartilage pad between the two joints formed by the femur (the thigh bone) and the tibia (the shin bone). The meniscus acts as a smooth surface for the joint to move on.

24. Meniscus tear – A meniscus tear is one of the most common knee injuries. Any activity that causes a person to forcefully twist or rotate the knee can lead to a torn meniscus. Each of knee has two C-shaped pieces of cartilage that act like a cushion between the shinbone and thighbone. A torn meniscus causes pain, swelling and stiffness and may result in a block to knee motion and difficulty with full knee extension.

25. Knee arthroscopy – This is a surgical technique to diagnose and treat problems in the knee joint. During the procedure the surgeon will make a very small incision and insert a tiny camera called an arthroscope into the patient's knee. The arthroscope allows a screen view of the inside of the joint. The surgeon can then investigate a problem with the knee and, if necessary, correct the issue using small instruments within the arthroscope. Arthroscopy is utilized to diagnose several knee problems, such as a torn meniscus, a misaligned kneecap or repair the ligaments of the joint. There are limited risks to the procedure and the outlook is good for most patients. Recovery time and prognosis will depend on the severity of the knee problem and the complexity of the required procedure. Conservative treatment such as rest, ice and medication is sometimes enough to relieve the pain of a torn meniscus and give the injury time to heal on its own.

26. Meniscectomy – A meniscectomy is defined as the surgical removal of cartilage from the knee.

27. Chondroplasty – Chondroplasty is defined as surgery of the cartilage.

28. Epicondylitis – Epicondylitis, sometimes referred to as "tennis elbow" is defined as an inflammation of the muscle and surrounding tissues of the elbow caused by repeated stress and strain on the forearm near the lateral epicondyle of the humerus or arm bone.

29. Maximum medical improvement [MMI] is a medical term used in the treatment of an injured worker who is receiving workers' compensation benefits for a work-related injury or illness. When the injured workers' condition reach reaches a point where there is no further improvement the injured worker has reached maximum medical improvement. Maximum medical improvement can mean the injured worker has fully recovered from the injury and is able to return to the job held before the injury or illness. However, maximum medical improvement may mean the injured worker has been left with a partial or total permanent disability because no additional improvement or healing is deemed possible. A physician conducts tests to measure the patient's level of impairment in order to confirm whether the injured worker is at maximum medical improvement. The physician must conduct tests to measure the injured worker's condition and their impairment level.

30. Platelet-rich plasma or PRP – is a treatment that injects a patient's blood cells into a specific area of the body to accelerate healing.

31. Radiculopathy is described as a range of symptoms produced by the pinching of a nerve root in the spinal column. The pinched nerve can occur at different areas along the spine [cervical, thoracic or lumbar] and vary by location but frequently include pain, weakness, numbness, and tingling. A common cause of radiculopathy is the narrowing of the space where nerve roots exit the spine, which can result from stenosis, bone spurs, disc herniation, or other conditions. Radiculopathy symptoms can often be managed with nonsurgical treatments, but minimally invasive surgery can also help some patients.

32. The Spurling test is a well-recognized provocative test [a provocative test is a method of obtaining diagnostic information by deliberately provoking a characteristic disease reaction]

routinely used in the evaluation of neck pain and cervical radiculopathy. If used appropriately in conjunction with other history and exam findings, the Spurling test can help determine the cause of cervical radiculopathy and guide further workup and imaging studies.

FACTUAL ALLEGATIONS

33. On December 17, 2019, the Board received a complaint from a lawyer on behalf of his client who wished to remain anonymous and to whom the attorney referred to as "Concerned Citizen" [CC] which requested that the Board investigate Respondent, who was an orthopedic surgeon at Stetson Powell Orthopedics & Sports Medicine [SPO] located in Burbank, California.

34. CC was employed at SPO from 2018 to 2019, from June 2018 to June 2019, in the one-year SPO Pre-Medical Interns program [SPO program] designed for college graduates applying to medical school. SPO employed six interns between June 2018 and June 2019.

