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

In the Matter of the First Amended Accusation Against: Mukesh Misra, M.D. Physician's and Surgeon's Certificate No. A 95774 Respondent.	Case No. 800-2021-081549

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on March 31, 2025.

IT IS SO ORDERED March 20, 2025.

MEDICAL BOARD OF CALIFORNIA

Reji Varghese
Executive Director

ROB BONTA
Attorney General of California
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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **MUKESH MISRA, M.D.** **P.O. Box 6711** **Lancaster, CA 93539-6711** **Physician's and Surgeon's Certificate No. A 95774,** Respondent.	Case No. 800-2021-081549 OAH No. 2023120248 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Rebecca L. Smith, Deputy Attorney General.

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

3. On or about June 1, 2006, the Board issued Physician's and Surgeon's Certificate No. A 95774 to Respondent. That license was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2021-081549 and will expire on January 31, 2026, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2021-081549 was filed before the Board and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on June 6, 2024. Respondent filed his Notice of Defense contesting the Accusation. A copy of First Amended Accusation No. 800-2021-081549 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2021-081549. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

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

CULPABILITY

8. Respondent understands that the charges and allegations in First Amended Accusation No. 800-2021-081549, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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

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

CONTINGENCY

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

12. Respondent understands that, by signing this stipulation, he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. A 95774 without further notice to, or opportunity to be heard by, Respondent.

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

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

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

ADDITIONAL PROVISIONS

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

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

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

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ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 95774, issued to Respondent Mukesh Misra, M.D., is surrendered and accepted by the Board, effective March 31, 2025.

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

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

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in First Amended Accusation No. 800-2021-081549 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the Board its costs of investigation and enforcement in the amount of $73,799.04 (seventy-three thousand seven hundred ninety-nine dollars and four cents) prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in First Amended Accusation No. 800-2021-081549 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

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

DATED: 1-13-25

MUKESH MISRA, M.D.
Respondent

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

DATED: 1/13/2025

DENNIS AMES
POGEY HENDERSON
Attorneys for Respondent

ENDORSEMENT

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

DATED: January 13, 2025

Respectfully submitted,

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

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

LA2023601865

Exhibit A

First Amended Accusation No. 800-2021-081549

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

In the Matter of the First Amended Accusation Against: **MUKESH MISRA, M.D.** **P.O. Box 6711** **Lancaster, CA 93539-6711** **Physician's and Surgeon's Certificate No. A 95774,** Respondent.	Case No. 800-2021-081549 **FIRST AMENDED ACCUSATION**

PARTIES

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

2. On or about June 1, 2006, the Medical Board issued Physician's and Surgeon's Certificate Number A 95774 to Mukesh Misra, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2026, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

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

(b) The administration and hearing of disciplinary actions.

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

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

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

(f) Approving undergraduate and graduate medical education programs.

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

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

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

5. Section 2220 of the Code states:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the

physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

6. Section 2227 of the Code states:

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

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

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

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

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

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

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

STATUTORY PROVISIONS

7. Section 2234 of the Code, states:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board no later than 30 calendar days after being notified by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

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

(i) Dissuading, intimidating, or tampering with a patient, witness, or any person in an attempt to prevent them from reporting or testifying about a licensee.

8. Section 2266 of the Code, states:

The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients for at least seven years after the last date of service to a patient constitutes unprofessional conduct.

COST RECOVERY

9. Section 125.3 of the Code states:

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

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

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of

investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

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

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

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

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

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

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

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

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FACTUAL ALLEGATIONS

Patient 1:[1]

10. Patient 1, a then 64-year-old male, was first evaluated by Respondent on December 12, 2019. Respondent noted that Patient 1 had a past history of spinal surgery in 2017 and a pacemaker for an irregular heart rhythm.[2] Respondent noted that Patient 1 stated that his symptoms were the "same as his prior symptoms before surgery for cervical spine." Respondent

[1] For privacy purposes, the patients in this Accusation are referred to as Patients 1, 2, and 3.

[2] Patient 1's intake form reflected that the pacemaker was placed in 2014.

did not document the symptoms for which the patient was being evaluated nor did he document any patient complaints specific to the cervical spine.[3] With respect to Patient 1's neck, Respondent documented that the patient "denie[d] neck stiffness, injuries or operations, enlarged glands, pain on turning or bending neck, and thyroid trouble." Respondent noted that Patient 1 was a former smoker.

11. With respect to the neurologic physical examination of Patient 1 on December 12, 2019, Respondent noted the following:

> "Awake and alert,
> significant long term speech impairmen. [sic]
> II-XII normal
> mild grip weakness 5/5
> decreased left C5 and rt C6 sensation
> absent rt BJ and left AJ
> No cerebellar signs
> Gait cannot do tandem
> positive SLR"

12. Respondent recommended a CT of the cervical spine and a follow up visit. Patient 1 was provided with information regarding exercise, smoking cessation (even though the patient was noted to be a former smoker), neck pain, and physical therapy. Respondent noted that the plan was discussed with the patient and family but did not identify the "family."

