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

In the Matter of the First Amended Accusation Against:	
Mark Anthony Spicer, M.D.	Case No. 800-2021-076573
Physician's and Surgeon's Certificate No. A 68609	
Respondent.	

DECISION

The attached Stipulated Surrender of License and 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 December 31, 2024.

IT IS SO ORDERED December 24, 2024.

MEDICAL BOARD OF CALIFORNIA

Jenna Jones Fox

Reji Varghese
Executive Director

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
State Bar No. 179733
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6475
Facsimile: (916) 731-2117
E-mail: Rebecca.Smith@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **MARK ANTHONY SPICER, M.D.** **29826 Haun Road, Suite 200** **Sun City, CA 92586-6547** **Physician's and Surgeon's Certificate No. A 68609,** Respondent.	Case No. 800-2021-076573 OAH No. 2024050632 **STIPULATED SURRENDER OF LICENSE AND 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 Rebecca L. Smith, Deputy Attorney General.

2. Mark Anthony Spicer, M.D. (Respondent) is represented in this proceeding by attorneys Dennis Ames and Pogey Henderson, whose address is 2677 North Main Street, Suite 901, Santa Ana, California 92705-6632.

3. On or about May 28, 1999, the Board issued Physician's and Surgeon's Certificate No. A 68609 to Respondent. That license was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2021-076573 and will expire on October 31, 2026, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2021-076573 was filed before the Board and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on May 16, 2024. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of First Amended Accusation No. 800-2021-076573 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2021-076573. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended 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.

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

CULPABILITY

8. Respondent understands that the charges and allegations in First Amended Accusation No. 800-2021-076573, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the First Amended Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the First Amended Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

11. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license."

12. Respondent understands that, by signing this stipulation, he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. A 68609 without further notice to, or opportunity to be heard by, Respondent.

13. This Stipulated Surrender of License and Disciplinary Order shall be subject to the approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for his consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

14. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to

approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director on behalf of the Board does not, in his discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

15. This Stipulated Surrender of License and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

16. The parties agree that copies of this Stipulated Surrender of License and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

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

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ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 68609, issued to Respondent Mark Anthony Spicer, M.D., is surrendered and accepted by the Board, effective December 31, 2024.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in First Amended Accusation No. 800-2021-076573 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $42,375.00 (Forty-Two Thousand Three Hundred Seventy-Five Dollars and No Cents) prior to issuance of a new or reinstated license.

6. 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 agency in the State of California, all of the charges and allegations contained in First Amended Accusation No. 800-2021-076573 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 licensure.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorneys Dennis Ames and Pogey Henderson. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: Nov-20-2024

M. Spicer

MARK ANTHONY SPICER, M.D.
Respondent

I have read and fully discussed with Respondent Mark Anthony Spicer, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 11/20/24

Pogey Henderson

DENNIS AMES
POGEY HENDERSON
Attorneys for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: 11/21/2024

Respectfully submitted,

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

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2021-076573

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

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

In the Matter of the First Amended Accusation Against: **MARK ANTHONY SPICER, M.D.** **29826 Haun Road, Suite 200** **Sun City, CA 92586-6547** **Physician's and Surgeon's Certificate No. A 68609,** Respondent.	Case No. 800-2021-076573 **FIRST AMENDED ACCUSATION**

PARTIES

1. Reji Varghese (Complainant) brings this First Amended 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 May 28, 1999, the Board issued Physician's and Surgeon's Certificate Number A 68609 to Mark Anthony Spicer, 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 October 31, 2024, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

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

(b) The administration and hearing of disciplinary actions.

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

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

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

(f) Approving undergraduate and graduate medical education programs.

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

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

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

5. Section 2227 of the Code states:

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

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

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

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

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

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

6. 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 no later than 30 calendar days after being notified by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

(h) Any action of the licensee, or another person acting on behalf of the licensee, intended to cause their patient or their patient's authorized representative to rescind consent to release the patient's medical records to the board or the Department of Consumer Affairs, Health Quality Investigation Unit.