35. The interns worked with Respondent and the other two doctors in the practice. The interns' responsibilities included obtaining patient past medical history and history of present illness; accompanying the physician and working as "scribes" documenting the physician's examination findings, assessment, and plan for each patient encounter in the electronic medical records system; placing orders for medication and therapy as prescribed; assisting with injections and diagnostic ultrasounds in the office; and writing letters of appeal to insurance companies.

36. Between September and October 2018, CC witnessed Respondent provide implicit and explicit instructions to SPO program interns which included orders to falsify medical exam findings, alter patients' reported symptoms, document disclosures of risks and alternatives that did not occur; and to use unsupported information to obtain insurance authorization to proceed with unnecessary and unindicated treatment, particularly surgery. In addition, CC witnessed Respondent repeatedly fail to adequately inform patients of the risks involved in certain treatments and alternative treatment options.

37. On November 26, 2018, CC reported these concerns internally to the other two doctors in the practice who told CC that they were unaware of any misconduct. Those two doctors requested CC defer to their judgment while they conducted an internal investigation to

address the situation themselves and CC agreed.

38. For approximately six weeks after this meeting, CC did not work with Respondent but CC continued to review Respondent's cases, discuss concerns with SPO Program interns, and document instances of troubling conduct. CC resumed working with Respondent on January 15, 2019.

39. After reporting the issue to the other two doctors, CC did not knowingly document any false findings in the medical records internally. However, CC was frequently pressured by Respondent and occasionally by other staff to do so in order to avoid insurance denials or obtain insurance approval.

40. In January or February 2019, Respondent's partners completed their review of Respondent's cases over the previous three years. They told CC that their review corroborated CC's concerns about Respondent's surgeries. Included in the complaint, Respondent's partners told CC they had mentioned these concerns to Respondent but had not taken any corrective action. CC unsuccessfully urged Respondent's partners to take more direct action.

41. Respondent's partners told CC that they subsequently had multiple direct conversations with Respondent regarding his conduct and provided him with three to four months to modify his behavior, but Respondent failed to do so.

42. In May 2019, CC went to Respondent's partners with additional supporting documentation regarding Respondent's practices. After that, Respondent's partners began to terminate their partnership with Respondent and their efforts to do so were ongoing at the time the complaint was filed with the Board.

43. Respondent's partners' termination of their partnership agreement with Respondent was arbitrated during which SPO interns provided declarations regarding Respondent's medical custom and practice.

44. CC remained concerned that Respondent would continue these practices at his office located in Santa Monica and related surgery centers even if he left SPO. CC was concerned about the possibility of future patient harm. As such the complaint requested that the Board conduct an expedited investigation into Respondent's practices, and that the Board temporarily suspend

Respondent's medical license during the pendency of the investigation.

45. Included with the complaint was a list of patients, with brief descriptions of CC's observations regarding each patient and a list of individuals with knowledge of Respondent's conduct and contact information for those people.

46. Included with the complaint was a list of statements from the SPO Program interns regarding the Respondent's treatment of various patients.

47. The Board referred the matter to the Division of Investigation's Health Quality Enforcement Unit (HQIU) for investigation. Medical records were obtained, and interviews were conducted with patients, staff, and witnesses. The Respondent was interviewed and denied falsifying medical records and performing unnecessary surgeries. After that, the case materials were provided to a medical reviewer who identified eight extreme departures from the standard of care.

Patient 1[1]

Patient 1 is described in Respondent's October 18, 2018, medical records as a 52-year-old new patient who had left knee pain, which Patient 1 said began two weeks earlier when he stumbled, twisted his left knee, and felt a tearing sensation. Patient 1went to a local emergency room, where x-rays were taken. The emergency room personnel told Patient 1 he did not have a fracture. The emergency room provided Patient 1with a knee immobilizer which he has been wearing in conjunction with a low-top walking boot he received eight months earlier after left ankle tendon reconstruction surgery. Patient 1 went to his general practitioner and underwent an MRI on October 16, 2018.

48. During the October 18, 2018, visit Patient 1 said he was experiencing pain at the lateral, posterior aspect of his knee with swelling, weakness, instability, limited range of motion, and locking/catching of his knee. Patient 1 said he was taking ibuprofen (600 mg) nightly with slight relief and denied taking other pain medications.

