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

In the Matter of the Accusation Against: Andy Yongde Zhu, M.D. Physician's & Surgeon's Certificate No A 104156 Petitioner.	Case No.: 800-2021-075490

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Andy Yongde Zhu, M.D., for the reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on April 1, 2025.

IT IS SO ORDERED: April 2, 2025

Richard E. Thorp, M.D., Chair
Panel B

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

In the Matter of the Accusation Against: **Andy Yongde Zhu, M.D.** **Physician's & Surgeon's Certificate No. A 104156** **Respondent.**	**Case No. 800-2021-075490** **ORDER GRANTING STAY** **(Government Code Section 11521)**

Respondent, Andy Yongde Zhu, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of March 20, 2025, at 5:00 p.m.

Execution is stayed until April 1, 2025, at 5:00 p.m.

This Stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: March 18, 2025

Shandene Smith For
Reji Varghese
Executive Director
Medical Board of California

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

In the Matter of the Accusation Against: Andy Yongde Zhu, M.D. Physician's and Surgeon's Certificate No. A 104156 Respondent.	Case No. 800-2021-075490

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 March 20, 2025.

IT IS SO ORDERED February 18, 2025.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

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

In the Matter of the Accusation Against:

ANDY YONGDE ZHU, M.D., Respondent

Agency Case No. 800-2021-075490

OAH No. 2023100891

PROPOSED DECISION

Administrative Law Judge Coren D. Wong, Office of Administrative Hearings, State of California, heard this matter on October 7 through 11, 14, 16, and 17, 2024, in Sacramento, California.

Megan R. O'Carroll, Deputy Attorney General, represented complainant Reji Varghese, Executive Director of the Medical Board of California (Board), Department of Consumer Affairs, State of California. Lindsay Brearley, Investigator, Department of Consumer Affairs, Division of Investigation, Health Quality Investigation Unit (HQIU), also appeared for complainant during part of the hearing.

Louis "Duke" H. DeHaas and Nicole D. Hendrickson of La Follette, Johnson, DeHaas, Fesler & Ames represented respondent Andy Yongde Zhu, M.D., who was also present.

Evidence was received, the record closed, and the matter submitted for written decision on October 17, 2024. The following day, a Protective Order sealing Exhibits 5–7, 9–13, 15, 18–23, U (B320–B469 only), AA, and BB was issued. Pseudonyms are substituted for patients' names below in accordance with the Protective Order.

FACTUAL FINDINGS

Jurisdiction

1. On May 30, 2008, the Board issued respondent Physician's and Surgeon's Certificate Number A 104156. The certificate will expire March 31, 2026, unless renewed. There is no history of prior discipline of the certificate.

2. Complainant authorized the Accusation solely in his official capacity on August 2, 2023. The Accusation alleges separate causes to discipline respondent's certificate for: (1) sexual exploitation; (2) sexual misconduct; (3) gross negligence; (4) repeated negligent acts; (5) dishonest or corrupt act substantially related to the qualifications, functions, or duties of a physician; and (6) general unprofessional conduct. The gravamen of the Accusation is three patients' complaints that respondent inappropriately touched their breasts during examinations, and that he was untruthful when he did not disclose the second complaint to a police detective investigating the third.

Respondent's Background

3. Respondent is 59 years old. He was born in a small, rural farming village in Southern China. His parents were farmers. They had four children, all boys. Respondent is the youngest. His family lived a humble lifestyle.

4. As a young child, respondent went to school and played in the fields with other children in his village. The village had its own local dialect of the Chinese language, and that is what he spoke at school and at home. Respondent heard the Mandarin dialect when he listened to the radio, but he was not taught Mandarin and his family did not speak it.

5. When respondent was 13 years old, his parents sent him to a boarding school about 10 to 20 minutes from home. It was the end of the Cultural Revolution, and he was the first in his family to have the opportunity to continue his education beyond elementary school.

6. Although the living conditions at boarding school were better than at home, respondent maintained a simple lifestyle. All the children slept on the wooden floor in "one giant room," with girls on one side and boys on the other.

7. While in boarding school, respondent took the entrance exam for Shanghai Medical University (SMU) (now Medical Center of Fudan University). He failed the exam twice, studied harder each time, and passed on his third attempt. He left boarding school in 1982 and enrolled at SMU.

8. Classes at SMU were taught in Mandarin, so respondent had to learn a new language in addition to the regular curriculum. Additionally, the regular curriculum included English classes.

9. Respondent's undergraduate studies and medical school were combined into a six-year joint program. He graduated from SMU with his medical degree in July 1988 at the age of 23 years.

10. Respondent was hired as a gastroenterologist at Shanghai Cancer Hospital, Medical Center of Fudan University, the month following graduation. He consulted and diagnosed patients suffering gastroenterological problems, determined their proper courses of treatment, consulted with other medical specialists, and performed surgeries on the digestive tract.

11. In the early 1990s, China began opening its borders to emigration, and several of respondent's college classmates moved to the United States. They shared their experiences after moving, and respondent decided to explore doing the same for a better life.

12. Respondent married his wife, Yi Sun, in China in May 1993. Shortly thereafter, he began researching the requirements for obtaining a student visa to come to the United States. He learned he needed to be accepted by an approved college and show he had the ability to support himself financially. Respondent applied for and was accepted into a Ph.D. program in comparative pathology at University of California, Davis (UCD) in Davis, California. He was awarded a scholarship.

13. Respondent applied for and was issued a student visa allowing him to study in the United States. He started the Ph.D. program at UCD in September 1993. He initially came to the United States by himself, but his wife joined him a few months later. Their first son was born while respondent was studying at UCD.

14. Respondent faced some language barriers at UCD. He had no trouble with written communication, but he struggled with verbal communication. He audio recorded lectures so he could replay them at a slower speed. Additionally, friends helped him and watching television also helped him.

15. Respondent earned his Ph.D. in comparative pathology in June 1998. He started his post-doctoral training as a research associate at Seattle Biomedical Research Institute in Seattle, Washington, in January 1999. He continued his training in Seattle as a research scientist at the University of Washington in August 2002. His training involved using pig-tailed macaque monkeys as animal models for developing a human immunodeficiency virus vaccine. Respondent's second son was born in Seattle.

16. Respondent enjoyed working in a laboratory setting. However, he longed to be a clinical physician. He was motivated to become one after seeing the effects of people in his village not having access to good healthcare. When his grandparents got sick, they tried to recover simply by staying in bed. They eventually died, and their causes of death remain unknown.

17. Respondent satisfied the educational requirements for being accepted into a medical residency program and only needed to pass the Step 1 Exam and Step 2 Exam. He took the Step 1 Exam and passed on his first attempt. However, the Step 2 Exam included an oral component, and he failed due to poor communication skills. Recognizing his weakness, respondent took English as a Second Language classes on the weekends and practiced speaking in front of a mirror to improve his communication skills. He passed the Step 2 Exam on his third attempt.

18. Respondent resigned his research position at University of Washington in June 2005 to start the family medicine residency program at the Medical Center of Central Georgia. He completed the program three years later. Respondent maintained a resident training medical license in Georgia throughout his residency. He did not renew it after it expired. Respondent and his wife enjoyed living in Davis when he attended UCD, so they decided to return in 2008 after his residency.

19. Community Medical Centers, Inc. (CMC) is a growing nonprofit network of neighborhood health centers serving San Joaquin and Solano Counties. CMC is a federally qualified health center (FQHC), a nonprofit health clinic that receives federal funds to provide primary care services to the underserved community. In California, that community includes those on Medi-Cal and the uninsured.

20. CMC has a health center in Dixon, California (CMC-Dixon). CMC-Dixon hired respondent as a primary care physician three months after licensure. He applied to CMC-Dixon because it is an FQHC serving those with no or limited access to healthcare. Respondent obtained board certification in family medicine the month after he started at CMC-Dixon. He has maintained certification ever since.

21. Respondent's work schedule at CMC-Dixon was generally weekdays from 9 a.m. to 6 p.m. Each morning, he was given a schedule of patients he was supposed to see, which usually consisted of 18 to 20 patients. Appointments were generally scheduled in 15-minute increments, but respondent never walked out of an appointment based on the arbitrary passage of time. Instead, he spent the amount of time necessary to finish each appointment. Therefore, he "often" worked past 6 p.m.

22. Respondent resigned from CMC-Dixon effective March 15, 2021. Dignity Health Woodland Clinic subsequently hired him as a primary care physician in Woodland, California. The process of obtaining privileges took an extended amount of time, so he worked as a locum tenens physician at the Sacramento County Jail for three months before starting at Dignity Woodland Health Clinic in June 2021. Eight months later, respondent also became the medical director for Alderson Convalescent Hospital in Woodland.

23. Dignity Health Woodland Clinic and Alderson Convalescent Hospital terminated respondent shortly after the Accusation was filed. He has not worked since then.

CMC's Report of Misconduct and Board's Investigation

24. A medical facility that receives a written complaint alleging one of its physicians engaged in sexual misconduct with a patient must disclose the complaint to the Board. CMC disclosed a complaint about respondent to the Board on February 23, 2021.

25. Lindsay Brearley was assigned to investigate the complaint. She has a bachelor's degree in criminal justice and completed a four-month Peace Officer Standards and Training Academy. She is a sworn peace officer. She has conducted investigations for the Board for approximately 17 years.

26. The Board hired Investigator Brearley in 2007. Seven years later, the HQIU was created, and the Board's investigators, including Investigator Brearley, were reassigned. Although she continues to conduct investigations for the Board, she also conducts investigations for the Osteopathic Medical Board of California, Physician Assistant Board, and Podiatric Medical Board of California. She has conducted more than 300 investigations during her career.

27. Investigator Brearley began her investigation by reviewing CMC's disclosure and Patient 3's attached complaint. Patient 3 wrote in her complaint, "[Respondent] was checking my heart with his hand and slid his hand all the way down my shirt and sexually touched one of my breast [*sic*][.]"

28. Investigator Brearley searched the Board's records for respondent's certificate history. She also contacted CMC staff, requested medical records, and scheduled interviews of witnesses. Patient 3 reported her complaint to the Dixon Police Department, so Investigator Brearley obtained a copy of the investigation report. She also contacted the Solano County District Attorney's Office and learned no criminal charges were filed against respondent.

29. While reviewing CMC's initial document production, Investigator Brearley discovered CMC-Dixon had received a complaint of sexual misconduct involving respondent and Patient 2 on June 29, 2015. Therefore, she expanded the scope of her investigation to include that complaint. During a subsequent witness interview, she learned Patient 1 disclosed at a November 2020 prenatal appointment that respondent had inappropriately touched her breast during an examination six years prior. Investigator Brearley broadened her investigation to include that complaint as well.

30. Investigator Brearley documented the different steps of her investigation as she took them or shortly thereafter in an investigation report. She also took notes during witness interviews. She used those notes to summarize the interviews in her report. Investigator Brearley finalized her report at the conclusion of her investigation.

31. As part of hearing preparation, Investigator Brearley issued a subpoena to the Dixon Police Department seeking all video footage of its investigation of Patient 3's complaint. The week prior to hearing, the Dixon Police Department produced video footage of three witness interviews and a telephone call with CMC's counsel. Additionally, the Department's records supervisor certified under penalty of perjury that video footage of respondent's interview could not be located. Complainant immediately provided the video footage and certification to respondent.

PATIENT 1

Interview with Investigator Brearley

32. Investigator Brearley interviewed Patient 1. Patient 1 estimated the appointment at which respondent inappropriately touched one of her breasts was around September or October 2014, when she was 21 years old. It was not respondent's first time treating her, as she had been going to CMC-Dixon for several years.

33. Patient 1 made an appointment with respondent to have two prescriptions refilled. She expected the appointment to be short and consist of only questions about how she was managing her medication. Her recollection was that she was taking Ambien for insomnia and diazepam for anxiety.

34. The appointment lasted less than 10 minutes. Patient 1 was seated when respondent approached from the front and reached inside her tank top while asking questions about her heart. He pressed on patient 1's chest area before he reached under her wired bra and "cupped" her right breast. She explained respondent scooped her breast up with his hand and almost lifted it out of her bra. It lasted approximately 30 seconds.

35. Respondent asked Patient 1 to lay supine on the examination table. He rolled up her tank top and exposed her stomach. He then reached through the top of her tank top, grabbed her right breast, and asked if she became anxious when he did that. Respondent then put his entire hand inside Patient 1's bra and made the same "cupping" motion with her right breast. He did that for 30 to 45 seconds. Respondent left immediately thereafter. Patient 1 grabbed her purse and left.

36. Patient 1 called her mother immediately after she left CMC-Dixon. Her mother encouraged her to report respondent's conduct to someone, but Patient 1's anxiety was "very, very intense" and she could not. Approximately one month later, she made an appointment at CMC-Dixon with a female provider. She disclosed what respondent had done during that appointment, but the provider dismissed Patient 1 by explaining she was not present during the appointment and did not want to get involved.

