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

In the Matter of the Accusation Against:	
James H. Chen, M.D.	Case No. 800-2021-078498
Physician's & Surgeon's Certificate No. A 70934,	
Respondent.	

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 August 29, 2024.

IT IS SO ORDERED: July 30, 2024.

MEDICAL BOARD OF CALIFORNIA

Michelle Bholat, M.D., Interim Chair
Panel A

ROB BONTA
Attorney General of California
MICHAEL C. BRUMMEL
Supervising Deputy Attorney General
JOHN S. GATSCHET
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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:	Case No. 800-2021-078498
JAMES H. CHEN, M.D. 112 Conductor Way Folsom, CA 95630-8018	OAH No. 2024030597
Physician's and Surgeon's Certificate No. A 70934, Respondent.	**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 John S. Gatschet, Deputy Attorney General.

2. Respondent James H. Chen, M.D. ("Respondent") is representing himself in this proceeding and has chosen not to exercise his right to be represented by counsel.

3. On or about February 25, 2000, the Board issued Physician's and Surgeon's Certificate No. A 70934 to Respondent. That Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2021-078498, and will expire on February 28, 2026, unless renewed.

JURISDICTION

4. Accusation No. 800-2021-078498 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 February 12, 2024. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2021-078498 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, and understands the charges and allegations in Accusation No. 800-2021-078498. Respondent has also carefully read, 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 be represented by counsel at his own expense; 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. 800-2021-078498, 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 for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

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

CONTINGENCY

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

13. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreement of the parties in this above entitled matter.

14. Respondent agrees that if an Accusation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2021-078498 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.

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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

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED THAT the Physician's and Surgeon's Certificate No. A 70934 issued to Respondent James H. Chen, M.D. shall be and is hereby publically reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Accusation No. 800-2021-078498, is as follows:

"On or between September 7, 2020, and November 3, 2020, while treating Patients 1, 2, and 3, at Napa State Hospital, you failed to adequately document the patient's medical records as more fully described in Accusation No. 800-2021-078498."

B. 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.

On or about April 25, 2024, through April 26, 2024, the Respondent participated in the U.C. San Diego, School of Medicine's Physician Assessment and Clinical Education Program's ("P.A.C.E.") Medical Record Keeping Course. Following the conclusion of the course, Respondent received a certificate of completion verifying that he completed seventeen (17) hours of continuing medical education. The Board shall give Respondent credit for completion of a

Medical Record Keeping Course in satisfaction of this term and condition. Respondent shall provide a copy of the Certificate of Completion to the Board in fulfillment of this condition within 60 days of the effective date of this Decision.

C. 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 successfully complete all coursework and provide proof of completion of the Professionalism Program to the Board within one (1) year of the effective date of the Decision and Order. This condition shall be monitored by the Probation Department.

D. COST RECOVERY (INVESTIGATION/ENFORCEMENT)

Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, legal reviews, investigation(s), and legal document preparation, as applicable, in the amount of $15,000.00 (fifteen thousand dollars and zero cents). Costs shall be payable to the Medical Board of California. Payment must be made in full to the Board within 180 calendar days of the effective date of the Order.

E. **FAILURE TO COMPLY**

If Respondent fails to enroll in, participate in, or successfully complete the educational program(s) and/or course(s), and/or complete the term(s) and condition(s) as described in conditions **B**, **C**, and **D**, within the designated time period as set forth in the Decision and Order, Respondent shall receive and comply with 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 not resume the practice of medicine until enrollment or participation or fulfillment in the educational program(s) and/or course(s), and/or completion of the term(s) and condition(s) has been provided to the Board as required by the express language of the Decision and Order. In addition, failure to successfully complete the educational program(s) and/or course(s), and/or complete the term(s) and condition(s) outlined above shall also constitute separate grounds for general unprofessional conduct and will be grounds for further immediate disciplinary action against Respondent's license.