13. Patient 1 was next seen by Respondent on January 15, 2020. At that time, Respondent noted that Patient 1 had complaints of neck, bilateral shoulder, and bilateral arm pain. Respondent noted that the patient had a CT of the cervical spine which showed multiple level cervical stenosis and disc disease. Respondent did not document his own detailed description and interpretation of the CT scan findings. Respondent did not document the date the CT scan was performed nor did he document whether there was neural foraminal stenosis, myelopathic findings indicative of spinal cord compression, or evidence of complete interbody fusion of the patient's prior cervical spinal surgery from C4 through C7. Respondent's "neurologic" physical examination at the time of this visit was identical to the "neurologic" physical examination documented on December 12, 2019. Respondent recommended a C3-C7 laminectomy and fusion following a physician's surgical clearance. Respondent documented that the risks and benefits

[3] Patient 1's intake form for that same date noted that the patient had no pain as of "today."

were discussed with the patient and family. The Impression and Recommendations section of the note reflected cervical degenerative disc disease with the assessment noted to be deteriorated. The orders were noted to be "99215–FU Comprehensive" and "Cerv Laminectomy." There was no documentation of the reason for the surgical recommendation.

14. Respondent prepared a History and Physical Report at Antelope Valley Hospital, dated February 3, 2020. The patient's chief complaint was noted to be neck pain, bilateral arm pain, tingling, numbness, upper extremity and right grip weakness. Patient 1 was admitted for posterior C3-C7 laminectomy and posterior C3-4, C4-5, C5-6 and C6-7 facet fusion and stabilization. Respondent noted that the patient understood and agreed to the proposed surgical intervention. Respondent noted that posterior cervical decompression and fusion were discussed at length with the patient.

15. The operative report, dictated by Respondent that same day, on February 3, 2020, reflected that Patient 1 underwent posterior C3 through C7 laminectomy as well as bilateral facet cage placement arthrodesis and fusion at C3-C4 through C6-C7. The left C6-C7 cage was removed due to a fractured facet. A Jackson Pratt (JP) drain was placed in the operative bed, secured with a 3-0 nylon suture. No complications were noted during the surgery.

16. There were no notations in Patient 1's medical records indicating that Respondent discussed with the patient and/or the patient's representative that Respondent was unable to place the left C6-7 inter-facet implant.

17. Respondent dictated a discharge summary on February 4, 2020, setting forth that Patient 1 was discharged home with family care and home physical therapy.[4] He noted that the physician would call the patient regarding JP care and that it was recommended that the patient follow up in the office in a couple of weeks.

18. Patient 1 was seen by L.M. at Respondent's office on February 11, 2020. It was noted that bandages from the incision area where the drapery drain was placed were removed and cleaned with an iodine swab. The stitch was removed and 20 milliliters was emptied from the JP drain. The incision area was noted to have some redness and swelling where the drain was

[4] The discharge summary incorrectly indicates that the patient was discharged on April 20, 2020.

placed.

19. Patient 1 was next seen by M.C.R. at Respondent's office on February 19, 2020. The patient was noted to be complaining of severe neck pain and numbness on the left side of his neck only. It was noted that the incision looked a little red and that there was no swelling or signs of infection. The note further stated that the patient's wound had signs of drainage, but was healing well. The patient was advised to follow up with Respondent.

20. Patient 1 was seen by Respondent on February 26, 2020. At that time, Respondent noted that the patient remained in a lot of pain and had slight redness along his incision. The physical exam section was the same as Respondent's note dated January 15, 2020. Respondent did not describe the appearance of the incision. Respondent noted that he had a discussion with Patient 1 regarding smoking cessation and techniques and options to help the patient quit, discussion regarding exercise, encouragement to lose weight for better health, and activity restriction. The patient was instructed to schedule a follow-up appointment in six weeks.

21. On March 5, 2020, Patient 1 presented to the Antelope Valley Hospital Emergency Department with complaints of neck pain for two weeks. He had no known injury, but was noted to have had prior surgery in February and a possible infection to the site. Upon physical exam, it was noted that Patient 1 had an approximate 6 inch closed wound on the posterior neck with no active drainage and surrounding erythema. He had limited neck range of motion due to pain. A CT scan of the cervical spine revealed a post-operative fluid collection in the posterior neck. Respondent was noted to be at the patient's bedside and would be performing a bedside drainage of the post-operative fluid collection.

22. That same day Respondent performed an aspiration of the posterior cervical collection. Respondent documented that approximately 45 to 50 mL of purulent aspirate was remove and sent to the laboratory. Respondent did not address the large postoperative wound infection and purulent fluid collection that extended to the epidural space and impinged on the thecal sac as was identified on the CT scan performed earlier that day.

23. On March 6, 2020, Respondent performed an incision and drainage of the posterior cervical incision. Part of the incision in the lower part was identified to have some purulent

collection and following adequate exposure of the incision, antibiotic irrigation was performed. A JP drain was also placed.

24. On March 11, 2020, Patient 1 underwent a CT scan of the neck with contrast. The results indicated that fluid remained in the post-operative area which could represent a benign seroma or abscess. The JP drain that had been placed was superficial to the fluid collection.