37. Patient 1 never discussed the incident again until six years later during a prenatal visit. She was responding to background questions about domestic violence or sexual abuse when she was asked, "Have you ever been touched inappropriately?" She disclosed the prior incident with respondent.

38. Patient 1 subsequently discussed the incident with people from CMC a few times. She learned for the first time during those discussions about another incident involving respondent during which a female patient left the exam room crying and the police were called.

Hearing Testimony

39. Patient 1 testified at hearing consistently with her interview with Investigator Brearley. She explained on November 12, 2014, she was sitting by herself on the edge of the examination table when respondent walked in by himself. He never provided or offered a chaperone.

40. Respondent was purportedly listening to Patient 1's heart when he put his hand in her shirt, reached under her bra, grabbed one of her breasts, cupped it with his fingers and palm, and squeezed for "a few seconds." He did the same thing to

the same breast after asking Patient 1 to lay supine on the examination table and rolling up the bottom of her shirt to expose her stomach.

41. Patient 1 "was very shocked any of this was happening" because she had been respondent's patient since 2012 or 2013. Additionally, her mother was his patient. Neither of them had any prior problems with respondent. Patient 1 went into "panic mode" and wanted to leave. She sat up, pulled her shirt down, grabbed her purse, and walked out of the examination room and CMC-Dixon.

42. Patient 1's appointment the following month was with Erica Ramirez, a physician assistant. When Ms. Ramirez walked into the examination room for the appointment, Patient 1 felt an immediate sense of relief because Ms. Ramirez is a Hispanic woman. Patient 1 is also Hispanic, and she thought Ms. Ramirez would relate to her and be more understanding. So her dismissiveness made Patient 1 "feel stupid" for reporting respondent, and she immediately regretted doing so. Patient 1 completed the appointment and "left and never talked about it again" until she became pregnant in 2020.

43. In 2020, Patient 1 received prenatal care at CMC-Dixon. She was assigned Marcella Ponce as her pregnancy coach. Patient 1 disclosed respondent's prior misconduct to Ms. Ponce during a November 2020 prenatal appointment. Ms. Ponce sympathized with Patient 1, comforted her, and assured her she was a strong woman. She also told Patient 1 she was required to report the incident to CMC management, and she immediately did so.

44. The incident with respondent changed how Patient 1 interacts with men in other settings. For example, prior to the incident, Patient 1 did not object to receiving massages from a male masseuse. Now, she insists on a female.

PATIENT 2

Interview with Investigator Brearley

45. Investigator Brearley interviewed Patient 2. On June 29, 2015, Patient 2 had an appointment with respondent for the physical examination required for obtaining a Permanent Resident Alien Card. It was a "normal check-up" to make sure she did not have any diseases and was medically cleared for immigration. Patient 2 did not think respondent would check her "private parts, like my breasts." This was the only time she went to CMC-Dixon. She was 21 years old.

46. Patient 2 went to the appointment alone. She wore an ankle-length dress that had small horizontal openings on either side of the midsection that were connected in the middle with a twisted knot of fabric. The openings were visible only when the fabric was pulled taught.

47. A medical assistant escorted Patient 2 to an examination room, asked general background information, said respondent would be in shortly, and left. Respondent entered the examination room by himself. He asked a few general questions and then told Patient 2 to lay on supine on the examination table. He did not explain why. Respondent did not provide or offer a chaperone.

48. Respondent stood on Patient 2's right side throughout the brief examination. He examined her abdomen before putting his right hand through one of the "slits" in her dress and touching the bare skin of her left breast. He "cupped and squeezed" Patient 2's breast for a few seconds. Respondent then pulled his hand out, reached into the other opening in the dress, and did the same thing to her right breast, also for a few seconds.

49. Respondent did not say anything to Patient 2 while touching her breasts. She did not want to make eye contact with him and just stared at the ceiling. After he checked both breasts, he removed his hand and said, "Okay, we're done, we're finished." Patient 2 sat up, and respondent said he would sign her paperwork and left the room abruptly. The appointment lasted "maybe" 10 minutes.

50. Patient 2 was initially confused as to whether she was supposed to wait in the examination room or the waiting room for respondent to return with her paperwork. She eventually left the room and picked up the paperwork from the front desk on her way out.

51. Patient 2 told her husband what respondent had done when she got home, and he convinced her to call CMC-Dixon to ask if a breast examination was typically part of an immigration physical. Patient 2 called CMC and asked the person who answered the telephone. The person placed her on a brief hold while she asked a provider. She returned and said, "Yeah, that's completely normal."

Hearing Testimony

52. Patient 2 testified consistently with the statement she provided Investigator Brearley. She explained she was sitting on the edge of the examination table while respondent examined her ears, nose, and throat; listened to her heart; and tested her patellar reflex. He asked her to stand up and bend over at her waist so he could examine her spine for any curvature.

53. Respondent had Patient 2 lay supine on the examination table so he could examine her abdomen. He examined her abdomen over her dress. He then reached one of his hands through one of the "slits" in Patient 2's dress, underneath her bra, and cupped and squeezed one of her breasts for approximately three to five

seconds. He then pulled his hand out, reached through the other opening in the dress, underneath her bra, and cupped and squeezed her other breast for about three to five seconds. Patient 2 "flinched" when respondent first grabbed one of her breasts because she was "in shock," did not anticipate him doing that, and his hand was cold. He was not holding a stethoscope in either hand when he touched either of her breasts.

54. After respondent pulled his hand out of Patient 2's dress the second time, he left the room without saying anything and never returned. Patient 2 was left sitting on the examination table confused about whether the examination was over and in shock over respondent's conduct. Eventually, she walked up to the nurses' station and asked if her examination was over. She was told a medical assistant would be in shortly for bloodwork. A medical assistant entered shortly thereafter and drew a sample of Patient 2's blood for testing. After, Patient 2 left and went home.

55. Patient 2 was so shaken by respondent's misconduct that she asked her husband to call CMC-Dixon. He made the call using a speakerphone with Patient 2 standing next to him during the entire conversation. They were told an immigration medical examination includes touching a female patient's breast. They also called the United States Citizenship and Immigration Services (USCIS) and were told an immigration physical could include breast examination. Based on the information CMC-Dixon and USCIS provided, Patient 2 did nothing further. She was also concerned about jeopardizing her application for permanent residency if she reported respondent to the police or CMC.

56. Patient 2 did not think about the incident until "years later" when a third-party investigator CMC hired to investigate Patient 3's complaint contacted her.

Patient 2 was unaware of any complaints of sexual misconduct or inappropriate touching against respondent until she spoke to the investigator.

57. Patient 2's experience with respondent "absolutely" continues to affect her. She has a general distrust for medical providers. She only treats with female providers and always asks for a chaperone. She brings her husband to all medical appointments.

PATIENT 3

Interview with Investigator Brearley

58. Investigator Brearley interviewed Patient 3 in person. Patient 3's mother scheduled the May 22, 2020 appointment with respondent because Patient 3 felt sick with "shortness of breath and wheezing." Patient 3 was 16 years old at the time. The appointment lasted "maybe 10 minutes." Patient 3's mother waited in the car to give her daughter privacy when discussing her symptoms of anxiety. Patient 3 was not offered a chaperone, and she was alone with respondent the entire time he was in the examination room.

59. Respondent asked Patient 3 about her symptoms of anxiety and how long she was experiencing them. He also checked her throat and listened to her heart. Patient 3 asked if her heart rate was high, and respondent said it was. Respondent put his stethoscope away and rested his right hand on Patient 3's chest above her left breast for four to five seconds. He then quickly reached under her sports bra with his right hand and "squeezed" and "lifted" her breast by its bare skin.

60. Patient 3 immediately stood up, said she needed to use the restroom, and hurried out of the examination room. She walked down a long hallway to the front

desk. She looked back and saw respondent watching her. Patient 3 told two women at the front desk respondent had groped her. She was crying.

61. Patient 3 called her mom, told her what had happened, and asked her to come inside. Once inside, Patient 3 and her mother were escorted to another examination room where they waited until the Dixon Police Department arrived 10 to 15 minutes later. The Dixon Police Department opted to have a specialist in interviewing child abuse victims interview Patient 3 rather than one of its officers. A multidisciplinary child interview was scheduled at the Courage Center in Fairfield, California. The interview was video recorded.

Multidisciplinary Child Interview

62. The statement Patient 3 provided Investigator Brearley was consistent with what she had told the interviewer at the Courage Center. Additionally, she told the interviewer CMC-Dixon was crowded when she and her mother arrived for the appointment, so there was no place for them to sit together. Her mother also was uncomfortable with being in a room full of people because of the Coronavirus. Therefore, her mother decided to wait in the car.

63. At the beginning of the appointment, a female nurse took Patient 3's blood pressure and temperature and brought her into an examination room. Respondent arrived shortly after the nurse left. He did not provide or offer a chaperone.

64. Respondent began by asking Patient 3 questions about her general health and the reason for her visit. He inspected her throat with a tongue depressor and light. After, he listened to her lungs through her back. He held the stethoscope with his right hand and placed his left hand on her shoulder to steady her. He asked

her to breathe in an out while moving the stethoscope to different parts of her back. Respondent then listened to Patient 3's heart, again holding his stethoscope in his right hand and placing his left hand on her shoulder.

65. Respondent examined around her neck and throat. He then put his stethoscope away, placed his right hand on her upper chest just below her throat, and reached his right hand down her shirt and under her bra. Respondent cupped Patient 3's left breast with his fingers together and squeezed.

66. Patient 3 was "shocked" by respondent's actions. She stood up and said she had to go to the bathroom as an excuse to leave the room because she "felt unsafe." Respondent lightly placed his hand on her shoulder as she stood up, but she continued standing up and walked out of the room toward the nurses' station. At some point, she looked over her shoulder and saw respondent following her.

67. Once Patient 3 reached the nurses' station, she told the closest nurse respondent just "touched my boob" and began crying. Respondent had reached the nurses' station and began explaining Patient 3 was having an anxiety attack. The nurse immediately stood up and began trying to comfort Patient 3 as she escorted Patient 3 to another examination room to call her mother.

68. After describing what had happened at the nurses' station to the interviewer, Patient 3 expressed embarrassment over her use of the slang term "boob" when telling the nurse what respondent had grabbed. She corrected herself by explaining she should have said "chest."

Hearing Testimony

69. Patient 3 testified consistently with her prior statements. She did not have her driver's license, so her mother drove her. On the way, she asked her mother not to be in the examination room so she could discuss her symptoms openly with respondent. Her mother agreed and waited in the car.

70. Respondent never asked Patient 3 for permission to examine or touch her breast, and he did not tell her he was going to touch her breast before he did so. Neither the nurse nor respondent offered Patient 3 a chaperone or suggested her mother be present during the examination. She was wearing a V-neck T-shirt.

71. Patient 3 recalled completing CMC's complaint form at someone's request but could not remember whose. The wording "sexually touched" was her own, and she used it to describe the manner of respondent's touching – gripping and squeezing. Patient 3 said he should not have done that "so it was sexual."

72. Respondent's conduct during the examination caused Patient 3 not to trust physicians in general and male physicians in particular. She is also more hesitant to seek medical treatment. When she does, she always requests a female provider.

RUBI SIMPLICIANO

Interview with Investigator Brearley

73. Investigator Brearley interviewed Rubi Simpliciano. Ms. Simpliciano worked for CMC-Dixon for nine years. She was respondent's medical assistant from 2013 to 2016 and then was the medical assistant team leader for the next four years.

74. Ms. Simpliciano escorted Patient 3 to the examination room for her appointment. She estimated Patient 3 was in the room for "maybe" 10 minutes before coming to the front desk and saying, "He grabbed my boob." Respondent approached the front desk and began asking what Patient 3 had said. Patient 3 repeated, "He grabbed my boob."

Interview with Dixon Police Department

75. An officer from the Dixon Police Department interviewed Ms. Simpliciano the afternoon of the incident. She provided the officer the same information she gave Investigator Brearley, including Patient 3's statement that respondent "grabbed my boob." Ms. Simpliciano told the officer respondent immediately began trying to explain himself, stating, "No, no, no, she was saying her chest was hurting so I was trying to see where it was hurting, but I did not touch her."

76. Respondent tried to interrupt Ms. Simpliciano when she escorted Patient 3 to an examination room by saying Patient 3 needed to be seen by behavioral health and asking where her mother was. Ms. Simpliciano explained the mother was in the car, and they were in the process of contacting her. Respondent went to his office.

CATHERINE MONTEMAYOR

Interview with Investigator Brearley

77. Investigator Brearley interviewed Catherine Montemayor. On May 22, 2020, respondent asked Ms. Montemayor to take over his examination of Patient 3. Ms. Montemayor agreed to after she finished with a patient. Respondent did not explain the reason for his request, and Ms. Montemayor did not ask. It was not unusual for them to help each other out, so she did not think much of respondent's request.

78. Ms. Montemayor asked Patient 3 about her symptoms, completed a physical examination, and discussed her care plan. Ms. Simpliciano was in the examination room the entire visit, which lasted no more than 15 minutes. Patient 3 said nothing about respondent's initial examination, and Ms. Montemayor did not learn something had happened until the end of the day.

