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

In the Matter of the Accusation Against: Paul Hing Ping Lee, M.D. Physician's and Surgeon's Certificate No. G 68537 Respondent.	Case No.: 800-2021-078682

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 JUL 0 5 2024.

IT IS SO ORDERED: JUN 0 5 2024.

MEDICAL BOARD OF CALIFORNIA

Randy W. Hawkins, M.D., Vice Chair
Panel A

ROB BONTA
Attorney General of California
MICHAEL C. BRUMMEL
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **PAUL HING PING LEE, M.D.** **1805 N. California St., Suite 201** **Stockton, CA 95204-6005** **Physician's and Surgeon's Certificate No. G 68537** Respondent.	Case No. 800-2021-078682 OAH No. 2023080268 **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 Megan R. O'Carroll, Deputy Attorney General.

2. Respondent Paul Hing Ping Lee, M.D. (Respondent) is represented in this proceeding by attorney Donna W. Low, Esq., whose address is: 2150 River Plaza Drive, Ste. 250 Sacramento, CA 95833

3. On or about May 7, 1990, the Board issued Physician's and Surgeon's Certificate No. G 68537 to Paul Hing Ping Lee, 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. 800-2021-078682, and will expire on May 31, 2025, unless renewed.

JURISDICTION

4. Accusation No. 800-2021-078682 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 4, 2023. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2021-078682 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. 800-2021-078682. 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. 800-2021-078682, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. 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. 800-2021-078682, 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 68537 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.

CONTINGENCY

13. 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.

14. 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. 800-2021-078682 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.

15. 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.

16. 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 68537 issued to Respondent Paul Hing Ping Lee, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for seven (7) years on the following terms and conditions:

1. COMMUNITY SERVICE - FREE SERVICES. Within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval a community service plan in which Respondent shall, within the first 2 years of probation, provide 80 hours of free services (nonmedical), to a community or non-profit organization.

Prior to engaging in any community service, Respondent shall provide a true copy of the Decision(s) to the chief of staff, director, office manager, program manager, officer, or the chief executive officer at every community or non-profit organization where Respondent provides community service and shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall also apply to any change(s) in community service.

Community service performed prior to the effective date of the Decision shall not be accepted in fulfillment of this condition.

2. 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.

3. 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.

4. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

A clinical competence assessment 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 course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, 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. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

5. MONITORING - PRACTICE. 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 monitor(s), 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 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, and whether Respondent is practicing medicine safely. 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.

6. 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.

7. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

8. 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.

9. 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 $39,323.50 (thirty-nine thousand three hundred and twenty-three dollars and fifty 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.

10. 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.

11. 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.

12. 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.

13. 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..

14. 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.

15. 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.

16. 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.

17. 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.

18. 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. 800-2021-078682 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Donna W. Low, 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: 02/22/2024

PAUL HING PING LEE, M.D.
Respondent

I have read and fully discussed with Respondent Paul Hing Ping Lee, 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: 2/23/2024

DONNA W. LOW, ESQ.
Attorney for Respondent

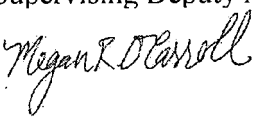
ENDORSEMENT

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

DATED: 2/28/2024

Respectfully submitted,

ROB BONTA
Attorney General of California
MICHAEL C. BRUMMEL
Supervising Deputy Attorney General



MEGAN R. O'CARROLL
Deputy Attorney General
Attorneys for Complainant

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EXHIBIT A

Accusation Case No. 800-2021-078682

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

In the Matter of the Accusation Against: **Paul Hing Ping Lee, M.D.** **1805 N. California St., Suite 201** **Stockton, CA 95204-6005** **Physician's and Surgeon's Certificate No. G 68537,** Respondent.	Case No. 800-2021-078682 **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 May 7, 1990, the Medical Board issued Physician's and Surgeon's Certificate Number G 68537 to Paul Hing Ping Lee, 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 May 31, 2025, unless renewed.

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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 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. 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.