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ACCEPTANCE

I have carefully read the Stipulated Settlement and Disciplinary Order. 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: ____________________ ______________________________________
JAMES H. CHEN, M.D.
Respondent

ENDORSEMENT

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

DATED: ______________________

Respectfully submitted,

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

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

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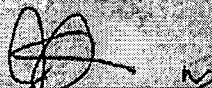
ACCEPTANCE

I have carefully read the Stipulated Settlement and Disciplinary Order. 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: 6/12/24



JAMES H. CHEN, M.D.
Respondent

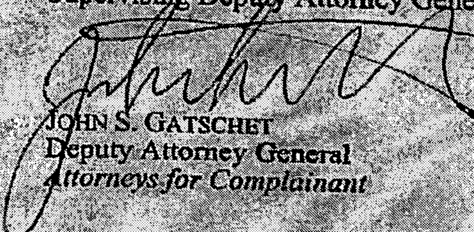
ENDORSEMENT

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

DATED: 6-13-2024

Respectfully submitted,

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



JOHN S. GATSCHET
Deputy Attorney General
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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:	Case No. 800-2021-078498
James H. Chen, M.D. **112 Conductor Way** **Folsom, CA 95630-8018**	**ACCUSATION**
Physician's and Surgeon's Certificate No. A 70934,	
Respondent.	

PARTIES

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

2. On or about February 25, 2000, the Medical Board issued Physician's and Surgeon's Certificate No. A 70934 to James H. Chen, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2026, unless renewed.

JURISDICTION

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

4. Section 2004 of the Code provides in pertinent part:

> 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.
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> (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.
>
> ...

5. Section 2227 of the Code provides, in pertinent part, 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.

STATUTORY PROVISIONS

6. Section 2234 of the Code, provides, in pertinent part:

> 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.
>
> ...
>
> (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.

...

7. Section 2266 of the Code provides, in pertinent part:

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

8. Section 125.3 of the Code provides, in pertinent part:

(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 period 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.

FACTUAL ALLEGATIONS

9. Respondent is a Board Certified physician in Internal Medicine. Respondent worked at Napa State Hospital ("NSH") on medical staff as a treating physician from on or around May 2006 to on or about March 12, 2021. NSH is a State owned facility located in Napa, California that provides care to felony defendants who are incompetent to stand trial, civilly committed parolees who have severe mental health disorders, felony patients who have been judged not guilty because of insanity, and patients who have been involuntarily civilly committed. On or about March 12, 2021, Respondent resigned from the medical staff at NSH. At the time Respondent resigned from the NSH medical staff, the NSH peer review committee had recommended Respondent take part in a Focused Professional Practice Evaluation due to clinical concerns.

10. At NSH during the time alleged in this Accusation, it was standard procedure for nursing staff working at night to document referrals for physicians working the next day in the nurse's communication book. While medical issues that required emergent care were immediately referred to physicians working at night, non-emergent issues that required follow-up physician care the next day were documented in the nurse's communication book. It was the standard procedure for physicians working the next day to read the patient referrals from the night shift nurses, mark that they had reviewed the entry, provide care, and document the care provided.

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At the time of the allegations alleged in the Accusation, Respondent worked as a unit physician during the day shift in the "T7" unit of NSH.

Patient 1[1]

11. On or about October 30, 2020, Patient 1 underwent ankle surgery. On or about November 2, 2020, Patient 1 was transferred from the "A9W" unit back to the "T7" unit of the NSH. Patient 1 was known to be non-compliant with medical orders. On or about the night of November 2, 2020, into the morning hours of November 3, 2020, a night shift nurse documented in the nurse's communication book that Patient 1's medical orders needed to be reviewed by a physician due to duplicate orders and requested that the orders be clarified. The night shift nurse documented that Patient 1 had a "CIO" order and 15-minute checks. The night shift nurse's entry in the nurse's communication book is crossed out and someone documented a date of November 3, 2020, and placed a capital C in the book under the night shift nurse's request.