[1] In the interest of privacy, the patients' names are rendered in this document by numbers and witnesses by initials.

49. Per Respondent's medical records he conducted a physical examination of Patient 1 and reviewed Patient 1's October 16, 2018, MRI.

50. Per Respondent's medical records, based on the above information Respondent advised the following: take Tramadol as prescribed; apply ice to the left knee as needed; wear the left knee brace as provided by Respondent's office in the office October 18, 2018.

51. Per Respondent's medical records, based on the above information Respondent discussed non-operative versus operative treatment options with Patient 1. Respondent described the operative treatment being an arthroscopic-assisted ACL, MCL, and/or LCL reconstruction. Respondent described non-operative treatment as physical therapy and recommended surgery. Thereafter Patient 1 said he wished to proceed surgically and Respondent scheduled his surgery at this time.

52. Respondent's operative report contained in Patient 1's medical records states Respondent performed a left knee ACL with autologous hamstring tendon on Patient 1 on November 2, 2018.

53. Respondent's medical records show CC was Respondent's scribe for Patient 1's October 18, 2018, visit, and was present for Respondent's history and clinical examination of Patient 1.

54. CC's declaration stated Respondent did not perform a physical examination of Patient 1, nor did he touch Patient 1. Nevertheless CC stated in her declaration that Respondent instructed her to document that as a result of Respondent's physical examination of Patient 1 he determined that the patient had positive Lachman's and anterior drawer tests, MCL laxity, and LCL laxity.

55. CC's declaration stated Respondent did not discuss conservative treatment with Patient 1, nor employ any conservative treatment attempts prior to performing surgery on Patient 1.

Patient 2

56. Patient 2 is described in Respondent's July 12, 2018, medical records as a 22-year-old man last seen approximately a year earlier regarding left shoulder pain. Patient 2 returned to see

Respondent on July 12, 2018, with a complaint of right shoulder pain which resulted when her right shoulder dislocated when she sneezed. Patient 2 said her right shoulder popped back into place a few minutes later. Patient 2 said her right shoulder has dislocated three other times 12 years ago. Patient 2 reported worsening pain, with pain at the posterior aspect with weakness, instability, limited range of motion, numbness/tingling, night pain, and denies popping or catching. Patient 2 stated she was taking Tramadol for pain relief.

57. Per Respondent's medical records he conducted a physical examination of Patient 2 as follows: "**Exam – Shoulder: Right Shoulder Exam** Inspection Deformities: absent Skin/scars: normal Atrophy: absent Position: normal Palpation Max tenderness: anterior capsule Range of Motion Rotator Cuff Biceps Obrien's Test: Positive Stability Tests Anterior Apprehension Test: Positive Relocation Test: Positive Crank Test: Positive Strength/Neurovascular Right upper extremity neurovascular exam is normal. Exam Comments: Right shoulder exam limited due to patient's pain.[sic]"

58. Respondent's medical records show KP was Respondent's scribe for Patient 2's July 12, 2018, visit, and was present for Respondent's history and clinical examination of Patient 2.

59. CC's December 17, 2019, complaint to the Board contained KP's statement that ". . . no physical exam was performed but the intern was told by Dr. Powell to put in exam findings and statement 'exam limited due to pain.'"

60. Respondent did not perform a physical examination of Patient 2, nor did he touch Patient 2.

Patient 3

61. Patient 3 is described in Respondent's February 12, 2019, medical records as a 69-year-old man with a complaint of left shoulder pain which began gradually without discrete injury approximately three months earlier. Patient 3 first went to his primary care physician, now retired, and after noting a visible mass at the lateral aspect of his left upper arm he believed was connected to his left shoulder pain he had an unknown surgeon removed the mass. Patient 3 said he completely recovered from the surgery, but his left shoulder pain persisted. Patient 3 then received a left shoulder cortisone injection from a different physician, which did not relieve the

pain. Patient 3 did not go to physical therapy nor did he undergo an MRI. Patient 3 complained of weakness, limited range of motion, and night pain. Patient 3 did not experience instability, popping or catching, numbness or tingling, and he stated he did not take any pain or anti-inflammatory medication.

