

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

**In the Matter of the Accusation
Against:**

Mohammed Habeeb Ahmed, M.D.

**Physician's and Surgeon's
Certificate No. A 69198**

Case No.: 800-2021-078610

Respondent.

DECISION

The attached Proposed Decision 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 February 13, 2025.

IT IS SO ORDERED: January 14, 2025.

MEDICAL BOARD OF CALIFORNIA

Michelle A. Bholat, MD

**Michelle Anne Bholat, Chair
Panel A**

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In the Matter of the Accusation Against:

**MOHAMMED HABEEB AHMED, M.D.,
Physician's and Surgeon's Certificate No. A 69198
Respondent.**

Agency Case No. 800-2021-078610

OAH No. 2024040279

PROPOSED DECISION

Administrative Law Judge Michael C. Starkey, State of California, Office of Administrative Hearings, heard this matter on November 19 through 22, 2024, via videoconference.

Deputy Attorneys General D. Mark Jackson and Harriet Newman represented complainant Reji Varghese, Executive Director, Medical Board of California, Department of Consumer Affairs.

Attorneys David A. Depolo and Jeffrey A. Grant represented respondent Mohammed Habeeb Ahmed, M.D., who was present.

The matter was submitted on November 22, 2024.

FACTUAL FINDINGS

Jurisdictional Matters

1. On July 9, 1999, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. A 69198 to respondent Mohammed Habeeb Ahmed, M.D. This certificate was in full force and effect at all relevant times and is scheduled to expire on January 31, 2027, unless renewed.

2. On October 25, 2022, acting in his official capacity as Executive Director of the Board, complainant William Prasifka issued and served an accusation against respondent. On June 23, 2023, Reji Varghese succeeded Prasifka as the Executive Director of the Board and assumed the role of complainant in this proceeding. Complainant alleges that cause exists to discipline respondent's certificate because he: on May 19, 2021, made inappropriate comments about the appearance of Patient A (name withheld for privacy) and inappropriately touched her breasts; implanted a loop recorder inside of Patient A's chest even though it was not medically indicated; inaccurately reported on his medical group's website and letterhead that he was board certified in cardiovascular diseases and interventional cardiology; and failed to maintain adequate and accurate medical records. Complainant also seeks costs.

3. Respondent filed a notice of defense and this proceeding followed.

Background

4. Patient A; Patient A's mother, boyfriend, and friend; the Board investigator; respondent; several of respondent's employees; and an expert witness for each party testified at hearing.

5. Respondent practices as a cardiologist in a multi-specialty medical group practice in San Jose and Gilroy.

6. In 2019, when Patient A was 19 years old, she consulted her primary care physician after experiencing an episode of heart palpitations at night, with no obvious cause. She was wearing an electronic device that measured her heart rate and it reported a heart rate greater than 180 beats per minute (bpm). Patient A's primary care physician referred her to respondent for evaluation.

Respondent's Treatment of Patient A

7. On January 2, 2019, respondent conducted a cardiology consultation for Patient A. He noted that she was experiencing chest pain, shortness of breath, palpitations, and dizziness, with several pre-syncopal (nearly fainting) episodes. During this visit, Patient A's pulse was 65 bpm and her blood pressure was 121/87 mm Hg. An electrocardiogram (ECG) 2 showed sinus rhythm at 69 bpm and sinus arrhythmia. Respondent recommended an echocardiogram (ECHO) and 24-hour Holter monitor (wearable device to measure heart rhythm) for Patient A.

8. On January 5, 2019, Patient A underwent an ECHO, which showed normal left and right ventricular size and function. A 24-hour Holter monitoring was also performed at this visit and showed an average heart rate of 75 bpm (range 52-142 bpm). There was a large amount of artifact on the tracing, but no significant atrial, or ventricular tachyarrhythmias were noted. There were no pauses.

9. On January 16, 2019, Patient A had an office visit with respondent. Patient A was accompanied by her mother at this visit. Patient A complained of dizziness, palpitations, and chest pain. Patient A's pulse was 81 bpm and her blood

pressure was 117/75 mm Hg. Respondent recommended treadmill stress testing and ambulatory outpatient cardiac monitoring for Patient A.

10. On January 18, 2019, Patient A performed an exercise stress test. Patient A exercised to 12.7 METS (metabolic equivalent thresholds) on a Bruce protocol, to a peak heart rate of 188 bpm. It is undisputed that this test suggested that there was no structural problem (blockage of valves or vessels) with Patient A's heart.

11. Between January 31, 2019, and February 14, 2019, an event monitor was performed on Patient A, which showed normal sinus rhythm with an average heart rate of 108 bpm (range 51 to 165 bpm). There were no supraventricular tachycardia (SVT) episodes and no premature ventricular contractions (PVC) (extra heartbeats) or ventricular tachycardia (VT) runs noted. There were no pauses over two seconds. There was one manual recording, which showed normal sinus rhythm.

12. On February 20, 2019, Patient A had a visit with respondent. Patient A was accompanied by her mother. Patient A had complaints of fatigue, dizziness, palpitations, and episodes of near syncope. Respondent discussed implanting a loop recorder under Patient A's chest.

13. On April 15, 2019, respondent placed an implantable loop recorder under Patient A's chest.

14. On April 23, 2019, Patient A presented to respondent's office for a follow-up appointment. Patient A was accompanied by her mother at this visit. Patient A's loop recorder incision was healing well and the suture was removed. Respondent recommended a one-month loop recorder check.

15. On May 8, 2019, Patient A had another visit with respondent. Respondent checked Patient A's loop recorder and noted that it showed appropriate function. No episodes of arrhythmia were detected. A device interrogation report was provided from that date. The report indicated an episode of atrial fibrillation (irregular and fast heart rhythm) lasting eight minutes and six seconds. However, the handwritten report states "no true episodes. Six month followup."

16. On August 14, 2019, Patient A had an appointment with respondent. Patient A was accompanied by her mother at this visit. Patient A reported occasional dizziness and palpitations. Respondent noted in the medical records that he checked the loop recorder and that it did not show any events. The loop recorder interrogation report showed two events detecting atrial fibrillations. However, respondent noted that he did not believe these to be real events and noted "no episodes, normal device function."

17. On November 13, 2019, Patient A had an in-clinic interrogation at respondent's office, which detected what appeared to be atrial fibrillation episodes. Respondent, however, handwrote on the report: "No true AF ... No pauses ... Not true episodes."

18. On November 20, 2019, Patient A returned to respondent's office for a follow-up visit. Respondent noted in her medical record that Patient A's loop recorder showed marked sinus arrhythmia and that her medications were refilled. However, in respondent's investigative interview (see Factual Finding 52), respondent stated that Patient A was not taking any medications at this time.

19. On February 12, 2020, Patient A presented to respondent for device interrogation. Patient A's presenting rhythm was sinus. No events were detected.

20. On July 29, 2020, Patient A saw respondent. Respondent noted that a previous loop recorder interrogation had shown a possible paroxysmal atrial fibrillation. Patient A had palpitations and dizziness. Respondent documented obesity as a diagnosis as well as noncompliance with medication and advice. Respondent recommended a loop recorder check, ECHO, and medication refill.

21. On April 28, 2021, Patient A saw respondent, who noted that she had not shown up for an interim appointment. Respondent noted that Patient A "complains of episodes of palpitations, occurring intermittently for the past few weeks, associated with dizziness and fatigue." She denied chest pain or shortness of breath. Respondent recommended a loop recorder check, ECHO, and medication refill.

22. On May 12, 2021, Patient A had a loop recorder device interrogation. No alerts were reported. Respondent documented in the medical records that five episodes of SVT were detected by the loop recorder's remote monitoring website. Patient A's fastest heart rate was 202 bpm on March 4, 2021. Respondent noted that the device battery was low and recommended replacement.