Hearing Testimony

79. Ms. Montemayor testified consistently with her statement to Investigator Brearley. She explained the Board of Registered Nursing issued her a registered nurse license on May 15, 2006, a public health nurse license two years later, and a nurse practitioner and nurse practitioner furnishing license seven years after that. The Physician Assistant Board issued her a physician assistant license on September 16, 2011.

80. Ms. Montemayor began working for CMC-Dixon as a physician assistant in 2012. She switched to working as a nurse practitioner once she received proper licensure three years later.

81. CMC-Dixon did not have a chaperone policy prior to 2020. However, a provider had discretion to request one, and Ms. Montemayor often did for male patients. In 2020, CMC adopted a policy requiring a chaperone during examinations of female patients' breasts or genitals.

82. CMC-Dixon's policy in December 2014 required employees to report any allegations of sexual or physical abuse made by a patient against a medical provider. If the patient was a child, the report was made to child protective services. If the patient was elderly, it was made to adult protective services. Staff assisted all other patients with reporting their allegations to local law enforcement. Ms. Montemayor expressed

confidence she would remember if a patient told her another provider had sexually or physically abused her. Ms. Montemayor said none has.

83. Patient 3's mother and Ms. Simpliciano were present for Ms. Montemayor's examination of Patient 3. Ms. Montemayor did not request a chaperone or the mother, but she did not object to either's presence. She had heard Patient 3 walked out of respondent's examination, returned with her mother, and was placed in a different examination room. Ms. Montemayor did not learn of Patient 3's allegations until the end of the day.

84. Ms. Montemayor worked with respondent at CMC-Dixon for approximately eight and a half years. They worked together providing patient care 40 hours per week over four or five days, but they maintained their own patient load. She got to know him "very well" over the years.

85. Ms. Motemayor liked respondent as a colleague and found him "very approachable." He was her supervising physician when she was a physician assistant. Ms. Montemayor opined respondent is open and honest. She believes he is safe to practice medicine and explained she trusted him with her patients at CMC.

BENJAMIN MORRISON, M.D.

Interview with Investigator Brearley

86. Investigator Brearley interviewed Benjamin Morrison, M.D. Dr. Morrison has worked for CMC since 2003. He has been the chief medical officer for approximately the last 10 years. He has oversight over CMC's 30 facilities, which include dental and mobile facilities. He works out of the administration building and one of the clinics, both of which are in Stockton, California.

87. Dr. Morrison met respondent in approximately 2012 when they both served on CMC's professional practice committee. They saw each other approximately every one or two months. He has never worked side-by-side with respondent in providing patient care.

88. Dr. Morrison confirmed respondent was no longer employed at CMC-Dixon. He explained he was terminated in February 2021. When asked for further details, Dr. Morrison explained respondent was immediately placed on leave while CMC-Dixon investigated Patient 3's allegations. The allegations were unsubstantiated, and respondent returned to work after about three or four weeks. Upon his return, his practice was limited to treating adult patients.

89. In November 2020, CMC management learned Patient 1 disclosed during a recent prenatal visit that respondent had touched her in a sexually inappropriate manner six years prior. CMC hired a third-party investigator to investigate Patient 1's complaint. It also reopened the investigation into Patient 3's complaint. Respondent was immediately placed on leave.

90. The investigation substantiated Patient 1's and Patient 3's allegations. CMC-Dixon ended its relationship with respondent. Dr. Morrison's recollection was that respondent resigned in February 2021.

91. Dr. Morrison believed CMC implemented chaperone policies prior to Patient 3's visit. One policy required a chaperone for all examinations of minor patients. Prior to the policy, a minor patient who was not accompanied by a parent was usually provided a chaperone. He was "hard-pressed" to recall an occasion when a provider treated a minor without a parent or chaperone. Another policy required a

chaperone anytime an adult patient's breasts, genitals, or rectum were examined, regardless of the patient's gender.

Hearing Testimony

92. Dr. Morrison explained he has been licensed to practice medicine in California since 2002. He is board-certified in family medicine. As CMC's chief medical officer, he is responsible for hiring medical providers and serving as the liaison between administration and providers.

93. Dr. Morrison's recollection had faded during the more than two years that had elapsed between Investigator Brearley's interview and hearing. At hearing, he could not recall the name of the patient whose complaint was the first he learned about (Patient 1). Nor could he recall the specifics of the complaint, other than the underlying conduct occurred "a while before" CMC learned of the complaint. The complaint "didn't really go anywhere" because it did not seem to have merit, and the patient was reluctant to provide additional information.

94. Dr. Morrison recalled learning about a complaint against respondent involving a minor patient (Patient 3). He believed it was the second complaint he was notified of. The complaint arose out of a visit that occurred "several years" after the conduct underlying the first complaint.

95. A third complaint (Patient 2's) was brought to Dr. Morrison's attention. CMC hired a third-party investigator to investigate the complaint, but Dr. Morrison was unaware of its outcome. He did not know if the investigation included re-examining the merits of the second complaint.

96. Dr. Morrison could not recall what CMC's chaperone policy was in 2015. The current policy has been revised multiple times over the years. He did not remember when the policy was first adopted. He did not explain the current policy or any of its prior reiterations. However, Dr. Morrison stated respondent was instructed to have a chaperone in the examination room whenever he performed a physical examination on a female patient when or shortly after CMC-Dixon learned of Patient 2's complaint.

97. Dr. Morrison said respondent resigned from CMC-Dixon because "there was writing on the wall." Prior to respondent's resignation, they "had a discussion" about the direction of his career at CMC, the pending investigation, possible outcomes, and his options. Respondent chose to resign.

98. Dr. Morrison's impression of respondent was that he was a thoughtful physician who was conscientious and thorough. He did a lot for patients from a medical standpoint. Dr. Morrison explained, "I thought he was a good physician." He never received any complaints about respondent acting inappropriately with other CMC employees, and he never saw respondent engage in such behavior. Dr. Morrison received "generally positive" feedback about respondent from his colleagues.

RESPONDENT

Interview with Investigator Brearley

99. Investigator Brearley interviewed respondent. He explained that throughout his tenure at CMC-Dixon, the "general rule" was a chaperone was required to be in the exam room when a female patient was undergoing a breast exam or Pap smear. He also honored any patient's request for a chaperone regardless of the type of examination. However, respondent did not offer a chaperone "because they are very

busy - - room their patient, taking the phone calls, so we usually - - I don't offer anything, you know, unless they ask for, or you know, the policy is to supply them a chaperone." A parent generally accompanied respondent's minor patients. If a parent was not present, he was notified and confirmed with the parent and the patient that it was okay to proceed.

100. Respondent recalled seeing Patient 3 three times. The first time she came with her mother, the second time was a telehealth visit, and the last time she came by herself in person.

101. When respondent entered the examination room for the third visit, Patient 3 was sitting on the examination table. He asked what he could do for her, and she explained she was experiencing discomfort and tightness on the left side of her chest. She also described having symptoms of anxiety. Respondent questioned the reason given for the appointment when it was made, which was a sore throat. Patient 3 explained her mother had made the appointment because she was complaining of a sore throat, but her throat had since gotten better.

102. Respondent started his examination by looking at Patient 3's throat, which appeared normal. He then listened to her heart and lungs. He heard nothing of concern. After, Patient 3 asked if her heart was beating fast, and respondent explained it was a little fast but not to the point of concern.

103. Respondent began palpating Patient 3's chest wall to determine if her discomfort and tightness were due to a pulled muscle. He used the four fingers on his right hand and began palpating horizontally from the sternal area toward the left armpit while asking "does this hurt" or something similar. He began near the shoulder level and worked his way down to breast level.

104. Patient 3 was wearing a low-cut shirt, and respondent palpated over the shirt except in those areas where the skin was exposed. He later stated he placed his hand through her shirt to examine her chest. He then reiterated his entire examination was "outside of the shirt," and he never palpated under any part of Patient 3's bra or bra straps.

105. While respondent was palpating Patient 3's chest wall, she suddenly "pull[ed] my arm out, you know, kind of freaking out." She said something he could not understand because she spoke too fast, exited the examination room, and walked to the nurses' station. Respondent followed behind.

106. Respondent arrived at the nurses' station shortly after Patient 3, told Ms. Simpliciano he thought Patient 3 was experiencing an anxiety or panic attack, and asked if a mental health therapist was available. He overheard Patient 3 on the telephone with her mother saying he had touched her breast. Therefore, respondent found Ms. Montemayor, told her Patient 3 was "acting out," said she accused him of touching her breast, and asked Ms. Montemayor to finish his examination. Respondent returned to his office to prepare for his next patient.

107. Respondent denied groping, squeezing, or lifting Patient 3's left breast. She remained seated on the table throughout the examination, and he stood facing her and slightly toward her right shoulder. However, he also said he asked her to lay supine on the table so she could palpate her stomach.

108. At the end of the day, one of the nurses told respondent Patient 3's mother called the Dixon Police Department. He sent an email about the incident to Dr. Morrison that evening. He described Patient 3 as an 18-year-old female who had an appointment for a sore throat. Respondent explained her subjective complaints

during examination, however, were "chest tight and trouble breathing with mild chest pain for 2 days, mild cough, no fever." He described examining Patient 3's throat and chest wall, writing, "When I press on her right side of chest, she did c/o [complain of] pain with touch, when I gradually examine her chest from top and move down, she suddenly freak out. Then I told another provider to continue take care of her if she needs anything. This is all I can tell." (Grammar original.)

109. Respondent admitted he told the police detective investigating Patient 3's allegations that he had never before been accused of inappropriately touching a patient's breasts even though he was aware of Patient 2's complaint. He explained during his interview with Investigator Brearley:

> Because this was -- they cleared for me, you know. My CMC -- they do the investigations.
>
> [¶] . . .]¶]
>
> They cleared for me. They never do any, for example, as I just said the (inaudible) or anything. Okay. Then it was just the first accusation. So at that time, I don't think I need to say, oh, I have things happening to me.

(Grammar original.)

110. Respondent also explained to Investigator Brearley:

> [Respondent]: Okay. I - - (inaudible) my understanding. Okay. Because I'm not the lawyer or anything like that. Okay. I thought an accusation it's not like - - just like - - uh - - police station, you know. It's more serious things. Okay.

INVESTIGATOR BREARLEY: So you're saying - - have you ever been accused of this in like a more formal setting.

[Respondent]: Yes.

INVESTIGATOR BREARLEY: Is that what you're trying to say?

[Respondent]: Yes.

INVESTIGATOR BREARLEY: I see. Okay. So - -

[Respondent]: So I thought it would be go to the police station for like I said - - file for things.

INVESTIGATOR BREARLEY: You're saying, like, if you had ever had charges, like - -

[Respondent]: No, file, you know - -

INVESTIGATOR BREARLEY: - - filed against you.

[Respondent]: - -like instead of - - instead of a case.

INVESTIGATOR BREARLEY: I see. Okay. All right.

[Respondent]: That is my understanding.

(Grammar and spelling original.)

111. Respondent told Investigator Brearley he recalled Patient 2. He also said, "Basically[,] I'll pick from memory from the record." When asked Patient 2's demeanor during her examination, respondent said, "I don't really remember for so long, if you know." When asked if he recalled any change in her demeanor or behavior during her

examination, he answered, "No. Nothing unusual." Respondent saw Patient 2 only once – on June 29, 2015, for an immigration physical. Respondent and Patient 2 were alone in the room during the physical.

112. Respondent explained an immigration physical is "just a routine health checkup." He did not perform a breast examination because "this is not required by the immigration physical." He did not touch either of Patient 2's breasts, although he used a stethoscope to listen to her heart and lungs. Respondent did not palpate her chest wall "because she [had] no chest pain." However, he palpated her abdomen to look for any masses. He also checked her ears and throat and tested her strength.

113. Respondent first learned about Patient 2's allegations when CMC-Dixon's clinic manager told him the afternoon of the incident that Patient 2's husband filed a complaint. The husband alleged respondent sexually touched Patient 2's breasts during her examination. Respondent denied the allegation. He believed the clinic manager told Dr. Morrison about the complaint because Dr. Morrison called him the next day or the day after that and told him to finish Patient 2's immigration paperwork so she could pick it up. They did not discuss Patient 2's examination.

114. Investigator Brearley showed respondent a copy of Dr. Morrison's June 29, 2015 email summarizing his conversation with respondent about the incident and asked if it accurately summarized their conversation. Respondent answered, "I don't remember. I said I don't remember I talk to Dr. Morrison about it because I thought I only talk to the manager about it." (Grammar original.) But when the email was read to him, respondent confirmed, "that was exactly what I said."

115. Respondent was not required to change his practice as a result of Patient 2's allegation. Nor was he told he had to have a chaperone present when examining female patients.

116. Respondent confirmed with Investigator Brearley that he reviewed Patient 1's medical records prior to his interview. When asked if he remembered Patient 1, he answered, "A little bit. Yes." He also said, "I have something in mind." He recalled seeing her about four times, mainly for back pain and anxiety.

