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

In the Matter of the Accusation Against: Jarrod Anthony Crum, M.D. Physician's & Surgeon's Certificate No. A 108918 Respondent.	Case No. 800-2021-083882

DECISION

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

This Decision shall become effective at 5:00 p.m. on October 2, 2025.

IT IS SO ORDERED: September 2, 2025.

MEDICAL BOARD OF CALIFORNIA

Veling Tsai, M.D., Vice Chair
Panel A

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JARROD ANTHONY CRUM, M.D.** **9333 Imperial Hwy** **Downey, CA 90242-2812** **Physician's and Surgeon's Certificate No. A 108918,** Respondent.	Case No. 800-2021-083882 OAH No. 2024120376 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

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

2. Respondent Jarrod Anthony Crum, M.D. (Respondent) is represented in this proceeding by attorney Lindsay Johnson, whose address is: 4100 Newport Place, Suite 670, Newport Beach, CA 92660.

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3. On or about July 17, 2009, the Board issued Physician's and Surgeon's Certificate No. A 108918 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2021-083882, and will expire on January 31, 2027, unless renewed.

JURISDICTION

4. Accusation No. 800-2021-083882 was filed before the Board and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on October 23, 2024. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2021-083882 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2021-083882. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2021-083882, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purposes of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in Accusation No. 800-2021-083882 and that Respondent hereby gives up his right to contest those charges.

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

CONTINGENCY

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

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

14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

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

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DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 108918 issued to Respondent JARROD ANTHONY CRUM, M.D., shall be and is hereby publicly reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Respondent's care and treatment of Patient A, as set forth in Accusation No. 800-2021-083882, is as follows:

You committed acts constituting negligence in violation of Business and Professions Code sections 2234, subdivision (c), and 2266, with respect to your post-operative care and treatment of a single patient in 2019, and oversight of physician assistants, as set forth in Accusation No. 800-2021-083882.

IT IS FURTHER ORDERED that Respondent is subject to the following terms and conditions:

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical

record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation as determined by the program for the assessment and clinical education and evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment

program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation.

5. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, in the amount of $29,311.00 (twenty-nine thousand three hundred and eleven dollars). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of this Disciplinary Order.

Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by Respondent to the Board. Failure to comply with the payment plan shall be considered a violation of this Disciplinary Order.

The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility to repay investigation and enforcement costs, including expert review costs.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Lindsay Johnson. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 5/23/2025

JARROD ANTHONY CRUM, M.D.
Respondent

I have read and fully discussed with Respondent Jarrod Anthony Crum, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 05/27/2025

LINDSAY JOHNSON, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: May 27, 2025

Respectfully submitted,

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

LATRICE R. HEMPHILL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2021-083882

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

In the Matter of the Accusation Against: **JARROD ANTHONY CRUM, M.D.** **9333 Imperial Hwy** **Downey, CA 90242-2812** **Physician's and Surgeon's Certificate Number A 108918,** Respondent.	Case No. 800-2021-083882 **ACCUSATION**

PARTIES

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

2. On or about July 17, 2009, the Board issued Physician's and Surgeon's Certificate Number A 108918 to Jarrod Anthony Crum, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2025, unless renewed.

JURISDICTION

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

4. Section 477 of the Code states:

As used in this division:

(a) "Board" includes "bureau," "commission," "committee," "department," "division," "examining committee," "program," and "agency."

(b) "License" includes certificate, registration or other means to engage in a business or profession regulated by this code.

5. Section 2004 of the Code provides, in pertinent part:

The board shall have the responsibility for the following:

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

(b) The administration and hearing of disciplinary actions.

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

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

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

(f) . . . (i).

6. Section 2220 of the Code provides, in pertinent part:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, . . . and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) . . . .

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his . . . professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

(c) . . . .

7. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

8. Section 2228 of the Code provides, in pertinent part:

The authority of the board . . . to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(d) Providing the option of alternative community service in cases other than violations relating to quality of care.

STATUTORY PROVISIONS

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

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

(a) Violating or attempting to violate, directly or indirectly, . . . any provision of this chapter.

(b) . . . .

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

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

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

(d) Incompetence.

(e) . . . (i).

10. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

11. Unprofessional conduct is conduct which breaches rules or ethical codes of a profession or conduct which is unbecoming a member in good standing of a profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3rd 564, 575.).