The May 19, 2021, Office Visit

23. Patient A saw respondent in his Gilroy office on May 19, 2021. The medical record is very similar to the record for the April 28, 2021, visit, except that respondent noted that Patient A's loop recorder was last checked on May 12, 2021, and showed several episodes of tachycardia, the fastest being 202 bpm, and respondent noted that he recommended replacing the loop recorder. It is undisputed that Patient A and respondent were alone together in the examination room. However, Patient A and respondent report very different versions of what transpired during this visit.

24. From the parking lot outside of respondent's office, just after the May 19, 2021, visit, Patient A sent text messages to her boyfriend, the gist of which was that respondent had inappropriately touched her breasts.

At some point "soon" after the May 19, 2021, visit with respondent, Patient A handwrote notes of what had transpired and took photographs of these notes. She reports that she did this because she did not want to forget what had happened, especially since her boyfriend was urging her to report the incident to the police. Patient A wrote (formatting in original):

- Didn't go to checkups because I didn't receive call for appointment since Covid lockdown Start Feb/March 2020.
- Called to make appointment myself
- Appointments that were done
 - Review
 - Check up on any signs
 - Monitor log check with technician
- Went to an appointment 5/19/2021
- Needed a[n] Ultrasound check but technician called in sick for 2 weeks.
- Sat down & reviewed the graphs he collected
- He told me my heartbeat was 202 bpm

- asked if I do drugs (cocaine, drink a lot, etc.)
- Didn't believe me & said "there's something that makes it high"
- I mentioned about having sex a lot & maybe could be a factor
- he asked how much, told him every other day
- Told me that it's not common for the female to want it alot (*sic*)
- He went in for a handshake like a friend [illegible] but kept holding my hand
- He proceeded to get up & hug me, grab my face to look at him but I moved my face to look away because I was getting uncomfortable
- He sat back down & told me that my battery is very low & needs to be replaced.
- I knew how its (*sic*) taken out but he still showed me how.
- His hand went in my bra to cup my left breast to show me how its (*sic*) pushed out
- * I didn't resist because I considered that professional as he's the doctor *

- He summarized it up & told me possibilities that it could be enlarging (heart chamber) telling me from where he sees it just sitting down that my left boob is a bit bigger than the other one.
- I of course was shocked & worried but didn't want to show him my boobs. *Told me that my boobs are big over & over again.
- He then said about my sex activity again, mentioned that my boyfriend is lucky to have me
- Dabbed handshake again and pulled me in to hug once again telling me I'm a "very pretty girl"
- Grabbed my face but I pulled away to go leave
- He was in front/side of the doorway & told me my boobs are big & look nice. I tried to play it off to just leave as soon as possible.
- He grabbed both of my boobs (2x) twice with both hands & I didn't know what to do besides bring my arms to the middle to make him stop
- He let me leave & I went to the front desk, I wanted to tell the lady in the front. I was thinking to (s/c) much like "is she a victim too? Maybe she's a part of it. I'm too embarrassed now."

- I went straight to my car & told my boyfriend
- Straight home told my mom
- Tried to go to work but broke down in the parking lot of work & inside in front of coworkers

25. At hearing, Patient A reported her memories of this incident, which were similar to the notes she wrote near the time it happened, as follows: Patient A was at that time working for a large pharmacy chain at a store very close to respondent's office. She went to the appointment in the afternoon, during her lunch break. She was wearing gray scrubs. She told respondent that she had never done cocaine, but respondent did not believe her and wanted to know why her heart rate was high at night and then asked about her sexual activity. After she told him "maybe every other day" he remarked that usually males want to "do it" more than females. She played along and did a "dap it up" handshake with him. Then he demonstrated how he would remove the loop recorder, initially through her scrub top, but then he put one hand under the top to push up her breast. She felt shocked, but saw this as a "professional thing" because he was a doctor trying to show her the procedure. He then mentioned that the breast with the loop recorder looked a bit larger and she "got worried" that maybe she had a tumor because her grandmother had breast cancer twice. Then he said maybe not, "you have good breasts," "really nice," "pretty sexually active," and that her boyfriend was lucky to have her. Patient A told him "I appreciate it" because she felt weird but wanted to take his statements as compliments, in order to "brush them off." She told him she had no more questions and stood up off the examination table. He got up from his rolling chair. Then they were at the door. He was in front like he was going to open it for her. But then he said "yes, don't worry maybe just big breasts." She said "oh thank you." He started to cut himself off and not finish his

sentence. Then he reached and grabbed her breasts and squeezed them. She didn't know what to do, and was shocked. She just flinched. She did not want anything more sexual to start. She wanted to "nip it in the bud." He let them go and said "have a nice day, see the front desk for next appointment." She exited the examination room, spoke very briefly with the receptionist about the next appointment, and left.

26. On cross-examination Patient A reported: she had reviewed her handwritten notes that morning before hearing. The visit was during her 30-minute lunch break but she does not remember what hours she was scheduled to work that day because they varied. She was not concerned about having enough time to get back to work, which was nearby. The reception desk was just across a small hallway from the examination room. She "think[s]" respondent was wearing a shirt, pants, shoes, and a white coat. She does not remember if respondent was wearing a mask or gloves. She was wearing just a brassiere underneath her scrub top. She did not take off her clothing or lift her top during the visit. Respondent had graphs of the loop recorder data with him. Respondent told her the loop recorder needed to be replaced because the battery was low. She asked to have it removed and that is when he demonstrated how he would do that. She remained sitting while he did that, using both hands. She was sitting on the examination table throughout the interaction with respondent until she stood up to leave. Respondent did not block the door or stop her from leaving, but she was waiting for him to open the door. He had his hand on the doorknob and was talking to her about one breast being bigger than the other and then he said that she had big breasts and they were really nice. Then, with both hands he grabbed both her breasts. He was not wearing gloves at that point, she does not remember whether he was wearing gloves earlier. She did not yell or scream or tell him to stop. She did not tell anyone in his office that something inappropriate was

occurring. She does not know of any other patient of respondent who complained of inappropriate touching.

27. Patient A reported the following after she left respondent's office on May 19, 2021: After texting her boyfriend from the parking lot, she went directly home, which was just a few blocks away. Her mother was home and she told her the gist of what happened, but Patient A does not like crying and did not want to show how upset she was. She felt "heavy" and "didn't want it to be a thing." It was "embarrassing and disgusting" to her. Patient A then drove back to work (also nearby). On the way and in the parking lot at work, she spoke to her boyfriend via telephone. She started breaking down, saying "I hate myself why would I let him do that." She pulled herself together and walked inside the pharmacy. One of the pharmacy technicians asked if she was okay. Patient A left work shortly afterwards and went home. At home, her boyfriend consoled her while she cried. She took a shower and then laid down with her boyfriend again. He had called a hotline for guidance. They recommended going to the police. Patient A just wanted the day to be over and did not contact the police that day or the next. The next day she started feeling better and tried to "push it back" and act like it did not happen.

28. Patient A reports that because her coworkers saw her breakdown at work, she quit the job and got a job in another town in June 2021. She never returned to see respondent.

29. Patient A does not remember if her boyfriend or mother lodged a complaint about the incident, but remembers that a couple of months later she received a call from a Board investigator. She talked to the investigator multiple times but did not want to feel those emotions again and was reluctant to discuss the incident.

30. Patient A's primary care physician recommended another cardiologist, a female per her request. Patient A reports that she saw this physician, who did some testing and told her that she did not need the loop recorder. At another appointment this physician removed the device without incident.

31. Patient A remembers making a report to the police at some point, at her boyfriend's urging. She does not remember hearing back from the police.

32. Patient A also reports that she told her best friend an abbreviated version of the incident (just that respondent touched her breasts at the end of the appointment), although she does not remember when. She reports that her friend listened, but also urged her to report the incident. Patient A reports that she also reported a similarly brief version of the incident to another friend.

33. Patient A reports that she has not discussed the incident with her mother since then, and it "went on the back burner." She reports that if anyone tried to bring it up, she felt hostile and vulnerable, so they "collectively agreed not to talk about it." She feels that this incident is still too sensitive to discuss. She felt very nervous to testify in this proceeding.