117. Respondent told Investigator Brearley his answers to questions about Patient 1's November 12, 2014 examination were "based on the medical record." He thought she made an appointment for anxiety and back pain. Additionally, she wanted to refill her anxiety medication.

118. Respondent performed a complete physical examination of Patient 1. That included examining her musculoskeletal system based on her complaint of back pain. He also examined her cardiovascular system based on her complaint of anxiety.

119. Respondent had no recollection of performing an abdominal examination. Investigator Brearley showed him the records of his examination, and he confirmed he did not document the need for an abdominal examination or having performed one. Therefore, he concluded one was not performed.

120. Respondent first learned of Patient 1's allegations of misconduct from Dr. Morrison in November 2020. Dr. Morrison told him child protective services reported the allegations to CMC. He explained a patient had accused respondent of touching her breast during an examination, but Dr. Morrison did not identify the patient.

121. Respondent asked Dr. Morrison the patient's name, but Dr. Morrison explained he did not expect respondent to remember anything about the patient and did not identify her. Dr. Morrison also explained he reviewed respondent's treatment notes, respondent did not document performing a breast examination, and that was it as far as Dr. Morrison was concerned. Neither respondent nor Dr. Morrison discussed Patient 1's November 12, 2014 examination.

122. Respondent confirmed from the medical records that November 12, 2014, was the last time he treated Patient 1. He spontaneously explained to Investigator Brearley, "Because Dr. Morrison is a CMC. That is the policy. If any patients complain about you, we don't touch the charts from that point." (Diction original.) Respondent estimated he did not learn Patient 1's identity until December 2000 or January 2021 when he was interviewed as part of CMC's investigation into her complaint.

123. Respondent told Investigator Brearley he was interviewed twice by a third-party investigator CMC hired. The first interview was in July 2020, and it concerned Patient 2's and Patient 3's complaints. The second interview was about Patient 1's complaint and occurred in December 2020 or January 2021. Respondent estimated he first learned Patient 1's identity during the second interview.

124. The investigator had questioned respondent about Patient 1's allegations that he put his hands in her bra and touched her nipples and then examined her stomach and touched her breast, and respondent had asked to review the patient's medical records. After reviewing the records, he explained he did not perform a breast examination and one was not medically necessary. He then said about the allegations, "I don't think I did it."

125. Respondent was also asked about the allegation he touched Patient 1's breasts and nipples, which he denied because "it's not medically necessary." When asked about the allegation he put his hand underneath Patient 1's wired bra and cupped her right breast so much that he almost lifted it out of her bra, he responded, "I don't -- I don't think so. I didn't do it."

126. In response to the allegation respondent cupped Patient 1's right breast a second time while she was laying on the examination table, he said, "As I said, I do not do any abdominal exam on that day, so I don't think how can I do it?" (Grammar original.) And regarding the allegation he asked if she became anxious when he touched her breast, he answered, "I don't think so. This is weird. Why I ask that? Did not make any s- - - make any sense at all." (Grammar original.)

127. Respondent was placed on administrative leave after Patient 1's complaint came to light. He was relegated to performing telehealth visits only. During his leave, he decided to resign from CMC-Dixon because the allegations had ruined his reputation. Respondent also felt CMC-Dixon did not provide sufficient protection against false accusations and figured it was not a good idea to continue working there. Finally, he thought CMC-Dixon did not want to continue his employment after the three complaints. However, respondent wanted to wait until after the third-party investigator completed her investigation, "otherwise make me even worse, you know." (Grammar original.) He said he voluntarily resigned in February 2021.

Interview with Dixon Police Department

128. A detective from the Dixon Police Department interviewed respondent regarding Patient 3's complaint. Patient 3's mother called CMC-Dixon for a same-day visit, and the person who made the appointment said the mother could not attend the

examination because of CMC-Dixon's COVID-19 protocols. Patient 3's mother was given the option of her daughter seeing respondent or a physician assistant, and she chose the former.

129. Respondent quickly reviewed Patient 3's medical chart prior to going into the examination room. He noticed her blood pressure and temperature seemed normal. He determined she was not exhibiting signs or symptoms of COVID-19.

130. Respondent wanted to examine Patient 3's chest because she complained of tightness, so he placed his right hand through her shirt to check for anything unusual such as a pulled muscle. After putting his hand under her sweater, she quickly stood up and left the room. Patient 3's reaction surprised him, and he suspected she was having an anxiety or panic attack. At no time did he touch her breast.

131. Respondent told the detective he had never been accused of similar misconduct in his 12 years of practicing medicine. He denied doing anything inappropriate and explained everything he did was part of a normal examination. Respondent thought Patient 3 was 18 years old until the detective informed him otherwise. He explained he would have asked for a chaperone had he known she was a minor.

Hearing Testimony

132. Respondent testified at hearing. He explained after Patient 1 arrived for her appointment, a medical assistant escorted her to an examination room, took her vital signs, and asked the reason for the visit. According to medical records, Patient 1 complained of anxiety and back pain.

133. Respondent entered the room shortly after the medical assistant left. Patient 1 reported still feeling anxious. She explained her initial symptoms had improved, but functioning remained somewhat difficult. She complained of anxious/fearful thoughts and being easily startled, but denied diminished interest or pleasure, excessive worrying, and feelings of guilt or restlessness. Patient 1's rating on the Global Assessment of Functioning Scale was 75, which translated into symptoms, if any, being transient and anticipated reactions to psychosocial stressors; no more than slight impairment in social, occupational, or school functioning.

134. Patient 1 also said she still had intermittent upper back pain that fluctuated in intensity and caused decreased mobility and muscle spasms. She rated her pain a 7 on a scale of 1 to 10 at its worst. Pain was aggravated by bending. It was relieved by pain medications, physical therapy, and rest.

135. Respondent began his physical examination by examining Patient 1's back. He noted a smooth, 4 x 6 centimeter bump on her upper back. She complained of neck pain when looking down. Respondent listened to Patient 1's breath sounds by asking her to breathe in and out as he placed his stethoscope on her right upper back, left upper back, right lower back, and left lower back. He did the same on her chest. Her breath sounds were normal.

136. Respondent listened to Patient 1's heart by placing his stethoscope over the aortic, pulmonic, Erb's point, tricuspid, and mitral areas of her chest. He explained listening to the mitral area on some female patients can be difficult because the area is just below the left breast and can be partially or completely covered by breast tissue. That makes it difficult to hold the stethoscope flat against the chest. Two techniques respondent uses when encountering this are: (1) using the back of his left hand to push the breast up while holding the stethoscope in his right; or (2) using the back of

his right hand to "scoop" under the breast while holding the stethoscope. Sometimes, it is necessary to have the patient lay supine for the examination.

137. Respondent could not recall which, if either, of the two techniques he used during Patient 1's examination. Nor could he remember if she was sitting up or laying down. However, respondent denied purposefully touching the bare skin of Patient 1's breast, cupping it, or placing his hand on it. He was adamant he did not examine her abdomen, insisting he would have "charted it" if he did. Respondent left the room after completing Patient 1's examination. She never complained to him about anything he did during the examination or otherwise expressed unhappiness with his examination.

138. Patient 2 had an appointment with respondent for an immigration physical on June 29, 2015. She had no complaints of medical significance, and respondent's physical examination revealed she was a healthy 21-year-old female. Patient 2 remained fully clothed throughout the examination, and no chaperone was present.

139. After completing the examination, respondent left the room and sent a medical assistant in to withdraw Patient 2's blood. Patient 2 left after providing blood samples. She did not complain to anybody about respondent's conduct during the examination or on her way out.

140. Respondent did not perform a breast examination on Patient 2 because it was not part of an immigration physical. He denied touching either of her breasts, explaining it was not medically necessary for him to do so.

141. Respondent could not recall if Patient 3's left breast hindered access to the mitral area when he listened to her lungs. He could not finish her examination

because Patient 3 removed his hand from her chest, stood up, and walked out of the room without warning or explanation. He was "shocked" because her reaction was unexpected. He was also confused about what was happening. He followed her to the nurses' station to ensure her safety.

142. Once respondent determined Patient 3 was safe, he returned to his office to prepare for his next patient. Later that evening, he sent Dr. Morrison an email describing the incident with Patient 3. Respondent corrected his email at hearing by explaining he pressed on the left side of Patient 3's chest, not the right. Additionally, he had assumed on the day of the appointment she was 18 years old because she came by herself, her mother attended the prior appointment, and she was a "bigger girl." He said he did not review her date of birth on her medical chart prior to entering the examination room.

143. CMC-Dixon did not have a chaperone policy for adult patients at the time of Patient 3's appointment. Additionally, no one ever told respondent he was required to have a chaperone when examining female patients. His practice, however, was to request a chaperone whenever examining a female patient's breasts, genitalia, or rectum. CMC-Dixon also did not have a formal chaperone policy for minor patients. However, respondent always requested a parent be present during examinations. If no parent was available or the patient requested the parent not be present, he asked a medical assistant to serve as a chaperone.

144. Respondent admitted he told the detective he had never been accused of inappropriately touching a patient's breast. He explained he did not consider Patient 2's complaint a "prior complaint" because there was no formal investigation. On cross-examination, he explained he did not disclose Patient 2's complaint because a "complaint" is "more mild," whereas an "accusation" is more serious. In other words,

the difference between a complaint and an accusation is the severity of the underlying conduct.

145. Respondent speculated Patient 1's, Patient 2's, and Patient 3's complaints were the result of them misunderstanding what he was doing during their examinations. To minimize the risk of future misunderstandings, he completed a two-day continuing education course entitled "PBI Medical Ethics and Professionalism" offered by the University of California, Irvine School of Medicine, in April 2024. Three weeks later, respondent completed a two-day continuing education course entitled "PBI Medical Professional Boundaries: Essential Addition" offered by the same entity. Additionally, he constantly reminds himself to speak more slowly and explain himself more clearly.

146. Respondent could not recall if Dignity Health Woodland Clinic asked during his job interview why he left CMC-Dixon. Assuming he was not asked, he believed he was not required to voluntarily disclose Patient 3's complaint because he was never informed of the outcome of CMC's investigation. Additionally, respondent did not know CMC reported the complaint to the Board. Therefore, he did not think Patient 3's complaint was serious, and he said he had no incentive to disclose it to Dignity Health Woodland Clinic.

147. Respondent generally denied all allegations he touched a patient's breasts for nonmedical reasons. He insisted: (1) he did not perform a clinical breast examination on any of the patients; (2) none of them had any subjective or objective signs or symptoms indicating one was needed; and (3) he did not document performing one on any of them. He also insisted each patient's examination was performed only for medical reasons and not for his sexual gratification.

148. Respondent was adamant he received each patient's consent prior to performing his examination. However, he admitted he had no independent recollection of specifically asking any patient for consent; he believes he did because it was his regular custom and practice to do so. Respondent had no independent recollection of needing to move a patient's breast to access her mitral area while listening to her lungs. He agreed there is no medical reason for him to put his hand down the front of a patient's shirt or under her bra.

Additional Evidence

FLAVIA TEARNEY-BERTHON

149. Flavia Tearney-Berthon was interviewed by an officer from the Dixon Police Department investigating Patient 3's complaint and testified at hearing. She worked at CMC-Dixon as a registered nurse from 2017 to August 2020. She returned in March 2024, works mostly from home, but goes into CMC-Dixon to help when needed. Ms. Tearney-Berthon is familiar with respondent because he was a physician at CMC-Dixon the first three years she worked there.

150. Ms. Tearney-Berthon was working in her office on May 22, 2020, when Ms. Simpliciano came and asked for help. In addition to treating patients at the time, Ms. Tearney-Berthon was serving as the RN case manager because the clinic manager position was vacant. Ms. Simpliciano told Ms. Tearney-Berthon a patient was in the clinic crying and upset over something that happened with respondent. Ms. Tearney-Berthon followed her back to the clinic to find out what was wrong.

151. Ms. Tearney-Berthon met Patient 3 and her mother at the nurses' station. She escorted them back to her office and interviewed them about the incident

involving respondent. After, she brought them back to the clinic so Ms. Montemayor could finish the physical examination respondent had started.

152. Ms. Tearney-Berthon contacted CMC-Dixon Behavioral Health and scheduled an appointment for Patient 3 to see a therapist. She also contacted the Dixon Police Department and coordinated the responding officer's interviews of her, Ms. Simpliciano, and Patient 3's mother. Ms. Tearney-Berthon completed an electronic incident report in CMC-Dixon's document management system and documented the date, time, location, parties involved, Patient 3's and her mother's statements, the police report number, and a drawing of Patient 3's body part involved.

ERICA RAMIREZ'S TESTIMONY

153. Erica Ramirez has been licensed by the California Physician Assistant Board as a physician assistant since 2009. She worked part-time at CMC-Dixon for four years. She could not recall her specific dates of employment, but the medical records established she treated Patient 1 on December 1, 2014.