COST RECOVERY

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

> (a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department . . . upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.
>
> (b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.
>
> (c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.
>
> (d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).
>
> (e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.
>
> (f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.
>
> (g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.
>
> (2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement

with the board to reimburse the board within that one-year period for the unpaid costs.

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

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

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

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

13. Respondent Jarrod Anthony Crum, M.D. is subject to disciplinary action under Code section 2234, subdivision (c), in that he committed repeated negligent acts in his care and treatment of Patient A.[1] The circumstances are as follows:

14. On or about February 1, 2019, Patient A, a then sixty-four-year-old female, was admitted to Southern California Permanente Medical Group (Kaiser), where Respondent performed a primary total knee replacement (TKR)[2] due to severe osteoarthritis[3] in her right knee. The surgical procedure was uneventful with no reported complications and an overnight stay was planned on a 23-hour out-patient basis and Patient A's discharge was scheduled to occur the next morning. Respondent's operative note for the TKR he performed on Patient A was a generic document in the EPIC electronic health record system and nothing in this note reflected what actually occurred during the surgery (i.e., there are no linear or angular measurements, information about stability, operative findings regarding severity and location of cartilage wear,

[1] For privacy reasons, the patient in this pleading is identified as Patient A. The patient's full name will be disclosed upon a timely request for discovery pursuant to Government Code section 11507.6.

[2] Total knee replacement, also known as knee arthroplasty, is a surgical procedure to replace the weight-bearing surfaces of the knee joint to relieve pain and disability, most commonly offered when joint pain is not diminished by conservative sources. In this surgery, the ligaments in the knee are also removed.

[3] Osteoarthritis is a degenerative joint disease, in which the tissues in the joint break down over time. It is the most common type of arthritis and is more common in older people. People with osteoarthritis usually have joint pain and, after rest or inactivity, stiffness for a short period of time.

tourniquet release and control of bleeding, final range of motion status of the posterior cruciate ligament, among other things). Respondent's note failed to adequately include any actual findings or description of the actual surgery performed, which should have been contained as edits to the body of the dictation of the generic template form used for this patient.

15. On or about February 2, 2019, the first post-operative (Post-op) day, Patient A's therapist recorded the patient's pain in her heel at the 10/10 level and that the patient could not tolerate normal weight bearing. Heel pain of this type and intensity is not normal after knee replacement surgery and should have been a cause for concern for Respondent. Chart notes in Patient A's medical records document that Patient A suffered from sensation impairment of the dorsum of the right foot and the medial ankle area. The therapist also documented as follows: "sensation impaired to light touch R medial ankle and dorsum of the foot and tenderness at the heel" and that the patient required a bed pan as she was unable to get to the bathroom or go home as originally planned. The patient was also instructed not to get out of bed without calling the nurse for assistance due to her condition.

16. On or about February 3, 2019, the second Post-op day, a Physician Assistant (PA) member of the orthopedic rounding team saw Patient A. The PA noted an unremarkable examination with "soft calf" and "intact neurovascular status" which was in conflict with the previously documented abnormal findings, and there is no mention of the patient's foot pain, numbness, loss of sensation or level of pain recorded by the PA. The plan was "Home vs. snf[4] tomorrow," but there was no explanation regarding why the patient would be considered for a SNF when she was expected to be discharged as an out-patient the day after surgery. That morning, the PA completed a discharge summary that documented that he had "Communicated with Dr. Crum about the patient's condition, and received verbal/telephone orders to discharge patient." Respondent signed the discharge summary early the following morning, but the patient was not discharged until several days later. The following very important warning signs

[4] SNF is an abbreviation for "skilled nursing facility," which is a type of inpatient facility that provides short or long-term skilled nursing care, and rehabilitation services to patients. These facilities provide 24-hour medical support to patients requiring transitional care following a qualifying hospital stay for illness, injury, or surgery.

regarding Patient A's condition in her early recovery stage from the surgery indicate that "something was wrong" and should have warranted a major escalation of attention:

A. The patient was noted to be "struggling with right ankle pain" and was in "severe distress with moving right ankle." An examination revealed her calf was significantly swollen with some erythema,[5] her thigh was swollen in comparison to the non-operative side, there was very "significant right ankle tenderness with attempted range of motion" and there "was warmth and erythema proximally to the ankle – at the ankle, and into the foot." The PA's assessment was "possible pseudogout" and a duplex ultrasound[6] of the right ankle was ordered for "extreme right calf swelling" and noted tenderness along with severe distress with moving the right ankle. The ultrasound was positive for popliteal (relating to or situated in the hollow at the back of the knee) deep vein thrombosis.[7] Respondent stated in his interview that he became aware of the positive DVT ultrasound results around 10:30 a.m. the morning of February 3.