(i) Dissuading, intimidating, or tampering with a patient, witness, or any person

in an attempt to prevent them from reporting or testifying about a licensee.

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.

COST RECOVERY

8. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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

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

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

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

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

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

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

DEFINITIONS

9. Cervical spinal cord compression, also known as cervical myelopathy, is a condition describing the compression of the spinal cord in the cervical spine (neck), resulting in spasticity, hyperreflexia, pathologic reflexes, and/or gait disturbance.

10. C1 to C7 refer to the seven vertebrae of the cervical spine, which also includes six intervertebral discs and eight nerve roots.

11. Ataxia describes poor muscle control that causes clumsy movements. Gait ataxia is characterized by difficulty walking in a straight line, poor balance, and lateral veering, among other things.

12. Disc flattening occurs as discs between the vertebrae degenerate and spread sideways, sometimes causing back or neck pain.

13. Endplate spurring refers to bone spurs that develop at the top or bottom edges of the vertebrae where they interact with the disc.

14. Spastic quadriparesis is a condition that occurs when there is a weakness in all four limbs. The weakness causes diminished mobility and can be temporary or permanent.

15. A laminectomy, also called a decompression, is a surgery used to relieve pressure on the spinal nerve roots caused by changes to the spine. The surgery involves removing bone and/or thickened tissue that is narrowing the spinal canal and squeezing the spinal nerve roots.

16. An autograft fusion is the standard technique used in spinal fusion surgery where extra bone is taken from one part of a patient's body and moved to another part of the body. An allograft fusion is when a surgeon uses bone that is harvested from a donor or cadaver during a spinal fusion surgery. The allograft does not form new bone, but works as a scaffold that allows the natural bone to grow through its surface.

17. An anterior cervical discectomy is a surgery in which a degenerative disc in the neck is removed and replaced with a graft, which will fuse together the bones above and below the disc. The surgical approach is from the throat area.

18. Intraoperative neuromonitoring is performed using a variety of neurophysiologic techniques to monitor the state of the nervous system in real-time during surgery. It is an important tool for providing safe and effective care to patients undergoing spine surgery. Surgeons can be alerted of potential evolving neurologic inquiry and may allow for corrective actions to be implemented to prevent permanent deficits, thereby improving safety and surgical outcomes.

19. Somatosensory evoked potentials (SEPs) are used as an integral method of intraoperative neurophysiological monitoring for spinal and vascular surgeries. In combination with other modes of neurophysiological monitoring, SEPs serve to signal potential or actual nerve injury and allow for correction to avoid the morbidity associated with the surgery.

20. Occipital cephalgia (neuralgia) is a type of headache characterized by a paroxysmal stabbing pain in the back of the scalp.

21. A subdural hematoma is a type of bleeding near your brain that can happen after a head injury. When there is a sufficient accumulation of blood to occupy a large intracranial space, the brain midline shifts to the opposite side, encroaching on the brain structures. Most subdural hematomas associated with a midline shift of 5 millimeters or more are surgically evacuated.

22. A craniotomy is an operation in which a small hole is made in the skull, or a piece of bone from the skull is removed, to access part of the brain. After which, the bone is replaced. A craniotomy is the main treatment for subdural hematomas, allowing a surgeon to gently remove the hematoma through suction and irrigation.

23. A craniectomy is a type of surgery to remove a portion of the skull, which helps relieve extra pressure on the brain. After a craniectomy, the bone is not immediately replaced.

24. A bur hole evacuation is a procedure in which one or more small holes are drilled in the skull and a flexible rubber tube is inserted to drain a hematoma.

25. Pneumocephalus is the presence of air in the epidural, subdural, or subarachnoid space.

FACTUAL ALLEGATIONS

26. Respondent is a board-certified neurosurgeon who worked at Seven Star Neurosurgery in Menifee, California.

Patient A

27. Patient A[1] is a seventy-two-year-old man with a history of cervical spinal cord compression, neuropathy, glaucoma, and muscle weakness, among other maladies.

