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

In the Matter of the Accusation Against: Nagasamudra S. Ashok, M.D. Physician's & Surgeon's Certificate No A 41589 Petitioner.	Case No.: 800-2022-085813

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Derek F. O'Reilly-Jones, attorney for Nagasamudra S. Ashok, 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 October 2, 2025.

IT IS SO ORDERED: September 26, 2025

MD.

Veling Tsai, M.D., Chair
Panel A

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

In the Matter of the Accusation Against: **Nagasamudra S. Ashok, M.D.** **Physician's & Surgeon's Certificate No. A 41589** **Respondent.**	**Case No. 800-2022-085813** **ORDER GRANTING STAY** **(Government Code Section 11521)**

Derek F. O'Reilly-Jones, Esq. on behalf of Respondent, Nagasamudra S. Ashok, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of September 22, 2025, at 5:00 p.m.

Execution is stayed until October 2, 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: September 17, 2025

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: Nagasamudra S. Ashok, M.D. Physician's and Surgeon's Certificate No. A 41589 Respondent.	Case No. 800-2022-085813

DECISION

The attached Proposed Decision is hereby amended, pursuant to Government Code Section 11517(c)(2)(C), to correct a clerical error that does not affect the factual or legal basis of the Proposed Decision. The Proposed Decision is amended as follows:

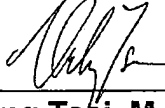
1. Page 1, Line 7: Certificate Number "41589" is corrected to read "A 41589."
2. Page 5, Line 11 and 17: Business and Professions Code section "2626" is corrected to read "2266."
3. Page 69, Line 1: "17. Costs" is corrected to read "16. Costs."

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 September 22, 2025.

IT IS SO ORDERED August 22, 2025.

MEDICAL BOARD OF CALIFORNIA



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

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

In the Matter of the Accusation against:

NAGASAMUDRA S. ASHOK, M.D.

Physician's and Surgeon's Certificate No. 41589

Respondent.

Agency Case No. 800-2022-085813

OAH No. 2024040804

PROPOSED DECISION

Administrative Law Judge Cindy F. Forman (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter on October 14, 16, 17, and 18, and December 5, 2024, and January 2, January 3, April 10, and April 11, 2025, by videoconference.

Vladimir Shalkevich, Deputy Attorney General, represented complainant Reji Varghese, Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

Derek O'Reilly-Jones, Esq., Bonne, Bridges, Mueller, O'Keefe, & Nichols, represented respondent Nagasamudra S. Ashok, M.D., who was present during the hearing.

Testimony and documentary evidence were received. The record was kept open until June 6, 2025, to allow the parties to file closing briefs. The briefs were timely filed. Complainant's brief was marked for identification as Exhibit 27; respondent's brief was marked for identification as Exhibit H. On June 6, 2025, respondent also filed a Request for Official/Judicial Notice (Request), which was marked for identification as Exhibit I; on June 9, 2025, complainant filed an objection to respondent's request (Objection), which was marked for identification as Exhibit 28. The transcripts of the hearing were added to Case Center and marked for identification as Exhibits 29 through 37.

The ALJ, on her own motion, reopened the record until June 9, 2025, to allow consideration of the Objection. The ALJ then closed the record, and the matter was submitted for decision on June 9, 2025.

On April 11, 2025, the ALJ issued an order granting complainant's motion to seal certain exhibits from public disclosure.

REQUEST FOR OFFICIAL/JUDICIAL NOTICE

The Request asks the ALJ to take official/ judicial notice under Government Code section 11515 of five documents, or in the alternative, admit the documents as administrative hearsay under Government Code section 11513, subdivision (c). The documents pertain to the impact of the COVID-19 (Covid) pandemic in California in 2022, and are as follows: (1) an article titled "Remember When? Timeline Marks Key Events on California's Year-Long Pandemic Grind, last updated July 2023 and

appearing in CalMatters (https://calmatters.org/health/coronavirus/2021/03/timeline-california-pandemic-year-keypoints/) (Item A); (2) California Governor Gavin Newsom's January 5, 2022 Executive Order N-12-21 extending the time for public government meetings to held remotely (Item B); (3) an article titled "California Deploys National Guard to COVID-19 Testing Sites, dated January 8, 2022, appearing in KRON-5 (https://www.kron4.com/news/california/newsomactivates-national-guard-to-support-covid-19-testing-capacity/ (Item C); (4) an article in Deadline titled "Omicron Surge Forecast to Peak in California with Nearly 30,000 Hospitalizations This Month," dated January 10, 2022 (Item D); and (5) a January 13, 2022 article from Emily Hoeven titled "California Hospitals Buckle Under Patient Surge, Sick Staff" in Cal Matters (Item E) (collectively Items).

Complainant objects to the Request based on Evidence Code section 352 and Government Code section 11513, subdivisions (d) and (f). Complainant contends the media articles (Items A, C, D, and E) cannot be subject to official notice because they contain hearsay or double hearsay insufficient by itself to establish any finding of fact, respondent fails to identify the evidence meant to be supplemented or explained by the articles, the probative value of the articles is substantially outweighed by the burden of reviewing the articles, and information contained in the articles is not relevant to the issues in this proceeding or is speculative. Complainant also contends Governor Newsom's order (Item B) is irrelevant to the issues in this case because it is limited to schools and government functions, not healthcare facilities.

Official notice is the administrative law counterpart to judicial notice in civil litigation. (Asimow, et al., Cal. Practice Guide: Administrative Law (The Rutter Group 2024) 9:166.) In an administrative matter, official notice may be taken, either before or after submission of the case for decision, of any generally accepted technical or

scientific matter within the agency's special field, and of any fact which may be judicially noticed by the courts of this State. (Gov. Code, § 11515.)

Official notice may also be taken of facts and propositions not reasonably subject to dispute and which are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy. (Evid. Code, § 452, subd. (h).) "Although the existence of a document may be judicially noticeable, the truth of statements contained in the document and its proper interpretation are not subject to judicial notice if those matters are reasonably disputable." (*Unruh–Haxton v. Regents of University of California* (2008) 162 Cal.App.4th 343, 364.) Any matters judicially noticed must also be relevant. (*Mangini v. R.J. Reynolds Tobacco Co.* (1994) 7 Cal.4th 1057, 1063, reversed on other grounds.)

The Items are relevant to the issues in this proceeding, although the degree of relevance varies. The Accusation alleges two causes for discipline based on whether respondent departed from the standard of care. The standard of care is based on the conduct by members of the same profession under similar circumstances at or about the time of the incidents in question. (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997–998.) The impact of the second surge of the Covid epidemic on the practice of medicine in Southern California is therefore relevant to determining the standard of care expected during that time. The Items speak to what was occurring in the California community during that surge.

The ALJ therefore takes official notice that the Items were written or issued in response to the Covid surge faced by California in January 2022. However, the contents of those articles and the preamble of the order constitute administrative hearsay. As such, the use of the Items' contents will be restricted to supplementing or explaining direct evidence. (Gov. Code, § 11513, subd. (d).) Respondent's Request

therefore is granted for this limited purpose, and complainant's objections to granting official notice of the Items are overruled.

SUMMARY OF DECISION

Complainant seeks to discipline respondent's medical certificate based on respondent's care and treatment of a 90-year-old Covid-positive patient admitted to San Gabriel Valley Medical Center (SGVMC) for altered mental status in January 2022. (The patient is identified as Patient 1 to protect his privacy.) Complainant alleges that respondent, as Patient 1's hospitalist, was grossly negligent in treating Patient 1's confusion and weakness and negligent in treating Patient 1's pulmonary infiltrates. Complainant also alleges the deficiencies in respondent's record keeping regarding Patient 1's care constituted gross negligence and violated the record keeping requirements set forth in Business and Professions Code section 2626. (All further undesignated statutory references are to the Business and Professions Code.)