12. On or about November 2, 2020, a different NSH physician documented a discharge note from "A9W" unit back to "T7" unit at approximately 4:09 p.m. The transfer note documented that the physician discussed Patient 1's care with Respondent at the time of discharge. A review of the progress notes for Patient 1 reveals that the next physician note in Patient 1's chart was documented on November 6, 2020. Respondent failed to document a progress note for Patient 1 on November 3, 2020, following the night shift nurse's request to review Patient 1's medical orders. Respondent never documented an acceptance note back to the "T7" unit on either November 2, 2020, or November 3, 2020. There is no record of Respondent providing care to Patient 1 on November 2, 2020, or November 3, 2020.

Patient 2

13. On or about the night of September 17, 2020, into the morning hours of September 18, 2020, a night shift nurse documented an entry in the nurse's communication book for Patient 2, who was housed in the "T7" unit. The night shift nurse documented, "Fyi" and noted that

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[1] In order to protect patient privacy and confidentiality, the patient and witness identities have been anonymized. All patients and witnesses will be fully identified in discovery.

Patient 2 continues to complain of diffuse pain with a pain level of 4 out of 10. The night shift nurse documented that the pain was on the right side of Patient 2's umbilicus. The night shift nurse documented, "soft, mobile, non-splinting, no apparent distress." Someone crossed out the night shift nurse's entry and placed a closed "C" below the entry.

14. A review of the physician progress notes for Patient 2 reveals that Respondent failed to document a progress note for Patient 2 on September 18, 2020. There is no record of Respondent providing care to Patient 2 on September 18, 2020. A different physician documented a "late entry" note on September 19, 2020. The physician documented that the abdominal pain had subsided and resolved from the day earlier.

15. On or about October 30, 2020, Respondent documented a Quarterly Medicine Progress Note in Patient 2's medical chart. Respondent documented that there were no changes in the patient's medical care over the past quarter. Respondent documented he did not perform a physical examination because of Covid-19. Respondent failed to document that Patient 2 had complained of abdominal pain on the night of September 17, 2020, and failed to document any information related to Patient 2's subsequent care on September 18, 2020, and September 19, 2020, in the October 30, 2020, note. In addition, on September 30, 2020, a nurse documented in the nurse's communication book that Patient 2 exhibited very poor fluid intake. The nurse noted that Patient 2 often grimaces when offered fluids and spits out fluids. Respondent also failed to document in the October 30, 2020, Quarterly Medicine Progress Note that Patient 2 was dealing with poor fluid intake issues on or about September 30, 2020.

Patient 3

16. On or about the night of September 7, 2020, Patient 3, a patient housed in the "T7" unit, complained of chest heaviness. An electrocardiogram ("EKG") was ordered by an on-call physician. A night shift nurse documented in the nurse's communication book that Patient 3 had experienced chest heaviness and that he had reported shortness of breath. The night shift nurse documented Patient 3's vitals and documented a "Stat EKG" had been performed that showed a result of sinus tachycardia with a rate of "102." The night nurse requested that Patient 3 be checked on September 8, 2020. On the side of the margin next to the nurse's note, it was

documented as "patient asymptomatic today." The nurse's note is not crossed out to indicate that Patient 3 was seen. A review of the physician progress notes for Patient 3 shows that Respondent failed to document a progress note for Patient 3 on September 8, 2020. There is no record of Respondent providing care to Patient 3 on September 8, 2020.

17. On or about September 24, 2020, Patient 3 complained he was having difficulty voiding his bladder. A different physician was covering for Respondent on September 24, 2020. In the nurse's communication book, it was documented that the unit MD would see the patient for urinary retention, and a bladder scan was ordered. On or about September 24, 2020, the covering physician documented a physician progress note that Patent 3 was having difficulty emptying his bladder and that testing would be ordered. The covering physician documented that the unit MD would see Patient 3 when the results of the tests were available. On the night of September 24, 2020, a night nurse documented in the nurse's communication book that Patient 3 agreed to comply with a bladder scan and urinalysis during morning void on September 25, 2020. The September 24, 2020, night entry is crossed out but is not initialed. Respondent next worked in the "T7" unit as the Unit physician on September 25, 2020.