28. Patient A was referred to Respondent by his primary care physician, due to his difficulty walking and increased leg stiffness. On or about April 30, 2020, Patient A first presented to Respondent at Advanced Neurosurgery Associates.[2] Respondent noticed that Patient A presented in a wheelchair with gait ataxia. Respondent conducted a physical examination and obtained additional medical history from Patient A. Respondent noted that on or about November 13, 2019, Patient A underwent magnetic resonance imaging (MRI) of the cervical spine, which demonstrated severe disc flattening and endplate spurring at C3-4, C4-5, C5-6 and C6-7. The MRI also showed multilevel facet and uncovertebral joint osteoarthritis.

29. Following his examination, Respondent found that Patient A had a degenerative disease and a severe spinal cord injury. Respondent indicated that Patient A would benefit from C3-6 decompressive laminectomies and performance of allograft fusions at each level. Respondent also suggested that Patient A undergo C3-4, C5-6, and C6-7 anterior cervical discectomy with instrumented fusion. Respondent noted that he discussed the risks of the procedure with Patient A during this visit, and Patient A expressed a desire to proceed.

30. On or about May 4, 2020, Patient A presented for surgery with Respondent at Menifee Global Medical Center (Menifee Global).[3] Respondent noted pre-operative and post-

[1] The patients are identified as "Patient A" and "Patient B" in this Accusation to protect their privacy.

[2] Advanced Neurosurgery Associates was Respondent's private practice that was acquired by Seven Star Neurosurgery in about 2017.

[3] Respondent had privileges at Menifee Global Medical Center during his treatment of Patient A.

operative diagnoses as cervical spondylotic myelopathy, spastic quadriparesis, severe spinal cord compression, and severe degenerative disc disease C3-4 through C6-7. Respondent noted that the following procedures would be performed: decompressive bilateral laminectomy C3-6, bilateral lateral mass screws C3-6, allograft/autograft fusion, and insertion of a Jackson-Pratt drain.[4]

31. During the surgery, specifically the decompression, the attending neurophysiologist informed Respondent that there was a drop in neuromonitoring signal potential and increased latency of the SEPs. The procedure was stopped immediately and Respondent confirmed that Patient A's blood pressure was adequate and requested that the blood pressure be increased. Respondent released the retractors, inspected the wound, and ruled out any technical issues. According to the neuromonitoring report, the SEPs eventually began to stabilize and returned to baseline. However, Respondent noted that the attending neurophysiologist reported sustained abnormal signals. Nonetheless, Respondent continued with the procedure by placing the necessary instruments on the left side. Ultimately, Respondent completed the decompressive bilateral laminectomy C3-6, with insertion of bilateral lateral mass screws at C3-6. Following the decompression, Respondent elected not to proceed with the anterior surgery.

32. Patient A was put into the intensive care unit following the surgery and required vasopressors[5] to keep his blood pressure raised. Post-operative records indicate that, following the procedure, Patient A was unable to move his lower extremities, had trace movements of his upper extremities, and had impaired sensation throughout his body. Patient A remained hospitalized from May 4-8, 2020.

33. On or about May 8, 2020, Patient A was transferred to Hemet Valley Healthcare Center (Hemet Valley), a skilled nursing facility, where he spent about 10 days. On or about May 12, 2020, Hemet Valley contacted Respondent indicating that Patient A would be discharged back to Hemet Valley's Rehabilitation facility.

34. On or about May 28, 2020, Patient A again presented to Respondent for post-operative follow-up. Patient A indicated that he had not improved since his stint at Hemet Valley

[4] A Jackson-Pratt drain is a surgical suction drain that gently draws fluid from a wound.

[5] Vasopressors are a group of medicines that constrict blood vessels and raise blood pressure.