25. On March 12, 2020, Respondent performed an incision and drainage and antibiotic pulse irrigation of the posterior cervical wound. Respondent noted that a deeper pocket of a collection of fluid was identified on the CT scan that had not been fully evacuated or drained from the JP drain. Additionally, dissection in the deeper epidural region revealed a new pocket of purulent collection that was fully irrigated. A drain was also placed. No complications were noted and the patient was transferred to the recovery room in stable condition.

26. Patient 1 was discharged from the hospital on March 13, 2020. He presented to Respondent's office on March 19, 2020 for a postoperative visit. Similar to Respondent's previous notes, the documented physical exam was the same as Respondent's February 26, 2020 and January 15, 2020 physical exam notes. Respondent did not include an evaluation of the incision or drain in the physical exam section of the note.

27. Patient 1 was next evaluated by Respondent on March 25, 2020. The documented physical exam was the same as Respondent's March 13, 2020, February 26, 2020, and January 15, 2020, physical exam notes.

28. On April 7, 2020, Patient 1 presented to Respondent for a follow-up evaluation. Respondent noted that it had been over a month since the patient's postoperative infection and abscess decompression. Respondent's documentation of a physical examination was the same as the prior office visit notes on March 25, 2020, March 13, 2020, February 26, 2020, and January 15, 2020.

29. On April 22, 2020, Patient 1 presented to Respondent for a follow up evaluation. Respondent's documentation of a physical examination was the same as the prior office visit notes on April 7, 2020, March 25, 2020, March 13, 2020, February 26, 2020, and January 15, 2020.

30. On June 2, 2020, Patient 1 underwent a CT scan of the cervical spine, without contrast. The report reflected that the hardware was intact without evidence of screw loosening. Bilateral inter-facet joint devices were noted. Bilateral laminectomies were present.

31. On June 22, 2020, Patient 1 presented to Respondent for follow-up regarding his ongoing neck and shoulder pain. Respondent's documentation of a physical examination was the same as the prior office visit notes on April 22, 2020, April 7, 2020, March 25, 2020, March 13, 2020, February 26, 2020, and January 15, 2020.

32. Patient 1's last visit with Respondent was on November 4, 2020.

Patient 2:

33. Patient 2, a then 55-year-old male, was first seen by Respondent in approximately 2012. On October 24, 2012, Patient 2 presented to Respondent with complaints of severe low back pain, worsening radiculopathy, tingling and numbness in the right leg with severe pain when walking, mainly on the right side. Over the course of the next several years, the patient had been followed intermittently by Respondent and underwent various imaging studies and conservative treatments for his back and leg pain symptoms, including medications and multiple facet blocks.[5]

34. On May 12, 2017, an MRI of the lumbar spine revealed facet arthropathy, neural foraminal stenosis, disc degeneration, including progression of degenerative spine disease at the L4-L5 level. Patient 2 continued to follow with Respondent and underwent additional interventional pain procedures, specifically facet blocks at L3-S1.

35. On September 28, 2017, Respondent noted that Patient 2's low back pain was unchanged. With respect to Patient 2's neurologic physical examination, Respondent noted:

> "Awake and alert
> cranial nerves II-XII normal
> Upper extremities normal
> LE left normal
> right leg severe limitation due to back/leg pain and new pain
> decreased KJ right, decreased SLR right and sensation L3- to S1 patchy
> SLR positive
> Gait cannot do tandum."

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[5] Respondent's treatment of Patient 2 prior to November 2017, is provided for historical purposes only.

36. Without adequate relief from the conservative treatment, Respondent recommended surgical intervention, specifically an L2 through L5 transforaminal lumbar interbody fusion and posterior stabilization procedure.

37. Respondent's undated History and Physical Report, dictated on November 19, 2017, reflected that Patient 2 was being admitted to the hospital on November 21, 2017 for surgery. There was no notation as to when Respondent performed the history and physical examination.

38. On November 21, 2017, Respondent performed a lumbar multilevel fusion, decompression with interbody cage placement, and posterior interspinous fixation with bone graft on Patient 2. Respondent's Operative Report is difficult to follow, but it appears that Patient 2 underwent a lumbar laminectomy at L2-L5, discectomy and decompression, transformanial interbody fusion using PEEK cage and plate system from L2 to L5, arthrodesis with autograft and fusion using bone marrow concentrate, and posterior spinous process lamina clamp with arthrodesis and stabilization at L2 through L5 levels. The surgery was noted to have been performed without intraoperative complications and Patient 2 was discharged home.

39. On December 7, 2017, Patient 2 followed up postoperatively with Respondent for the removal of staples at his incision site. The neurologic physical exam for December 7, 2017 was the same as the neurologic physical exam for September 28, 2017. The physical exam section of the note did not document inspection of the incision site.

40. Patient 2 returned to see Respondent on January 25, 2018, at which time Respondent documented that the patient's surgical site was healing well and he was "doing better." The neurologic physical exam for January 25, 2018 was the same as the neurologic physical exam for December 7, 2017, and September 28, 2017. The physical exam section of the note did not document inspection of the incision site.