Complainant did not prove by clear and convincing evidence respondent was grossly negligent in treating Patient 1's confusion and weakness or negligent in treating Patient 1's pulmonary infiltrates. However, complainant proved by clear and convincing evidence respondent's documentation of Patient 1's care was grossly deficient and violated section 2626. Although respondent's poor records did not interfere with Patient 1's care at SGVMH, his records would be of no assistance to a doctor treating Patient 1 elsewhere or in any legal proceedings relating to Patient 1's care and treatment.

Respondent's failure to keep proper records occurred while he was on probation based in part on allegations of poor recordkeeping in two separate earlier

instances and after he had taken a medical record course ordered as part of that probation. However, respondent's misconduct also coincided with a Covid surge where conditions, particularly in community hospitals, made it difficult to practice medicine, and doctors, particularly older doctors with comorbid conditions such as respondent, were fearful of Covid exposure and took shortcuts to limit their time in the hospital preparing records.

While the emergency conditions of the Covid surge mitigate some of respondent's record-keeping shortcuts, they do not excuse respondent's significant omissions or misreporting of critical facts and analysis. At hearing, respondent acknowledged the gaps in his records and testified that his current records are more detailed and complete. Respondent has also taken another medical record course to make further improvements. Under these circumstances and the challenges of Covid on respondent's practice of medicine, public protection will be ensured by imposing a shortened probation period of three years with the requirement that respondent's records be monitored by a third party to make sure the records meet the regulatory requirements.

FACTUAL FINDINGS

Jurisdictional Matters

1. On March 25, 1985, the Board issued Physician's and Surgeon's Certificate Number A 41589 to respondent. The certificate is scheduled to expire on June 30, 2026.

2. On January 11, 2024, complainant, acting in his official capacity, signed the Accusation in this action. The Accusation alleges (a) respondent's treatment of

Patient 1's delirium and weakness and his documentation of his care and treatment of Patient 1 constituted gross negligence in violation of section 2234, subdivision (b); (b) respondent's grossly negligent acts and his negligent care of Patient 1's pulmonary infiltrates constitute repeated negligent acts in violation of section 2234, subdivision (c); and (c) respondent violated section 2266 and committed unprofessional conduct by failing to keep adequate and accurate records of his care and treatment of Patient 1.

3. On January 29, 2024, respondent timely filed a Notice of Defense requesting a hearing to present a defense to the charges contained in the Accusation.

4. All jurisdictional requirements were met to allow this hearing to proceed.

General Background

COMPLAINT TO THE BOARD

5. On February 14, 2022, the Board received a consumer complaint from one of Patient 1's two daughters concerning respondent's care and treatment of Patient 1 during Patient 1's stay at SGVMC from January 3, 2022, until January 12, 2022. (All further date references are to 2022 unless stated otherwise.) According to the complaint, Patient 1's health deteriorated under respondent's supervision, and Patient 1 had to be transferred to another hospital.

RESPONDENT'S BACKGROUND

6. Respondent earned his medical degree in 1974 in India. He completed his internship and residency in internal medicine and a fellowship in critical care medicine in the United States. Respondent became board-certified in Internal Medicine in 1982 and in Emergency Medicine in 1992. His Emergency Medicine board

certification has since lapsed. Respondent is also board-eligible in Critical Care Medicine.

7. During his medical career, respondent has held numerous clinical, managerial, and administrative positions, including medical director, chief of staff, emergency room physician, and hospitalist at various hospitals and clinics in Southern California. Respondent currently sees patients in private practice, is the medical director and owner of several medical clinics, and is a contract provider at several hospitals.

8. Respondent was Patient 1's hospitalist during Patient 1's stay at SGVMC. At the time, respondent treated approximately 25 patients a day at SGVMC and other facilities in addition to fulfilling managerial duties at several clinics and skilled nursing facilities. Respondent worked approximately eight to 10 hours a day. Because of comorbid conditions and his age, respondent did not treat hospitalized patients during the initial stage of the Covid pandemic. He returned to performing hospital work after he was vaccinated.

9. Southern California was experiencing a Covid surge when Patient 1 was admitted to SGVMC in January. SGVMC, as a community hospital, was especially hard hit and suffered from patient overload and staff shortages. Doctors and nurses were in short supply. Emergency department (ED) admissions were delayed. Covid patients were segregated on separate floors. SGVMC protocols required hospital personnel to wear masks and personal protective equipment (PPE) when examining and treating patients. SGVMC also implemented quarantine measures, including prohibiting Covid patients from having visitors.

///

RESPONDENT'S PRIOR DISCIPLINE

10. On May 28, 2019, in case number 800-2015-017490, the Board revoked respondent's certificate, then immediately stayed the revocation, and placed respondent on probation for four years with terms and conditions (May 2019 Order). The May 2019 Order was based on an accusation filed in 2018 charging respondent with repeated negligent acts in prescribing controlled substances to two patients between 2012 and 2017, inadequate record keeping reflecting his care of the two patients, and failure to provide certified medical records to the Board (2018 Accusation). Specifically, and pertinent here, the 2018 Accusation alleged respondent departed from the standard of care because he failed to formulate a well-defined treatment plan for both patients and failed to document a physical examination and important aspects of the presentation of one of the patients.

11. In a stipulated settlement of the action, respondent agreed that the charges and allegations in the 2018 Accusation, if proven at a hearing, would constitute cause for discipline. As part of the agreed-upon terms and conditions of his probation, respondent took a prescribing practices course and a medical record keeping course. Respondent complied with the terms and conditions of his probation. The Board fully restored respondent's certificate and released him from any probation requirements on June 26, 2023. At the time of the daughter's complaint to the Board, respondent had been on probation pursuant to the May 2019 Order for nearly two and a half years.

///

///

///

Treatment of Patient 1

PRE-HOSPITALIZATION

12. On January 3, Patient 1, a 90-year-old unvaccinated man, was admitted to SGVHC for altered mental status. Patient 1 had tested positive for Covid two weeks earlier. After exhibiting mild symptoms, Patient 1 had been treated with Vitamin D3, oral antibiotics, fluvoxamine, ivermectin, and hydroxychloroquine. On December 28, 2021, Patient 1 received a monoclonal antibody infusion, ordered by his then-treating physician.

13. The day before he was admitted to the SGVMC, Patient 1 began exhibiting uncharacteristic confusion. Although he was previously cognizant of time, respondent began asking odd and redundant questions regarding when certain events were supposed to happen. The doctor treating Patient 1 advised his two daughters to take Patient 1 to the hospital for testing.

14. Because of the Covid surge, Huntington Hospital, the daughters' preferred hospital, was closed to new patients. Patient 1 was therefore taken by ambulance to SGVMC. SGVMC's ED was at capacity when Patient 1's ambulance arrived, and Patient 1 waited several hours in the ambulance in the hospital's parking lot before he was permitted entry.

15. Patient 1's daughters, who both testified at hearing, described Patient 1 before his hospitalization as active and independent with intact cognitive abilities. Although both daughters lived with Patient 1, Patient 1 walked without assistance, drove, and paid bills on his own. The daughters characterized Patient 1 as alert and mobile before his SGVMC admission.

16. Patient 1 had pre-existing health problems, including hypotension, a pacemaker, thyroid problems, and chronic painful orthopedic ailments. To ease his pain, Patient 1 had taken Norco up to six times a day for 20 years. Patient 1's daughters did not observe Patient 1 exhibit any cognitive or functional deficits resulting from his Norco use.