B. A hospitalist diagnosed Patient A with right plantar fasciitis[8] vs. gout.[9] That afternoon, the same PA noted (PA Note of February 3) "weak EHL[10] muscle and

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[5] Erythema is redness of the skin caused by congestion of the capillaries in the lower layers of the skin and occurs with any skin injury, infection, or inflammation.

[6] A duplex ultrasound is a medical ultrasonography that employs the Doppler effect to generate imaging of the movement of tissues and body fluids (usually blood), and their relative velocity to the probe. By calculating the frequency shift of a particular sample volume, for example, flow in an artery or a jet of blood flow over a heart valve, its speed and direction can be determined and visualized. Color Doppler or color flow Doppler is the presentation of the velocity by color scale. Color Doppler images are generally combined with grayscale (B-mode) images to display duplex ultrasonography images, allowing for simultaneous visualization of the anatomy of the area.

[7] Deep vein thrombosis, abbreviated as DVT, refers to the formation of one or more blood clots, also known as a "thrombus," while multiple clots are called "thrombi," in one of the body's large veins, most commonly in the lower limbs [e.g., lower leg or calf]).

[8] Plantar fasciitis is inflammation of the band of connective tissue on the sole of the foot, characterized by pain in the heel when walking and elicits foot and heel pain.

[9] Gout is a type of inflammatory arthritis that causes pain and swelling in the joints, usually as flares that last for a week or two, and then resolves. Gout flares often begin in the big toe or a lower limb.

[10] EHL is the abbreviation for the "extensor hallucis longus" muscle, a key muscle located (continued...)

Dorsiflexion of foot" and plantar foot paresthesia; however, there is no mention of the patient's calf, a Homen's test,[11] or the level of pain.

C. Within forty-eight hours after surgery, Patient A had evidence of partial paralysis, sensory impairment, pain that was out of proportion and in the foot, which is an unusual location, and a blood clot. These findings were significant deviations from the normal recovery process where most patients who go home the day of surgery or the day after are able to get up independently to go to the bathroom, take short walks with crutches or a walker, and have no pain or impairments of their foot function, which should have raised concerns that something was wrong as DVT of the leg does not cause paralysis or sensory defects or heel pain two days post-op. Respondent co-signed the PA Note of February 3 the following morning.

D. On or about February 3, 2019, in the evening, a nurse practitioner (NP) noted the patient's right leg and foot were swollen, and that she still had numbness in her right mid-tibia down to her foot with no sensation in the heel or the bottom of her right foot.

17. On or about February 4, 2019, the third Post-op day, the PA orthopedic team member who saw Patient A the day before documented that Patient A's calf and thigh were soft with no significant swelling. However, within the same hour, a hospitalist noted that Patient A's "right leg swollen hard to touch, able to move ankle." These two assessments are in conflict and neither addressed the presence of significant sensory impairment which is not part of the clinical picture of DVT. DVT does not cause numbness, firmness of the calf or intense pain in the foot and ankle. During the first three Post-op days, Patient A's recovery was markedly atypical for a routine TKR. In the early aftermath of an unexpected problem, all reasonable etiologies need to be considered. At that time a differential diagnosis should have included a direct contusion injury to the nerve during surgery, an injury to a nerve from a pain-relieving block, tourniquet-related

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in the anterior compartment of the lower leg that is responsible for extending the big toe at both the metatarsophalangeal and interphalangeal joints.

[11] A Homan's test determines if there is pain in the calf and popliteal area on passive dorsiflexion of the foot, indicating deep venous thrombosis of the calf (also known as dorsiflexion sign) positive on the right.

neuropathy, or compartment syndrome,[12] among others. In the first few post-op days, neither Respondent or another covering orthopedic surgeon adequately physically examined Patient A in-person and/or adequately documented such an examination. Instead, Patient A was examined by PAs, NPs and/or perioperative hospitalists who were not surgeons and there is no documentation of any communications with Respondent or a covering surgeon about Patient A's unusual recovery, and no documented feedback from Respondent or a covering surgeon with an appropriate plan of care addressing Patient A's presentation.