6. Unprofessional conduct under section 2234 of the Code is conduct which breaches

the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.).

7. 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.

8. 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

9. Respondent is a Board-certified urologist. From approximately November 2014 through the present he has had a urology practice in Stockton with Dignity Medical Group. In addition to an office-based practice, he performs procedures at St. Joseph Medical Center (SJMC), in Stockton.

Patient 1

10. Patient 1 was a 78-year-old man with end stage renal failure requiring chronic hemodialysis. Despite the dialysis, he produced small amounts of urine, and noticed blood in the urine. Respondent diagnosed Patient 1 with gross hematuria due to tumor or tumors of the bladder and recommended surgery. Patient 1 had a history of cardiac disease, cardiac bypass surgery, and stroke. Although Respondent stated in Patient 1's medical records that he obtained informed consent before performing the surgery, the medical records do not contain documentation of a satisfactory informed consent, including the risks, benefits and alternatives to surgery. Nonetheless, Respondent performed a transurethral resection of bladder tumor (TURBT) on Patient 1 at SJMC on or about January 4, 2018.

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11. The day after Patient 1's surgery, in the early morning hours, Patient 1 developed dangerously high potassium levels. Blood work resulted at approximately 4:03 a.m. on January 5, 2018 showed that Patient 1's potassium level had risen to 7.8. High potassium levels, known as hyperkalemia, can cause abnormal heart rhythms, leading to cardiac arrest and death. Patient 1's hyperkalemia was sufficiently severe to be a life-threatening emergency, requiring emergency measures such as immediate administration of glucose, bicarbonate, calcium, and even insulin, as well as a Kayexalate enema and/or transfer to an ICU for management of cardiac abnormalities. Respondent visited the patient bedside at approximately 8:10 a.m. Respondent's progress notes from this visit contain the abnormal laboratory finding of a 7.8 potassium level, but Respondent nonetheless documented that Patient 1 was doing well. Despite the elevated potassium level, Respondent took no further action other than to order dialysis and enter orders for Patient 1 to be discharged that day.

12. The SJMC Charge Nurse observed Patient 1's extremely elevated potassium levels at approximately 9:55 a.m. on January 5, 2018, and directed Patient 1's nurse to contact Respondent urgently about the high levels. The nurse quickly paged Respondent and informed him of the test result, but Respondent took no further action.

13. SJMC Nursing staff continued to check on Patient 1 frequently between 10:15 and 11:45 a.m. on January 5, 2018. At 11:45 a.m., a nurse found Patient 1 to be non-responsive and called for emergency assistance from the hospital physicians. Hospital physicians responded and provided emergency treatment, but were unable to restore Patient 1. Hospital physicians pronounced him dead at approximately 12:20 p.m. on January 5, 2018.

Patient 2

14. Patient 2 was a 66-year-old man with a persistent 2 cm mass on his left kidney that physicians were concerned was a renal cell carcinoma. Patient 2 had a complex medical history with multiple medical comorbidities including COPD, stroke, hypertension, end stage renal disease requiring chronic hemodialysis, hepatitis C, diastolic cardiac dysfunction, IV heroin abuse, and mitral valve endocarditis.

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15. Medical consultants at SJMC who evaluated Patient 2 reported that he was a poor candidate for surgery. Regardless, Respondent performed an open left partial nephrectomy[1] on Patient 2 on or about August 2, 2018 at SJMC. Respondent failed to obtain and document a proper informed consent from Patient 2, including the options, risks, and alternatives to the surgery. In this case, alternatives that Respondent failed to discuss with Patient 2 or document in his medical record, include robotic surgery, a percutaneous ablation with Interventional Radiology, or monitoring the mass for a longer time before attempting any intervention.

16. Several days postoperatively, Patient 2 developed gross hematuria. Patient 2 underwent a segmental renal artery embolization in the Interventional Radiology department. This was unsuccessful. On or about August 14, 2018, Respondent performed a right nephrectomy and cystoscopic evacuation of bladder hematoma. Once again, Respondent failed to obtain and document a proper informed consent from Patient 2, including the options, risks, and alternatives to the surgery. In this case, Respondent should have discussed with Patient 2, and documented, the consideration of renal preserving interventions short of a nephrectomy.