Rehabilitation. Respondent noted that Patient A had not demonstrated any significant change in his neurologic examination versus immediately post-operatively. Respondent indicated that he would obtain an MRI of the cervical and thoracic spine and a computerized tomography (CT) of the cervical spine, in addition to ordering more rehabilitation.

35. The MRI and CT of the cervical spine were completed on or about June 9, 2020. On or about June 18, 2020, after review of the MRI and CT, Respondent noted that he reviewed the scans and there was not much more he could do surgically.

36. On or about July 2, 2020, Patient A was transferred from Hemet Valley to ManorCare Health Services in Hemet, California.

37. On or about July 23, 2020, Patient A returned to Respondent for a follow-up appointment. Respondent noted that Patient A made significant improvement in strength in all four extremities, and Respondent recommended continued therapy. At another follow-up appointment, on or about September 3, 2020, Respondent noted that Patient A had residual numbness on the left side, but the upper extremity strength continued to improve. Respondent indicated that an anterior approach was no longer needed, as there was no evidence of instability or for the need for further stabilization. Respondent recommended continued physical therapy.

Patient B

38. Patient B is a sixty-five-year-old woman with a history of diabetes, hypertension, and gout, among other maladies. Patient B experienced episodes of syncope, tremors, blurry vision, and trouble with urination.

39. Patient B had prior hospital admission visits, including on or about September 18, 2021, when Patient B presented to the emergency department at Loma Linda University Medical Center (Loma Linda)[6] after she fell and hit her head.

40. Patient B was examined by the attending physician, who noted a 3 centimeter x 1 centimeter (cm) laceration over the right parietal region. The laceration was closed in the

[6] Respondent had privileges at Loma Linda University Medical Center during his care and treatment of Patient B.

emergency department and a CT scan was performed, which showed a small right subdural hematoma measuring 4 millimeters (mm).

41. The attending physician contacted Respondent, who was the neurosurgeon on-call, for a consult. In the early morning on or about September 19, 2021, Respondent requested a repeat CT scan and recommended that Patient B be admitted to the hospital. Respondent indicated that he would follow Patient B as the consulting neurosurgeon. The repeat CT scan showed a larger subdural hematoma, measuring 9 mm, with a 6.7 mm midline shift to the left. Subsequently, Patient B was put into the intensive care unit (ICU) and Respondent indicated that she would be observed and checked hourly. Respondent also ordered another CT scan in 12 hours. Respondent noted that Patient B was aware that surgery may be necessary for any progression of her subdural hematoma, or if her symptoms worsened.

42. On or about September 20, 2021, another CT scan was performed, which showed improvement to the size of the hematoma and the extension of the midline shift. As a result, Patient B was downgraded from the ICU.

43. On or about September 22, 2021, an occupational therapist noted that Patient B had some left-sided drooping and mild slurred speech, so she was evaluated for a stroke. Another CT scan was performed and, by the time Patient B returned from the scan, she was back to her normal baseline. Respondent indicated that the subdural hematoma appeared to be resolving slowly and surgical intervention was not planned at that time.

44. On or about September 24, 2021, Patient B was discharged from Loma Linda.

45. On or about September 30, 2021, Patient B again presented to the emergency department at Loma Linda. Patient B complained of increased nausea, occasional vomiting, and right-side occipital cephalgia.

46. The attending physician ordered an electrocardiogram (EKG), which revealed a right bundle-branch block, and a CT scan of the head, which revealed an acute on chronic subdural hematoma that had increased in size, from 6 mm to 1.2 cm. The physician discussed the findings with a radiologist and immediately notified Respondent.

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47. As Patient B's neurosurgeon, Respondent requested a brain MRI with and without contrast. The MRI revealed a right subdural hematoma measuring 11.7 mm along the frontal convexity. There was no abnormal post-contrast enhancement of the brain. The attending physician notified Respondent of the results, and Respondent advised him to initiate Keppra (an anti-epileptic drug) and mannitol (a sugar alcohol used to reduce intracranial and intraocular pressure), which he did. Subsequently, Patient B was admitted to the ICU.