18. On or about February 5, 2019, Post-op day four, Patient A's right leg still had pain, but had improved. A nurse reported that Patient A was "feeling much better today," but her pain was rated as 10/10 earlier that morning. Patient A was formally discharged from physical therapy and was turned over to the nursing staff for continued mobilization.

19. On or about February 6, 2019, Post-op day five, Patient A complained about calf knee pain and was cleared to be discharged home. The discharge summary by the PA dated February 3, 2019, was amended by the NP to reflect the actual date of discharge, but made no mention of unusual pain, loss of sensation of leg and foot, calf firmness, weakness of dorsiflexion of the foot or any plans other than future follow-up visits with the NP on February 15, and March 19 for the first follow-up visit with Respondent.

20. Two days later, on or about February 8, 2019, Patient A presented to Kaiser emergency room (ER) for acute worsening of knee pain and numbness that occurred several hours earlier. Patient A reported that her pain was at the 10/10 level and that her pain was not controlled by Percocet (an opioid pain medication). Localized swelling and bruising were noted, but the location was not specified. She experienced numbness of the foot which progressed to a foot drop.[13] She was eventually seen by a PA covering for the orthopedic surgeon that night. The

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[12] Compartment syndrome is a serious condition that involves increased pressure in a muscle compartment and can lead to muscle and nerve damage and problems with blood flow.

[13] Foot drop is an inability to lift the forefoot due to the weakness of the dorsiflexor muscles of the foot. This can lead to an unsafe antalgic gait, potentially resulting in falls. The etiologies behind this presentation are varied and include muscular, neurologic, spinal, autoimmune, and musculoskeletal disorders.

PA saw the patient multiple times and contacted Respondent, who recommended that Patient A be kept overnight for observation, treatment and a new ultrasound of her leg. Patient A had numbness and no active dorsiflexion of the right great toe or foot. The follow-up ultrasound showed changes in Patient A's posterior calf consistent with edema or hematoma. At 10:23 p.m. on or about February 8, 2019, the PA noted that Patient A's "Pain was out of proportion" and that "Very low threshold for latent compartment syndrome, labs are not indicative of septic joint." The standard of care requires a doctor be vigilant to consider compartment syndrome in their differential diagnoses whenever there is reasonable cause for it to be considered because irreversible death of muscle and nerve tissues can occur within hours, leading to permanent impairment or amputation. The standard further requires that compartment pressure measurements be performed urgently whenever compartment syndrome is considered and the decision to do or not to do fasciotomies[14] is determined by the magnitude of the pressure measurements. Although Respondent stated during his interview with an investigator and medical consultant on behalf of the Board that "compartment syndrome" was in his differential diagnoses with respect to Patient A, Respondent failed to adequately consider and act on it, take compartment pressure measurements to address it, and document it.

21. On or about February 9, 2019, the same PA who created the early discharge summary on February 3, reassessed Patient A and noted she was "still not able to move toes and ankle." Persistent paralysis of the foot with severe pain and an abnormal ultrasound are clear indicators of a compartment syndrome. Respondent should have taken Patient A's compartment pressure measurements, but he failed to do so. Another PA took over Patient A's care and ultimately concluded that her paralysis was a manifestation of "transient peroneal[15] palsy" attributable to "overuse of an ice machine at home." Thereafter, Patient A was discharged home on pain medications with trace movement only of her right foot and toes.

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[14] Fasciotomy is a surgical procedure where the fascia is cut to relieve tension or pressure in order to treat the resulting loss of circulation to an area of tissue or muscle and is a limb-saving procedure when used to treat acute compartment syndrome.

[15] Peroneal means pertaining to the outer aspect of the leg.

22. On or about February 11, 2019, Respondent co-signed the discharge summary as amended by the NP, but failed to make any edits, modification or addenda to the summary after adverse patient recovery symptoms had been charted, including admission to the ER two-days after an extended hospital discharge.