EMERGENCY ROOM TREATMENT

17. Patient 1 tested positive for Covid based on an antigen rapid test administered to him when he was seen in the ED. In the ER, Patient 1 denied any symptoms. The ED doctor who initially examined Patient 1 found no shortness of breath, cough, or respiratory symptoms in her exam. She noted Patient 1 had no focal deficits and "moved all extremities with good strength." (Exhibit 11, p. A368.) However, because of complaints by Patient 1's daughters regarding Patient 1's confusion, the ED doctor ordered full laboratory testing, a Covid workup, and imaging of Patient 1's head and chest. Patient 1 spent the night of January 3 in the ED.

18. Patient 1's head scan showed no acute abnormalities, so the second ED doctor treating Patient 1 ruled out a stroke. However, the doctor determined Patient 1 had pneumonia based on Patient 1's chest CT scan. That scan showed diverse bilateral multifocal, multilocular ground glass opacifications, which the radiologist deemed suspicious for multifocal pneumonia, and showed Patient 1 to be suffering from coronary artery disease. The scan showed no evidence of a pulmonary embolism. The lab test results confirmed Patient 1 was Covid positive and that he had a low sodium level of 129 (normal range is between 135 and 142), which was considered mild hyponatremia. (Hyponatremia is a known cause for confusion.) The ED doctor's diagnostic impression was of Covid pneumonia and encephalopathy. He noted Patient 1's condition had "a high potential for decompensation and/or shock." (Exhibit 11, p.

A365.) Patient 1 was admitted to rule out a stroke "versus metabolic encephalopathy versus Covid-associated encephalopathy" due to Patient 1's "acute onset of confusion and mental status change." (*Id.*, p. A364.) Patient 1 was not hypoxic at the time.

19. Patient 1 was not transferred out of the ED until late January 4 or early January 5. While in the ED, Patient 1 received medication and intravenous (IV) fluids, including two IV antibiotics (azithromycin and Rocephin), a steroid (dexamethasone), and IV sodium boluses. The ED medical notes did not mention the basis for treating Patient 1 with these medications. Patient 1 also received haloperidol, Benadryl, and lorazepam during his stay in the ER after he purportedly became agitated and combative after he was unable to receive his regular Norco dose.

20. While in the ED, Patient 1's oxygen saturation levels on room air ranged from 92 to 97 percent. (Exhibit 11, pp. A193–A196.) The nursing notes show Patient 1 was intermittently confused, required maximum assistance with movement, was at high risk for falling, and was generally weak in all his extremities, contrary to the ED doctor's report. (*Id.*, p. A230–A233.) The nurses also reported that Patient 1 repeatedly attempted to get out of bed and pulled off his heart monitor. (*Id.*, p. A233.)

POST-ED TREATMENT

Respondent's Care of Patient 1

21. Respondent previously treated Patient 1 without issue at SGVMC for a blood clot caused by an arm injury after a fall, although the dates of the treatment were not made known. A physical therapy note states Patient 1 was previously admitted to SGVMC in May 2021 (Exhibit 11, p. A293); it is unclear whether respondent treated Patient 1 during that admission.

22. Respondent was assigned to Patient 1's care on January 4, and he learned of Patient 1's transfer out of the ED in the early morning of January 5. Before seeing Patient 1, respondent ordered Patient 1 admitted to the telemetry floor and placed in isolation per SGVMC's Covid protocols. Respondent also continued the ED's administration of IV fluids and antibiotics as well as ordered an infectious disease (ID) consult. Respondent ordered Patient 1 to receive three more days of steroids. Because of the ED nurses' stated concerns regarding Patient 1's fall risk and his pulling off his heart monitor, respondent ordered Patient 1 to be restrained with bilateral soft wrist restraints; however, consistent with SGVMC protocol, he placed a 24-hour limit on the restraint order and directed the nurses to reassess Patient 1's need for restraints every two hours.

23. Respondent restarted Patient 1's Norco prescription, which had been discontinued while Patient 1 was in the ED. The nurse's order states that Patient 1 was to receive the medication every four hours. The records show the nurses gave Patient 1 Norco approximately every four hours except when he was asleep or refused the medication. In each instance, Patient 1's pain level was assessed to be high, and after taking Norco, Patient 1 reported decreased pain.

24. Respondent first saw Patient 1 later in the morning of January 5. In his note of that visit (January 5 Progress Note), respondent reported the chief complaint to be "altered mental status." In his history of present illness (HPI), respondent wrote that Patient 1 presented to the ED for evaluation of his altered level of consciousness and noted that Patient 1 was Covid positive with a CT chest scan showing multifocal pneumonia. Respondent included in the January 5 Progress Note a list of the dose and frequency of Patient 1's home medications as well as Patient 1's vital signs, which he imported from Patient 1's nursing notes. Respondent's physical examination found

Patient 1 to be "in no distress but confused," yet also alert and oriented to person, place, and time with no focal neurological deficits and his cranial nerves intact. Respondent found Patient 1's chest sounds to be clear.

25. The January 5 Progress Note included laboratory results from tests ordered earlier by respondent, which showed Patient 1's sodium levels were now within the normal range (136). Respondent also included the imaging study results from Patient 1's CT scans. Respondent's assessment of Patient 1's condition was COVID pneumonia and encephalopathy. (Exhibit 11, pp. A372–A373.)

26. The January 5 Progress Note states respondent's plan was to seek a pulmonary evaluation, an infectious disease (ID) evaluation, and "as per order sheet." (Exhibit 11, p. A373.) Respondent's nursing orders that day included a consult with Rupdev Khosa, M.D., a physiatrist and pain management specialist; a swallow evaluation and skilled speech therapy; physical therapy consult; an occupational therapy consult; continuous pulse oximetry monitoring; a lipid panel; and repeat labs, including a basic metabolic panel and complete metabolic panel. (*Id.*, pp. A158–A163, A307, A317, A318, A322.)

27. Over the next seven days, respondent's treatment of Patient 1 was essentially unchanged. Respondent kept Patient 1 on the telemetry floor, restrained by soft wrist restraints and under Covid quarantine. Patient 1 received Norco, IV fluids, and IV antibiotics through the course of his stay. Respondent stopped Patient 1's steroids after three days, but Jessica Mantilla, M.D., the ID doctor consulting on Patient 1's care, restarted them on January 11, two days before Patient 1's discharge.

28. On January 7, Patient 1 had another chest CT scan, which showed his pulmonary infiltrates had improved. That same day, the lab reported that as of January

4, Patient 1 had a positive culture showing a possible urine infection. On January 9, respondent ordered another complete blood count, basic metabolic panel, and a PCR Covid test. Those test results indicated Patient 1 was still Covid-positive, but his sodium levels had dropped to 130. Except for two more PCR Covid tests, respondent did not order any additional testing for Patient 1 after January 9 or any additional chest radiographs after January 7. Respondent did not seek another urine culture. Respondent did not seek a neurology consult. On January 9, he ordered a psychiatric consult, but canceled the order the same day.

29. Patient 1 was treated by a speech therapist during his hospital stay, as ordered by respondent. The speech therapist diagnosed Patient 1 with dysphagia, administered a swallow test, and monitored Patient 1's food intake. Patient 1 also received a physical therapy consult on January 6, during which the therapist concluded Patient 1 was ambulatory and did not require skilled physical therapy. After additional orders by Dr. Khosa and respondent, Patient 1 resumed physical therapy on January 10 and was again treated on January 12. It appears Patient 1 never received the occupational therapy consult ordered by respondent; there was no evidence presented on this issue.