48. On or about October 1, 2021, Respondent evaluated Patient B. Respondent discussed the risks and benefits associated with a craniotomy versus burr hole evacuation of the subdural hematoma, as well as those associated with no intervention other than medical treatment.

49. According to Patient B's medical records, she declined any invasive intervention. However, Respondent was later informed that Patient B changed her mind and wanted to proceed with surgery. Respondent made the arrangements for Patient B's surgery.

50. According to records, later on or about October 1, 2021, Patient B underwent a right frontotemporoparietal craniectomy for evacuation of subdural hematoma. Respondent noted that there were no intraoperative complications.

51. Later that night, Respondent was notified that Patient B's neurological status changed, and she was not opening her eyes or following commands. Subsequently, a head CT was ordered and, after reviewing the results, Respondent indicated that the new changes were expected post-operatively and nurses should continue to monitor Patient B.

52. On or about October 2, 2021, Respondent evaluated Patient B and found that she remained non-verbal. There was a finding of residual subdural hematoma, but Respondent indicated that it was actually saline that was instilled at the time of surgery to minimize post-operative pneumocephalus.[7] Respondent directed nurses to keep Patient B in the supine position to assist in the resolution of post-operative pneumocephalus, and he would add supplemental oxygen. Respondent also planned to insert a cranial bolt for intracranial pressure (ICP) monitoring, but the plan was aborted due to lack of equipment at Loma Linda.

[7] Pneumocephalus is the presence of intracranial air, which is a complication after neurotrauma or brain surgery.

53. Respondent visited another local area hospital to obtain suitable equipment but was unsuccessful in his efforts. Respondent advised the attending physician that Patient B would need to be transferred for a higher level of care. However, there were no beds available for transfer.

54. On or about October 3, 2021, Patient B was returned to the operating room for an emergency evacuation of recurrent subdural hematoma. According to records, Respondent again performed a right frontotemporoparietal craniectomy for evacuation of subdural hematoma.

55. Following the procedure, bloody drainage was noticed in the external ventricular drains collection chamber. A nurse stated that there was equipment available to measure ICP, but Respondent stated that ICP measurement was not needed and directed the nurse to keep the chamber low and open to gravity.

56. On or about October 4, 2021, Respondent noted that there were significant neurological improvements and no evidence of postoperative seizures. Patient B underwent another CT scan, which was reviewed by Respondent. The CT scan demonstrated continued resolution of midline shift with good evacuation of the subdural hematoma, and the subdural drain was in good position.

57. Later, on or about October 4, 2021, at the request of her family, Patient B was transferred to Loma Linda's Main Campus.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

58. Respondent Mark Anthony Spicer, M.D. is subject to disciplinary action under Code section 2234, subdivision (b), in that he was grossly negligent in his care and treatment of Patients A and B. The circumstances are as follows:

Patient A

59. Complainant hereby re-alleges the facts set forth in paragraphs 26 through 37, above, as though fully set forth.

60. Surgical interventions can produce anticipated and unanticipated complications. A physician should evaluate and manage intra-operative and post-operative complications. During a decompression procedure, a significant change in the intra-operative SEPs constitutes a

common intra-operative complication. This significant change can reflect a technical, anesthetic, or non-physiologic issue, which is either a reversible or non-reversible condition. When the change represents a reversible condition, time is of the essence to prevent the development of a neurological deficit.

61. The standard of care requires a physician to confirm the absence of a technical and anesthetic issue by immediately completing a wake-up test,[8] or a physician should proceed with imaging to evaluate for a source that cannot be visualized.

62. At the time of the change in SEPs during Patient A's procedure, Respondent appropriately confirmed the absence of technical issues and addressed the elevating blood pressure with the anesthesiologist. Respondent also released the retractors, inspected the wound, and performed x-rays. Despite this, Respondent failed to identify the source of the change in SEPs, and did not have evidence to sufficiently support that the signals had normalized before resuming the surgery.