23. On or about February 15, 2019, an NP saw Patient A for her regularly scheduled follow-up visit. That NP documented that Patient A had erythema from the mid tibia to the ankle and there was a blister on the medial side of the ankle. That NP also charted that Patient A's calf was firm and tender, and that she was having "severe pain" despite taking both morphine and Percocet. However, the chart notes for this visit fail to document any examination for Patient A's muscle function of the toes and foot or sensory numbness, there was no documentation of walking function (e.g., able or unable to bear weight normally on right foot, whether she was using a walker or crutches or cane), nor any visual analogue scale (VAS) assessment for the level of pain. Patient A was diagnosed with cellulitis[16] and she was advised to come back "on Monday or Tuesday" for a re-examination as her first follow-up appointment with Respondent was still over a month away in March 2019.

24. On or about February 18, 2019, Patient A called to schedule an appointment with the same NP she previously saw on February 15, and an appointment was scheduled for the following day.

25. On or about February 19, 2019, Patient A was seen by the NP who noted that the patient began self-medicating with CBD oil. A physical exam showed ecchymosis[17] and blisters distally, sluggish capillary refill, numbness, and diminished pulses. The NP referred Patient A to Respondent who determined that a vascular assessment for Patient A was indicated. A special request was made to have Patient A seen that day for a vascular assessment, but the appointment was postponed to the follow day. Respondent approved the postponement because he did not feel

[16] Cellulitis is an acute, spreading infection of the deep tissues of the skin and muscle that causes the skin to become warm and tender and may also cause fever, chills, swollen lymph nodes, and blisters.

[17] Ecchymosis is a purplish patch caused by extravasation of blood into the skin, differing from petechiae only in size (that is, larger than 3 mm diameter).

the situation was "emergent." However, Patient A should have been immediately sent to the ER for compartment pressure testing, magnetic resonance imaging,[18] and emergency consultations. Patient A subsequently went to the ER in the middle of the night on or about February 19, due to excruciating pain.

26. On or about February 20, 2019, the ER doctor noted that Patient A had "been unable to move her foot for a week" and was "unable to feel her foot for days." A computed tomography angiography (CTA)[19] was ordered and revealed a hematoma with edema in the deep muscular compartment of the right calf and the right popliteal artery (the main blood supply to the leg) was occluded[20] at the knee joint. The plan was to try and save the leg by performing an emergent fasciotomy with debridement (the process of removing nonliving tissue). Each of the pre and post-op diagnosis was non-traumatic compartment syndrome. The time required for irreversible necrosis of muscles and nerves under pressure is measured in hours, not days, and it had been over ten days since Patient A's presentation to the ER on or about February 8, 2019, with clear signs and symptoms of a compartment syndrome.

27. Thereafter, Patient A underwent multiple fasciotomies and debridement which did not resolve her symptoms.

28. On or about February 22, 2019, another surgeon recommended that Patient A undergo an amputation procedure to resolve her condition.

29. On or about March 12, 2019, Patient A underwent an above-the knee amputation[21]

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[18] A "magnetic resonance imaging," abbreviated MRI, is a noninvasive nuclear procedure for imaging tissues of high fat and water content that cannot be seen with other radiologic techniques. The MRI image gives information about the chemical makeup of tissues, thus making it possible to distinguish normal, cancerous, atherosclerotic, and traumatized tissue masses in the image.

[19] "Computed tomography angiography," abbreviated CTA, uses an injection of contrast material into the blood vessels and CT scanning to help diagnose and evaluate blood vessel disease or related conditions, such as aneurysms or blockages.

[20] "Occluded" is a complete or partial blockage of a blood vessel. While occlusions can happen in both veins and arteries, the more serious ones occur in the arteries. An occlusion can reduce or even stop the flow of oxygen-rich blood to downstream vital tissues like the heart, brain, or extremities.

[21] Above-knee amputation, also known as transfemoral amputation, is a surgical procedure (continued...)

procedure on her right leg.