62. Per Respondent's medical records he conducted a physical examination of Patient 3 as follows: "**Left Shoulder Exam** Inspection Posture: normal Deformities: absent Skin/scars: Deformities: absent Skin/scars: well-healed surgical scars Atrophy: absent Position: normal Palpation Max tenderness: anterior capsule, anterior bursa, lateral bursa

Rage of Motion Flexion: 160 degrees External Rotation: 80 degrees Internal Rotation: T6 degrees Range of motion: active painful range of motion Rotator Cuff Biceps Stability Tests Strength/Neurovascular Supraspinatus strength: 4/5 Infraspinatus strength: 4/5 Exam Comments: Exam limited because of pain, [sic]"

63. Respondent's medical records show KP was Respondent's scribe for Patient 3's February 12, 2019, visit, and was present for Respondent's history and clinical examination of Patient 3.

64. CC's December 17, 2019, complaint to the Board contained KP's statement that ". . . no physical exam was performed but the intern was told by Dr. Powell to put in exam findings and statement 'exam limited due to pain.'"

65. Respondent did not physically examine Patient 3, nor did he touch Patient 3.

Patient 4

66. Patient 4 is described in Respondent's October 25, 2018, medical records as a 60-year-old man with a complaint of right knee pain that began gradually without discrete injury three months before his visit. Patient 4 attributed his pain to increasing his exercise regimen. Patient 4 had no previous history of injury to or formal treatment of his right knee. Patient 4 said his pain had worsened and was located at the lateral, anterior aspect of the knee with numbness in the lateral aspect of his right knee, swelling, weakness, and limited range of motion. Patient 4 did not experience weakness, locking, or catching. Patient 4 was taking ibuprofen as needed and was not taking any other pain medication.

67. Per Respondent's medical records, he conducted a physical examination of Patient 4 as follows: "Right Knee Exam Inspection Gait: Normal Alignment: Normal Skin/Scars: Normal Swelling: None Effusion: mild. Atrophy: None Palpation Max Tenderness medial joint line Range of Motion Extension: 0 degrees Flexion: 120 degrees Range of Motion: active painful range of motion Crepitus: None Meniscus McMurray's Test: positive, medial Stability Lachman Test: Negative Anterior Drawer: Negative Posterior Drawer: Negative MCL: No valgus instability LCL: No varus instability Patella Patellar Position: Normal Patellar Grind: Negative Patellar Apprehension: Negative Strength/Neurovascular Right lower extremity strength is normal. [sic]"

68. Respondent ordered an MRI for the Patient 4's right knee to evaluate for a medial meniscus tear and instructed him to return to the office after the MRI has been performed to discuss further treatment options. Patient 4's MRI performed on November 15, 2018, and the MRI radiologist's report, reviewed by Respondent, stated Patient 4's menisci had no tears or extrusions with mild proximal patella tendinosis.

69. Notwithstanding Patient 4's MRI results on December 3, 2018, Respondent performed knee arthroscopy on Patient 4's right knee. Respondent's operative report stated, "There was posterior junction medial meniscus tear. This was resected back to smooth stable rim with baskets and shaver. The lateral meniscus was probed and was stable."

Patient 5

70. Patient 5 is described in Respondent's February 7, 2019, medical records of Patient 5's visit as a 58-year-old man with bilateral knee pain, which he reports began gradually three months earlier without discrete injury or attributable cause. Patient 5 said his left knee pain was exacerbated acutely three weeks ago with a discrete injury when he bent over in the shower and felt four cracks in his left knee with immediate pain. Patient 5 went to an urgent care clinic the following day, where bilateral knee radiographs were taken and bilateral knee MRIs were ordered. On January 29, 2019, Patient 5 had MRIs performed on both knees, which were available for the Respondent's review.

71. Patient 5 had not had any medical treatment for his current bilateral knee conditions.

In 1980, Patient 5 had undergone a left knee ligament reconstruction which he never wholly recovered from, and continued to experience pain and limited range of motion. Patient 5 had no previous history of injury to his right knee. Patient 5 said that since he had begun suffering pain in both knees before the February 7, 2019, visit to Respondent, his left knee symptoms had improved, but his right knee symptoms have not changed.