30. Dr. Mantilla, the ID specialist, examined Patient 1 almost every day during his hospital stay. Dr. Mantilla did not raise any questions regarding respondent's treatment and care of Patient 1 in her notes. She noted Patient 1's altered mental status, his hyponatremia, and encephalopathy. According to her progress notes, Dr. Mantilla heard rales when examining Patient 1's lungs. Dr. Mantilla noted Patient 1's positive urine culture results, but did not address those results in her assessment or plan. Dr. Mantilla also noted that Patient 1 did not need further Covid-specific therapy because he had already been treated with monoclonal antibodies and was

asymptomatic. It was Dr. Mantilla's suggestion and order that resulted in Patient 1's January 7 chest CT.

31. Regarding Patient 1's medication, Dr. Mantilla stated Patient 1 was "on steroids per primary." (Exhibit 11, p. A352.) After Patient 1 completed his course of steroid therapy, Dr. Mantilla ordered the resumption of steroids after Patient 1's oxygen saturation levels decreased on January 11. Dr. Mantilla stopped Patient 1's antibiotics on January 12, the day of his discharge, after respondent had taken each of them for seven days.

32. Dr. Mantilla's notes were often inaccurate, unclear, and susceptible to conflicting interpretations. Dr. Mantilla noted the number of days of Patient 1's antibiotic course, but the number was often wrong. For instance, on January 10, Dr. Mantilla reported Patient 1 was on his fifth day of antibiotics; however, the medical records indicate Patient 1 had taken antibiotics for six days at the time of the report. Her January 11 progress report refers to "s/p [status post] antibiotics"; however, the medical records indicate respondent was still taking antibiotics at that time. Dr. Mantilla never made clear her intent regarding the timing of Patient 1's antibiotic treatment. (Exhibit 11, p. A191.)

33. Dr. Khosa saw Patient 1 almost every day of his hospitalization. He too did not raise any questions about respondent's care and treatment of Patient 1 in his progress notes. In those notes, Dr. Khosa noted Patient 1's confusion and altered mental status but reported that Patient 1 obeyed commands. He too found no shortness of breath, but he also heard a few rales. According to Dr. Khosa's initial note, he performed a neuromuscular examination which found Patient 1 to have moderate muscular strength in both arms (between 3/5 and 4/5) and to have weaker strength in his hips, knees, and ankles (between 2/5 and 3/5). Dr. Khosa also reported that Patient

1 had difficulty with balance, had functional deficits, and required moderate to maximal assistance. According to Dr. Khosa's plan and assessment, which was generally same through Patient 1's hospitalization, Patient 1 was to start with physical therapy and then transfer to an intensive rehabilitation treatment and intervention after treatment in the hospital for a few days.

34. During his hospital stay, Patient 1's condition waxed and waned; some aspects of his condition improved, while others worsened. Patient 1 continued to test positive for Covid as of January 12 based on a PCR test. His chest sounds varied between clear, diminished, or rales; on January 12, respondent reported Patient 1's chest to sound clear to auscultation. Patient 1's pneumonia improved as evidenced by the January 7 CT scan. Patient 1 remained intermittently confused, and he was continuously restrained until a few hours before his discharge. However, on January 11, the speech therapist noted Patient 1 "verbalized at the phrase level in clear vocal quality," and on January 12, Patient 1 was "constantly talking and moving." (Exhibit 11, p. A296.) Although he experienced no shortness of breath or respiratory difficulties, by the end of his stay, Patient 1's oxygen saturation level had decreased so that he required a nasal cannula and was at times receiving up to four liters of oxygen.

35. Although Patient 1's physical strength appeared to diminish during his hospitalization, the extent of that diminishment was unclear from the evidence. Patient 1's daughters testified that he walked to the ambulance and into the ED. Dr. Margaritis's January 3 note states that Patient 1 had good strength in his extremities. However, the next day, the ED nurses reported Patient 1 was generally weak in all his extremities and a fall risk, and he needed moderate to maximal assistance. Dr. Khosa, too, found on January 5 that Patient 1 needed moderate to maximal assistance, had balance difficulties, and evidenced weakness in his hips, ankles, and legs and moderate

strength in his arms. A physical therapy examination on January 6 contradicted Dr. Khosa's and the ED nurses' observations, noting Patient 1 to be ambulatory and finding no indication for skilled physical therapy. On January 10, a physical therapist found respondent to have poor standing balance but scored Patient 1 to have a 4 out of 5 in muscle strength and indicated Patient 1 could walk with a walker. On January 12, Patient 1 was able to perform three sit-to-stand exercises, standing for less than 30 seconds each time, and was also able to take three side steps. However, the therapist also noted Patient 1 needed moderate to maximal assistance scooting, going from sitting to standing, and from the bed to the chair.

PATIENT 1'S DISCHARGE FROM SGVMC

36. Patient 1's daughters were unhappy with Patient 1's treatment by SGVMC and frustrated by their inability to communicate with Patient 1's doctors. From January 5 through January 9, Patient 1's daughters were unable to speak with any doctor regarding Patient 1's care. They learned of plans to send Patient 1 to a rehabilitation facility only after receiving a call from Patient 1's case manager regarding the proposed transfer. The nursing notes indicate the daughters insisted on speaking with respondent on January 8, but respondent did not speak to the daughters until January 9.

37. In their telephone call with respondent and their communications with SGVMC management and Patient 1's nurses, the daughters made clear they wanted Patient 1 released as soon as possible. The daughters objected to transferring Patient 1 to an intensive rehabilitation facility for physical therapy and insisted they were able to care for Patient 1 at home. The daughters were aware respondent disagreed with discharging Patient 1 at this time because he was still Covid-positive and had not completed his antibiotic treatments.

38. After his call with Patient 1's daughters, respondent and SGVMC case management prepared for Patient 1's discharge. Respondent ordered Patient 1 to receive home health care with home physical therapy, home oxygen, and a front-wheel walker. Respondent also placed a hold on Patient 1's discharge until his antibiotic therapy was finished.

39. On January 12, 2022, Patient 1 was discharged from SGVMC to his daughters' care. The daughters testified that Patient 1's condition on discharge was worse than when he was admitted to the hospital. They reported he was unable to speak or stand, and his mental state had deteriorated.

HUNTINGTON HOSPITAL

40. On January 14, less than two days after his discharge from SGVMC, Patient 1's daughters brought Patient 1 to Huntington Hospital because of confusion and poor oxygenation. Patient 1 remained at Huntington Hospital for five days. On January 20, Patient 1 was transferred to Huntington Hospital's rehabilitation unit, where he remained until February 1.

Documentation

41. In January 2022, at the time of Patient 1's stay, SGVMC lacked the technology to allow its physicians to prepare their charting outside of the hospital. Physicians had to input their notes at a hospital computer terminal. The physicians had access to a patient's lab tests, imaging studies, nursing notes, and notes from consulting doctors and health providers via the terminal when they prepared their own charts. The different health provider charts were accessible at separate tabs in the patient's electronic file.

42. Respondent prepared eight progress notes, including his initial note, reflecting each of his visits with Patient 1. Respondent's subjective observations contained in the notes were terse and contained little detail. Although respondent repeatedly described Patient 1 as confused, he did not explain how that confusion manifested. Respondent did not address his reasoning for prescribing antibiotics and steroids. He at times noted a change in Patient 1's oxygen saturation rate, but he offered no analysis to explain the reasons for its change.

43. Respondent's progress notes were not up to date and often inaccurate. Although the progress notes imported the most recent vital signs from the nursing notes and the January 5 through January 9 progress notes either reported the most recent laboratory test results or stated no laboratory results were available in the past 12 hours, the January 10 through January 12 progress notes incorrectly stated no laboratory results were available and omitted the January 9 lab results altogether. Respondent never commented on the January 9 lab results in the notes. The notes did not indicate his awareness of Patient 1's positive urine culture.