30. During his interview with an investigator and medical consultant on behalf of the Board, Respondent stated that "he took responsibility" for Patient A on February 8, 2019, once he became aware she was in the ER. He further said that compartment syndrome was in his differential diagnosis, although not documented or acted upon, but he relied more on the reports that she was "getting better" and attributed her heel numbness to "positioning in the OR" during surgery a week earlier. Respondent admitted that he was not aware of the extent of the pain medications she was receiving in the ER and acknowledged that numbness in the foot and foot drop were a "very big deal." Respondent rejected that he was doing pressure testing because the diagnosis of compartment syndrome is a "clinical one," but his own clinical criterion for such a diagnosis is "pain out of proportion," which is exactly what the PA documented at 10:23 p.m. on or about February 8, 2019, and that he reserves pressure monitoring for patients who are "mentally handicapped." This demonstrates a lack of knowledge. Respondent demonstrated his misunderstanding about how to properly assess and address Patient A by failing to focus on the importance of objective compartment pressure measurements in a patient suspected of having a compartment syndrome. In the assessment and treatment of compartment syndrome, if pressures are high enough to cause tissue death and are not measured as quickly as possible, followed by fasciotomies, the muscles and nerves will die, and no amount of debridement will reverse the outcome. Respondent stated he did not feel that a neurology assessment was indicated at that time as he attributed her symptoms to "cryo phenomenon" and concluded that the cellulitis and blister were also due to the ice, however, the records indicate that icing had been discontinued for several days at that time.

31. The standard of care requires that a careful physical examination be performed and serial physical exams be performed every two hours to mark the area of numbness with a skin marker, grade the degree of weakness of toes and foot, and assess the calf for tenderness, swelling and firmness when abnormal findings are present after a TKR in a patient presenting as Patient A.

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that involves the removal of a leg above the knee joint due to severe injury, infection, or disease. The remaining limb is typically fitted with a prosthetic device to restore function and mobility.

Respondent should have outlined his differential diagnosis of Patient A based on her presentation, including, without limitation, possible direct nerve injury in the popliteal space during the total knee operation, external pressure on proximal lateral fibular area, compression injury from an intraoperative boot, among other things.

32. The standard of care requires that a discharge summary be completed for anyone hospitalized for more than one night either on the day of discharge or within 14-days of discharge. It is a violation of the standard of care to complete and sign a discharge summary days before the actual discharge. The standard further requires that the discharge summary include information about any complications with the patient, or abnormalities or deviations from the normal routine recovery of a patient because it is used by subsequent treaters to understand efficiently and effectively what happened during the patient's hospitalization, especially in respect of any deviations from the norm.

33. Respondent committed repeated negligent acts in his care and treatment of Patient A when he:

A. Failed to properly evaluate acute neurologic abnormalities of the right foot in the immediate post-op period;

B. Failed to adequately consider and/or act on Patient A's presentation, and/or document compartment syndrome in his diagnosis during the patient's post-op course, including, without limitation, during Patient A's emergency admission to the ER for an overnight stay on or about February 8, 2019, seven days post-op and two days after an extended hospital stay discharge;

C. Failed to adequately document in Patient A's hospital discharge summary that the patient experienced severe, incapacitating heel pain, and had numbness and weakness of the leg, ankle and foot, and calf firmness on various examinations during her extended six-day hospitalization; and

D. Signed Patient A's deficient hospital discharge summary on or about February 4, 2019, without making any edits, modification or addenda days before the patient was actually discharged, and signed the amended discharge summary on or about February 11, 2019,

after Patient A experienced adverse recovery symptoms, without making any appropriate edits, modification or addenda to the same.

SECOND CAUSE FOR DISCIPLINE

(Lack of Knowledge)

34. Respondent Jarrod Anthony Crum, M.D. is subject to disciplinary action under Code section 2234, subdivision (d), in that he demonstrated incompetence in his care and treatment of Patient A. The circumstances are as follows:

35. Paragraphs 14 through 32, above, inclusive, are incorporated herein by reference as if fully set forth. Respondent demonstrated a lack of knowledge in connection with his care for Patient A.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

36. Respondent Jarrod Anthony Crum, M.D. is subject to disciplinary action under Code section 2266 in that he failed to maintain adequate and accurate records in his care and treatment of Patient A. The circumstances are as follows:

37. Paragraphs 14 through 32, above, inclusive, are incorporated herein by reference as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

38. Respondent Jarrod Anthony Crum, M.D. is subject to disciplinary action under Code section 2234, in that Respondent committed unprofessional conduct, generally, which includes conduct which breaches the rules or ethical code of the medical profession or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. The circumstances are as follows:

39. Paragraphs 13 through 37, above, inclusive, are incorporated herein by reference as if fully set forth.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 108918, issued to Respondent Jarrod Anthony Crum, M.D.;

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

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

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

DATED: OCT 23 2024

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

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