72. Respondent's medical records stated that during this visit, Patient 5 stated he had pain and swelling in his left knee with no weakness, instability, limited range of motion, or locking/catching. Patient 5 said he had pain in his right knee with swelling and limited range of motion with no weakness, instability, or locking/catching. Patient 5 was taking aspirin as needed and was not taking any other pain medication.

73. During his February 7, 2019, visit Patient 5 specified he had not received physical therapy or other conservative treatment for his knee pain.

74. Respondent's medical records show CC was Respondent's scribe for Patient 5's February 7, 2019, visit and was present for Respondent's history and clinical examination of Patient 5.

75. CC stated in her declaration that during Patient 5's February 7, 2019, visit the patient requested the "least invasive treatment possible."

76. However, Respondent scheduled Patient 5 for a right knee partial meniscectomy at that visit without discussing noninvasive treatment options. Respondent's notes for Patient 5's February 7, 2019, visit state that operative management was discussed. The operative treatment was described as bilateral knee arthroscopies with meniscectomies, beginning with the right side due to the more severe pain on that side. [Patient 5] has agreed to proceed with surgery, beginning with the right knee.

77. On March 26, 2019, Patient 5 returned to see Respondent for a pre-operative visit, during which he stated that his symptoms had improved and he was no longer taking pain or anti-inflammatory medication. Despite this information and his request for the "least invasive treatment possible," on April 3, 2019, Respondent performed arthroscopy, chondroplasty, patella ridge, partial medial and lateral meniscectomy on Patient 5's right knee.

78. Despite Patient 5's request for the "least invasive treatment possible" on October 2, 2019, Respondent performed arthroscopy chondromalacia, patellar ridge, chondroplasty, and partial lateral meniscectomy on Patient 5's left knee.

Patient 6

79. Respondent was treating 51-year-old Patient 6 for a work-related injury that occurred when Patient 6 stood up from a chair and felt a sharp pain resulting in a meniscus tear. SM, the Respondent's physician assistant, frequently saw Patient 6 throughout her treatment.

80. During the patient's appointment on January 3, 2019, SM noted Patient 6 could not fully bend or straighten the knee. SM ordered an MRI for Patient 6 to assess her symptoms better.

81. During Patient 6' s next appointment on February 14, 2019, the Respondent reviewed the MRI. Respondent determined that there was nothing else he could do for Patient 6 and decided the patient would be placed on MMI.

82. Respondent's medical records show RH was Respondent's scribe for Patient 6's February 14, 2019, visit and was present for Respondent's history and clinical examination of Patient 6.

83. A full examination of a patient is required when a patient is placed on MMI. Respondent did not examine Patient 6 during her February 14, 2019, visit. Respondent ordered intern RH to document that a complete examination had been performed and Patient 6 had a full range of motion. Respondent could not have known this information because Respondent did not perform a full examination of Patient 6.

Patient 7

84. Patient 7 is described in Respondent's December 11, 2018, medical records as a 49-year-old woman who came to Respondent's practice to receive a right elbow PRP injection due to continuing elbow pain.

85. Respondent's medical records for Patient 7's December 11, 2018, office visit describe the visit as follows:

"Procedures: Manual Palpation Right Elbow Lateral Epicondyle Platelet-Rich Plasma

(PRP) Injection: Risks and benefits of a right elbow lateral epicondyle injection, including but not limited to bleeding, infection, nerve/vessel damage, stiffness, allergic reaction and possible skin de-pigmentation were discussed. Verbal consent was obtained. A time-out was done confirming a lateral epicondyle platelet-rich plasma injection of the right elbow. Twelve (12) ccs of blood were aspirated from the ante-cubital vein in a sterile fashion. Two alcohol scrubs were used and the aspiration was completed without complication using an Arthrex Platelet-Rich Plasma kit. The blood was then centrifuged for 5 minutes and a triple syringe was used to separate the platelet-rich plasma. The site was prepped using an aseptic technique with alcohol, and ethyl chloride was used for an anesthetic. A palpation-guided injection of 2.5 ccs of 2% lidocaine was administered into the right elbow joint using a 25-gauge needle. A direct lateral epicondyle injection site was prepared in a sterile fashion, and a 22-gauge needle was used to administer a manually palpated platelet-rich plasma injection into the right elbow joint. **Three (3) ccs of platelet-rich plasma were injected into the right elbow.** [emphasis added]