Patient 3

17. Patient 3 was a 35-year-old woman who was diagnosed with an adrenal mass in April of 2019. She was admitted to SJMC in June of 2019 for a transabdominal left adrenalectomy[2]. Respondent failed to obtain and document a proper informed consent noting the risks, benefits, and alternatives for the surgery. Respondent failed to discuss or document the potential for laparoscopic or laparoscopic robotic excision rather than open surgery.

18. Respondent performed the surgery on or about June 4, 2019. During the surgery, Respondent injured Patient 3's spleen, causing it to bleed and obscure the surgical field. This required him to remove Patient 3's spleen. Also during the surgery, Respondent failed to properly identify the anatomical markers before removing tissue. As a result, he misidentified Patient 3's pancreas as the adrenal gland he was attempting to remove. The Pathology

[1] A nephrectomy is the surgical removal of a kidney.
[2] An adrenalectomy is a surgery to remove an adrenal gland.

Department at SJMC performed an analysis and discovered Respondent had mistakenly removed the tail of Patient 3's pancreas.

19. After the Pathology Department informed Respondent that he had not removed the tumor, he scheduled Patient 3 for a repeat surgery on June 6, 2019 to actually remove the tumor, and to have a general surgery repair the pancreas. On or about June 6, 2019, Respondent took Patient 3 back to surgery, and removed a left adrenal tumor.[3] A general surgeon was present and performed a distal pancreatectomy.[4] Following the surgeries, Patient 3 developed a large left flank hernia requiring yet another repair with mesh.

Patient 4

20. Patient 4 was a 48-year-old man with end stage renal disease on chronic hemodialysis. Patient 4 had a complex medical history with many comorbidities including anemia, hypothyroidism, hypertension, and a mental health disorder, which required him to have a conservator. He was admitted to SJMC on or about December 6, 2019, after being found to have low hemoglobin on a routine blood work panel. At SJMC he was diagnosed with sepsis due to a right perinephric abscess[5] and hydronephrosis[6] with retained ureteral stent.

21. During his hospitalization, Patient 4 developed acute respiratory failure. He had a pleural effusion that was drained by thoracentesis. The Interventional Radiology Department at SJMC performed a percutaneous drainage, and the Infectious Disease Department administered intravenous antibiotics, but it did not solve the problem. Patient 4 had a CT scan that showed a patent inferior vena cava without thrombus. When consulted, Respondent recommended Patient 4 undergo a right nephrectomy.

22. Respondent took Patient 4 to surgery on or about December 25, 2019 to perform a nephrectomy. Despite Patient 4 having a CT scan that showed a patent inferior vena cava without

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[3] The final pathology report found that the tumor was actually a neuroendocrine tumor rather than adrenal tumor.

[4] Pancreatectomy is the surgical removal of all or part of the pancreas.

[5] A perinephric abscess is a collection of puss that occurs due to a bacterial infection in the area around the kidney.

[6] Hydronephrosis is a condition where one or both kidneys become stretched due to buildup of urine inside them.

thrombus, during the surgery, Respondent believed he saw a malignant tumor that extended into Patient 4's inferior vena cava.[7] If Respondent believed he saw a malignant tumor extending into the vena cava, he should have quickly obtained a frozen section pathology analysis to confirm before attempting further high risk procedures. Instead, he proceeded to remove the perceived tumor, and in the course of doing so, he caused a 2-3 cm injury to Patient 4's vena cava.

23. At this point, Respondent should have immediately obtained vascular control and repaired the injury, or obtained a consultation from a vascular surgeon to do so. Instead, Respondent continued to attempt to remove further perceived malignant tumor from the vein, and completely transected Patient 4's inferior vena cava. Only after completely transecting the inferior vena cava did Respondent call the vascular surgeon, but by then Patient 4 was losing blood rapidly and exsanguinated and expired on the surgical table. The pathology reports showed that the tissue Respondent removed from Patient 4 was not a tumor, malignant or otherwise. What Respondent believed to be a tumor was merely hematoma and infection with hydronephrosis, which Respondent could have left in place, thus sparing Patient 4 vascular injury and death.