41. Postoperative lumbar spine x-rays performed at the Renaissance Imaging Center at Antelope Valley Hospital on July 2, 2018, were incorrectly read as "interspinous fusion device is in place at L2-3, L3-4, and L4-5." Nine weeks later, a CT of the lumbar spine was performed at the same imaging center and was read correctly by a different radiologist and revealed placement of the devices at L1-L4 levels.

42. Subsequently, Patient 2 continued to have back pain and return of the symptoms that he had prior to surgery. Patient 2's primary care physician referred Patient 2 to another neurosurgeon, Dr. Q.M. On August 10, 2018, Dr. Q.M. diagnosed Patient 2 with failed back syndrome of the lumbar spine. Imaging studies showed prior L2-L5 interbodies and L1-L4 posterior clamps. Dr. Q.M. ordered a CT scan without contrast to evaluate the bony anatomy, morphology, and position of the interbody, as well as the posterior instrumentation.

43. Patient 2 was then seen by Dr. T.P. at Cedars-Sinai Medical Center. Over the course of Patient 2's evaluation and care with Dr. T.P., including the review of various imaging studies, it was felt that the patient's hardware included L1-L4 posterior instrumentation as well as posterior positioning of the L4-L5 interbody graft. Patient 2 reported weakness and on examination was found to have weakness involving the left foot including extensor halluces longus and dorsiflexion. Patient 2 underwent a revision surgery for the removal of the interspinous fusion devices, a complete L3 and L4 laminectomy, T10 to pelvis posterior instrumentation, T10 to pelvis posterior arthrodesis, right L4 foraminotomies, right L4-5 lateral recess decompression, left L4-5 complete revision facetectomy, revision decompression of the left L5 nerve root and left L4 nerve root, and reimplantation of interbody cage at L4-5 from the left.

44. During the course of follow-up with Dr. T.P., Patient 2 complained of severe low back pain. Additional imaging studies were performed and it was determined that the patient had additional findings. On May 31, 2019, Patient 2 underwent a second revision surgery by Dr. T.P. which included extension of the fusion up to T8. After this extensive surgery, Patient 2 was again found to have pseudoarthrosis and further hardware failure. On July 10, 2020, Patient 2 underwent a third revision surgery by Dr. T.P. for hardware failure with further spinal fixation.

Patient 3:

45. Patient 3, a then 61-year-old male, was first seen by Respondent on April 4, 2019, following a referral by neurologist, Dr. V.S. Patient 3 filled out a Health Questionnaire and wrote that his chief complaint was "RT HAND (NECK)." On the Patient Pain Drawing form, Patient 3 marked that he had numbness in his right hand and aching in his posterior cervical and lumbar regions.

46. In Respondent's Initial Consult Note, dated April 4, 2019, Respondent documented that Patient 3 was being seen for complaints of neck pain, bilateral shoulder pain, and right arm pain. Respondent noted that Patient 3 had undergone "steroid block months ago and since then has developed severe neck pain and right arm pain and weakness on the right side Respondent also noted that he reviewed Patient 3's MRI which "shows that he has local syrinx[6] on the right side with significant distal disease with stenosis at C5-C6 and moderate to severe foraminal stenosis at L5 and 611[sic]."[7]

47. Patient 3's MRI of the cervical spine performed on March 20, 2019, demonstrates moderate to severe right neural foraminal stenosis at C5-C6 and moderate right neural foraminal stenosis at C6-C7. This correlates with the right C6 and right C7 nerve roots, respectively. The MRI also confirms the presence of a syrinx within the spinal cord on the right side along with blood products at approximately the C7-T1 to T1-T2 level, without evidence of significant stenosis or spinal cord compression.

48. With respect to Patient 3's physical examination on April 4, 2019, Respondent noted that the patient had mild cervical tenderness and significant decrease in grip with claw deformity on the right hand.[8] Respondent also noted that Patient 3 had diminished reflexes involving the right triceps and biceps as well as weakness involving the biceps and grip strength. Other than the review of Patient 3's prior MRI findings and physical examination, Respondent did not perform any further work-up of Patient 3 prior to the procedure to evaluate the syrinx and blood produce findings within the spinal cord. Respondent's impression was central cord syndrome and his assessment was noted to be "deteriorated." Respondent recommended an anterior cervical

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[6] A syrinx is a fluid-filled cyst.

[7] Though Respondent did not document the date of the MRI, it appears that Respondent is referring to an MRI ordered by Dr. V.S. and performed on March 20, 2019.

[8] A "claw deformity" of the hand causes the patient's fingers to bend in towards the wrist (a flexed in position) and can also make it hard to straighten the fingers. The differential diagnosis for patients presenting with a "claw deformity" includes ulnar nerve and/or median nerve palsy, musculoskeletal disorders, cervical spinal cord injury affecting the lower cervical spine/upper thoracic spine (C8, T1 nerve roots), and brachial plexus injury.

discectomy and fusion at C3-C6.[9]

49. On April 23, 2019, Patient 3 was admitted to Antelope Valley Hospital by Respondent for an anterior cervical discectomy and fusion surgery at C4-C7. Respondent's History and Physical Report, as well as, Patient 3's Authorization for and Consent to Surgery reflect that Patient 3 was to undergo an anterior cervical discectomy and fusion surgery at C4-C7. There is no documentation reflecting that Respondent explained or discussed the reason for the change to Respondent's April 4, 2019 recommendation for an anterior cervical discectomy and fusion at C3-C6.