34. Patient A has never made a complaint about any other physician.

35. Patient A did not file a civil suit against respondent. There is no evidence or claim that Patient A ever tried to seek compensation from respondent or profit from her allegations.

The Investigation and Police Report

36. On June 7, 2021, Santa Clara Family Health Plan (SCFHP) filed a complaint against respondent with the Board. SCFHP provides health care through MediCal and

HMO plans. It appears that SCFHP was Patient A's health insurance provider. SCFHP reported respondent's information, the date of the incident, and the following description: "During appointment visit member reported that doctor kept touching her breasts. Member stated she showed signs of rejection, but doctor continued touching her." The matter was assigned to a Board investigator.

37. Pursuant to an incident report from the Gilroy Police Department (GPD), a police officer met with Patient A at the GPD at 4:56 p.m. on August 26, 2021. Patient A reported essentially the same narrative that she set forth in her handwritten notes and to which she testified in this proceeding. However, the reporting officer wrote that Patient A reported that she had to lift her scrub top above her breasts when respondent demonstrated the replacement procedure. The officer also wrote that Patient A had reported the incident to "consumer affairs," they opened an investigation, and Patient A provided the officer with the contact information for the Board investigator. Later that day, Patient A sent the police officer via email a copy of her handwritten notes of the incident.

38. The officer spoke with Patient A's supervisor at the pharmacy. The supervisor confirmed that on May 19, 2021, Patient A had returned to work upset after a doctor's visit, immediately began to cry, and told the supervisor that her doctor had touched her on her breasts inappropriately and she was having trouble being at work without crying. The supervisor reported that she excused patient A from work and Patient A sent her a text message apologizing for leaving work early, and that the supervisor was sure this happened on May 19, 2021, because she still had this text message.

39. In a supplemental report dated October 6, 2021, a GPD detective reported that he was assigned to the matter, was contacted by the Board investigator,

and made an appointment to interview Patient A. He reported that she failed to show up for this appointment and he spoke with her via telephone on October 6, 2021, and attempted to reschedule. At that point Patient A told him that "she just wanted to move on with her life," did not want to cooperate with the investigation, and would "rather just let it go." She said she was willing to speak about the incident with the Board investigator, but not with the police.

40. At hearing, the Board investigator reported that she spoke with Patient A and the essence of her statement was that she had been under respondent's care for some time, and during one appointment, respondent had cupped her left breast at some point and then towards the end of the appointment grabbed both of her breasts twice.

41. On cross examination, the Board investigator was asked questions about her investigation report (which was not offered into evidence). She reported that another physician ("Dr. Rueben") was a consultant on the case, and he found no departure from the standard of care, but there was an error in the way he went about his analysis, so he was never disclosed as an expert.

Additional Testimony of Patient A's Mother, Boyfriend and Friend

42. Patient A's mother was also a patient of respondent, in the early 2010's. She experienced many symptoms similar to those that Patient A later experienced. She saw respondent numerous times. She reports that respondent told her she would eventually need a pacemaker. She reports that she stopped seeing him in approximately 2013, after she reported "heart pounding" to him and he told her to go to the Emergency Department and report chest pains. She felt that he was telling her to falsely report chest pains to get authorization for a pacemaker. She began seeing a

different cardiologist after that and ultimately had loop recorders implanted (three times) for a total of approximately seven or eight years. She denies ever having a pacemaker.

43. Patient A's mother reports that respondent never touched Patient A's mother inappropriately. Patient A's mother accompanied Patient A to several of her visits with respondent and never observed respondent act inappropriately during those visits. However, Patient A's mother was not present during the May 19, 2021, visit.

44. Patient A's mother corroborates Patient A's reports that Patient A told her that on May 19, 2021, respondent touched her breasts as she was leaving the examination room. Patient A's mother reports this conversation occurred in the late afternoon soon after the incident, but she does not remember if it was the same day of the incident.

45. Patient A's mother reports that a day or a few days after the incident, she called Patient A's primary care physician, and spoke to a nurse who said to report the incident to the police and the Board. Patient A's mother reports that she handed the phone to Patient A because what the nurse was saying "felt like a lot to take in" and Patient A "is pretty thorough and likes to get things straight."

46. Patient A's mother reports that after the May 19, 2021, incident, there was a "difference in the atmosphere." Patient A was quiet in her room and more reserved than normal.

47. Patient A's mother reports that she has never known Patient A to be dishonest and she believes that Patient A is telling the truth.

48. Patient A's friend reported that she received a telephone call from patient A in 2021 and noticed that Patient A seemed disoriented and slightly upset. She asked Patient A if she was "okay" and how her doctor visit went. Patient A told her that the doctor touched her inappropriately, on her breasts while performing an examination. Patient A's friend asked Patient A if she needed anything, but they did not further discuss the details of the incident that day, or since then. Patient A's friend reports that Patient A had never mentioned respondent before that day or made an allegation about any other physician. Patient A's friend reports that she has never known Patient A to be dishonest and has no reason to doubt her report of the incident.

49. Patient A's boyfriend corroborated Patient A's reports that they exchanged text messages directly after the May 19, 2021, incident and discussed the incident in person that afternoon. He recalls being very angry and urging Patient A to report the incident, but she was reluctant and expressed unspecified concerns. He recalls that he later accompanied Patient A to the GPD station to make a report, but he does not remember the details of her response to the police attempts to follow up. He reports that he has not discussed the incident with Patient A since the visit to the police station. Since then, they have "ignored the subject." He reports that Patient A has never made any allegation about anyone else touching her inappropriately. He has no reason to think she is not being truthful.

50. When asked if there was any discussion about whether Patient A had her clothes on at all times during the May 19, 2021, examination, her boyfriend reported that she told him she took her shirt off for the examination, but kept her brassiere on.

The Investigative Interview of Respondent

51. On May 9, 2022, respondent was interviewed, under oath, by the Board investigator and Jeffery Urman, M.D., a medical consultant for the Board. During the interview respondent provided the following testimony:

- His Internal Medicine Board-certification expired December 31, 2009, and his "Cardiovascular Boards" ended on December 31, 2014. He chose not to recertify "in any of the Boards essentially."
- Respondent admitted that his medical records for the treatment of Patient A in 2019 stated he held numerous board-certifications and "that is automatic -- uh -- in the chart, like I have not had a chance to look at it actually. I apologize for that."
- When asked why he implanted a loop recorder in Patient A, respondent replied:

For one thing, [ECG] was sinus arrhythmia. Treadmill was sinus arrhythmia. And she had tachycardia at rest with a history of recurring near syncope for about two years -- or a year and a half. So, we need to monitor something more, because I mean she could have had any kind of arrhythmia occurring at its own time.

- After he was asked if he considered sinus arrhythmia a serious disturbance, he replied:

It is not, but if somebody has a heart rate as high as 160 at rest, it's definitely something that needs to be done. With

the family too, the mother having a loop recorder,
obviously something needs to be looked at.

- In relation to the record that the loop recorder was checked on November 13, 2019, and showed a marked sinus arrhythmia, but a week later Patient A was seen and denied symptoms, respondent was asked if he thought the sinus arrhythmia was at this point significant? He replied:

I mean -- see, if you go to the -- the note two -- two pages before that, there's a marked sinus arrhythmia. It's pretty clear -- uh -- it is not normal. Absolutely. And I'm not sure whether she was correlating that to her symptoms or not, but that was the recording which showed us there was marked sinus arrhythmia.

¶ ... ¶

And again, the computer read as afib episode, which again we determined that it's not a true afib. It shows an irregularity that the computer's reading as afib.

- When asked why he recommended replacement (instead of just removal) of the loop recorder in May 2021, after Patient A had it implanted for two and one-half years already, respondent replied:

Uh -- one is sinus arrhythmia (inaudible). Number two, the computer has read several times afib, which we have determined it's not. Number three, she has supraventricular tachycardia which is new, which was not detected before.

So, with the history of recurrent near syncope in the past, and the mother having a recorder, with sinus arrhythmia, SVT, and possible afib which the computer's reading, it would be prudent to monitor complete -- monitor further, and if the patient has a heart rate of 202 that's definitely a very, very significant arrhythmia.