Patient 5

24. Patient 5 was a 55-year-old man when he met with Respondent on or about January 22, 2020, to discuss his CT report of a small, right renal mass suspicious for renal cell carcinoma. At the January 22, 2020 appointment, Respondent did not personally review Patient 5's CT films, and did not review or order a complete metabolic panel or chest x-ray to evaluate metastasis. Nonetheless, he recommended Patient 5 undergo a nephrectomy. Respondent did not discuss alternative surgical approaches such as robotic partial nephrectomy and did not have or document a discussion of risks or options with Patient 5 as necessary to obtain full informed consent.

25. Before the surgery could take place, on or about February 26, 2020, Patient 5 presented to SJMC Emergency Room for treatment of pneumonia. At this visit, Patient 5 had a CT scan with IV contrast showing the mass on the right kidney. Respondent failed to perform a

[7] The inferior vena cava is the largest vein in the body. It carries blood back to the heart from the lower part of the body.

preoperative metastatic evaluation before recommending a partial nephrectomy to Patient 5. This evaluation is necessary because findings of metastasis would alter the surgical approach and treatment. The evaluation would include a complete metabolic panel, bone scan if alkaline phosphatase is elevated or patient has bone pain, further evaluation of the liver if liver function tests are abnormal, and chest x-ray. Respondent's preoperative notes do not detail findings of any blood work or chest x-ray that may have been ordered by another provider.

26. On or about April 7, 2020, Respondent performed a right, partial nephrectomy on Patient 5 at SJMC. During the surgery Respondent was not able to see or palpate any mass. Respondent noted some deformity, but also reported that the abnormality "does not have the typical features of a carcinoma." Respondent failed to perform an intraoperative ultrasound or send the mass to pathology for frozen section analysis. Respondent did not have Patient 5's CT scans available and present in the operating room during surgery.

27. Pathology reports of the tissue Respondent removed from Patient 5 revealed no malignancy. On or about June 17, 2020, Patient 5 had a follow up CT scan. This CT scan showed that the mass was still present, indicating that Respondent missed the mass during his April 7, 2020 surgery. On or about July 2, 2020, Respondent telephoned Patient 5 and his wife and informed them that the most recent imaging showed that that the renal mass had "recurred." He did not admit the truth, that he had missed the mass during the surgery. He did not explain that the tissue he removed from Patient 5 during the surgery was not cancerous. Respondent telephoned Patient 5 again on or about July 30, 2020, and reiterated that the mass was "recurrent." Multiple care providers reported to the hospital administration that Respondent failed to truthfully inform Patient 5 that the mass was not recurrent, rather it was the original mass that Respondent failed to remove. The Medical Staff Quality Improvement Committee met and determined that Respondent was not upfront with Patient 5 and his family. Subsequently, on or about September 1, 2020, Respondent telephoned Patient 5 and his wife again, explaining that the mass had not recurred, but rather that he failed to remove the mass during the April 7, 2020 surgery.

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28. Patient 5 underwent robotic partial nephrectomy with a different physician at UCSF Medical Center in early November 2020. The robotic surgery was successful and Patient 5's subsequent CT scans showed no further mass on the right kidney.

Patient 6

29. Patient 6 was a 60-year-old man when he began seeing Respondent in approximately June of 2019. Patient 6 had a complicated medical history, with an array of medical comorbidities including cirrhosis, rectal cancer, past substance abuse, aortic valve replacement, endocarditis, fatty liver, and blood platelet disorder. Respondent recommended Patient 6 undergo a surgery to reduce the prostate, called a transurethral resection of the prostate (TURP) procedure. At an office visit on or about April 9, 2020, Respondent documented that Patient 6 would benefit from the TURP procedure "for chronic prostatitis to treat recurrent infections." Respondent did not document or discuss bladder outlet obstruction. TURP is indicated for cases of bladder outlet obstruction, not for cases of chronic prostatitis and urinary tract infection, as the procedure has been shown not to benefit these conditions. Respondent did not document specific risks or alternatives to the TURP procedure.