44. Similarly, respondent repeated the imaging study results from the ER in each progress note, but he did not include the updated January 7 radiograph results in his progress notes until January 12. There was no indication in his progress notes that he was aware of the January 7 radiograph. Respondent also cut and pasted Dr. Khosa's assessment and plan from January 5 into every progress note. After January 6, 2022, respondent copied and pasted the same assessment of Patient 1's condition, i.e., Covid pneumonia, encephalopathy, functional deficits, recent Covid infection and pneumonia, low blood pressure and orthostasis on midodrine, and dysphagia, into every note.

45. Respondent's progress notes did not address the recommendations or findings of the other health care providers involved in Patient 1's care. Respondent did not mention the physical therapy he ordered for Patient 1, and there is no indication he was aware that the therapy had stopped on January 6, and did not resume until January 10. Respondent's notes did not refer to the occupational therapy respondent ordered for Patient 1, and it is unclear whether respondent knew if it was ever initiated.

46. Respondent's notes offered no insight into his decision making. He did not explain why he first ordered a psychiatric consult and then canceled it. He also did not explain why he did not pursue Dr. Mantilla's recommendation of a neurology consult. The notes contained no discussion regarding the orders regarding Patient 1's discharge. The notes did not reflect any of the conversations respondent had with Patient 1's daughters. The notes also did not address Dr. Mantilla's antibiotic dosage miscalculations.

47. None of respondent's entries under the "Plan" section of in his progress notes detailed respondent's intended course of Patient 1's treatment or the anticipated discharge of Patient 1. Respondent's Plan entries often directed the reader to look elsewhere to determine his treatment plan. For example, on January 6, January 11, and January 12, the entirety of respondent's Plan was to "continue current treatment," which had to be gleaned from several different sources; on January 7, the entirety of the Plan was to "discharge with hh [home health] for pt9medcare plus" without explanation; on January 8, the Plan was "dc [discharge] planning home with MedPlus home health," again without explanation; and on January 9, the Plan was "as per order sheet" (Exhibit 11, pp. A375, A377, A379, A381, A385.) On January 10, respondent reported no Plan; the Plan section was blank. (*Id.*, p. A382.)

48. Respondent's discharge summary is likewise sparse and omits critical information. The purpose of the discharge summary is to describe a patient's hospital stay and inform a future health care provider about a patient's treatment and care. Respondent's discharge summary of Patient 1's care and treatment contained no analysis or a full explanation of Patient 1's hospitalization. Respondent failed to note that SGVMC's discharge of Patient 1 was against medical advice. Respondent stated Patient 1's Covid pneumonia had been treated, and his encephalopathy had improved, but provided no details. Respondent stated Patient 1 had received telemetry, oxygen therapy, antibiotic therapy, and adjustment of medication during his hospital stay, but he did not describe the nature, effects, or success of such treatments. Respondent did not include Patient 1's steroid therapy or note Patient 1's worsening oxygen status.

49. Respondent did not identify Patient 1's consulting physicians in the Discharge Summary; the summary states only that Patient 1 had a physical therapy consult. The summary states that fall and safety precautions were implemented, but the summary fails to mention Patient 1 was restrained for the entirety of his stay. Respondent notes that Patient 1's course of hospitalization was "stable," even though Patient 1 had worsening oxygenation. Respondent inexplicably incorporated Dr. Khosa's assessment and plan into the summary. He included the results of Patient 1's first chest CT but omitted the results of the second chest CT taken on January 7.

///

///

///

Respondent's Evidence

DR. KHOSA'S TESTIMONY

50. Dr. Khosa is board-certified in physical medicine and rehabilitation medicine. Dr. Khosa treats patients who present with neurological problems and muscle weakness, and he also has experience in pain management. Most of Dr. Khosa's patients are elderly, and he has experience treating Covid patients. On July 27, 2017, the Board publicly reprimanded Dr. Khosa for his inadequate or inaccurate documentation in violation of sections 2234 and 2266 and ordered Dr. Khosa to take a recordkeeping course and a prescribing practices course.

51. Dr. Khosa did not have a specific recollection of Patient 1, and his testimony was based on his review of Patient 1's records. Dr. Khosa testified that a patient presenting with pneumonia would take 10 to 14 days to recover in the hospital, and the patient then would be eligible for rehabilitation. Dr. Khosa explained that Patient 1's loss of muscle strength and increasing functional deficits during his hospitalization were not unusual for someone who is elderly, hospitalized, and bedridden for seven days with little activity. Dr. Khosa asserted that Patient 1's weakness could be addressed successfully through intensive physical therapy and rehabilitation, preferably at an acute rehabilitation facility. Dr. Khosa therefore concurred with respondent that Patient 1 should be treated at an acute rehabilitation facility after Patient 1 was well enough to be transferred.

52. Dr. Khosa testified he did not believe Patient 1 needed to see any other consults. He was not concerned about Patient 1's declining oxygenation rate, considering the length of his hospital stay. Dr. Khosa averred that Patient 1's mental status was improving while he was at SGVMC. Dr. Khosa noted that by the end of his

hospital stay, Patient 1 was more interactive, talked in short sentences, and followed one-step instructions.

RESPONDENT'S TESTIMONY

53. At hearing, respondent explained his approach to treating patients was to find the most likely and immediate medical problem and then address it. Respondent did not look for outliers or "zebras," as he described them, when he first saw a patient. When caring for the elderly, respondent also did not implement changes in treatment too quickly unless the circumstances warranted such an approach. Respondent intended his treatment to be "slow" and to do only "little things" because the patient's status might improve without too much intervention. Respondent asserted this approach was consistent with a community hospital's clinical approach.

54. Respondent contended that Patient 1's encephalopathy stemmed from his pneumonia, and treating the pneumonia would assist in resolving Patient 1's confusion. Respondent explained that an individual presenting with pneumonia and encephalopathy takes about 10 to 14 days to improve. Respondent's treatment was to order steroids and antibiotics during that time to address Covid and bacterial pneumonia, respectively. Respondent also ordered a swallow study to rule out aspirational pneumonia. Respondent recognized that keeping an elderly patient in the hospital for that length of time would result in significant muscle weakness; however, respondent expressed it was more important first to effectively treat the pneumonia and then treat the patient's muscle weakness through either home physical therapy or therapy at a rehabilitation facility. He ordered Dr. Khosa to consult on the matter to monitor Patient 1's weakness. Respondent also ordered Patient 1 to receive a physical

therapy consult. Respondent expected that once Patient 1's condition improved, he would discharge Patient 1 to a rehabilitation facility.

55. Respondent explained and defended each of his decisions relating to Patient 1's care. Respondent viewed Patient 1 to be at high risk of decompensation because of his age and his Covid and pneumonia status, as well as his history of coronary artery disease. Respondent asserted these conditions required the close and constant monitoring available in a telemetry room. According to respondent, Patient 1 would have access to more nurses in a telemetry room. Additionally, Patient 1's medications required IV administration, and Patient 1 was receiving IV saline boluses to make sure his sodium levels remained within the normal range.

56. Respondent allowed Patient 1 to continue his Norco use in the hospital because he did not believe taking an opiate was problematic in Patient 1's case. Patient 1 had taken Norco for 20 years without impairing his functional activities. His daughters had insisted that Patient 1 receive his regular Norco dose. Patient 1 had become violent and agitated in the ED when he did not have access to Norco to alleviate his pain. Respondent testified he told the nurses only to provide Norco to Patient 1 when needed, i.e., when his pain status was between six to 12. He believed the nurse taking his order mistakenly stated that Patient 1 should receive Norco every four hours.