50. Respondent performed an anterior cervical discectomy and fusion surgery at C4-C7 on Patient 3 and noted that there were no complications. Following the procedure, Patient 3 was transferred to the recovery room in stable condition. On April 24, 2019, Respondent discharged Patient 3 from the hospital with instructions to follow up with Respondent in a couple of weeks.

51. On May 9, 2019, Patient 3 presented to Respondent for his first post-operative visit. Respondent noted that Patient 3 was "a little better" since surgery. With respect to Patient 3's physical exam, Respondent's findings were essentially the same as the April 4, 2019 physical exam findings: the patient had mild cervical tenderness and significant decrease in grip with claw deformity on the right hand.[10] Respondent did not document any comparison to Patient 3's pre-operative examination. Respondent's impression was cervical degenerative disc disease that had improved. Respondent recommended that Patient 3 return to in six to eight weeks.

52. On July 3, 2019, Patient 3 followed up with Respondent. Respondent noted that Patient 3's neck pain was "a lot better" and that "he still has some grip issues from central cord." With respect to Patient 3's physical exam, Respondent again documented that Patient 3 had mild

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[9] Referring physician, Dr. V.S. had performed an electromyography (EMG) on Patient 3 on March 27, 2019 to evaluate for neuropathy versus cervical radiculopathy in the right upper extremity. The results were abnormal and the electrophysiological findings were noted to be most consistent with mild and chronic right C6 and C7 radiculopathy, moderate right median entrapment neuropathy across the right wrist (as in carpal tunnel syndrome), and severe right ulnar neuropathy. Respondent's records for Patient 3 do not reflect that he reviewed or considered the March 27, 2019 EMG study.

[10] Respondent testified in a deposition taken on October 25, 2022, that his physical examination findings were copied from the patient's initial examination. Respondent further testified that he could not recollect if a physical examination was performed at each and every office visit.

cervical tenderness and significant decrease in grip with claw deformity on the right hand. Respondent noted that Patient 3's cervical region radiculopathy had improved. Respondent recommended that Patient 3 return for a follow-up appointment in three months.

53. On August 14, 2019, Patient 3 presented to Respondent with complaints of pain in his neck, right arm, low back and both legs as well as ongoing neck and back issues. Respondent noted that Patient 3 continued to have right hand grip issues and numbness. With respect to Patient 3's physical exam, Respondent again documented that the patient had mild cervical tenderness and significant decrease in grip with claw deformity on the right hand. In the History of Present Illness portion of the note, Respondent documented that he recommended that Patient 3 continue to undergo pain management and that an MRI of the cervical spine would be ordered if there was no improvement. In the Impressions and Recommendations portion of the note, Respondent's documentation was the same as the prior visit, noting that Patient 3's cervical region radiculopathy had improved and that Patient 3 should return for a follow-up appointment in three months.

54. On September 26, 2019, Patient 3 returned to see Respondent for a follow-up consultation. Respondent noted that Patient 3 "continued to complain of harvesting [sic] of neck and arm pain." Respondent noted that he performed a cervical discectomy decompression in April and that Patient 3 had an "iatrogenic injury to the spinal cord following an injection at the outside facility" which resulted in central cord syndrome. Respondent also noted that Patient 3 recently started feeling some loss of muscle mass in his right hand. With respect to Patient 3's physical exam, Respondent again documented that Patient 3 had mild cervical tenderness and significant decrease in grip with claw deformity on the right hand. Respondent's impression was cervical region radiculopathy that had deteriorated. Respondent recommended an MRI of the cervical spine and noted that Patient 3 may need a posterior cervical decompression and possible stabilization.

55. On or about October 9, 2019, Patient 3 underwent an MRI of the cervical spine. The findings indicated residual neural foraminal stenosis with likely C6 and C7 right nerve root impingement. The MRI demonstrated no significant central canal stenosis/spinal cord

compression and there was no significant change in the degree of spinal stenosis.

56. Following the completion of the MRI, Patient 3's surgery was scheduled for December 16, 2019. Respondent did not document seeing Patient 3 preoperatively in his office to discuss the MRI findings prior to the patient presenting to the hospital for surgery. Respondent testified in deposition on October 25, 2022, that he does not why there was no documented preoperative visit with Patient 3 after the MRI was complete and prior to the second surgery. Respondent also testified that he does not recollect whether he discussed the MRI results with Patient 3 prior to December 16, 2019.

57. On December 16, 2019, Patient 3 underwent a C4-C7 posterior facet fusion and laminectomy by Respondent at Antelope Valley Hospital. In his Operative Report, Respondent noted that Patient 3's symptoms continued to be persistent despite having undergone an anterior decompression and fusion. Respondent noted that Patient 3's MRI showed that Patient 3 continued "to have some signal in syrinx along with compression of the exiting nerve root..." Respondent noted that Patient 3 tolerated the surgery very well, there were no complications, and the patient was transferred to the recovery room in stable condition.