63. After failing to identify the source of the change in SEPs, Respondent should have immediately proceeded to performing an MRI or CT scan instead of completing the surgery.

64. When Patient A woke from surgery, he was found to have significant and new neurological deficits, and Respondent was contacted by the nursing staff regarding these findings. The standard of care requires a physician to evaluate and manage any new post-operative neurological deficits.

65. While Respondent made an order on May 4, 2020, regarding Patient A's blood pressure, Respondent failed to immediately evaluate or manage the post-operative complications. Respondent did not order any post-operative imaging of the cervical spine between May 4-8, 2020, although he indicated that he managed and evaluated Patient A on these dates. Respondent also failed to document any immediate post-operative evaluation or management of the new neurological deficits between May 4-8, 2020. During an interview with the Board, Respondent indicated that Menifee Global did not have the capability of performing a post-operative MRI and

[8] The wake-up test, also known as the Stagnara test, is a simple and reliable method of recognizing an intro-operative complication. The patient is awakened during surgery and asked to move their feet to demonstrate intact spinal cord motor function.

hospital logistics prevented him from performing a CT scan. Additionally, Respondent stated that Patient A was too unstable to transfer. However, Respondent's records do not support a finding that Patient A was too unstable to transfer for imaging and there were interventions that could have been done to support the transfer.

66. Respondent's collective failures, as outlined above, constitute an extreme departure from the standard of care.

Patient B

67. Complainant hereby re-alleges the facts set forth in paragraphs 38 through 57, above, as though fully set forth.

68. The standard of care requires urgent intervention following clinical deterioration with worsened imaging findings.

69. On or about October 1, 2021, nurses noted that Patient B was no longer responsive, and the emergency CT scan showed that the subdural hematoma measured 12 mm thick, with a 16 mm midline shift. After being notified of the results, Respondent indicated that the changes were expected post-operatively and Patient B should be monitored. When Respondent saw Patient B on or about October 2, 2021, she was noted to be Glasgow Coma Scale level 7[9] and was intubated. A repeat CT scan on October 2, 2021, did not show significant change and Respondent noted that the hematoma reported was saline. However, post-operative imaging showed blood and air with little saline.

70. Worsened imaging findings should not be expected post-operatively, but call for urgent intervention. However, most of October 2, 2021 was spent trying to find an ICP monitoring system and arranging for Patient B's transfer, due to a lack of a complete ICP monitoring system and electroencephalogram (EEG)[10] monitoring. Neither of the aforementioned aid in the direct treatment of the re-accumulation of blood and likely brain

[9] The Glasgow Coma Scale is a tool used to measure a person's level of consciousness following a brain injury. The Scale assesses a person based on their ability to perform eye movements (eye opening), speak (verbal response), and move their body (motor response). The total possible Glasgow Coma Score is 15, which means the patient is responsive. A Glasgow Coma Score of 3-8 indicates severe traumatic brain injury.

[10] Electroencephalogram (EEG) is a test that measures electrical activity in the brain using small, metal discs attached to the scalp.

swelling. Another operation to decompress the brain would have been the most effective treatment, which was not done until October 3, 2021. A craniectomy was performed, leaving the bone off, which was appropriate and should have been done during the first surgery.

71. Respondent's collective actions and inactions, regarding his response to Patient B's deterioration post-operatively, constitute an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

72. Respondent Mark Anthony Spicer, M.D. is subject to disciplinary action under Code section 2234, subdivision (c), in that he was repeatedly negligent in his care and treatment of Patient B. The circumstances are as follows:

73. Complainant hereby re-alleges the facts set forth in paragraphs 38 through 57, above, as though fully set forth.

74. The standard of care provides that acute subdural hematomas over 1 cm thick, with over 5 mm midline shift, require surgery. Earlier surgery typically leads to a better outcome.