57. Respondent initially considered ordering neurological, pulmonary, and psychiatric consults, but he then decided Patient 1's condition did not warrant further intervention. Patient 1 never suffered from respiratory stress, so respondent decided a pulmonary consult was not needed. Respondent did not call for a neurology consult for Patient 1 because he did not suspect Patient 1 to have another neurological infection, and the CT scan showed Patient 1 did not have a stroke or any structural

neurological problems. Respondent was also concerned that a neurologist would order a lumbar puncture, and respondent did not want to subject Patient 1 to an invasive procedure that appeared to be unnecessary.

58. Respondent asserted his order for passive restraints was in response to the nurses' concerns. Respondent continued the order because the nurses repeatedly reported Patient 1 pulled out his tubes and wires and tried to climb out of bed whenever they removed the restraints.

59. Respondent explained that he did not order another urine culture after receiving the January 7 results because the positive culture was not significant. Respondent maintained that a 20,000 streptococcal colony count, which was reported for Patient 1, was of little concern, and action was only required if Patient 1's streptococcal colony count rose to or above 100,000. Respondent asserted that Patient 1's urine culture results were most likely an indication of a contaminant and were not the result of an infection. Respondent also asserted that the Rocephin antibiotic Patient 1 received would address any urinary tract infection.

60. Respondent acknowledged that his notes reflecting Patient 1's course of treatment did not contain detail or analysis. He asserted that the lack of detail and analysis was a result of the emergency conditions of the Covid surge, and the notes were not typical of his usual style of charting. Respondent described his charting during Covid as "lean and mean." According to respondent, he and other doctors did their charting quickly outside the patient's room and after seeing their patients to limit their time in the hospital and reduce their exposure to Covid. Respondent therefore cut and paste the patient's vital signs, lab and image study results, and pertinent consultant observations and recommendations into the chart to signal to others he had considered that information. Nonetheless, respondent maintained he personally

charted the patient's main complaint, his examination results, his impressions, and his plan.

61. Respondent acknowledged his plan oftentimes directed the reader to look elsewhere, including his phone orders and the nurse's notes, to determine and analyze his actions. Respondent asserted the phone orders, notes, and other patient records were easily accessible on the computer terminal to all the patient's treating physicians. According to respondent, during Covid, doctors increasingly relied on phone orders to communicate with nursing staff and other doctors because the calls could be initiated outside the hospital. Respondent also testified his failure to include a plan in one progress note was a mistake.

62. Respondent acknowledged he also made a mistake in his discharge summary by omitting that SGVMC had discharged Patient 1 against his medical advice. He did not explain his other omissions or reporting of incorrect facts. However, respondent defended his description of Patient 1's hospitalization as uncomplicated. He asserted that although Patient 1 had a complex pneumonia, Patient 1 only suffered a small dip in oxygenation that was addressed with supplemental oxygen, he was never in acute respiratory distress, his hyponatremia was treated, his cognition slightly improved, Patient 1 was never agitated outside of the ED, and everything else was stable and ran the expected course. Respondent further asserted that a slight change in oxygenation and the use of a nasal cannula are not significant developments for an elderly bedridden patient, and in Patient 1's case, did not represent a total deterioration of his condition.

63. Respondent testified that the Covid protocols, including medication protocols, were constantly changing during 2021 and 2022, and "everyone was learning at that time." Before and during Patient 1's stay, respondent attended weekly

or bi-weekly education seminars on Covid testing therapies and guidelines offered in collaboration with the University of Southern California, the University of California, Los Angeles, and the University of California, San Francisco. Since then, respondent has taken additional courses on Covid treatments.

64. After the Accusation was filed, and to address the Board's concerns about his medical record keeping, respondent participated in a two-day (17 AMA PRA Category 1 Credits) PBI Medical Record Keeping Class at the University of California, Irvine School of Medicine. Respondent asserted the class was not duplicative of the medical record keeping class he took as part of his probation. Respondent also participated in a three-day (19 AMA PRA Category 1 Credits) Pri-Med West 2024 conference on primary care in Anaheim. Respondent testified he is constantly expanding his knowledge through his use of UpToDate, a clinical information website.

65. Respondent presented as a knowledgeable physician who understood the diseases he treated. His testimony about working conditions during the Covid surge was credible. Respondent's testimony regarding his treatment choices for Patient 1 is less credible. Respondent treated Patient 1 three years ago, and respondent's notes regarding those treatments contained no detail or analysis. At hearing, respondent acknowledged several times that he could not recall certain events relating to Patient 1's care. Therefore, it cannot be determined whether respondent's current rationale for his treatment of Patient 1 is the same as it was in January 2022. Since that time, respondent has been exposed to an influx of information about Covid as well as the opinions of his lawyers and his expert regarding his care and treatment of Patient 1. Thus, without a written record of respondent's thoughts and analysis contemporaneous with his care and treatment of

Patient 1, it is impossible to assess what effect, if any, those opinions and newly acquired knowledge had on respondent's recollection.

Expert Testimony

COMPLAINANT'S EXPERT

66. Bruce Cohn, M.D., testified as an expert witness on complainant's behalf. Dr. Cohn set forth his opinions of respondent's treatment of Patient 1 in an expert report dated May 25, 2023 (Exhibit 17). The opinions in his report are based on his review of the complaint, SGVMC's medical records, the records from Patient 1's treating physician for Covid, the Board's investigative report, and the transcript of respondent's interview with the Board. After completing his report, Dr. Cohn reviewed Huntington Hospital's records of Patient 1's treatment. Dr. Cohn's testimony expanded on the opinions in his report.

67. Dr. Cohn obtained his California medical certificate in 1981. He has been board-certified in internal medicine since 1984. He currently practices as a hospitalist at Kaiser Permanente in Roseville in Northern California (Kaiser). He also practices as an outpatient primary care and HIV-treating physician at Kaiser. Dr. Cohn is a volunteer clinical professor at the University of California, Davis, and has been an expert reviewer for the Board for over 20 years.

RESPONDENT'S EXPERT

68. Andrew Stuart Wachtel, M.D., testified as an expert on respondent's behalf. His testimony and his report, dated October 9, 2024 (Exhibit C), was based on his review of the complaint, Patient 1's hospital records from SGVMC and Huntington Hospital, the records from Patient 1's treating physician for Covid, the transcript of

respondent's interview, Dr. Cohn's expert report, and the Board's investigation reports. Dr. Wachtel's testimony was consistent with his report.

69. Dr. Wachtel is licensed to practice medicine in California. He is triple-board certified, having obtained certification in internal medicine in 1984, in pulmonary medicine in 1986, and in critical care medicine in 1989. Dr. Wachtel served as the Clinical Chief of Pulmonary Medicine at Cedars-Sinai Medical Center (Cedars-Sinai) from 1990 to 1994, was a member of the Executive Committee at Cedars-Sinai from 1990 to 1994 and 2002 to 2003, and was an Associate Clinical Professor of Medicine from 2006 through 2017 at the University of California, Los Angeles. Dr. Wachtel is a co-director of the Southern California Institute for Respiratory Diseases, a board member of the American Lung Association of Los Angeles, and the previous director of the Adult Cystic Fibrosis Center at Cedars-Sinai. He is currently in private practice and serves as an attending physician and a full clinical professor of medicine at Cedars-Sinai.

CONSIDERATION OF EXPERT TESTIMONY

70. In determining the weight of each expert's testimony, the expert's qualifications, credibility, and bases for the opinions were considered. California courts repeatedly underscore that an expert's opinion is only as good as the facts and reason upon which that opinion is based: "Like a house built on sand, the expert's opinion is no better than the facts on which it is based." (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923.)