30. On or about May 5, 2020, Respondent performed a greenlight laser TURP surgery on Patient 6 at SJMC. Patient 6's surgery was complicated by bladder spasms and blood in the urine. In the operative report, Respondent documented that Patient 6's prostate was "not very large in size." Following surgery Patient 6 was discharged, but had to be readmitted to SJMC on or about May 8, 2020 due to encephalopathy and respiratory failure due to pneumonia. Patient 6 was found to have blood in the urine, requiring bladder irrigation. He was discharged home again, on or about May 18, 2020, with a Foley urinary catheter.

31. On or about June 19, 2020, Patient 6 returned for an office visit with Respondent, complaining of persistent blood in the urine and incontinence. On or about December 10, 2020, Respondent performed a cystoscopy and found a bladder wall mass.[8] Respondent documented the mass as a "2-3 cm polypoid mass right bladder wall near trigone." He further noted there was

[8] Cystoscopy is a procedure to look inside the bladder using a thin camera called a cystoscopy.

a "blockage . . . recurrent growth" of the prostate. Respondent did not note that Patient 6 had a bladder outlet obstruction or perform objective testing to establish obstruction such as postvoid residual or urodynamic testing. Respondent recommended Patient 6 undergo a second surgery to include a repeat TURP procedure and also a procedure to remove the bladder tumor, called a transurethral resection of bladder tumor, (TURBT). Respondent did not discuss or document any alternative options, or the risks and benefits of the planned second surgery.

32. On or about February 16, 2021, Respondent performed the second surgery on Patient 6, which included both a TURP and TURBT procedure. Respondent documented in the operative report that he removed a papillary tumor on the right side of the bladder, and sent it to pathology for analysis. The pathology report, however, stated that the sample Respondent provided was not a tumor, it was only a small amount of bladder tissue with significant cautery artifact. This indicates that Respondent either missed the tumor, or destroyed it with his cautery equipment. In addition, Respondent's operative report noted that Patient 6 had "a large prostate," despite the fact that his previous operative report from the TURP procedure a few months earlier stated that the prostate was small. Respondent did not discuss or administer postoperative intravesical chemotherapy.

33. Patient 6 was discharged after the surgery, only to be readmitted the following day, on or about February 18, 2021 due to acidosis and respiratory issues. He was discharged with a Foley catheter on or about February 20, 2021, and told to follow up with Respondent on an outpatient basis. In March of 2021, Patient 6 developed a urinary tract infection. He was admitted to SJMC on or about March 1, 2021, and treated for sepsis. After treatment, he was discharged on or about March 9, 2021, with a Foley catheter due to urinary retention.

34. Patient 6 suffered another urinary tract infection in May, and was admitted to SJMC on or about May 28, 2021, again with sepsis. At this time Patient 6 began to see another urologist separate and apart from Respondent. After several more complications, the new urologist diagnosed Patient 6 as still having a tumor on the right side of his bladder. The new urologist performed a TURBT surgery on Patient 6 on or about September 22, 2021. The operative report

from the September 22, 2021 surgery with the new urologist showed that the urologist removed a 2 cm tumor from Patient 6 during the surgery. This was confirmed by pathology.