A bandage was applied over the injection site, and post-injection instructions were given, including icing if the elbow becomes sore or presenting to an emergency room if there are signs of an allergic reaction. The patient reported a pain intensity of 1/10 and was discharged in the office today without complication."

86. SM, Respondent's physician assistant, was present throughout Patient 7's December 11, 2018, office visit, and PP was Respondent's scribe. In her declaration, SM described what CC said occurred during the visit:

"[Respondent] recommended a platelet-rich plasma (PRP) injection for her elbow. I drew 12 ccs of blood from the patient on this occasion and then the blood is put into a centrifuge to separate the red blood cells from the platelets. I prepared the injection of the platelet-rich plasma for [Respondent] to administer. The patient is lying down on the patient table for this procedure. I provided [Respondent] with the preinjection materials (alcohol, ethyl chloride, etc. [sic]). I then provided the syringe with the PRP to [Respondent]. I saw that Doctor Powell was pushing on the syringe as hard as he could and that nothing was going through when attempting to administer the PRP. I offered another needle, and he switched to that needle.

Unfortunately, no material went through. [Respondent] gave the syringe back to me with the same amount of fluid that was present at the beginning. The injection had failed. The patient was not informed that the injection had not been completed. The patient was sent home, but the procedure had not been completed. [Respondent] did not tell the patient that the procedure had failed. Instead, it is my understanding, based upon my review of the medical note for this date for this patient, that Doctor Powell had [PP] documented that 3 ccs of plasma were administered. In fact, the patient was charged full price for the procedure."

87. PP's declaration described what occurred during Patient 7's December 11, 2018, office visit as follows:

"On December 11, 2018, a patient presented to the office for a PRP (Platelet Rich Plasma) injection in her right elbow. The patient requested that [Respondent] administer the injection. [SM] drew the blood from the patient in order to prepare the plasma injection. [SM] assisted [Respondent] with the injection. After it was done, [SM] told me that zero cc's of plasma had been injected into the elbow because the blood had clotted. [SM] then showed me the full syringe in the sink of the exam room. Then had to call [Respondent], who had left the office, to obtain the value for the procedure in order to document the EMR. [Respondent] told me to document that he injected three cc's of plasma into the elbow. The patient was charged full price for the injection, which is rarely if ever covered by insurance."

Patient 8

88. Patient 8 is described in Respondent's November 29, 2018, visit medical records as a 64-year-old woman who came in for a follow-up visit and a new condition. Patient 8's cervical spine pain began acutely 50 years ago after she suffered a discrete injury while pole vaulting, when she reports she landed on her right shoulder and neck. Patient 8's cervical symptoms got worse four to five months earlier with no discrete injury.

89. Patient 8's lumbar spine pain began acutely after she suffered a discrete injury 35 years ago when she twisted to lift her son from a car seat and felt pain at the right lateral aspect. Patient 8's symptoms worsened four to five months earlier, which Patient 8 attributed to compensating after right and left knee surgeries.

90. Respondent's medical records show RH was Respondent's scribe for Patient 8's November 29, 2018, visit and was present for Respondent's history and clinical examination of Patient 8.

91. The medical records for Patient 8's November 29, 2018, visit state Respondent performed the following examinations during this visit: "Exam - Cervical Spine: Cervical Spine Exam Inspection Palpation Tenderness: midline Range of Motion Painful range of motion in flexion, rotation Provocative Tests Spurling's Test: Positive Strength/Neurovascular Patient is neurovascularly intact except for radiating pain - right, decreased sensation Exam Comments: Decreased range of motion. Paraspinous muscle spasm."