71. An expert's failure to consider all the facts may make his opinions less persuasive (*People v. Coddington* (2000) 23 Cal.4th 529, 614), and the expert may be examined about whether the expert sufficiently took into account matters arguably

inconsistent with the expert's conclusions. (*People v. Ledesma* (2006) 39 Cal.4th 641, 695.) An expert's opinion may be rejected if the reasons given for it are unsound. (*Kastner v. Los Angeles Metropolitan Transit Authority* (1965) 63 Cal.2d 52, 58.)

72. Here, both Dr. Cohn and Dr. Wachtel are well-qualified to opine regarding the standard of care and whether respondent's treatment of Patient 1 comported with that standard. However, to the extent that the standard of care relates to pulmonary issues, the opinions of Dr. Wachtel, as a board-certified pulmonologist with extensive experience treating Covid and lung ailments, are entitled to greater deference. Dr. Wachtel additionally has practiced medicine in Southern California since 1984. Unlike Dr. Cohn, Dr. Wachtel is familiar with the impact of the Covid surges on the practice of medicine in Southern California hospitals.

TREATMENT OF DELIRIUM AND WEAKNESS

Dr. Cohn's Opinion

73. Dr. Cohn asserted that the standard of care for evaluation of delirium requires an assessment of the cause of the delirium, identifying factors that could exacerbate the delirium, and introducing interventions that may favorably modify the delirium. Dr. Cohn asserted that the standard of care for evaluation and management of weakness requires clinicians to attempt to identify medical conditions that may be contributing to the weakness and introduce interventions to prevent further weakness and improve functional status. Dr. Cohn opined respondent's treatment of Patient 1's encephalopathy and weakness was an extreme departure from these standards of care.

74. Dr. Cohn contended respondent did little to address the causes of Patient 1's delirium. According to Dr. Cohn, respondent immediately concluded Patient 1's encephalopathy stemmed from his pneumonia, and he offered no differential

diagnosis. Dr. Cohn asserted the standard of care required respondent to explore whether Patient 1's delirium was due to his use of Norco or from possible nutritional deficiencies, liver disease, or steroids. Dr. Cohn asserted the standard of care also required respondent to have taken additional urine tests to confirm that Patient 1's positive urine culture was insignificant and not contributing to his confusion. Dr. Cohn opined respondent departed from the standard of care by failing to order a psychiatric or neurological consult to further explore the causes of Patient 1's confusion.

75. Dr. Cohn maintained respondent did not order any interventions to modify Patient 1's delirium. He faulted respondent for a lack of a plan to treat the condition. According to Dr. Cohn, respondent's only plan was to wait until Patient 1's condition improved, although he failed to identify the criteria for such improvement, and then transfer Patient 1 to an acute rehabilitation facility. In the meantime, Dr. Cohn asserted that Patient 1 remained in restraints, and his cognitive abilities and weakness worsened.

76. Dr. Cohn opined that respondent pursued treatments that aggravated Patient 1's delirium. Dr. Cohn cited respondent's choices to treat Patient 1 with steroids and continue Patient 1's Norco as problematic, as both medications could aggravate Patient 1's delirium. It was Dr. Cohn's opinion that respondent had no reason to prescribe steroids to Patient 1 because the medication was not recommended for treating Covid patients who had normal oxygen saturation. Dr. Cohn acknowledged Patient 1 had taken Norco for 20 years without incident, but he opined Patient 1's Covid infection may have affected his tolerance. He further asserted the standard of care required respondent to consider tapering Norco to test the necessity of the high dose then administered.

///

77. Dr. Cohn asserted respondent's failure to assess whether respondent's placement of Patient 1 in a telemetry room contributed to Patient 1's delirium departed from the standard of care. Dr. Cohn opined that Patient 1 did not require IVs or constant monitoring because he had no current cardiac issues and his IV antibiotics could have been taken orally. Dr. Cohn further opined that restraining Patient 1 may have been unnecessary if Patient 1 had been free of IV tubing and monitoring devices. Dr. Cohn also criticized respondent for failing to advocate for a sitter or Patient 1's daughters to be with Patient 1.

78. It was Dr. Cohn's opinion that respondent departed from the standard of care because he failed to address Patient 1's weakness. In his report, Dr. Cohn mistakenly faulted respondent for failing to consider physical therapy interventions to counteract Patient 1's weakness and stated he could not identify any physical therapy orders in the records. However, the medical records include both respondent's and Dr. Khosa's physical therapy orders and indicate Patient 1 was seen three times by physical therapists. Dr. Cohn also opined respondent's decision to keep Patient 1 in restraints exacerbated Patient 1's weakness.

Dr. Wachtel's Opinion

79. Dr. Wachtel disagreed with Dr. Cohn's opinion that respondent's treatment of Patient 1's delirium and weakness constituted an extreme departure from the standard of care. His opinion is that respondent's treatment of Patient 1's delirium and weakness was appropriate and consistent with the standard of care.

80. Dr. Wachtel disputed Dr. Cohn's assertion that respondent failed to investigate the reasons for Patient 1's delirium and weakness. Dr. Wachtel acknowledged respondent's differential diagnosis was not identified in his charts.

However, Dr. Wachtel asserted respondent had considered and excluded other causes of delirium. He noted the CT scan, several repeat chemical panels, a thyroid panel, and other laboratory tests ordered by respondent excluded structural abnormalities and thyroid issues that could cause delirium, and Patient 1's urine tests did not show significant abnormalities. Dr. Wachtel also disagreed that respondent needed to test for thiamine or folate deficiencies, contending that Patient 1 was not an alcoholic, he was well-nourished, and there were no abnormal red blood cells.

81. Based on the results of the tests ordered for Patient 1, Dr. Wachtel opined it was reasonable and consistent with the standard of care for respondent to presume pneumonia was the primary cause of Patient A's neurocognitive symptoms and his encephalopathy was Covid-related. According to Dr. Wachtel, the appropriate treatment for Covid-related encephalopathy at the time respondent treated Patient 1 was to treat the underlying Covid pneumonia and wait for the patient to recover, which was consistent with respondent's decisions and orders relating to Patient 1. Dr. Wachtel asserted that, while a patient was recovering from Covid pneumonia, it was the treating physician's responsibility to ensure the patient's nutrition and electrolytes stayed within normal bounds, rule out aspirational pneumonia through speech therapy, and provide physical therapy and occupational therapy, all of which respondent ordered and addressed.

82. Dr. Wachtel also maintained respondent's treatment of Patient 1's hyponatremia (low sodium), another potential cause of Patient 1's delirium, was within the standard of care. Patient 1's sodium scores fluctuated during his hospitalization, starting at 129, increasing to 136, and then dropping to 130 (below 135 is considered low). Dr. Wachtel testified that this fluctuation was not troubling because a patient's sodium levels can fluctuate, depending on water intake, and he would not be

concerned unless Patient 1's numbers dropped to the 110 range. However, Dr. Wachtel asserted respondent correctly dealt with the issue by continuously treating the fluctuating sodium levels with sodium boluses.

83. Dr. Wachtel disputed Dr. Cohn's opinion that respondent's care and treatment of Patient 1 exacerbated Patient 1's delirium. Dr. Wachtel opined it was highly unlikely Patient 1's use of Norco or steroids contributed to his delirium, as Dr. Cohn maintained. Dr. Wachtel disagreed with Dr. Cohn's opinion that Patient 1's Covid infection would impact Patient 1's tolerance of the medication based on Patient 1's 20-year history of taking Norco without complications. Dr. Wachtel also maintained that Patient 1's pain level without medication was high enough to warrant continued Norco use. He testified that when Patient 1 did not receive his pain medication in the ED, Patient 1 became more confused and combative, and when Patient 1 did not receive Norco in the hospital, he suffered significant pain, which the nurses consistently documented. Patient 1's daughters were also adamant that Patient 1 receive his standard pain medication.