He later explained:

One thing is, see the recorder helped us find out that the patient has SVT, which is a very significant arrhythmia. With a heart rate of 200, (inaudible) anybody would go -- well, it would be pretty difficult for a person to have a heart rate of 200 -- 200 and not pay for it. And that only came up because of the recorder was there. If there's no recorder, we would have never found that she had sinus -- she had SVT. Sinus arrhythmia is just hinting that the patient needs to be looked into. That's -- that's all it is. And sometimes non-cardiologists or without a recorder, afib can be misinterpreted and diagnosed unnecessarily with more medication, whatever, and anticoagulants or whatever -- uh -- that needs to be treated -- uh -- to be (inaudible) if the patient has a true afib.

- Respondent acknowledged that his medical records for Patient A all stated "refill the medications" when (except for the first visit) she was not on medications. He apologized, explained that it was a reminder from the

recordkeeping software, and stated: "I'll definitely, you know, reassess, and see what I can do about that."

- Respondent acknowledged receiving an inquiry from the medical director of Patient A's "HMO" (presumably SCFHP) regarding Patient A's report that he had touched her breasts. He explained:

Yes. But (inaudible) complaints weren't there. It was just a single statement saying -- uh -- you were touching her breasts. And I -- and -- and his suggestion was that I should have a chaperone when I'm examining patients -- um -- getting the patients undressed, to which I responded saying the patient was not undressed, and nothing unusual happened.

- Respondent acknowledged that he wrote a response stating that Patient A told him that she thought the loop recorder might have moved and that he "examined her properly with her consent to make sure that the loop recorder is in place." Respondent admitted that he did not document this in her medical record. He explained: "It was a routine visit, Dr. Urman. So, that's the reason probably that never -- uh -- that's why it never came up until I saw that letter." He further stated:

Uh -- the Physical Examination is when we speak to the patient and say, can I examine you? If they say yes, then that's -- that's -- that's when we proceed. So, it's -- I mean we don't get a paper signed at that time saying can I examine you?

¶ . . . ¶

Dr. Urman, the way I do is I touch -- you see this is -- I mean first of all everybody's masked and with -- and -- uh -- - gloved. I touch my clavicle, and then, I say, the first intercostal space, the second intercostal space, and third space. That's where we do (inaudible) someone 15, 20 seconds to do it, and that is it. And the patient is not undressed. If there is any reason for undressing, the chaperone is always there. That's been the policy for the last 20 years.

Inadequate and Inaccurate Recordkeeping

52. At all relevant times, respondent's practice used an electronic system to maintain his patients' medical records. However, respondent and his staff used (and still use) paper copies of a form he created that is titled "PROGRESS NOTES." Before a patient is seen by a physician, a medical assistant measures and records the patient's vital signs, and weight on the form, as well as the reason for the patient's visit and current symptoms reported by the patient. This form is provided to the physician (respondent or one of his colleagues) and the physician reviews the information and may also take notes on the form during the examination. After the visit, the physician is supposed to dictate the information on the form into the electronic medical record. Respondent's practice group routinely keeps the paper forms, but does not provide copies of the forms in response to requests for patients' medical records from subsequent providers. Nor did respondent initially provide copies of these forms to complainant in response to a request for the relevant medical records.

53. Physicians are required to maintain accurate and complete medical records for each patient for numerous reasons, the most important of which is to facilitate future care and treatment for the patient. Because respondent's practice is not to include copies of the paper Progress Notes to subsequent providers, these documents do not serve the primary purpose of medical records (or many of the other purposes). Therefore, these "Progress Notes" are not properly considered to be part of the patient's medical records for the purpose of evaluating the completeness of the records. In this proceeding they have been considered to establish relevant facts about respondent's treatment of Patient A, but not to supplement the completeness of his recordkeeping.

54. In each office visit note, respondent indicated that medications were refilled for Patient A, but respondent admitted that this information was not accurate. In addition, regarding "current medications," Respondent noted "see list" but no list, was included in the medical record (it was part of the paper Progress Note). Respondent also documented "risk factor modification," but did not detail what was specifically discussed with Patient A. Respondent provided sparse and limited information regarding Patient A's symptoms. For instance, respondent noted that Patient A suffered from palpitations, dizziness, and fatigue, but he failed to provide any details regarding the frequency, duration, precipitating, or alleviating factors, or associated symptoms related to Patient A's complaints. Some of this information was recorded in the Progress Notes, but was not available to subsequent treaters.

Respondent's Inaccurate Report of Two Board-Certifications

55. The medical records include a letter addressed to Patient A's primary care physician, dated January 2, 2019, briefly describing respondent's initial evaluation of Patient A. In the letterhead, respondent represents the following credentials:

INTERVENTIONAL CARDIOLOGY & PERIPHERAL VASCULAR
MEDICINE

DIPLOMATE AMERICAN BOARD OF INTERNAL
MEDICINE-CARDIOVASCULAR DISEASES

DIPLOMATE AMERICAN BOARD OF INTERNAL MEDICINE-
INTERVENTIONAL CARDIOLOGY

DIPLOMATE AMERICAN BOARD OF VASCULAR MEDICINE-
ENDOVASCULAR MEDICINE &

BOARD CERTIFIED VASCULAR TECHNOLOGY

Respondent made the same representations in multiple other similar medical records for Patient A.

56. At hearing, respondent's business office manager, Mohiyuddin Khan, explained that this letter was generated within the electronic medical record software respondent used at the time. Khan testified that such letters were actually sent to the referring physician only about 50 percent of the time. Khan testified that this letterhead was not the same one used when actually creating letters outside of the medical record.

57. Respondent reports that he held the five board certifications listed in Factual Finding 56 For at least ten years each, but did not recertify for the internal medicine or cardiology certifications because his other certifications were sufficient and maintaining five certifications is too time-consuming. Respondent's cardiovascular board certification expired in 2014 and his interventional board certification expired at the end of 2019. Respondent reports that as soon as it was brought to his attention

that his letterhead listed board certifications that had expired, he promptly removed those representations from the letterhead.

58. Khan was also asked about a website for respondent's office with the URL (uniform resource locator, colloquially known as "web address") "kaajlincoln.wixsite.com" ("KAAJ Healthcare" is the name of respondent's practice group). Khan testified that someone helped them set up a website in 2019, but he never followed up or updated it since then, and does not remember this URL. He admitted that no one in the office was "tasked" with keeping the website information accurate. No further evidence was submitted regarding respondent's representations of his credentials on any website.

Respondent's Additional Evidence

59. Respondent testified at hearing. He is married and has four adult daughters.

60. Respondent graduated from medical school in India in 1990. For the three years that followed, he worked as a physician at a hospital during the day and in private practice at night, seeing 50 to 100 patients per day.

61. In late 1994, respondent emigrated to the United States. In 1999, he completed a three-year residency in internal medicine. In 2002, he completed a three-year fellowship in cardiology. In 2004, he completed a fellowship in interventional cardiology. In 2005, he completed further fellowship training in interventional peripheral vascular medicine and peripheral angioplasty. He then completed a three-month training in cardiovascular magnetic resonance angiography.

62. In 2005, respondent began private practice as a cardiologist in San Jose. He started a multispecialty group and has operated this group and practiced as a cardiologist and endovascular expert ever since. Over the years, respondent acquired the practices of several other physicians. Respondent's practice now includes an office in San Jose and one in Gilroy. Respondent treats men and women, but only adults, not minors.

INAPPROPRIATE TOUCHING

63. Respondent flatly denies Patient A's allegations that he touched her inappropriately. He testified that he has never touched a patient's breast except as medically necessary. He testified that this is the first time he has ever been accused of inappropriate touching. Respondent estimates that he has seen more than 200,000 patients in his medical career, the majority of whom were female.