154. Ms. Ramirez did not remember Patient 1 or her December 1, 2014 appointment. Nor did she remember any patient telling her while she worked at CMC-Dixon that a medical provider had inappropriately touched them during an examination. Had a patient said that, Ms. Ramirez expressed confidence she would remember because she is required to report all complaints of sexual and physical abuse.

Expert Witnesses

MARY NIKOULA KASEM, M.D.

Background

155. Mary Nikoula Kasem, M.D., received her Bachelor of Arts in cellular and molecular biology from California State University, Northridge, in September 1994. Four years later, she received her Doctor of Medicine from Keck School of Medicine of the University of Southern California (USC). Dr. Kasem completed a family medicine residency at Kaiser Permanente Riverside Medical Center in 2001.

156. The Board issued Dr. Kasem a certificate to practice medicine in California on June 29, 2000. The American Board of Family Medicine made her a Diplomate the following year. She has remained a Diplomate continuously ever since.

157. Dr. Kasem currently works as the medical director at Claremont Manor Care Center, a family medicine physician for Chaparral Medical Group, and a hospitalist for PROMED Pomona Valley Medical Group. She spends approximately 90 percent of her time working as a clinician, and the remaining 10 percent is divided equally as the medical director and a hospitalist.

158. Dr. Kasem is a member of the adjunct clinical faculty for Touro College of Osteopathic Medicine, volunteer faculty at Keck School of Medicine of USC, and affiliate faculty of Indiana State University's Physician Assistant Program. She also serves as a preceptor for the Family Nurse Practitioner Program at Samuel Merritt University.

159. Dr. Kasem has served as the Board's expert witness on numerous occasions. However, she has never testified at an administrative hearing. She has never

been retained as an expert witness by a physician facing an accusation or statement of issues.

Assignment

160. The Board asked Dr. Kasem to review respondent's treatment of Patient 1, Patient 2, and Patient 3 and opine whether he deviated from the applicable standards of care. She prepared a written report summarizing: (1) her understanding of respondent's treatment for each patient; (2) each patient's allegations; (3) the applicable standards of care; (4) her opinion as to whether respondent's treatment deviated from the standard of care and, if so, whether he committed a simple departure or an extreme departure; and (5) her analysis. Dr. Kasem itemized in her report the documents she reviewed and relied upon in reaching her conclusions. The documents included the Board's Expert Reviewer Guidelines (rev. Jan. 2013) (2013 Guidelines) and the Dixon Police Department's investigation report.

161. The Board uploaded the documents Dr. Kasem reviewed to Box, an encrypted electronic document management application accessible only by password, and provided her access. The Board revoked her access "a few weeks" after she submitted her report to the Board on June 8, 2023. Dr. Kasem was given access to complainant's proposed exhibits in Case Center prior to hearing.

162. Complainant attached Dr. Kasem's report to its expert witness disclosure required by Business and Professions Code section 2334, subdivision (b). Complainant provided no other written disclosure of Dr. Kasem's opinions in this matter.

The 2013 Guidelines

163. The 2013 Guidelines define "standard of care" as "that level of skill, knowledge and care in diagnosis and treatment ordinarily possessed and exercised by other reasonably careful and prudent physicians in the same or similar circumstances at the time in question." "Negligence" is:

> [T]he failure to use that level of skill, knowledge and care in diagnosis and treatment that other reasonably careful physicians would use in the same or similar circumstances. A negligent act is often referred to as a **"simple departure"** from the standard of care.

(Bolding original.)

164. "Gross negligence" is:

> "[T]the want of even scant care" "or an **extreme departure** from the standard of care." Gross negligence can be established under either definition, both are not required. The difference between gross negligence and ordinary negligence is the degree of departure from the standard of care.

(Bolding and underlining original.)

165. When analyzing allegations of sexual misconduct, the expert witness is "to assume the allegations are true." Furthermore:

> If the issue involves a patient's account of what they feel to be an inappropriate exam, please make sure to describe in detail in your standard of care section, what the appropriate physical exam should have entailed. Then comment on what the patient described and whether or not the exam itself met the standard of care.

Dr. Kasem's Report

166. Dr. Kasem described the standard of care for examining an adult female patient's breasts as follows:

> The standard of care is to perform a breast exam in the presence of a female chaperone. It also includes advising the patient that her breasts are going to be examined and to obtain her permission for a breast examination. The standard of care does not include rubbing the breasts or touching them for no medical reason. A medical chaperone should be provided for all sensitive exams or if requested. The standard of care is to avoid exposure of the breasts while a chaperone is not present in the room. If any part of the examination may be physically or psychologically uncomfortable, every effort should be made to alleviate discomfort.

167. Dr. Kasem also explained the standard of care for examining, inspecting, or palpating a minor patient's genitals, rectum, or breasts (female patients only) requires the presence of a chaperone. Additionally, the physician should include the

parent and the patient in the shared decision-making process when deciding treatment "if the patient is old enough."

168. Dr. Kasem concluded respondent committed multiple extreme departures from the standard of care when examining Patient 1, Patient 2, and Patient 3 because he: (1) had no medical reason for touching their breasts; (2) did not explain to them he was going to touch their breasts or obtain their consent prior to doing so; and (3) did not offer or provide them a chaperone. Additionally, he did not ask Patient 3's mother to attend her daughter's examination.

169. Dr. Kasem further concluded respondent's failure to disclose Patient 2's allegations during his police interview constituted a simple departure from the standard of care. However, she did not describe what the applicable standard of care was.

Dr. Kasem's Testimony

170. Dr. Kasem testified at hearing. She reviewed all the documents itemized in her report. However, she also reviewed the Accusation, which was not itemized. Dr. Kasem followed the 2013 Guidelines's instruction that she assume the truth of Patient 1's, Patient 2's, and Patient 3's allegations.

171. Dr. Kasem said she watched video footage of Patient 3's multidisciplinary interview and relied on it in drawing her conclusions. She recalled watching the footage "recently." She also said she reviewed video footage of Ms. Tearney-Berthon's and Ms. Simpliciano's police interviews. All videos were provided by the Board. Dr. Kasem did not identify any video footage in her report as evidence she reviewed.

172. Dr. Kasem's recollection of the 2013 Guidelines at hearing was that "standard of care" is defined as that which a reasonable, prudent physician would do under the same or similar circumstances. A departure from the standard of care occurs when the physician's skills or knowledge do not meet the applicable standard of care. She described an "extreme departure" as "definitely more serious" than a simple one, and explained the difference is "only one of degree."

173. Dr. Kasem relied on the standard of care for performing a breast examination in this matter because each patient described respondent inappropriately examining her breasts. She wanted to describe the standard for examining female breasts in a medical setting. She reiterated that the standard requires the physician to: (1) explain what he intends to do; (2) discuss the reasons for his examination; (3) obtain consent; (4) provide a chaperone; (5) explain what he is doing during examination; and (6) discuss his clinical findings.

174. Examining a female patient's breasts is within the standard of care only when the concomitant touching is medically necessary. It is never medically necessary to squeeze or cup a patient's breasts. Dr. Kasem saw nothing in the medical records indicating it was medically necessary for respondent to touch Patient 1's or Patient 2's breasts. And though she found it appropriate for him to touch Patient 3's left breast while palpating her chest wall based on her subjective complaints, there was no medical need to touch her breast in the manner respondent did.

175. Dr. Kasem distinguished between touching a patient's breast during a general examination and performing a clinical breast examination. When a physician touches part of a patient's body during examination, that is an examination of that part. For instance, palpating the breast area of the chest wall is a breast examination in the generic sense, but it is not a clinical breast examination.

176. There are specific criteria for performing a clinical breast examination that do not apply when examining the breast during a general examination. The patient is examined while sitting and laying supine. While sitting, the physician looks at the breasts for size, symmetry, appearance, and lesions. He palpates the lymph nodes near both armpits. In the supine position, the physician palpates the full breast tissue for unusual masses, nodules, and tenderness. This includes the area around both armpits.

177. Dr. Kasem explained the importance of a physician telling his patient he will examine her breasts and obtaining consent prior to the examination. Such communication is critical to the patient understanding what is going to happen and why. It also tells the patient what the physician is looking for or trying to accomplish. Obtaining consent serves as confirmation the patient understands what the physician explained and is agreeable to his plan of action. Providing a chaperone is an important way of acknowledging and respecting the patient's modesty during examinations that are inherently intrusive and personal.

178. Dr. Kasem reiterated her conclusion that respondent committed a simple departure from the applicable standard of care by telling the detective he had never before been accused of engaging in misconduct with a patient when he was aware of Patient 2's allegations. At hearing, Dr. Kasem explained for the first time the applicable standard of care required him to truthfully answer all questions about prior complaints of misconduct.

ROBERT MICHAEL NORMAN, M.D.

Background

179. Robert Michael Norman, M.D., earned his Bachelor of Medical Science from Northwestern University in 1978. Two years later, he earned his Doctor of Medicine from Northwestern University School of Medicine. He completed a one-year internship in internal medicine at Mount Zion Hospital in 1981 and a two-year residency in family medicine at San Jose Medical Center two years later.

180. The Board issued Dr. Norman a license to practice medicine in California on September 15, 1981. The American Board of Family Medicine made him a Diplomate two years later, and he has remained a Diplomate continuously ever since. The Hawaii Medical Board issued Dr. Norman a license to practice medicine in Hawaii on September 24, 2018.

181. Dr. Norman currently serves as a teaching physician with O'Connor Hospital's Family Medicine Residency Program and a practicing clinician in family medicine with Stanford Health Care. He also serves as a clinical professor in the Department of Medicine, Stanford University School of Medicine.

Assignment

182. Dr. Norman previously worked with respondent's counsel as an expert witness. Counsel contacted Dr. Norman to review respondent's treatment of Patient 1, Patient 2, and Patient 3 and opine whether the treatment met the applicable standards of care. In evaluating respondent's treatment, counsel instructed Dr. Norman to follow the Board's Expert Reviewer Guidelines (rev. Nov. 2023) (2023 Guidelines). In particular,

he was instructed to "assume the [patients'] allegations are true." Dr. Norman summarized his review and evaluation of respondent's treatment in a report.

Dr. Norman's Report

183. Dr. Norman described "standard of care" as care provided based on the degree of learning and skill ordinarily possessed by a primary care physician in California practicing in a similar locality and under similar circumstances as those presented in a given case. In other words, it is the care, skill, and treatment deemed acceptable and appropriate by other reasonably prudent primary care physicians in the same or similar circumstances. The failure to exercise the requisite skill and care constitutes a departure from the standard of care and medical negligence. Gross negligence is a significant or extreme departure from the standard of care or utter lack of care or total disregard for a patient's safety or care.

184. "The standard of care for an examination of a patient includes an appropriate indication for the system examined and an appropriate technique for the exam performed." Based on his review of all the records provided, Dr. Norman concluded respondent was "conducting a chest wall examination, which includes a cardiovascular and respiratory exam," on each patient when his alleged misconduct occurred. He explained:

> [Sexual misconduct cases] are difficult to analyze as an expert for several reasons. From a personal and ethical perspective, I do not want to defend a physician's actions if he was engaging in intentional sexual misconduct. However, I do not agree with the Medical Board's expert guidelines that require an expert accept everything a patient say[s] as

> true as patient statements often conflict with the medical records or logical medical care as we can see in a standard case involving allegations below the standard of care. Thus, I try to analyze these cases from the same perspective and try to not be distracted by the allegations themselves.
>
> The question I ask myself in these cases is whether the provider was engaging in a necessary or reasonable part of treatment and whether his care could have been misinterpreted by the patient(s), or whether the physician was engaging in an act(s) that were pretext for sexual misconduct rather than engaging in a legitimate exam. Based on the information offered to me, the complaints made by these patients appears [*sic*] to me to be a case of misinterpretation.

185. The standard of care for a cardiac examination involves three steps: (1) observing the chest wall; (2) palpating the chest wall and cardiac area; and (3) listening to the heart. The physician listens to the patient's heart by holding a stethoscope in his dominant hand and placing it flat against the front of the patient's body, a process called "auscultation." The five areas of auscultation for a cardiac examination are: (1) aortic; (2) pulmonic; (3) Erb's point; (4) tricuspid; and (5) mitral, which correspond to the names of the heart's four valves and the approximate center of the heart (Erb's point). All areas are to the left of the sternum, except the aortic which is to the right.

186. Palpation refers to the process of assessing the arterial pulse, checking for any thrills (vibratory sensations) in the chest, and evaluating the characteristics of the heart's beat, including the location, strength, and duration of the apical impulse.

The physician places the palm of his dominant hand across the patient's left chest so it covers the heart. His heel rests along the sternal border with his extended fingers below the left nipple. He moves his hand across the areas to be palpated.

187. Dr. Norman explained, "The cardinal rule is to respect patient autonomy." Therefore, prior to examination the physician is required to: (1) tell his patient he is going to listen to her heart; and (2) ask for permission to do so. The physician is not required to describe the examination in detail. He need only provide sufficient information for the patient to provide informed consent. There is no fixed answer as to the amount of information that must be provided, and sound clinical judgment is essential. Also, consent may be implied, especially for evaluation and care related to the patient's subjective complaints. Consent may also be implied by submitting to and cooperating with the interview and examination.