18. On or about September 25, 2020, at approximately 11:45 a.m., a nurse documented a nursing chart note that contained the results of Patient 3's bladder scan. The nursing chart note documented that Respondent was notified of the result. A review of the physician progress notes shows Respondent failed to document a progress note on September 25, 2020, for Patient 3. There is no record of Respondent providing care to Patient 3 on or about September 25, 2020, however, there is a passing reference to Respondent changing physician orders in Patient 3's chart. There is no progress note that explains why Respondent discontinued some orders.

19. On or about September 28, 2020, Respondent documented a Quarterly Medicine Progress Note for Patient 3. Respondent documented that he was deferring Patient 3's physical examination due to Covid-19. Respondent documented there were no changes in the past quarter with Patient 3's health and that Patient 3 had no complaints since his last review. Respondent failed to document in the Quarterly Medicine Progress Note that Patient 3 had experienced an

episode of chest heaviness on or about September 7, 2020, and that Patient 3 had undergone an EKG. Respondent failed to document in the Quarterly Medicine Progress Note that Patient 3 had experienced difficulty emptying his bladder on or about September 24, 2020, and that he had undergone a bladder scan.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

20. Respondent James H. Chen, M.D.'s license is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent failed to document medical progress notes for Patients 1, 2, and 3, and failed to properly document Quarterly Medicine Progress Notes with updated medical information for Patients 2 and 3.. The circumstances are as follows:

21. Complainant realleges paragraphs 9 through 19, and those paragraphs are incorporated by reference as if fully set forth herein.

22. Respondent committed the following separate and distinct negligent acts during the care and treatment of Patients 1, 2, and 3:

(a) On or about November 2, 2020, Respondent failed to document an acceptance note for Patient 1 back to the T7 unit following his transfer from the A9W unit;

(b) Respondent failed to document a progress note on or about November 3, 2020, for Patient 1 despite receiving a request from a night shift nurse to see Patient 1 to review medical orders;

(c) Respondent failed to document a progress note on or about September 18, 2020, for Patient 2 despite receiving a request from a night shift nurse to see Patient 2 for follow-up related to abdominal pain;

(d) On or about October 30, 2020, Respondent documented an incomplete Quarterly Medicine Progress Note for Patient 2 that failed to include relevant medical information from September 17, 2020, and September 30, 2020;

(e) Respondent failed to document a progress note on or about September 8, 2020, for Patient 3 despite receiving a request from a night shift nurse to see Patient 3 for follow-up related to chest pain;

(f) Respondent failed to document a progress note on or about September 25, 2020, for Patient 3 despite receiving a request from a covering physician that Respondent would see Patient 3 for follow-up related to bladder issues; and,

(g) On or about September 28, 2020, Respondent documented an incomplete Quarterly Medicine Progress Note for Patient 3 that failed to include relevant medical information from September 7, 2020, and September 24, 2020.

SECOND CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Medical Record Keeping)

23. Respondent James H. Chen, M.D.'s license is subject to disciplinary action under section 2266 of the Code in that Respondent failed to document adequate and accurate medical records for Patients 1, 2, and 3. The circumstances are as follows:

24. Complainant realleges paragraphs 9 through 22, and those paragraphs are incorporated by reference as if fully set forth herein.

25. As alleged above, Respondent's repeated failure to document progress notes for Patients 1, 2, and 3, after receiving referrals from other medical staff and Respondent's repeated failure to incorporate new medical issues into the Quarterly Medicine Progress Note for Patients 2 and 3, represents a failure to keep adequate and accurate medical records.

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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 No. A 70934, issued to Respondent James H. Chen, M.D.;

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

3. Ordering Respondent James H. Chen, M.D., to pay the Board the reasonable 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: FEB 1 2 2024

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

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