64. Respondent reports that he first learned of Patient A's allegations via a letter from SCFHP, and that when he received the letter he recognized her name, but "wouldn't recognize her" and he had not specific memory of the May 19, 2021, visit. He reports that he then reviewed the medical record to see what treatment he provided on that date. He reports no other memory of the visit.

65. Respondent is a practicing Muslim, a leader within his mosque, and a religious scholar who has delivered religious sermons in at least 50 countries. He reports that he follows the Koran in his day-to-day life. He reports that in his culture, men do not even look at women unless it is necessary; that if a man wanted to shake hands, he would reciprocate, but if a woman tries to shake his hand, he usually puts his hand on chest, or both hands up in defensive gesture (as if to push away). Respondent

heard Patient A testify that they shook hands during the May 19, 2021, office visit and he denies this; it "would never happen."

66. Respondent reports that neither his wife nor any of his four daughters has ever told him that he acted inappropriately with a female in their presence.

67. Respondent reports that the examination room in which he saw Patient A on May 19, 2021, has a window that faces the street. He reports that this window has blinds, but the blinds are not typically lowered. He reports that, if someone outside on the street wanted to look into the examination room through the window, this person would have to stand "right up against" the window. Asked if there was some mechanism to prevent people from looking in, respondent testified that "there is a tint, but I don't know."

68. Respondent reports that the examination room is directly across a narrow hallway from the reception desk, but the door to the examination room is thick enough that conversations in the examination room cannot be heard at the reception desk.

69. Respondent reports that he was wearing scrubs, not pants, shirt or a white coat, on May 19, 2021, and that he has been exclusively wearing scrubs at work for the last 20 years.

MEDICAL NECESSITY OF IMPLANTING THE LOOP RECORDER IN PATIENT A

70. Respondent reports that he believed that, based on Patient A's complaints, family history, multiple visits, the results of several less invasive tests, and his clinical judgment, Patient A would benefit from further evaluation through implantation of a loop recorder. He explained that one looks at the patient as a human

being, not just as their symptoms. Patient A's persistent symptoms suggested the possibility of a potentially fatal heart attack, which can start with arrhythmia. The ECG, 24-hour Holter monitor, and the two-week monitor all showed further inquiry was needed because there were arrhythmias and there can be long gaps between the most concerning episodes.

71. In a graph of Patient A's heart rhythm produced from the data collected by the loop recorder ("strips") on November 13, 2019, respondent pointed out examples of arrhythmia, including instances where the sinus rhythm varied by more than 300 milliseconds. He also pointed to instances where the "P-waves" (measures of atrial contraction) varied in shape and amplitude. He opined that some sinus arrhythmia is not concerning and there is no specific definition of arrhythmia, but a physician must use clinical judgment to determine the significance of such variations. Respondent reports that he observed arrhythmias in the vast majority of Patient A's strips and that Patient A's mother also had significant arrhythmia, and this family history amplified his concerns about Patient's A's cardiovascular condition.

72. Respondent does not believe testing (such as a "tilt-table test") for vasovagal syncope was indicated because there was never any indication that Patient A's blood pressure ever dropped in a way that would implicate a vasovagal response.

OTHER TESTIMONY OF RESPONDENT

73. Respondent reports that he does not remember why he told Patient A's mother to go to the hospital, but he knows it was not to get a pacemaker. "If I thought she needed one, I would have placed one then."

RESPONDENT'S WITNESSES

74. Maria Torres worked for respondent as a medical assistant for 11 years. She reports that she never saw him act sexually inappropriately and never heard of a patient (other than Patient A) complaining that he acted inappropriately.

75. Hamya Mazhar was a licensed physician in Pakistan. She is working towards becoming licensed to practice medicine in the United States, which she expects to achieve in approximately three years. Since 2022, Mazhar has worked for respondent. She describes her position as an "assistant" and "scribe." She reports that she shadows respondent and "documents everything" into the electronic medical record. She reports that respondent later reviews each record before signing it. She also testified that she serves as a chaperone and is in the room with every patient that respondent sees, regardless of gender. Mazhar reports that since she was hired, she has only taken two weeks of vacation, but otherwise worked five days per week.

76. In addition to her medical training and brief practice in Pakistan, Mazhar reports that she has taken several courses related to medical recordkeeping, mostly on patient privacy laws. She has not taken classes specifically aimed at training medical chaperones. Mazhar reports that one other person in respondent's office is trained to be and sometimes acts as a chaperone.

77. Two medical assistants and respondent's office supervisor also testified at hearing. They have worked for respondent since 2020, 2021, and 2011, respectively. All three report becoming aware of Patient A's allegations a couple of months before hearing. All three report that they have not observed respondent act in a sexually inappropriate manner towards patients or staff or heard of patients complaining of

such misconduct. Khan similarly testified that he has not observed respondent acting inappropriately.

Expert Opinions

DR. GALLIK

78. Complainant engaged Donna M. Gallik, M.D., as an expert witness for this matter. Dr. Gallik has been licensed as a physician in other jurisdictions since 1989 and in California since 1995. After receiving a medical degree, she completed a one-year internship in internal medicine and then a two-year urology residency in internal medicine. Then she completed a three-year fellowship in cardiology followed by a one-year fellowship in electrophysiology and pacing. From 1994 through the present, she served as an assistant and then associate clinical professor of medicine at UCLA Medical Center. From 1997 through the present, she has practiced as a cardiac electrophysiologist at Cedars-Sinai Medical Center in Los Angeles. Dr. Gallik is board-certified in internal medicine, cardiology, and cardiac electrophysiology.

79. Dr. Gallik reviewed the complaint, the electronic medical records, and the transcript of the investigative interview of respondent. She issued a report dated September 4, 2022, and testified at hearing:

80. Dr. Gallik opines that respondent's implantation of a loop recorder in Patient A was not medically indicated; the medical records of his treatment of Patient A were not accurate and complete; and he represented that he held current board certifications that had actually lapsed; and that all three of these acts were simple departures from the applicable standards of care. Dr. Gallik also opines that respondent's inappropriate comments about and touching of Patient A's breasts

(assuming this conduct occurred) constituted sexual misconduct and an extreme departure from the standard of care.

81. Regarding the standard of care for insertion of a loop recorder, Dr. Gallik opined that it "is generally indicated for various conditions, including assessment of transient loss of consciousness and falls, unexplained syncope, palpitations and to evaluate possible atrial fibrillation [or] post-cryptogenic stroke." She opined that:

This is generally performed after a thorough evaluation, complete history and noninvasive evaluation. In this case, minimal detail was provided regarding the patient's symptoms, such as precipitating/alleviating factors, duration, frequency and nature of symptoms. In this young patient with normal cardiac function based on noninvasive testing and no significant findings on Holter and event monitor, the likelihood of a significant arrhythmia is low. Sinus arrhythmia is a normal finding. The diagnostic yield of an insertable loop recorder is predicted to be low, and for this reason, loop recorder placement is not indicated.

82. At hearing, Dr. Gallik opined that Patient A did not have true syncope (actual fainting); the 24-hour monitor "showed a lot of noise," and two-week monitor also "did not show anything," and the one time Patient A reported a symptomatic event, the monitor showed a normal heart rhythm. Dr. Gallik acknowledges that respondent's notes show Patient A complained of chest pains, palpitations, and dizziness, but opined that "main factors, precipitating events, and alleviating factors" were absent from the records.

83. Dr. Gallik opined that it was very unlikely that Patient A's symptoms were due to a serious arrhythmia, not likely enough to justify an invasive procedure like inserting a loop recorder. Dr. Gallik opined that the most common cause of syncope was vasovagal syncope, which is typically not a serious condition. She opined that the test to determine whether a patient has this condition is a "tilt-table" or "standing test" and there is no indication in the records that respondent considered this diagnosis or a diagnosis of orthostatic syncope (blood pressure drop when standing up). Dr. Gallik also opined that an alternative to installing a loop recorder for monitoring was an "external cardio monitor."