188. Dr. Norman relied exclusively on documents respondent's counsel provided for the factual bases of his evaluation. He specifically relied upon each patients' medical records. He said the following about those records:

> As an expert reviewer, we cannot effectively analyze cases unless we are provided a complete set of records for patients. The custodian of records for CMC did not provide a complete set of medical records to the Medical Board for patient 1 [or Patient 2 or Patient 3] despite certifying the records as "complete" "under penalty of perjury."

189. Dr. Norman concluded respondent's treatment for Patient 1 did not include any departures from the applicable standards of care. Patient 1's subjective complaints of anxious thoughts and a fast heartbeat justified respondent performing a

cardiac examination. His examination met the standard of care as established by the notation in the medical records that the examination revealed nothing of medical significance. Additionally, Dr. Norman provided sufficient notice to Patient 1 he was going to perform a cardiac examination, and she consented to such treatment. She complained of increased anxiety and an elevated heart rate, so it would have been reasonable for her to expect respondent to perform a cardiac examination. Her voluntary submission to treatment constituted implied consent.

190. The standard of care in 2014 did not require a chaperone for a cardiac examination. Additionally, Patient 1 was an adult and could have, but did not, request a chaperone. Therefore, respondent did not deviate from the standard of care by not providing or offering one.

191. Dr. Norman rationalized Patient 1's allegations with his conclusions there were no extreme departures from the standard of care as follows:

> The patient's complaint is consistent with performing a standard heart exam. When palpating the apex of the heart, it can be difficult to feel the cardiac impulse, especially in an obese patient like patient 1. Therefore, it would make sense, as she described, if [respondent] was unable to feel the cardiac impulse that he would ask her to lay down on the table to complete his cardiac exam. The patient then described him palpating her abdomen. As the picture I show above demonstrates, the hand is below the patient's breast when properly palpating the apex of the heart. In a 5'0 tall patient, like patient 1, [respondent's] hand is on the lower chest wall/upper abdomen. It would be difficult for

[the] patient to know if [respondent] was performing a cardiac exam or upper abdominal exam at the time.

The patient states in her interview with the Board that [respondent] had used his right hand while standing on her right side to cup and lift her right breast. She described this both while she was sitting and then laying supine. She also stated that he was asking about her heart and performing a heart exam at the time. There is a critical disparity here as the heart is located on the left anterior chest under the left breast. I am aware the patient's report was a "summary" prepared by the investigator and the interview occurred over Zoom. Was this an error in the report or was this accurate? This needs to be clarified.

192. Dr. Norman also concluded respondent's treatment of Patient 2 included no departures from the applicable standards of care because she presented for an immigration physical, which includes a cardiac examination. The records indicated he performed a proper examination based on his notation that examination revealed nothing of medical significance. In 2015, the standard of care for a cardiac examination did not require the physician to provide a chaperone. Additionally, Patient 2 was an adult, and she did not request one.

193. Patient 2 had sufficient notice respondent was going to perform a cardiac examination and implicitly consented to him doing so. She voluntarily made an appointment for an immigration physical. She presented with no subjective complaints. Patient 2 should have reasonably expected the physical to include a

cardiac examination. Although she described respondent as saying nothing during his examination, he was not required to describe his examination in detail.

194. Dr. Norman explained his conclusions were consistent with Patient 2's complaint as follows:

> The patient's complaint is consistent with performing a standard heart exam including palpation. The patient's husband and the patient stated that [respondent] had performed the maneuver on both breasts. If that is found to be true, then I cannot provide a reasonable explanation for what the patient is describing.

195. Dr. Norman noted a discrepancy over the type of examination respondent performed on Patient 3. Patient 3 wrote in her written complaint, "He was checking my heart with his hand and slid his hand all the way down my shirt and sexually touched one of my breast[.]" During his Board interview, respondent described performing a chest wall examination. Dr. Norman determined respondent performed a chest wall examination. He further determined there were no deviations from the applicable standard of care during examination.

196. Dr. Norman described the standard of care for a chest wall examination as being the same as that for a cardiac examination. Patient 3 presented with subjective complaints of chest tightness and shortness of breath, which justified a cardiac examination. The records indicated respondent performed a proper examination because he noted examination revealed nothing of medical significance. In 2020, the standard of care did not require a chaperone for examinations of minor

patients that did not involve the genitals, anus, or female breasts. Additionally, Patient 3 and her mother could have requested a chaperone, but neither did.

197. Patient 3 voluntarily made an appointment with respondent and complained of chest tightness and shortness of breath. She should have reasonably expected the examination to include a chest wall examination. Also, Patient 3 described respondent asking if she felt any pain as he palpated her chest wall. Therefore, she implicitly consented to such examination by actively participating in it. Although Patient 2 was a minor, her mother had provided her consent to respondent's treatment when she dropped off Patient 2.

198. Dr. Norman criticized Dr. Kasem's opinion that respondent committed extreme departures from the standard of care when treating Patient 1, Patient 2, and Patient 3 as follows:

> Dr. Kasem's standard of care and analysis applies [*sic*] to a clinical breast exam. That exam was not performed in this case, so her described standard of care for a breast exam does not apply. The patient does not describe [respondent] performing a breast exam. [Respondent] does not describe performing a breast exam, there was no clinical need to do a breast exam as the patient's symptoms were non-breast related, nor was there documentation of a breast exam, so any mention of a breast exam would be irrelevant to this patient's complaint.

199. Dr. Normal also noted the following about Patient 2:

> [Patient 2] stated [to Investigator Brearley], "No part of him touching her mimicked a breast exam, like checking for lumps." [Citation.] Thus, a clinical breast exam was not performed in this case, so her described standard of care for a breast exam does not apply. The patient does not describe [respondent] performing a breast exam. [Respondent] does not describe performing a breast exam, there was no clinical need to do a breast exam as the patient's symptoms were non-breast related, nor was there documentation of a breast exam, so any mention of a breast exam would be irrelevant to this patient's complaint.

200. Dr. Norman said the following about the allegation respondent was negligent in not disclosing Patient 2's allegations when the detective asked about prior allegations similar to Patient 3's:

> As an expert, determining whether or not [respondent] was intentionally misleading police when he was interviewed about patient 3 is not, in my opinion, in the realm of medical expertise. I do not believe my degree, education and training assists in responding to this issue as it involves nonmedical conduct. Thus, I do not believe it would be appropriate to comment [on] or consider issues that are nonmedical as a standard of care expert in this matter.
>
> However, if it is determined medical opinion would aid the trier of fact on the subject, I also understand that my opinions would be excluded if not disclosed. To avoid that

issue, I will comment as follows. [Respondent] explained in his interview that his understanding of the question asked by the police officer regarding prior incidents was correctly answered. He understood that he was cleared from his previous report of inappropriate touching by his employer, and it never rose to the level of a police report. It appears that [respondent] did not seem clear on his interpretation of the question asked to him by the police officer regarding prior incidents that may have occurred. [Respondent] notes that English is his second language, and that at times subtleties in interpretation are difficult. [Respondent] appears to have misunderstood the question, and this was not an act of intentional deception.

201. Dr. Norman concluded:

There are still uncertainties in this case as far as what exactly occurred due to a lack of complete records, the passage of time, and an unclear picture from each person of what occurred. From the records and information presented to me, I believe that [respondent's] exams were misinterpreted by the patients. Ultimately, I acknowledge that I will not be the trier of fact who will hear from each person themselves at hearing.

If the trier of fact believes that this was a case of misinterpretation by these patients, I do not believe discipline is the appropriate outcome in this case. I believe

[respondent] acted reasonably for the reasons I stated above. However, I also believe it would be in his best interest[,] as well as the best interest of patients, that [respondent] enroll and attend a course in patient communication and professional boundaries to improve his skills and communication with patients.

Hearing Testimony

202. Dr. Norman testified at hearing. He has been retained as an expert witness for a physician facing discipline on "about 20" occasions. He has also been retained by both sides in civil litigation. He estimated he has been retained by defendants about 90 percent of the time. He has provided deposition testimony between 30 and 40 times, and he has testified in court on 15 to 20 occasions.

203. The Board has previously provided Dr. Norman treatment records to review and provide an opinion on whether the treating physician committed any departures from the applicable standards of care. He estimated this has occurred on approximately 10 to 15 occasions. The Board stopped sending him cases to review for reasons unbeknownst to him. This matter was the first time Dr. Norman was retained as an expert by a physician facing discipline.

204. Dr. Norman described "standard of care" as care provided by a reasonable physician similarly trained, under similar circumstances, and with similar resources. The difference between a simple departure and an extreme departure from the standard of care is "a matter of degree." By way of example, Dr. Norman explained a simple departure might be a documentation error or a mistake precipitated by

conduct below the standard of care that did not result in harm or an adverse outcome. An extreme departure is conduct "several degrees below the standards of care."

205. Dr. Norman confirmed he reviewed and followed the 2013 Guidelines when analyzing respondent's treatment and care of the three patients. Specifically, he "assume[d] the [patients'] allegations are true" and interpreted them by using the medical records to provide "the clinical context of what's going on at the time."

206. Dr. Norman explained when auscultating the mitral area during a cardiac examination of a female patient, it is within the standard of care for the physician to tell the patient she "may need to lift the left breast" so the stethoscope lays flat. Alternatively, it is appropriate for the physician to inform the patient the physician will lift the breast. The physician uses the back of his nondominant hand to lift the breast while holding the stethoscope against the mitral area with his dominant hand. However, it is improper for the physician to reach in the patient's shirt and grab and squeeze one or both breasts.

207. Dr. Norman also explained a "clinical breast examination" is a specific type of examination, and there must be a clinical indication one is necessary before it can be performed. None of the patients' medical records contained any subjective complaints or objective findings indicating a clinical breast exam was medically necessary, none of the patients described respondent performing one, and he denied performing one on each patient. Therefore, Dr. Norman criticized Dr. Kasem's reliance on an inapplicable standard of care to evaluate respondent's treatment of the patients.

208. Dr. Norman reiterated the complaint in his report about not having a complete set of medical records for any patient. He said it is always "best" for him to

have a complete set. Nonetheless, he explained the records provided contained sufficient information for him to evaluate respondent's treatment of all three patients.

209. Dr. Norman reiterated the conclusion in his report that respondent was performing a cardiac examination on each patient when his alleged misconduct occurred. He repeated that none of respondent's alleged misconduct constituted an extreme departure from the applicable standard of care because he performed a proper cardiac examination by listening to each patient's heart sounds in the five areas required. And though Dr. Norman was adamant he accepted each patient's allegations as true, he also conceded respondent's conduct "would be below the standards of care" if he did what any patient alleged. He further conceded each patient's complaint described conduct that constituted extreme departures from the standard of care.

Character Evidence

210. Respondent called three witnesses to vouch for his character, Yi Sun, Rona Mao, and Yulong Ji, each of whom also wrote letters of support (Mr. Ji's letter was from him and his wife). He also introduced 14 letters of support from authors who did not testify. Each witness and author acknowledged his or her awareness of the allegations against respondent and expressed his or her utmost confidence they are not true.

211. Ms. Sun is respondent's wife. She corroborated his testimony about his: (1) humble beginnings as the youngest child of farmers in rural Southern China; (2) struggles with SMU's entrance examination and learning Mandarin once admitted; (3) perseverance in passing the examination required for acceptance into a medical residency program; and (4) achieving his lifelong goal of becoming a clinical physician. She described him as a faithful and loyal partner, dedicated and responsible father of

their sons, faithful servant of God, and a person with honesty and integrity who is committed to helping others.

212. Ms. Mao and her husband met respondent and his family approximately 15 years ago. Respondent and his family moved into a home a few doors down from them around 2010. Their children are the same age, and both families used to attend children's activities together and have family get-togethers. Now that the children are older, Ms. Mao and her husband continue to see respondent and his wife around the neighborhood and at church. The two wives go on daily walks.

213. Ms. Mao described respondent as a person with good character and integrity. He is hard-working, always trying to improve himself, and enjoys a good reputation in the community. He values his family and giving back to the community, and he encourages his sons to do the same. Respondent leads a weekly Bible study and serves as the neighborhood safety marshal. He frequently takes in UCD students from China while they settle and acclimate to their new surroundings.

214. Mr. Ji is respondent's former roommate at SMU. He has worked as a clinical lab scientist for the last 32 years. He described respondent as a "lifelong friend." Mr. Ji lives in Palo Alto, California, and he and respondent communicate by telephone or through chats at least two times a month and see each other at least three times a year. He was "shocked" and "angry" when he learned of the allegations against respondent because he knows respondent as an open and honest physician.

215. Dr. Morrison and Ms. Montemayor were called as percipient witnesses but were also asked about respondent's character. Dr. Morrison described respondent as a thoughtful physician who was conscientious and thorough. He "thought

[respondent] was a good doctor." Ms. Montemayor trusted respondent with her patients at CMC-Dixon. She opined he remains safe to practice medicine.