58. In Patient 3's Discharge Summary, Respondent noted that other than head pain and discomfort, Patient 3 had no major issues following surgery. Respondent discharged Patient 3 from the hospital on December 18, 2019, with orders that Patient 3 continue present management and follow up with Respondent in a couple of weeks.

59. Patient 3 continued to follow up with Respondent post-operatively. On January 8, 2020, Respondent noted that Patient 3's symptoms were slightly better and that the plan was to continue the present management. Respondent's documentation of Patient 3's physical examination findings was the same as the findings documented by Respondent on September 26, 2019. Respondent recommended follow-up in two to three months.

60. On February 13, 2020, Patient 3 underwent a comprehensive neurology evaluation by Dr. L.J., a neurologist who works in the same office as Respondent. Dr. L.J. assessed Patient 3 as mostly likely having "a severe degree of ulnar neuropathy with a claw hand right more than the left, rule out C7 radiculopathy." Dr. L.J. recommended and performed an EMG, which was noted

to be abnormal, showing a severe degree of ulnar neuropathy across the right elbow with unobtainable ulnar nerve conductions below and above the right elbow behind the medial epicondyle. Dr. L.J. recommended ulnar nerve decompression behind the right medial elbow.[11]

61. Patient 3 subsequently sought care and treatment by upper extremities specialist, Dr. M.S. On June 17, 2020, an EMG/NCV study revealed severe right ulnar neuropathy with no axonal continuity. Patient 3 then underwent a neurological evaluation by Dr. M.S., who diagnosed Patient 3 with severe right ulnar nerve palsy.

62. Patient 3 underwent multiple surgeries by Dr. M.S., including an endoscopic cubital release on December 28, 2020, a carpal tunnel release on July 8, 2021, and a right Guyon Canal release, external neuroplasty of the right ulnar nerve along the forearm, internal neuroplasty motor division of the right ulnar nerve, sensory division, and nerve transfers on January 21, 2022. Thereafter, Patient 3 continued to experience pain to his right hand.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

63. Respondent is subject to disciplinary action under Code Section 2234, subdivision (b), in that he engaged in gross negligence in his care and treatment of Patients 1 and 3. The circumstances are as follows:

Patient 1:

March 5, 2020 Incision and Drainage of Patient 1's Post-Surgical Abscess.

64. When performing an incision and drainage of a post-surgical abscess or infection, the standard of care requires that the physician completely evacuate the purulent fluid collection as safely as possible, and that the procedure be performed in a quick and timely fashion.

65. After reviewing the CT scan images and performing a "tap" or aspiration of fluid on March 5, 2020, Respondent determined that Patient 1 was likely experiencing a postsurgical wound infection.

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[11] Respondent testified at his deposition on October 24, 2022 that he did not consider the diagnosis of ulnar neuropathy until after the EMG study by Dr. L.J. revealed severe right ulnar neuropathy.

66. The March 5, 2020 CT scan report indicated that there was severe impingement on the thecal sac as a result of the large fluid collection. Respondent documented in his March 6, 2020 operative report that he identified a purulent collection and following adequate exposure of the incision, around 350 to 500 mL of antibiotic irrigation was performed along the operative site. That operative report does not state that the dissection was performed to the level of the epidural space. Another CT scan performed on March 11, 2020 revealed only a slight decrease in the size of the primary fluid collection and the JP drain was noted to be within the subcutaneous tissue, not in the bed of the operative site.

67. The initial incision and drainage procedure performed by Respondent on March 5, 2020 failed to address the underlying issue, namely the large postoperative wound infection and purulent fluid collection extending to the epidural space and impinging upon the thecal sac. During the second incision and drainage procedure performed by Respondent on Patient 1 on March 6, 2020, Respondent did not document that the dissection was performed down to the level of the dura. Respondent set forth in the operative report that a JP drain was placed in the bed of the operative site. However, according to the March 11, 2020 CT scan, the JP drain was within the dorsal subcutaneous soft tissues, superficial to the dominant fluid collection.

68. Respondent's failure to promptly and fully evacuate the underlying large and compressive fluid collection and purulent infectious abscess from Patient 1's posterior neck area on March 5, 2020 is an extreme departure from the standard of care.

Cervical Laminectomy and Instrumented Inter-Facet Fusion.

69. Cervical laminectomy surgery is a procedure performed in order to decompress the cervical spinal cord and/or the neurological components within the cervical spinal canal. Cervical instrumented fusion is a procedure performed to address various cervical conditions, including but not limited to instability, spine fracture, and spinal deformity.

70. Without evidence of myelopathy and/or concern for spinal cord compression, a laminectomy without a foraminotomy is not an appropriate recommendation for a patient with possible symptoms of radiculopathy. In the setting of a previous osseous fusion, a foraminotomy would have been an appropriate procedure, however, this was not documented in the operative

reports. Interfacet fusion is not indicated when there has been complete and healed osseous fusion across the C4-C7 vertebral body levels from the prior anterior cervical discectomy and fusion procedure(s).