84. On cross-examination Dr. Gallik opined that there was no documentation of "arrhythmia," only "sinus arrhythmia" (fast heart rate), which did not require treatment. She opined that the medical records did not document what Patient A was doing at the time her heart rate was elevated, therefore Dr. Gallik did not know if she was having an elevated heart rate at rest. She opined that a resting heart rate of 180 bpm is not normal, but she did not see evidence of that in the medical record. When shown in a Progress Note that respondent documented "marked sinus arrhythmia" with a heart rate "as high as 144 bpm at rest," and in another Progress Note, 165 bpm at rest, Dr. Gallik acknowledged that respondent documented tachycardia at rest (although only in the Progress Notes). Dr. Gallik also opined that Patient A did not need a loop recorder because the 24-hour and two-week monitor tests were sufficient and the likelihood of a concerning arrhythmia was very low. Regarding the history of cardiac symptoms and testing of Patient A's mother, Dr. Gallik opined that there is not a genetic link to arrhythmia.

85. Dr. Gallik acknowledged that SVT "is a problem." When asked to confirm that five such episodes were documented by Patient A's loop recorder, Dr. Gallik

opined that the recorders are often not accurate. She explained that when the software's algorithm identifies such episodes, it is often wrong. She also questioned the qualifications of the technicians (employees of the manufacturer) who enter analysis into the reports prepared from the loop recorder data, but admitted that she is not familiar with the particular technicians involved.

86. Dr. Gallik also acknowledged that the only risks of an implantable loop recorder are pain and possible infection and bleeding, and that these are minor concerns, except infection, and such infection is rarely serious.

87. Dr. Gallik is familiar with "Stat Pearls" a publication of the National Institute of Health (NIH). Asked if she would agree that implantable loop recorders are most commonly used for evaluation of recurrent palpitations, Dr. Gallik replied that she does not agree and this not the most common use for loop recorders.

88. Dr. Gallik opined that the "[s]tandard of care with regard to medical records, whether written or electronic, is that the records contain sufficient, accurate information to support the diagnosis, justify the treatment and document the treatment and results." She opined:

In this case, each office visit indicates that medications are refilled, which, per the physician's interview, is incorrect. Also, regarding "current medications," each note states "see list" but no list is provided. Each note also indicates "risk factor modification," but no details of what was specifically discussed was provided in any note. Documentation of the patient's symptoms is also very limited, with each visit indicating symptoms of palpitations, dizziness and fatigue,

but no details provided (frequency, duration, precipitating or alleviating factors, associated symptoms).

89. At hearing, Dr. Gallik opined that respondent's records did not indicate the frequency of Patient A's symptoms, in what setting they occurred, or what precipitated or alleviated these symptoms. She opines that a reasonable physician in this situation would want to know and would document these things. On cross-examination Dr. Gallik acknowledged that respondent did document some, but not all of these things in handwriting in the paper Progress Notes, but she had not reviewed these documents when she wrote her report or before the hearing. She agreed that if the medical record included a list of medications for each visit, that would be reasonable charting regarding medications. After reviewing the handwritten notes, Dr. Gallik opined that, considering them in combination with the electronic medical records she initially reviewed, they are "better," but still incomplete because they lack context for Patient A's symptoms and an assessment as to possible diagnoses to explain those symptoms.

90. Regarding the allegations of sexual misconduct, Dr. Gallik clarified that for the purpose of her opinion, she was assuming that respondent touched Patient A's breast in a manner unrelated to his medical examination. She opined that a physician should have no sexual interaction with a patient, "it's just that simple." She further opined that there was no medical reason for respondent to compliment Patient A's breasts or grab them.

DR. BROWN

91. Respondent engaged Ryan A. Brown, M.D., as an expert witness. Dr. Brown has been licensed as a physician in California since 2003. After receiving a

medical degree, he completed a three-year residency in internal medicine, then a three-year fellowship in cardiology, then a two-year fellowship in interventional cardiology. Since 2010, he has practiced as an interventional cardiologist in Walnut Creek. Dr. Brown is board-certified in cardiovascular medicine, nuclear cardiology, and interventional cardiology. He was previously board-certified in internal medicine. Dr. Brown's practice includes the diagnosis and treatment of arrhythmias, and the use of diagnostic testing methodologies similar to those used with Patient A, including implantable loop recorders. Dr. Brown reviewed the medical records including the Progress Notes not provided during the Board's investigation, the transcript of the investigative interview of respondent, the investigation report, the report of Dr. Gallik, and some relevant medical literature. Dr. Brown signed a declaration dated May 16, 2023, and testified at hearing.

92. Dr. Brown opines that respondent's care and treatment of Patient A met the applicable standards of care.

93. In his report, Dr. Brown explained:

Although a loop recorder is often used for patients with unexplained syncope, implantation is within the standard of care where, as here with Patient A, other methods have failed to document the cause of unexplained palpitations as it has a higher diagnostic yield than Holter monitors; it can be effectively used in patients with extremely infrequent but symptomatic palpitations associated with presyncope or syncope.

94. At hearing, Dr. Brown opined that implantation of the loop recorder in Patient A was reasonable and appropriate because: during the two-week test she experienced periods of a very high heart rate at rest and her overall average heart rate was 108 bpm; she continued to experience symptoms of palpitations, fatigue, shortness of breath; and she had a family history of arrhythmia. Dr. Brown opined that one of the indications for implantation of a loop recorder is recurrent palpitations, which were present. He opined that another indication is unexplained fainting, and while Patient A did not faint, she had many episodes of near-fainting. Dr. Brown further opines that, although the loop recorder never showed data that suggested immediate intervention was necessary, it was nevertheless reasonable to keep it implanted for the duration of the battery life because her symptoms persisted and were not explained, including tachycardia at rest, which "can be a problem." Dr. Brown opined that the data collected showed that Patient A had, at different times, episodes of both high and irregular heart rate.

95. Dr. Brown was asked about the 2023 NIH "Stat Pearls" publication that Dr. Gallik was asked about when she testified. Dr. Brown is familiar with it and opined that it is not a peer-reviewed journal article, rather a "consensus expert document." He agrees with the document's statement that recurrent palpitations are one of the most common indications for implantation of a loop recorder. Dr. Brown did not do any research to see if there were earlier versions of this 2023 document, but opines that the consensus opinion was the same in 2019, when respondent implanted the loop recorder in Patient A.

96. Regarding the allegation that respondent's medical records were inaccurate or incomplete, in his report Dr. Brown opined:

The reports provided and reviewed contain accurate and sufficient information to document and support the diagnosis and treatment rendered by [respondent]. Although the reports do not set forth a detailed and minute by minute description of every detail related to the diagnosis and treatment provided, they are certainly adequate and do chronicle and document the necessary information for ongoing treatment, including the necessity for the loop recorder based on Patient A's presentation of ongoing cardiac complaints based on [respondent's] experience and training. As such, there is no breach in the standard of care on the part of [respondent] in his documentation pertaining to Patient A; this does not constitute a justifiable basis for discipline.

97. At hearing, when asked about medical records for Patient A that state "refill the medications" at times when Patient A was not prescribed any medications, Dr. Brown characterized these statements as "sloppy and error, and something we see very often where things are populated." Regarding the failure to document the frequency of Patient A's symptoms, Dr. Brown pointed to the fact that this was documented in the Progress Notes.

98. Dr. Brown acknowledges that a physician should not list board certifications that have lapsed and that doing so might cause someone to misunderstand the physician's credentials. Dr. Brown noted that respondent promptly corrected his letterhead when this issue was identified and opined that there is no

longer a problem for the Board to address. Dr. Brown did not expressly opine that listing lapsed board certifications is within the standard of care.