216. Each character letter described respondent in an equally laudatory manner. Several discussed his dedication to his wife and two sons, both of whom wrote letters attesting to their father's generosity and sacrifices for their betterment. Others talked about respondent's involvement in the church and commitment to helping those in need. A former coworker of 11 years described respondent as an "excellent medical provider" who was: (1) "very respectful with staff and patients"; (2) always "very productive"; and (3) "very dedicated to his profession."

Analysis

WITNESS CREDIBILITY

Patient 1, Patient 2, Patient 3, and Respondent

217. The only witnesses who know what happened during each physical examination were the patients and respondent. Therefore, their respective credibility is outcome determinative. Indeed, Dr. Norman conceded each patients' allegations, if proven, described conduct that constituted an extreme departure from the standard of care. Respondent agreed there would be no medical reason for him to put his hand down the front of a patient's shirt or under her bra. Both parties admitted this matter is about respondent's and the three patients' credibility.

218. Considering the applicable criteria for evaluating witness credibility outlined in Evidence Code section 780, subdivisions (a) through (k), each patient presented as a more credible witness than respondent. Therefore, the clear and

convincing evidence established respondent engaged in the conduct Patient 1, Patient 2, and Patient 3 described.

219. Each patient was questioned about their allegations in multiple forums. In addition to all of them having testified at hearing, Investigator Brearley interviewed them. Patient 3 was also interviewed as part of the Dixon Police Department's investigation. Regardless of who asked the questions, each patient described respondent's abuse in substantially the same manner every time. Additionally, all three patients testified at hearing in a straightforward, matter-of-fact manner.

220. Although Patient 3 appeared to have corrected herself during her multidisciplinary interview by explaining she should have used the word "chest" instead of "boob" when describing to Ms. Simpliciano where respondent had grabbed her, the context surrounding Patient 3's statement and her demeanor when making it indicated she was not describing a different part of her body. Rather, Patient 3 was expressing embarrassment to the interviewer over her use of the slang term "boob." She has consistently described respondent as having touched her breast, as corroborated by Ms. Simpliciano's statements that Patient 3 told her respondent "grabbed my boob."

221. Each patient is understandably unhappy with respondent's misconduct. However, none demonstrated any outward hostility toward him during hearing. Nor did any articulate or demonstrate an interest in a particular outcome in this matter. Though all three patients are involved in civil litigation with respondent, each made her accusations long before the litigation commenced.

222. Perhaps the most persuasive evidence in favor of each patient's credibility is the similar nature of their accusations. Each described respondent

grabbing, squeezing, and/or cupping one or both breasts while examining her chest or abdomen. There was no evidence any of the patients know each other. Patient 1 was, and remains, a long-time patient at CMC-Dixon. Patient 2 has been to CMC-Dixon only once, and the incident was only Patient 3's third visit. Patient 2 did not learn of other complaints against respondent until years after her husband complained to CMC's clinic manager. Patient 3's appointment was almost five years after Patient 2's and almost six years after Patient 1's.

223. Patient 1 explained she "was very shocked any of this was happening" because respondent had treated her and her mother on prior occasions without incident. Patient 2 explained she was so much "in shock" over respondent's conduct she could not call CMC-Dixon or USCIS to ask if a breast examination was part of an immigration physical, so her husband did while she listened on the speakerphone. Patient 3 was "shocked" by respondent's actions and "felt unsafe."

224. There was a discrepancy in the evidence over the timing of Patient 1 reporting respondent's misconduct to CMC-Dixon. She testified she first reported his conduct during a December 1, 2014 appointment with Ms. Ramirez. She reported his misconduct a second time during a prenatal appointment almost six years later.

225. Dr. Morrison testified CMC first learned of Patient 1's allegations in November 2020. Additionally, Ms. Ramirez did not remember Patient 1 or their appointment. She also did not remember any patient telling her when she worked at CMC-Dixon that a medical provider had inappropriately touched them. Ms. Ramirez expressed confidence she would remember if a patient had reported such abuse because she was required to report any complaints of sexual or physical abuse.

226. Patient's 1's testimony was more persuasive than Dr. Morrison's or Ms. Ramirez's. Dr. Morrison understandably had limited recall of the relevant events at hearing. The passage of time had also caused Ms. Ramirez's memory to fade. Indeed, she could not recall specifically when she worked for CMC-Dixon, and the general timeframe for her employment was established through medical records.

227. There were discrepancies between Patient 3's testimony and statements explaining why her mother was not present for respondent's examination. But it was undisputed Patient 3's mother was not present. It was also undisputed she was waiting outside in the car. The specific reason she waited outside is inconsequential.

228. On the other hand, respondent has a strong interest in a particular outcome in this matter – proving the allegations false. He has not worked since the Accusation was filed, and he has suffered financially as a result. He enjoys a good reputation and is well-regarded in the community, and his status would undoubtedly be in jeopardy if any of the allegations are found true.

229. There were numerous inconsistencies in respondent's testimony and prior statements. Investigator Brearley showed respondent a copy of Dr. Morrison's June 29, 2015 email purporting to summarize Dr. Morrison's and respondent's conversation about Patient 2's examination. She asked if it was an accurate summary. Respondent answered, "I don't remember. I said I don't remember I talk to Dr. Morrison about it because I thought I only talk to the manager about it." (Grammar original.) But after Investigator Brearley read the email to respondent, he claimed, "That was exactly what I said."

230. Respondent told Investigator Brearley he learned about Patient 1's allegations in November 2020 when Dr. Morrison disclosed them to him. However, Dr.

Morrison did not identify the patient, and respondent did not learn it was Patient 1 until told by CMC's investigator in December 2020 or January 2021. Nonetheless, respondent confirmed November 12, 2014, was the last time he treated Patient 1. He spontaneously explained:

> Because Dr. Morrison is a CMC. That is the policy. If any patients complain about you, we don't touch the charts from that point.

(Diction original.)

231. Respondent learned of Patient 2's allegations on June 29, 2015, but he did not disclose those allegations when a detective asked almost five years later if he had ever been accused of inappropriately touching a patient's breasts. Respondent subsequently gave conflicting reasons for not disclosing Patient 2's complaint. He initially told Investigator Brearley he did not disclose the complaint because CMC-Dixon's investigation had cleared him of any wrongdoing. He later claimed he misunderstood the meaning of "accusation" and did not think Patient 2's complaint constituted an accusation.

232. Respondent later testified he did not disclose Patient 2's complaint because it was never formally investigated and, therefore, did not constitute a "prior complaint." In addition to him having justified not disclosing Patient 2's complaint because he was cleared by an investigation, he testified to delaying his resignation from CMC-Dixon until it completed its investigation because "otherwise make me even worse, you know." (Grammar original.) Respondent also said CMC hired an investigator who interviewed him about Patient 2's complaint.

233. Respondent told Investigator Brearley he palpated Patient 3's chest over her shirt, except those areas not covered by her shirt. He subsequently explained he put his hand through her shirt to examine her chest. He then said the entire examination was "outside of the shirt." But when describing the moment Patient 3 supposedly started "freaking out," respondent explained she suddenly "pull[ed] my arm out, you know, kind of freaking out." He also told the detective he placed his right hand through Patient 3's shirt to check for anything unusual such as a pulled muscle.

234. Respondent also said he overheard Patient 3 on the telephone with her mother at the nurses' station. Patient 3 accused him of touching her breast, so he found Ms. Montemayor, told her Patient 3 was "acting out," said she accused him of touching her breast, and asked Ms. Montemayor to finish his examination. However, he did not provide any of that information in his email to Dr. Morrison later that evening. In particular, he did not disclose Patient 3's accusation. Additionally, Ms. Montemayor denied any knowledge of respondent's reasoning for asking her to complete his examination. Furthermore, she said she did not learn what had happened during respondent's examination until the end of the day. Ms. Montemayor has no interest in the outcome of this matter. She was a more credible witness than respondent.

235. Last, respondent was adamant he obtained each patient's consent prior to her examination. Upon further questioning, however, he admitted he had no independent recollection of specifically asking any patient for consent. Instead, respondent assumed he did because it was his custom and practice.

Dr. Kasem

236. Dr. Kasem testified she was certain she watched video footage of Patient 3's multidisciplinary interview and relied on it in drawing the conclusions stated in her report. She also said she reviewed video footage of Ms. Tearney-Berthon's and Ms. Simpliciano's interviews. Dr. Kasem recalled watching the footage "recently." Yet the Dixon Police Department did not produce any video footage to the Board until the week prior to hearing, long after Dr. Kasem wrote her report. Dr. Kasem did not obtain video footage from any source other than the Board.

237. However, Dr. Kasem received access to complainant's proposed hearing evidence shortly before the hearing. That proposed evidence included the video footage Dr. Kasem referenced. Based thereon, it appears Dr. Kasem was mistaken about when she reviewed the video footage. She could not have reviewed videos before they were produced, nor could she have relied on videos she had not seen when generating her report.

238. Despite this error, Dr. Kasem's mistake does not impair her credibility. Her opinions presupposed the truth of the Patients' allegations, as required by the 2013 Guidelines. Therefore, the absence of video review of witness interviews does not undermine the validity of her opinions. Additionally, Dr. Norman corroborated Dr. Kasem's conclusion that, if the allegations were true, respondent committed extreme departures from the standard of care.

Touching Patients' Breasts for No Medical Reason

239. The clear and convincing evidence established respondent touched Patient 1's, Patient 2's, and Patient 3's breasts under the guise of performing physical examinations. However, he had no medical reason for doing so.

GROSS NEGLIGENCE

240. Dr. Kasem, in conjunction with Dr. Norman, persuasively established the standard of care applicable to respondent's examinations of each patient. The evidence as a whole established Dr. Kasem's references to "breast examination" referred to breast examinations in a general sense, rather than clinical breast examinations. As she persuasively explained, a physician is examining the patient's breast in a general sense when palpating the breast area of the chest wall, but he is not performing a clinical breast examination.

241. The standard of care required respondent to do the following prior to each examination: (1) explain he was going to examine the patient's breasts; (2) discuss the reasons for doing so; (3) obtain consent; (4) provide a chaperone; (5) explain what he was doing simultaneously with doing it; and (6) discuss his clinical findings. Additionally, he was required to include Patient 3's mother in the decision-making process for Patient 3's treatment. Respondent's claim he thought Patient 3 was an adult was not credible for the reasons explained above.

242. It was undisputed none of the patients had any subjective or objective signs or symptoms that warranted a breast examination. Respondent did not document performing a breast examination in any patient's medical records. Therefore, he touched Patient 1's, Patient 2's, and Patient 3's breasts without a medical necessity for doing so.

243. Additionally, respondent did not tell any patient he was going to examine her breasts prior to doing so. Nor did he ask for consent prior to touching anyone. He also did not provide or offer a chaperone to any patient. He did not include Patient 3's mother in the examination. The clear and convincing evidence

established respondent committed multiple extreme departures from the standard of care when he examined Patient 1's, Patient 2's, and Patient 3's breasts.

REPEATED ACTS OF NEGLIGENCE

244. The clear and convincing evidence also established respondent committed repeated negligent acts when examining Patient 1, Patient 2, and Patient 3. Each extreme departure from the standard of care described in Factual Findings 242 and 243 constitutes a separate negligent act, and together they constitute repeated negligent acts.

245. Complainant did not prove respondent's failure to accurately and honestly answer the detective's question about prior accusations constituted a negligent act. Dr. Kasem did not describe the standard of care applicable to such conduct in her June 8, 2023 report. Although she articulated that standard at hearing, complainant disclosed only the opinions expressed in her report as required by Business and Professions Code section 2334, subdivision (b). Therefore, her hearing testimony about the applicable standard was not considered. (*Id.*, subd. (a)(2)(A).)

DISHONEST OR CORRUPT ACT

246. The clear and convincing evidence established respondent falsely told the detective investigating Patient 3's allegations he had never been accused of improperly touching a patient's breast. The truth of the matter was that respondent knew Patient 2 had accused him of such conduct almost five years prior. And his untruthful statement related directly to patient care. Therefore, respondent engaged in a dishonest or corrupt act substantially related to the qualifications, function, or duties of a physician.

General Unprofessional Conduct

247. The clear and convincing evidence established respondent engaged in general unprofessional conduct for the reasons explained in Factual Findings 239 through 244 and 246.

Appropriate Discipline

248. The Board is required to consider the Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th Ed./2016) (Disciplinary Guidelines) "in reaching a decision on a disciplinary action under the Administrative Procedure Act." (Cal. Code Regs., tit. 16, § 1361, subd. (a).) The Disciplinary Guidelines itemize different grounds for discipline and provide minimum and maximum discipline for each. The discipline specified for the causes alleged against respondent ranges from a stayed revocation with five years' probation to revocation.