75. The CT scan performed on September 30, 2021, around 3:40 p.m., showed a subdural hematoma with a 1.2 cm midline shift. Respondent did not see Patient B until October 1, 2021, around 7:48 a.m. While Respondent discussed evacuation surgery with Patient B once he made contact with her, he should have visited Patient B earlier to confirm her neurologic status and to avoid any assumption that a delay in response time supported her desire to avoid surgery. Surgery was eventually performed on October 1, 2021, around 2:58 p.m. Respondent's delay in discussing and performing surgery constitutes a simple departure from the standard of care.

76. When determining whether to perform a craniotomy versus a craniectomy, a physician must determine if post-operative swelling is anticipated. If so, a physician should perform a craniectomy, leaving off the bone, with a plan to replace it later. The CT scan, performed prior to the first surgery, suggested that there may be an underlying contusion, which may swell post-operatively. Respondent's operative report indicates that a craniectomy was performed, which would be appropriate, but Respondent also documented that the bone was

replaced, indicating that a craniotomy was actually performed. Respondent's performance of a craniotomy instead of a craniectomy constitutes a simple departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate or Accurate Medical Records)

77. Respondent Mark Anthony Spicer, M.D. is subject to disciplinary action under Code section 2266 in that he failed to maintain adequate and accurate medical records. The circumstances are as follows:

Patient A

78. The facts and allegations set forth in paragraphs 26 through 37 and 58 through 66, above, are incorporated herein by reference as if fully set forth.

79. The standard of care requires a physician to keep adequate, complete, and accurate medical records.

80. Prior to his surgery, Patient A signed a consent form, which listed the planned procedure as a posterior lateral fusion. The consent form failed to list the decompression procedure or the anterior procedure. On or about May 4, 2020, a nurse contacted Respondent to inform him that the consent form failed to accurately reflect the planned procedure. The nurse noted that the language of the consent was based on Respondent's order and was discussed with Respondent. Neither the consent form nor the order were changed.

81. In actuality, Respondent planned to perform a posterior cervical decompression and instrumented fusion, and an anterior cervical discectomy and fusion. These are distinct procedures and reflect both an anterior and posterior approach to the cervical spine. Despite being informed by a nurse regarding the consent form's inaccuracies, Respondent failed to correct the consent form. This failure constitutes a departure from the standard of care.

82. Patient A was admitted at Menifee Global from May 4, 2020 through May 8, 2020. However, Respondent used his April 30, 2020 office visit note as the admitting history and physical examination results. This is a departure from the standard of care.

83. On or about May 8, 2020, Respondent made a discharge summary which incorrectly stated that Patient A's hospitalization was without complication, that Patient A's surgery was

performed without intra-operative or post-operative complication, and that at no time did Patient A manifest any new, overt neurological deficits. This record was inaccurate and constitutes a departure from the standard of care.

Patient B

84. Complainant hereby re-alleges the facts and allegations set forth in paragraph 76, which are incorporated herein by reference as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

85. Respondent Mark Anthony Spicer, M.D. is subject to disciplinary action under Code section 2234 in that he engaged in unprofessional conduct. The circumstances are as follows:

86. The allegations in the First, Second and Third Causes for Discipline are incorporated herein by reference as if fully set forth,

DISCIPLINARY CONSIDERATIONS

87. To determine the degree of discipline, if any, to be imposed on Respondent Mark Anthony Spicer, M.D., Complainant alleges that on or about June 7, 2019, in a prior disciplinary action titled In the Matter of the First Amended Accusation Against Mark Anthony Spicer, M.D. before the Medical Board of California, in Case Number 18-2013-232559, Respondent's license was revoked, with the revocation stayed for a period of three (3) years, subject to additional terms and conditions. This discipline was the result of sustained allegations of gross negligence, repeated negligent acts, dishonesty, creating false medical records, altering medical records, failure to maintain adequate and accurate medical records, and unprofessional conduct, resulting from his care and treatment of three patients. That decision is now final and is incorporated by reference as if fully set forth herein.

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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 Number A 68609, issued to Respondent Mark Anthony Spicer, M.D.;

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

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

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

DATED: MAY 16 2024

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

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