92. The medical records for Patient 8's November 29, 2018, visit state that based on this examination Respondent produced the following treatment plan: "Plans - General: With regard to her cervical spine pain, the patient was advised to take diclofenac as prescribed upon clearance from her psychiatrist. At this time, we would like more information. Her symptoms are concerning for a possible herniated disc. An MRI of the cervical spine was ordered at today's visit to evaluate for this condition. [Patient 8] was instructed to return to the office after the MRI has been performed, at which time further treatment options will be discussed."

93. The medical records for Patient 8's November 29, 2018, visit state Respondent performed the following examinations during this visit: "Exam - Lumbar Spine: Lumbar Spine Exam Inspection Gait: limps Skin/Scars: Normal Flexibility: decreased Palpation Tenderness: paravertebral Range of Motion Painful Range of Motion: flexion, extension Tests Strength/Neurovascular Sensory exam reveals decreased sensation radiating pain laterally Exam Comments: Tenderness left lateral paraspinous."

94. The medical records for Patient 8's November 29, 2018, visit state that based on this examination, Respondent produced the following treatment plan: "With regard to her lumbar spine pain, the patient was advised to take diclofenac as prescribed upon clearance from her psychiatrist. At this time, we would like more information. Her symptoms are concerning for a possible herniated disc. An MRI of the lumbar spine was ordered at today's visit to evaluate for this condition. [Patient 8] was instructed to return to the office after the MRI has been performed,

at which time further treatment options will be discussed."

95. Respondent ordered intern RH to document tenderness and positive tests for cervical radiculopathy to enable Respondent to order an MRI of Patient 8's cervical spine. Per RH the tests were not performed.

96. Respondent ordered intern RH to document tenderness and positive tests for lumbar radiculopathy to enable Respondent to order an MRI of the patient's lumbar spine. Per RH the tests were not performed.

Standard of Care

97. The standard of care regarding a physician's performance of a history and physical is to document the actual history and examination as it was performed by the physician.

98. The standard of care is to document history and examination as performed by the physician that supports symptoms, examination, and image findings that the patient is likely to benefit from surgical management.

99. The standard of care regarding surgically treating a patient is to recommend surgery only when the symptoms, examination, and image findings indicate that surgery is necessary and the patient will not benefit from treatment other than surgery.

100. The standard of care for providing informed consent when treating a patient is to provide the patient with all treatment options.

101. The standard of care for providing informed consent when treating a patient is to discuss all non-operative and surgical treatment options with the patient.

102. The standard of care for providing informed consent when treating a patient is to both obtain and document the discussion of all non-operative and surgical treatment options with the patient.

103. The standard of care regarding treating a patient by injection is to provide a properly administered amount of the injected substance.

104. The standard of care regarding billing for treating a patient by injection is only bill for the treatment if the substance is actually injected.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence, Bus. & Prof. Code, § 2234, subd. (b))

105. Respondent Scott Evan Powell, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed acts or omissions involving gross negligence. The circumstances are as follows:

106. The facts and circumstances set forth in paragraphs 33 through 96 are incorporated by reference as if set forth in full herein.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts, Bus. & Prof. Code, § 2234, subd. (c))

107. Respondent Scott Evan Powell, M.D., is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts. The circumstances are as follows:

108. The facts and circumstances set forth in paragraphs 33 through 96 are incorporated by reference as if set forth in full herein.

THIRD CAUSE FOR DISCIPLINE

(Inadequate Record Keeping, Bus. & Prof. Code, § 2266)

109. Respondent Scott Evan Powell, M.D., is subject to disciplinary action under section 2266 of the Code in that he failed to keep adequate and accurate medical records. The circumstances are as follows:

110. The facts and circumstances set forth in paragraphs 33 through 96 are incorporated by reference as if set forth in full herein.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct, Bus. & Prof. Code, § 2234)

111. Respondent Scott Evan Powell, M.D., is subject to disciplinary action under section 2234 of the Code, in that he committed unprofessional conduct. The circumstances are as follows:

112. The facts and circumstances set forth in paragraphs 33 through 96 are incorporated by reference as if set forth in full herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 73757, issued to Scott Evan Powell, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants and advanced practice nurses;

3. Ordering him 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: DEC 0 6 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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