71. Respondent documented that Patient 1 was experiencing symptoms such as neck pain, upper extremity weakness, and numbness. Respondent failed to identify the specific etiology and causes of the patient's symptoms. Respondent failed to interpret the patient's CT scan findings, including those performed on December 19, 2019. Respondent failed to note neural foraminal stenosis, myelopathic findings indicative of spinal cord compression, or evidence of complete interbody fusion of Patient 1's prior cervical spinal surgery from C4 through C7. Patient 1 had undergone a prior anterior cervical discectomy and fusion surgery. The imaging studies demonstrate complete and full fusion across the C4 through C7 levels. The operative report from the initial surgery does not indicate that foraminotomies were performed nor do the medical records demonstrate acknowledgment of neural foraminal stenosis. Post-surgical CT scans demonstrated stable appearance of the neuroforamen throughout the cervical spine. Respondent failed to document the reason for recommending laminectomy and fusion surgery.

72. Respondent's recommendation and performance of a cervical laminectomy and instrumented inter-facet fusion without an adequate rationale and explanation for its recommendation and performance is an extreme departure from the standard of care.

Patient 3:

Anterior Cervical Discectomy and Fusion.

73. An anterior cervical discectomy and fusion procedure is an accepted surgical approach to the treat patients with radiculopathy and/or spinal cord compression as a result of neural stenosis and/or central canal stenosis.

74. Patient 3's MRI revealed no significant central canal stenosis/compression of the spinal cord. Respondent's work-up of Patient 3 prior to the procedure was inadequate for understanding the syrinx and blood product findings within the spinal cord. The MRI, performed on March 20, 2019, also revealed no significant C7-T1, T1-T2 neuroforaminal stenosis and the EMG study, performed on March 27, 2019, revealed severe ulnar neuropathy. Respondent's

performance of an anterior cervical discectomy and fusion surgery on Patient 3 on April 23, 2019 was unnecessary. This is an extreme departure from the standard of care.

C4-C7 Posterior Facet Fusion and Laminectomy.

75. The C4-C7 posterior facet fusion and laminectomy surgery performed by Respondent on December 16, 2019 was an unnecessary procedure at the time it was performed given the lack of significant change in the degree of spinal stenosis on the preoperative MRI, the lack of further diagnostic testing to assess for, and rule out, alternative etiologies within the differential diagnosis for treatment of Patient 3's right hand claw deformity, and Respondent's own admission that he cannot recall if a physical examination was performed prior to the recommendation for surgery. This is an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

76. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts with respect to his care and treatment of Patients 1, 2, and 3. The circumstances are as follows:

77. Each of the alleged acts of gross negligence set forth above in the First Cause for Discipline is also a negligent act.

78. Respondent committed the following additional repeated acts of negligence:

Patient 1:

Deviation from Intended Surgical Procedure.

79. When performing a surgical procedure, the standard of care requires that the surgeon discuss intraoperative findings with the patient and/or the patient's representative after the surgical procedure is completed, especially if there is a deviation from the intended procedure.

80. The operative report indicates that Respondent was unable to place a left C6-C7 interfacet instrumentation device due to a fracture at this location. Respondent failed to document that his inability to place the left C6-7 inter-facet implant was discussed with Patient 1 and/or the patient's representative.

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81. Respondent's failure to disclose the deviation from the intended surgical procedure as a result of the fracture involving the left C6-C7 facet is a simple departure from the standard of care.

Physical Exam Documentation.

82. The standard of care requires that the documentation of physical examination only include those aspects of the physical examination that were actually performed.

83. Throughout Respondent's office notes for Patient 1, the physical examination section includes multiple lines that were copied at each and every office visit after the initial visit on December 12, 2019. The failure to document new findings or make new entries in Patient 1's medical record regarding the physical examination raises concern that an examination was not actually performed at each office visit that documents a physical examination. At the time of Patient 1's post-operative visits, Respondent failed to document an inspection of the incision site and/or the JP drain site in the physical exam section of the patient's medical records. This is a simple departure from the standard of care.

Patient 2:

Surgical Technique.

84. The standard of care requires that the surgeon perform the surgical procedure as intended according to the consent, including the correct side (right versus left) as well as the appropriate level or levels (such as lumbar 4 [L4]).

85. A review of the various postoperative imaging studies available, including x-ray and CT scans, consistently demonstrates that the interspinous devices were placed at the L1-L2, L2-L3, and L3-L4 levels rather than as intended at L2-L3, L3-L4, and L4-L5.

86. Respondent's placement of interspinous posterior clamps at the wrong level in Patient 2 is a simple departure from the standard of care.

Medical Record Documentation.

87. Throughout the follow-up office visit notes entered by Respondent in Patient 2's chart, he repeated the same physical examination, without deviation. Respondent also failed to document an inspection of the patient's incision site post operatively.

88. The preoperative history and physical was dated November 21, 2017, while the dictation was performed on November 19, 2017. There was no documentation reflecting when the preoperative history and physical examination was actually performed.

89. Respondent's documentation in Patient 2's medical charts and records represents a simple departure from the standard of care.

Patient 3:

Medical Record Documentation.