35. During his interview with investigators working on behalf of the Board, Respondent was asked about Patient 6's care and treatment. During the interview, Respondent told investigators that he performed the repeat TURP procedure on Patient 6, "not because of an obstruction, but just to fill [sic] the bleeding tissue." Furthermore, Respondent told investigators that the tissue he removed from Patient 6 during the February 2021 surgery was not papillary. He stated that it was just thickened tissue. This is in direct contradiction of the cystoscopy he performed only two months before the surgery, during which he specifically noted that Patient 6 had a 2-3 cm polypoid mass. It is also contradicted by the fact that another surgeon successfully removed a 2 cm high grade tumor from that same area only a few months later. These facts demonstrate that Respondent was being untruthful with the investigators in statements in order to evade the reality that he had either missed the tumor or destroyed it with his cautery resection.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

36. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he was grossly negligent in his care and treatment of Patients 1, 3, 4, 5, and 6. The circumstances are set forth in paragraphs 9 through 35, above, which are hereby incorporated by reference and realleged as if fully set forth herein. Additional circumstances are as follows:

37. Respondent was grossly negligent in his care and treatment of Patients 1, 3, 4, 5, and 6 for his acts and omissions, including, but not limited to, the following:

a. Failing to respond to and treat Patient 1's life threatening hyperkalemia, even after being alerted by nursing staff, leading to Patient 1's unnecessary and avoidable death;

b. Failing to perform standard anatomic landmark identification as a primary surgical step in Patient 3's June 4, 2019 surgery, causing him to miss a large adrenal tumor and instead remove part of Patient 3's pancreas, requiring a repeat adrenal surgery and further pancreatic surgery;

c. Failing to obtain frozen section pathology of the suspected tumor rupture before attempting a dangerous, and unnecessary surgical intervention that caused Patient 4's exsanguination and death;

d. Failing to review all of Patient 5's relevant CT scans before performing surgery on April 7, 2020;

e. Failing to have all Patient 5's relevant CT scans present in the operating room for reference while performing the April 7, 2020 surgery;

f. Removing normal tissue from Patient 5 instead of the tumor during the April 7, 2020 surgery without sending the tissue for a frozen section analysis or performing an intraoperative ultrasound, thus requiring Patient 5 to need a second major surgery to remove the tumor;

g. Failing to perform a preoperative metastatic evaluation to ensure no metastasis of a suspected cancerous renal mass before performing surgery on Patient 5;

h. Performing the May 5, 2020 TURP surgery on Patient 6 for the treatment of chronic prostatitis without having established that Patient 6 had a bladder outlet obstruction by history and objective testing; and

i. Being dishonest in his Board interview by falsely stating that Patient 6 only had simple bladder wall thickening, despite having previously documented a 2-3 cm polypoid mass, in order to justify the lack of significant pathology, and avoid admitting that he either missed or destroyed the mass during the February 16, 2021 TURBT surgery.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

38. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he was repeatedly negligent in his care and treatment of Patients 1, 2, 3, 4, 5, and 6. The circumstances are set forth in paragraphs 9 through 35, above, which are hereby incorporated by reference and realleged as if fully set forth herein. Additional circumstances are as follows:

39. Respondent was repeatedly negligent in his care and treatment of Patients 1, 2, 3, 4, 5, and 6 for his acts and omissions, including, but not limited to, the following:

a. Failing to respond to and treat Patient 1's life threatening hyperkalemia, even after being alerted by nursing staff, leading to Patient 1's unnecessary and avoidable death;

b. Failing to perform and document a thorough and complete informed consent for surgery, including the risks and alternative options for surgery;

c. Failing to obtain proper informed consent from Patient 2, including a discussion of the risks and alternative options for surgery for either the left partial nephrectomy of August 2, 2018 or the August 14, 2018 right nephrectomy;

d. Failing to consider, document, and perhaps perform renal salvage surgery on Patient 2 to control the bleeding from the small partial nephrectomy defect before performing the August 14, 2018 right full nephrectomy of a normal kidney;

e. Failing to perform standard anatomic landmark identification as a primary surgical step in Patient 3's June 4, 2019 surgery, causing him to miss a large adrenal tumor and instead remove part of Patient 3's pancreas, requiring a repeat adrenal surgery and further pancreatic surgery;

f. Failing to obtain proper informed consent for surgery from Patient 3 including failure to discuss or document the potential for laparoscopic or laparoscopic robotic excision rather than open surgery;