249. As previously explained, the crux of this matter was determining the credibility of the three patients, on the one hand, and respondent, on the other. The clear and convincing evidence established the three patients were more credible. Additionally, respondent maintains he did nothing wrong, a position wholly inconsistent with demonstrating a physician who violated three patients in the manner he violated Patients 1, Patient 2, and Patient 3 is capable of practicing medicine in a manner consistent with public health, safety, and welfare.

250. Also, the numerous inconsistencies between respondent's testimony and prior statements outlined above do not depict a physician who is safe to practice medicine. More alarming was his testimony when asked if Dignity Health Woodland Clinic asked why he left CMC-Dixon. He could not recall if he was asked. But assuming he was not, he explained he was not required to voluntarily disclose Patient 3's

complaint because he did not know CMC-Dixon had disclosed the complaint to the Board, so he did not think the complaint was serious. Additionally, respondent said he had no incentive to tell Dignity Health Woodland Clinic. Furthermore, he explained he did not offer patients chaperones when one was not required because the medical assistants were always so busy.

251. Respondent's character witnesses described him in a laudatory manner. However, each also explained they did not believe the allegations established by clear and convincing evidence. Therefore, none of the witnesses' assessment of respondent's character was persuasive.

252. Considering all the evidence, the only outcome justified is the outright revocation of respondent's certificate.

Request for Costs of Investigation and Enforcement

253. Complainant requested costs of investigation and enforcement in the total sum of $65,154.75 pursuant to Business and Professions Code section 125.3. That amount includes $11,739 the Board spent investigating this matter. It also includes $53,415.75 the Office of the Attorney General billed the Board for enforcing this matter prior to hearing.

254. At hearing, complainant introduced a Declaration of Investigative Activity certifying the Board spent $11,739 for two investigators' work in this matter. The Declaration itemized that amount by fiscal year (2021/2022 and 2022/2023), number of hours, hourly rate, and total charges. It also noted an increase in the hourly rate became effective December 14, 2022. An Investigator Log itemizing the costs by date, hours spent, name of investigator, and task was attached to the Declaration. All the time except 0.25 hours ($42.50) was attributed to Investigator Brearley. Neither the

Declaration nor the Investigator Log includes any time or cost for Dr. Kasem's work in this matter.

255. Complainant also introduced a Certification of Prosecution Costs: Declaration of Deputy Attorney [*sic*] Megan R. O'Carroll, confirming the Office of the Attorney General billed the Board $53,415.75 through September 30, 2024. Ms. O'Carroll declared that she "anticipate[d] that the DOJ will bill the Medical Board of California approximately another 30 hours" the week prior to hearing, and she "will provide an updated billing declaration on the morning of hearing to reflect the billing actually billed to the Medical Board by the DOJ up to that date." No updated declaration was presented at hearing.

256. The Certification included a Matter Time Activity By Professional Type itemizing the time spent by the Office of the Attorney General by employee, date, task performed, hours worked, hourly rate, and amount charged. The time included 0.25 hours ($57) Deputy Attorney General John S. Gatschet spent on trial preparation on August 22, 2024. It also included 1.0 hour ($228) Supervising Deputy Attorney General Brummel spent on trial preparation on September 18 through 20, 2024.

257. Respondent did not object to complainant's evidence of the Board's costs. Although he has not worked since Dignity Health Woodland Clinic and Alderson Convalescent Hospital terminated him, Ms. Sun has worked for California Public Employees' Retirement System as an accounting officer since 2022 or 2023. Prior to that, she had not worked since 2012 or 2013 because she was caring for their two sons.

258. Nor did respondent introduce direct evidence of his or Ms. Sun's expenses. She testified to an inability to pay costs, even under a payment plan,

because respondent has been unemployed for over a year, she is the sole source of income, and they have a lot of debt, but provided no specifics. She explained they owe a lot in outstanding attorney's fees, but could not specify how much other than "around $200,000" when she last checked. Ms. Sun did not specify if the outstanding attorney's fees included the cost of respondent's defense in the pending litigation with the patients. There was no evidence of the couple's current living expenses.

259. Complainant's reasonable costs of investigation and enforcement in this matter are discussed further in Legal Conclusions 6 through 12.

LEGAL CONCLUSIONS

Applicable Burden/Standard of Proof

1. Complainant has the burden of proving the causes for discipline alleged in the Accusation by clear and convincing evidence to a reasonable certainty. (*Daniels v. Dept. of Motor Vehicles* (1983) 33 Cal.3d 532, 536 ["When an administrative agency initiates an action to suspend or revoke a license, the burden of proving the facts necessary to support the action rests with the agency making the allegation"]; *Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856 [the standard of proof applicable to proceedings for the discipline of professional licenses is clear and convincing evidence to a reasonable certainty].) "The courts have defined clear and convincing evidence as evidence which is so clear as to leave no substantial doubt and as sufficiently strong to command the unhesitating assent of every reasonable mind. [Citations.] It has been said that a preponderance calls for probability, while clear and convincing proof demands a *high probability* [citations]." (*In re Terry D.* (1978) 83 Cal.App.3d 890, 899; italics original.)

Applicable law

2. A physician "who engages in an act of . . . sexual contact with a patient . . . is guilty of sexual exploitation." (Bus. & Prof. Code, § 729, subd. (a).) "Sexual contact" refers to "the touching of an intimate part of a patient for the purpose of sexual arousal, gratification, or abuse." (*Id.*, subd. (c)(3).) "Intimate part" and "touching" refer to those terms as defined in Penal Code section 243.4. (*Id.*, subd. (c)(4).) "Sexual exploitation . . . is a public offense." (Bus. & Prof. Code, § 729, subd. (b); see *Roy v. Super. Ct.* (2011) 198 Cal.App.4th 1337, 1352–1352 [comparing the conduct prohibited under Bus. & Prof. Code, § 726, with that prohibited under Bus. & Prof. Code, § 729, and recognizing the former exposes the physician to license discipline while the latter exposes him to criminal liability].)

3. Penal Code section 243.4, subdivision (e)(2), defines "touching" as making "physical contact with another person, whether accomplished directly, through the clothing of the person committing the offense, or through the clothing of the victim." It includes having "physical contact with the skin of another person whether accomplished directly or through the clothing of the person committing the offense." (*Id.*, subd. (f).) "The breast of a female" is an "intimate part." (*Id.*, subd. (g)(1).)

4. The Board may discipline a physician's and surgeon's certificate if the physician has committed unprofessional conduct. (Bus. & Prof. Code, § 2334.) Unprofessional conduct includes "any act" of sexual misconduct. (Bus. & Prof. Code, § 726.) It also includes "gross negligence." (Bus. & Prof. Code, § 2334, subd. (b).)

5. "Repeated negligent acts" constitute unprofessional conduct. (Bus. & Prof. Code, § 2334, subd. (c).) "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." (*Ibid.*) "The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon" also constitutes unprofessional conduct. (*Id.*, subd. (e).)

Award of Costs

6. An agency may be awarded "the reasonable costs of investigation and enforcement of the case" if it prevails in a license disciplinary proceeding. (Bus. & Prof. Code, § 125.3, subd. (a).) "A certified copy of the actual costs . . . shall be prima facie evidence of reasonable costs of investigation and prosecution of the case." (*Id.*, subd. (c).) "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." (*Ibid.*)

7. Costs may be proven at hearing "by Declarations that contain specific and sufficient facts to support findings regarding actual costs incurred and the reasonableness of the costs." (Cal. Code Regs., tit. 1, § 1042, subd. (b).) If the services are provided by an agency employee, "the Declaration may be executed by the agency or its designee and shall describe the general tasks performed, the time spent on each task and the method of calculating the cost." (*Id.*, subd. (b)(1).) If the services are provided by someone other than an agency employee, "the Declaration shall be executed by the person providing the service and describe the general tasks performed, the time spent on each task and the hourly rate or other compensation for the service." (*Id.*, subd. (b)(2).)

8. In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth factors for evaluating the reasonableness of the

costs sought pursuant to statutory provisions like Business and Professions Code section 125.3. These factors include: 1) the licentiate's success in getting the charges dismissed or the severity of the discipline imposed reduced; 2) the licentiate's subjective good faith belief in the merits of his position; 3) whether the licentiate raised a colorable challenge to the proposed discipline; 4) the licentiate's financial ability to pay; and 5) whether the scope of the investigation was appropriate in light of the alleged misconduct. (*Zuckerman v. Bd. of Chiropractic Examiners, supra*, 29 Cal.4th at p. 45.)

9. Complainant introduced prima facie evidence that the Board's reasonable costs of investigation and enforcement in this matter are $65,154.75. (Bus. & Prof. Code, § 125.3, subd. (c); Cal. Code Regs., tit. 1, § 1042, subd. (b)(1), (2).) Respondent did not rebut that evidence.

10. Considering the pertinent *Zuckerman* factors, respondent did not prove that a reduction to the reasonable costs is warranted. He was unsuccessful in getting any of the causes for discipline dismissed, and he did not raise "a colorable challenge" to any of the causes or the proposed discipline. Respondent did not present persuasive evidence that his belief in his innocence was held in good faith. Nor did he present persuasive evidence of his financial ability to pay costs. Ms. Sun provided only vague testimony that they have limited income and a lot of expenses without providing specifics.

11. Investigator Brearley's investigation started with only Patient 3's complaint. Her review of the initial medical records CMC produced revealed the existence of a prior complaint by Patient 2, so she included it in her investigation. Investigator Brearley interviewed Dr. Morrison, and he disclosed Patient 1's complaint. Therefore, she included that complaint in her investigation as well. Given the discovery

of two additional complaints and the fact that respondent and the respective patients were the only ones present during the relevant examination, the scope of Investigator Brearley's investigation was necessary and appropriate.

12. Nonetheless, the evidence of the Attorney General's costs did not establish the appropriateness of some of the charges. Supervising Deputy Attorney General Brummel billed $684 for trial preparation, and Deputy Attorney General Gatschet billed $57. However, neither was actively involved in or appeared at hearing. A reduction of $741 to the Board's enforcement costs is justified. Therefore, the Board is awarded investigation and enforcement costs in the total sum of $64,413.75 as set forth in the Order below.

Conclusion

SEXUAL EXPLOITATION

13. Although Business and Professions Code section 729 imposes criminal liability for respondent improperly touching Patient 1's, Patient 2's, and Patient 3's breasts with no medical reason for doing so, it does not define such conduct as "unprofessional conduct." Nor does it authorize discipline for engaging in such conduct. (See *Roy v. Super. Ct., supra*, 198 Cal.App.4th at pp. 1352–1352.) Therefore, no cause exists to discipline respondent's physician's and surgeon's certificate pursuant to Business and Professions Code section 729.

SEXUAL MISCONDUCT

14. Respondent engaged in sexual misconduct with Patient 1, Patient 2, and Patient 3 in violation of Business and Professions Code section 726 as explained in Factual Finding 239. Therefore, cause exists to discipline his physician's and surgeon's

certificate pursuant to Business and Professions Code section 726 as that statute relates to Business and Professions Code section 2234.

GROSS NEGLIGENCE

15. Respondent committed gross negligence when he treated Patient 1, Patient 2, and Patient 3 as explained in Factual Findings 240 through 243. Therefore, cause exists to discipline his physician's and surgeon's certificate pursuant to Business and Professions Code section 2234, subdivision (b).

REPEATED ACTS OF NEGLIGENCE

16. Respondent committed repeated acts of negligence when he treated Patient 1, Patient 2, and Patient 3 as explained in Factual Findings 240 through 244. Therefore, cause exists to discipline his physician's and surgeon's certificate pursuant to Business and Professions Code section 2234, subdivision (c).

DISHONEST OR CORRUPT ACT

17. Respondent committed a dishonest or corrupt act substantially related to the qualifications, functions, or duties of a physician when he falsely told the detective investigating Patient 3's allegations he had never been accused of improperly touching a patient's breast, as explained in Factual Finding 246. Therefore, cause exists to discipline his physician's and surgeon's certificate pursuant to Business and Professions Code section 2234, subdivision (e).

GENERAL UNPROFESSIONAL CONDUCT

18. Respondent engaged in general unprofessional conduct as discussed in Factual Findings 239 through 244 and 246. Therefore, cause exists to discipline his

physician's and surgeon's certificate pursuant to Business and Professions Code section 2234.

APPROPRIATE DISCIPLINE

19. Considering the evidence as a whole, respondent did not demonstrate his ability to continue practicing medicine in a manner consistent with public health, safety, and welfare, even under a probationary certificate, for the reasons explained in Factual Findings 248 through 252. Therefore, his physician's and surgeon's certificate must be revoked.

ORDER

Physician's and Surgeon's Certificate Number A 104156 issued to respondent Andy Yongde Zhu, M.D., is REVOKED by reason of Legal Conclusions 14 through 19, individually and collectively. Respondent shall pay the Board the costs associated with its investigation and enforcement pursuant to Business and Professions Code Section 125.3 in the amount of $64,413.75. He shall be permitted to pay these costs pursuant to a payment plan approved by the Board.

DATE: November 21, 2024

Coren D. Wong (Nov 21, 2024 16:26 PST)

COREN D. WONG

Administrative Law Judge

Office of Administrative Hearings