99. Regarding the allegations that respondent made inappropriate comments and touching of Patient A's breasts, for the purpose of his expert opinion, Dr. Brown assumed that "there is no clear and convincing evidence of misconduct." At hearing, Dr. Brown reported that he has implanted 15 to 20 loop recorders in female patients, and a few times (less than five) he had to examine the patient's chest area because they reported it had moved and was "in the bra line and they were uncomfortable with it." He reports that he never had to put his hand on a patient's breast in these examinations and would get informed consent if that were necessary, and would "typically" document such consent in the medical record. Dr. Brown acknowledges that respondent did not document in Patient A's medical record that she reported the loop recorder moved, there was any need to examine her chest, or that she consented to touching her breasts. Dr. Brown agrees that there is no legitimate medical reason for a cardiologist to reach out with both hands and cup two breasts. Dr. Brown agrees that, if respondent complimented Patient A's breasts, and as she moved towards the door to leave, reached out and cupped both breasts with his hands through her clothes, that would have been "100 percent" an extreme departure from the standard of care.

Ultimate Findings

100. On May 19, 2021, at the end of an office visit, respondent made sexually inappropriate comments about Patient A's breasts and grabbed both of her breasts with his hands, through her clothing and brassiere. Patient A's testimony at hearing appeared sincere and it was very credible. She reported these allegations to her boyfriend immediately after the incident occurred, from the parking lot of

respondent's office. She reported them again to her supervisor shortly thereafter when she attempted to go back to work and she was noticeably distraught. She promptly reported the allegations to her mother, probably that same afternoon, and also to her best friend. However, by all reports Patient A was uncomfortable discussing this incident because each of these individuals (except her boyfriend) reported that she only spoke of it once. She did not cooperate with the police investigation after her initial report. She did not sue or seek compensation from respondent. She has no plausible reason to lie. Conversely, respondent has many obvious reasons to deny this misconduct, including the desire to avoid professional discipline and the social stigma of this transgressive behavior. After respondent received notice of the general allegations from the SCFHP, he told them that Patient A was concerned that the loop recorder had migrated, he obtained consent and examined her chest area. But none of these claims were documented in her medical record and he claimed not to remember the details of the visit.

101. Respondent points to numerous minor inconsistencies in Patient A's testimony, such as discrepancies between her testimony of her weight and the weight recorded in the medical records; exactly which symptoms she reported at specific visits; her testimony that she was unable to complete the treadmill stress test; her inability to remember some of the office visits documented in the medical record; her report that respondent was wearing a shirt, slacks, and white coat versus his report that he always wears scrubs to the office; conflicting testimony as to whether respondent cupped her breast while she was on the examination table; and her boyfriend's testimony that she said she removed her top during the examination versus her testimony to the contrary. The minor inconsistencies did not diminish the credibility of Patient A's testimony. First, for many of these inconsistencies, it is not clear which source of information is incorrect. Second, many relate to non-salient

details, and are the kinds of inconsistencies one would expect from a sincere witness testifying about events that took place years earlier.

102. Likewise, respondent's argument that the blinds of the window in the examination room were open and therefore respondent would not have been likely to touch Patient A's breasts, is not persuasive. The only information about the blinds comes from respondent. He admitted there might be some tint on the windows, but he was not sure. He admitted that no one could see into the room from outside unless they were standing right by the window. And presumably he and his patients reasonably expected privacy in the examination room, even when patients were fully clothed.

103. Respondent presented the testimony of several employees who reported that they never observed him act inappropriately or hearing of such patient complaints. However, almost all of them had also not heard of Patient A's complaint until very recently, and all but one of this group of witnesses depend on respondent for their livelihood. Similarly, respondent's impressive medical credentials and status as a family man and religious scholar do not weigh heavily in determining the credibility of his denial of Patient A's allegations of sexual misconduct. Clear and convincing evidence to a reasonable certainty supports the finding that respondent made inappropriate comments about and inappropriately touched Patient A's breasts. Both experts agreed such sexual misconduct constitutes an extreme departure from the standard of care.

104. Respondent's representation in his letterhead that he was board certified in internal medicine or cardiology, after those certifications had lapsed, was a simple departure from the standard of care. Khan admitted that such letters were actually sent to referring physicians approximately 50 percent of the time. The opinion of

Dr. Gallik that this conduct was a simple departure was persuasive. There is no allegation or significant evidence that this misrepresentation was intentional. However, the false statements of his credentials were acts of dishonesty because it is a physician's responsibility to avoid making such false statements.

105. Respondent committed a simple departure from the standard of care by keeping incomplete and inaccurate medical records of his treatment of Patient A. Dr. Gallik's opinion was more persuasive than Dr. Brown's on this issue partially because Dr. Brown's opinion was based on the electronic records, supplemented by the paper "Progress Notes," but these Progress Notes were not part of the medical record for the purposes of this inquiry, as discussed in Factual Finding 54. Also, Dr. Brown conceded that respondent's references to "refill the medications," at times when Patient A was not prescribed any medications, were "sloppy."

106. It was not proven that respondent's implantation of a loop recorder in Patient A was a deviation from the standard of care. Dr. Brown's opinion on this issue was more persuasive than that of Dr. Gallik. It appears that reasonable cardiologists might differ on this issue, but respondent's decision to implant the loop recorder was not a departure from the standard of care.

107. Respondent has shown rehabilitation regarding the recordkeeping and misrepresentation of credentials issues. He now has an assistant specifically tasked with ensuring that all handwritten notes get inputted into the electronic medical record, and he corrected the representations of his board certifications.

108. Respondent has not acknowledged his inappropriate sexual comments about and touching of Patient A's breasts. However, respondent he shown some

rehabilitation in that he has changed his medical practice to include a chaperone during all patient visits, greatly reducing the risk that this misconduct might reoccur.

Costs

109. In connection with the investigation and enforcement of this accusation, complainant requests an award of costs in the total amount of \$48,640.25, comprising \$2,567.50 in investigative services, \$2,400 in expert witness fees, and \$43,672.75 in attorney and paralegal services provided by the Department of Justice and billed to the Board. That request is supported by declarations that comply with the requirements of California Code of Regulations, title 1, section 1042. These costs are found to be reasonable.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. Complainant is required to prove cause for discipline of a professional license, permit, or registration by "clear and convincing proof to a reasonable certainty." (Cf. *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) To the extent respondent contends mitigation or rehabilitation, it is his burden to prove those contentions by a preponderance of the evidence. (Evid. Code, §§ 115, 500.)

First Cause for Discipline (Gross Negligence and Sexual Misconduct)

2. The Board may discipline the physician's and surgeon's certificate of a licensee who commits unprofessional conduct. (Bus. & Prof. Code, § 2234 [all further statutory references are to the Business and Professions Code unless stated

otherwise].) Unprofessional conduct includes conduct that is grossly negligent. (§ 2234, subd. (b).) An extreme departure from the standard of care constitutes gross negligence. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) Unprofessional conduct also includes "any act of sexual abuse, misconduct, or relations with a patient, client, or customer." (§ 726, subd. (a).) Respondent committed both gross negligence and sexual misconduct of a patient on May 19, 2021, by making sexually inappropriate comments about and grabbing Patient A's breasts. (Factual Findings 101-104.) Cause exists to discipline respondent's physician's and surgeon's certificate under sections 726, subdivision (a), and 2234, subdivision (b).

Second Cause for Discipline (Repeated Acts of Negligence or Dishonesty)

3. Unprofessional conduct includes conduct that is repeatedly negligent (§ 2234, subd. (c)) and the "commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon" (§ 2234, subd. (e)). Respondent successfully defended that allegation that his implantation of the loop recorder in Patient A was negligent. (Factual Finding 107.) Cause does not exist to discipline his physician's and surgeon's certificate on that basis. However, Respondent's misrepresentation of his board certifications was a simple departure from the standard of care, and also, although not intentional, an act that involved dishonesty. (Factual Finding 105.) Respondent's fondling of Patient A's breasts and inaccurate and incomplete recordkeeping were also acts of negligence. (See Factual Findings 101-104, and 106.) Cause exists to discipline respondent's physician's and surgeon's certificate under section 2234, subdivisions (c) and (e).

Third Cause for Discipline (Inaccurate and Incomplete Recordkeeping)

4. Pursuant to section 2266, a licensee's failure to maintain adequate and accurate records also constitutes unprofessional conduct. Cause exists to discipline respondent's physician's and surgeon's certificate under section 2266, in light of the matters set forth in Factual Finding 106.