90. Respondent documented the same physical examination in Patient 3's office chart for essentially every visit, and Respondent could not recall if an examination was performed at every visit a physical examination was documents. Respondent's documentation in Patient 3's office chart represents a simple departure from the standard of care.

Work-up of a Neurosurgical Patient in order to Establish the Correct Diagnosis.

91. In working up a neurosurgical patient, the standard of care requires that the neurosurgeon obtain a thorough medical history from the patient, conduct an appropriate physical examination, review diagnostic studies (including imaging studies, diagnostic tests and laboratory tests) in order to form a list of differential diagnoses. Additional tests and/or studies may be necessary to confirm or rule out specific diagnoses from the list of differential diagnoses.

92. Respondent formed the impression that Patient 3's symptoms were stemming from cervical radiculopathy. Before performing two surgeries, Respondent failed to consider and rule out differential diagnoses for Patient 3's claw deformity, including ulnar nerve and/or median nerve palsy, musculoskeletal disorders, cervical spinal cord injury affecting the lower cervical spine/upper thoracic spine, and brachial plexus injury. Respondent's failure to consider the diagnosis of ulnar neuropathy until after two surgical procedures were performed is a simple departure from the standard of care.

Change in Plan for Surgical Intervention.

93. The standard of care requires that a neurosurgeon discuss with the patient the rationale for any changes to an initial recommendation for surgical intervention.

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94. At the time of Patient 3's initial consultation on April 4, 2019, Respondent recommended a C3-C6 anterior cervical discectomy and fusion surgery.

95. Respondent's change of surgical plan from C3-C6 anterior cervical discectomy and fusion surgery to C4-C7 anterior cervical discectomy and fusion surgery, without discussing the change with Patient 3 and documenting that discussion is a simple departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

96. Respondent is subject to disciplinary action under section 2266 of the Code, in that he failed to maintain adequate and accurate records concerning the care and treatment of Patients 1, 2, and 3. The circumstances are as follows:

97. The standard of care requires that physicians maintain adequate and accurate medical records that provide a complete and accurate description of the patient's medical history, including any medical conditions, diagnoses, the treatment provided, the rationale and indications of those diagnoses and treatments, and any further results and recommendations.

98. A patient's medical records serve multiple purposes which include providing documentation regarding the care provided to the patient as well as providing a means of communication with other physicians, nurses and others regarding the patient's status and/or needs.

99. Complainant refers to and, by this reference, incorporates Paragraphs 10-62, 82-83, and 87-90, above, as though set forth fully herein.

DISCIPLINARY CONSIDERATIONS

100. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on March 10, 2021, in a prior disciplinary action entitled *In the Matter of the Accusation Against Mukesh Misra, M.D.* before the Medical Board of California, in Case No. 800-2017-033333, the Board issued a decision in which Respondent's Physician's and Surgeon's Certificate was revoked for gross negligence, repeated negligent acts, and failure to maintain adequate and accurate medical records as to two patients and unprofessional conduct as

to one patient. However, the revocation was stayed and Respondent was placed on five (5) years' probation, to run consecutively from the conclusion of Respondent's probation term in the Board's Decision in Case No. 800-2017-033193, for a total of ten (10) years' probation, with requirements that he complete education coursework, a medical record keeping course, an ethics course, a clinical competence assessment program, maintain a practice monitor, obey all laws and other standard terms and conditions. That decision is now final and is incorporated by reference as if fully set forth herein.

101. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on January 23, 2020, in a prior disciplinary action entitled *In the Matter of the Accusation Against Mukesh Misra, M.D.* before the Medical Board of California, in Case Number 800-2017-033193, Respondent's license was revoked for gross negligence and repeated negligent acts in the care and treatment of one patient. However, the revocation of Respondent's license was stayed and Respondent was placed on probation for two (2) years to run consecutively from the conclusion of Respondent's probation term in the Board's Decision in Case No. 800-2014-005853, for a total of five (5) years' probation with the requirement to complete education coursework, a medical record keeping course, a Clinical Training Program, maintain a practice monitor and other standard terms and conditions. That decision is now final and is incorporated by reference as if fully set forth herein.

102. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on May 3, 2018, in a prior disciplinary action entitled *In the Matter of the Accusation Against Mukesh Misra, M.D.* before the Medical Board of California, in Case Number 800-2014-005853, Respondent's license was revoked for gross negligence and repeated negligent acts in the care and treatment of one patient. However, the revocation of Respondent's license was stayed and Respondent was placed on three (3) years of probation with the requirement to complete a Clinical Training Program, maintain a practice monitor and other standard terms and conditions. That decision is now final and is incorporated by reference as if fully set forth herein.

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103. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about June 28, 2012, in a prior disciplinary action entitled *In the Matter of the Accusation Against: Mukesh Misra, M.D.*, before the Medical Board of California, Case No. 08-2007-186068, Respondent's license was disciplined and he was required to take educational courses, a medical record keeping course, and a professionalism program. Respondent successfully completed the coursework and, on or about April 26, 2016, Respondent was publicly reprimanded for failing to adequately document a surgical procedure and the post-operative condition and care of the patient. That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 95774, issued to Respondent Mukesh Misra, M.D.;

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

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

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

DATED: JUN 06 2024

for

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

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