g. Mishandling the initial 2-3 cm vena cava injury to Patient 4 by failing to immediately obtain vascular control and/or obtain an immediate vascular consultation before proceeding any further;

h. Failing to perform and document a thorough and complete informed consent for surgery, including the risks and alternative options for surgery;

i. Failing to obtain frozen section pathology of the suspected tumor rupture before attempting a dangerous, and unnecessary surgical intervention that caused Patient 4's exsanguination and death;

j. Failing to review all of Patient 5's relevant CT scans before performing surgery on April 7, 2020;

k. Failing to have all Patient 5 's relevant CT scans present in the operating room for reference while performing the April 7, 2020 surgery;

l. Removing normal tissue from Patient 5 instead of the tumor during the April 7, 2020 surgery without sending the tissue for a frozen section analysis or performing an intraoperative ultrasound, thus requiring Patient 5 to need a second major surgery to remove the tumor;

m. Failing to perform a preoperative metastatic evaluation to ensure no metastasis of a suspected cancerous renal mass before performing surgery on Patient 5;

n. Failing to obtain proper informed consent from Patient 5 including failing to advise him of less morbid and more appropriate surgical approaches for his condition, such as robotic laparoscopic procedures;

o. Failing to discuss and document a detailed discussion of the risks, options, alternatives to the surgical procedures with Patient 6;

p. Destroying or missing Patient 6's tumor during the February 16, 2021 TURBT surgery;

q. Performing the repeat February 16, 2021 TURP with the TURBT surgery on Patient 6 without having established a bladder outlet obstruction by history and objective testing;

r. Performing the May 5, 2020 TURP surgery on Patient 6 for the treatment of chronic prostatitis without having established that Patient 6 had a bladder outlet obstruction by history and objective testing; and

s. Being dishonest in his Board interview by falsely stating that Patient 6 only had simple bladder wall thickening, despite having previously document a 2-3 cm polypoid mass, in order to justify the lack of significant pathology, and avoid admitting that he either missed or destroyed the mass during the February 16, 2021 TURBT surgery.

THIRD CAUSE FOR DISCIPLINE

(Act of Dishonesty Related to Practice of Medicine)

40. Respondent is subject to disciplinary action under section 2234, subdivision (e), in that he committed dishonest and corrupt acts substantially related to the qualifications, functions, or duties of a physician and surgeon. The circumstances are set forth in paragraphs 9 through 35, above, which are hereby incorporated by reference and realleged as if fully set forth herein. Additional circumstances are as follows:

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41. Respondent was dishonest in his care and treatment of Patients 5, and 6, for his acts and omissions, including, but not limited to, the following:

a. Telling Patient 5 and his family that his tumor recurred to cover up the fact that Respondent missed the tumor during the April 7, 2020 surgery, and not telling Patient 5 the truth until after his dishonesty was reported to SJMC's administration and peer review committee; and

b. Being dishonest in his Board interview by falsely stating that Patient 6 only had simple bladder wall thickening, despite having previously documented a 2-3 cm polypoid mass, in order to justify the lack of significant pathology, and avoid admitting that he either missed or destroyed the mass during the February 16, 2021 TURBT surgery.

FOURTH CAUSE FOR DISCIPLINE

(Inadequate Medical Recordkeeping)

Respondent is subject to disciplinary action under section 2266 by failing to maintain adequate and accurate record relating to the provision of medical care to Patient 1, 2, 3, 4, 5, and 6. The circumstances are set forth in paragraphs 9 through 35, above, which are incorporated here by reference as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

42. Respondent is subject to disciplinary action under Code section under section 2234 in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as alleged in paragraphs 9 through 35, above, which are incorporated by reference and realleged as if fully set forth 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 68537, issued to Paul Hing Ping Lee, M.D.;

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2. Revoking, suspending or denying approval of Paul Hing Ping Lee, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Paul Hing Ping Lee, 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;

4. Ordering Respondent Paul Hing Ping Lee, M.D., if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and

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

DATED: MAY 04 2023

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

SA2022304595