Determination of Discipline

5. Cause for discipline having been established, the next issue is what discipline is appropriate. The Board's highest priority is protection of the public. (§ 2229.) However, "to the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of licensees." (Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines ("Guidelines") (12th ed. 2016), at p. 2; see Cal. Code Regs., tit. 16, § 1361.) The Board may consider a respondent's attitude toward his offense and his character, as evidenced by his behavior and demeanor at hearing. (*Yellen v. Board of Medical Quality Assurance* (1985) 174 Cal.App.3d 1040, 1059–1060.) The Guidelines expressly provide for disciplinary orders that deviate from the recommended discipline, in appropriate circumstances where the departures and supporting facts are identified.

6. For the violations found in this case, the Guidelines recommend a maximum discipline of outright revocation and a minimum disciplinary order of revocation, stayed, with a seven-year period of probation, including a suspension of at least 60 days, and conditions including: education course, an ethics course, a professional boundaries program, a psychiatric evaluation, psychotherapy, monitoring of practice and/or billing, third party chaperone, and areas of prohibited practice. Complainant argues for the minimum discipline, with a solo practice prohibition, 40

hours of general medical education courses, a medical recordkeeping course, an ethics course, a professional boundaries course, a chaperone for female patients, a practice monitor, and a solo practice prohibition. Respondent maintains that there is no cause for discipline.

7. Respondent's sexual misconduct is a serious concern. He also misrepresented his board certifications, albeit unintentionally, and failed to maintain accurate and complete medical records. He refuses to admit his sexual misconduct, which suggests a lack of rehabilitation. However, respondent has had a long and distinguished career with no prior discipline. He has shown some mitigation and rehabilitation, including hiring an assistant to act as a chaperone and ensure input of handwritten notes into the electronic medical record. The public will be adequately protected by the imposition of the minimum discipline recommended by the Guidelines, seven years of probation including the additional conditions of probation specified therein.

8. Although the Guidelines recommend Optional Condition 21 (Psychotherapy) for a sexual misconduct violation, this condition contains the following instruction:

Note: This condition is for those cases where the evidence demonstrates that the respondent has had impairment (impairment by mental illness, alcohol abuse and/or drug self-abuse) related to the violations but is not at present a danger to respondent's patients.

There is no allegation or indication of such impairment here and therefore cause exists to deviate from the Guidelines in this respect and not impose this condition of probation.

9. The Guidelines also recommend Optional Condition 26 (Prohibited Practice) for a sexual misconduct violation. The parties did not address this issue, but there is no apparent need to prohibit respondent from any specific area of practice and this condition will not be imposed.

10. Likewise, the Guidelines recommend Optional Condition 20 (Psychiatric Evaluation), but no need for this is apparent and this condition will not be imposed.

Costs

11. A licensee who is found to have committed a violation of the licensing act may be ordered to pay a sum not to exceed the reasonable costs of investigation and enforcement. (§ 125.3.) Cause exists to order respondent to pay the Board's costs in the amount of \$48,640.25. (Factual Finding 110 and Legal Conclusions 2–4.)

12. Cost awards must not deter licensees with potentially meritorious claims from exercising their right to an administrative hearing. (*Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45.) Cost awards must be reduced where a licensee has been successful at hearing in getting the charges dismissed or reduced; a licensee is unable to pay; or where the scope of the investigation was disproportionate to the alleged misconduct. (*Ibid.*) The agency must also consider whether the licensee has raised a colorable challenge to the proposed discipline, and a licensee's good faith belief in the merits of his or her position. (*Ibid.*) Respondent successfully defended one of the four substantive allegations against him (that his implantation of the loop recorder was not medically indicated). This issue occupied a significant amount of

hearing time and presumably prehearing costs as well. The cost award will be reduced from \$48,640.25 to \$30,000.

ORDER

Physician's and Surgeon's Certificate No. A 69198, issued to respondent Mohammed Habbib Ahmed, M.D., is revoked; however, revocation is stayed, and respondent is placed on probation for seven years under the following terms and conditions:¹

1. Actual Suspension

As part of probation, respondent is suspended from the practice of medicine for 60 days, beginning the 16th day after the effective date of this decision.

2. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense

¹ Please note that, although the Guidelines recommend Optional Conditions 20 (Psychiatric Evaluation), 21 (Psychotherapy), and 26 (Prohibited Practice), these conditions are not imposed. (See Legal Conclusions 8–10.)

and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

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 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 year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the 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. Professional Boundaries Program

Within 60 calendar days from the effective date of this Decision, respondent shall enroll in a professional boundaries program approved in advance by the Board or its designee. Respondent, at the program's discretion, shall undergo and complete the program's assessment of respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24-hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the decision(s), accusation(s) and any other information that the Board or its designee deems relevant. The program shall evaluate respondent at the end of the training and the program shall provide any data from the assessment and training as well as the results of the evaluation to the Board or its designee.

Failure to complete the entire program not later than six months after respondent's initial enrollment shall constitute a violation of probation unless the Board or its designee agrees in writing to a later time for completion. Based on respondent's performance in and evaluations from the assessment, education, and training, the program shall advise the Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that respondent can practice medicine safely. Respondent shall comply with program recommendations. At the completion of the program, respondent shall submit to a final evaluation. The program shall provide the results of the evaluation to the Board or its designee. The professional boundaries program shall be at

respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

The program has the authority to determine whether or not respondent successfully completed the program.

A professional boundaries 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 not practice medicine until respondent has successfully completed the program and has been so notified by the Board or its designee in writing.

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 and accusation, and a proposed monitoring plan. within 15 calendar days of receipt of the decision, accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the decision and accusation, 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 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 five 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 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. Third-Party Chaperone

During probation, respondent shall have a third-party chaperone present while consulting, examining or treating female patients. Respondent shall, within 30 calendar days of the effective date of the decision, submit to the Board or its designee for prior approval name(s) of persons who will act as the third-party chaperone.

If respondent fails to obtain approval of a third-party chaperone 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 calendar days after being so notified. Respondent shall cease the practice of medicine until a chaperone is approved to provide monitoring responsibility.

Each third-party chaperone shall sign (in ink or electronically) and date each patient medical record at the time the chaperone's services are provided. Each third-party chaperone shall read the decision and the accusation, and fully understand the role of the third-party chaperone.

Respondent shall maintain a log of all patients seen for whom a third-party chaperone is required. The log shall contain the: 1) patient initials, address and telephone number; 2) medical record number; and 3) date of service. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

Respondent is prohibited from terminating employment of a Board-approved third-party chaperone solely because that person provided information as required to the Board or its designee.

If the third-party chaperone resigns or is no longer available, respondent shall, within five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name of the person(s) who will act as the third-party chaperone. If respondent fails to obtain approval of a replacement chaperone within 30 calendar days of the resignation or unavailability of the chaperone, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement chaperone is approved and assumes monitoring responsibility.

Respondent shall provide written notification to respondent's patients that a third-party chaperone shall be present during all consultations, examination, or treatment with female patients. Respondent shall maintain in the patient's file a copy of the written notification, shall make the notification available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the notification for the entire term of probation.

7. Notification

Within seven days of the effective date of this Decision, 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.

8. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

9. 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.

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 a 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 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 Board'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 years. Periods of nonpractice 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; and Quarterly Declarations.

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. 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. Cost Recovery

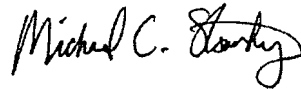
Respondent is hereby ordered to reimburse the Medical Board of California the amount of \$30,000 for its enforcement costs, pursuant to Business and Professions Code section 125.3. Respondent shall complete this reimbursement within 90 days

from the effective date of this decision, or pursuant to a payment plan authorized by the Board.

18. 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.

DATE: 12/18/2024

A handwritten signature in black ink, reading "Michael C. Starkey". The signature is fluid and cursive, with the first name "Michael" and last name "Starkey" clearly legible.

MICHAEL C. STARKEY

Administrative Law Judge

Office of Administrative Hearings