84. Dr. Wachtel acknowledged steroid treatment could cause delirium, but he asserted treating Patient 1 with steroids was justified and consistent with the standard of care because of Patient 1's pneumonia. He opined that the steroids may have had a positive effect because Patient 1's radiographs showed improvement while he was on steroids, and when the steroids were stopped, Patient 1 needed oxygen support.

85. Dr. Wachtel acknowledged that telemetry monitoring and the use of IV lines also could contribute to a patient's delirium. However, Dr. Wachtel opined that continuous monitoring was necessary in this case because Patient 1 had a pacemaker, a history of coronary heart disease, and presented with respiratory issues, a Covid

infection, and symptoms of delirium. It was also Dr. Wachtel's opinion that Patient 1 required an IV line because he was receiving IV antibiotics and other medications, in addition to fluids to regulate his electrolytes. Having telemetry monitoring also would result in Patient 1 having a better nurse-to-patient ratio, which would benefit Patient 1. Under these circumstances, Dr. Wachtel opined that the monitoring and IV treatment respondent ordered for Patient 1 was appropriate and within the standard of care.

86. It was also Dr. Wachtel's opinion that respondent's use of physical restraints was reasonable and within the standard of care in this case. Dr. Wachtel noted the nursing records showed Patient 1 was confused even when he was not in restraints, as he repeatedly pulled on his IV line and telemetry monitors when the restraints were loosened. The restraints also were necessary because Patient 1 was a fall risk, and SGVMC did not have a 24-hour sitter available to stay with him to ensure his safety. Dr. Wachtel also disagreed with Dr. Cohen's opinion that respondent should have advocated SGVMC for a quarantine exemption for Patient 1's daughters. Dr. Wachtel agreed with SGVMC's quarantine policy, which was consistent with Cedar-Sinai's policy, because Patient 1 was Covid-positive and therefore potentially infectious.

87. Dr. Wachtel also disagreed that Patient 1 would have benefited from a neurological consult. Dr. Wachtel opined that a neurological examination is entirely in the purview of an internal medicine doctor, such as respondent, when no structural or focal abnormalities are present, as was in Patient 1's case. Here, respondent performed a neurological examination that consisted of documenting Patient 1's confusion, obtaining the CT head scan, and performing a cranial nerve examination, as reflected in the January 5 Progress Note. The only thing respondent did not do was ask Patient 1 to count backward by seven; however, Dr. Wachtel testified it was obvious Patient 1

would not be able to do so. Dr. Wachtel also noted that doctors at Huntington Hospital did not seek a neurology consult for Patient 1 when Patient 1 was admitted there.

88. Dr. Wachtel opined respondent adequately addressed Patient 1's weakness at SGVMC by ordering physical therapy and a physiatrist consult. Dr. Khosa monitored Patient 1's muscular strength by daily measuring the strength of Patient 1's upper and lower extremities. Once the physical therapy resumed on January 10, the physical therapist worked on Patient 1's balance and strength issues. Dr. Wachtel also observed that weakness from an elderly bedridden patient was to be expected.

Analysis

89. Dr. Cohn presented a detailed analysis to support his opinion that respondent's treatment and care of Patient 1's delirium and weakness constituted an extreme departure from the standard of care. His testimony was clear and thorough. It was Dr. Cohn's opinion that respondent failed to consider and address all possible sources of Patient 1's delirium and weakness. He pointed out tests that respondent should have administered, and medications respondent should have discontinued or should have considered discontinuing. Dr. Cohn asserted respondent did little to improve Patient 1's condition.

90. Dr. Wachtel effectively countered Dr. Cohn's opinion and challenged many of Dr. Cohn's assumptions. Dr. Wachtel provided cogent reasons for respondent's decisions. Dr. Wachtel showed that the results of the tests administered to Patient 1 only affirmed that the most obvious diagnosis for Patient 1's condition was Covid-related encephalopathy, for which there was no cure or standard treatment at the time. According to Dr. Wachtel, respondent took the appropriate actions while

waiting for the antibiotics and steroids intended to treat Patient 1's pneumonia to take effect. Dr. Wachtel's opinion that the weakness and decreasing oxygenation Patient 1 experienced in the hospital was an expected result of his age and being bedridden for nine days was persuasive. Dr. Wachtel opined that many of the measures advocated by Dr. Cohn, such as taking Patient 1 out of the telemetry floor, removing Patient 1's restraints, or taking another urine culture, were either contrary to the standard of care or unnecessary.

91. Dr. Wachtel, unlike Dr. Cohn, also acknowledged the impact of the Covid surge on medical care in Southern California and correctly considered that impact in determining the standard of care. Dr. Wachtel was aware that on a telemetry floor Patient 1 would receive more attention from nurses, who were in short supply because of Covid. Dr. Wachtel recognized the impact of Covid on the availability of doctors who would be willing to come to a hospital to consult. Dr. Wachtel found the idea of advocating for a quarantine exemption for Patient 1's daughters to allow them to visit Patient 1 untenable, considering the paramount necessity of limiting exposure to the virus in the Southern California community.

92. Dr. Cohn and Dr. Wachtel presented two diametrically opposed opinions on whether respondent's treatment of Patient 1's delirium and confusion departed from the standard of care. It was Dr. Cohn's opinion that the standard of care required an aggressive approach, and he faulted respondent for not considering a wide range of tests, environmental modifications, and changes in medication. It was Dr. Wachtel's opinion that respondent's more conservative approach of performing the necessary lab tests, monitoring and restraining Patient 1, and treating Patient 1's pneumonia met the standard of care. Considering Dr. Wachtel's experience, his opinion cannot be discounted.

93. In short, neither expert was more persuasive than the other, and they both posited valid approaches to treating Patient 1's condition. Given that both experts were equally credible regarding their respective opinions, complainant failed to meet his burden by clear and convincing evidence to establish respondent's treatment of Patient 1's delirium and weakness constituted an extreme departure from the standard of care.

TREATMENT OF PULMONARY INFILTRATES

Dr. Cohn's Opinion

94. Dr. Cohn asserted that the standard of care for evaluating multifocal pulmonary infiltrates requires the treating physician to establish a differential diagnosis of likely causes, order appropriate diagnostic testing, and consider potential therapeutic interventions as well as the risks and benefits of such interventions. Dr. Cohn found respondent's treatment of Patient 1's pulmonary infiltrates constituted a simple departure from the standard of care.

95. Dr. Cohn faulted respondent's conclusion that Patient 1 had an active COVID pneumonia infection based solely on Patient 1's CT scan. Dr. Cohn acknowledged Patient 1's CT scan showed radiologic abnormalities consistent with COVID pneumonia; however, he maintained respondent departed from the standard of care by failing to establish a differential diagnosis, particularly when Patient 1 did not exhibit hypoxemia (low oxygen saturation), respiratory distress, or hemodynamic instability in the ED. Dr. Cohn asserted that the multifocal pulmonary infiltrates may have been sequelae of Patient 1's earlier COVID infection, viral pneumonia, or bacterial pneumonia. He also asserted respondent departed from the standard of care by failing to order a pulmonary consult.

96. It was Dr. Cohn's opinion that prescribing steroids when a patient is not hypoxic was contrary to COVID guidelines at the time of respondent's treatment of Patient 1, and therefore constituted a departure from the standard of care. The guidelines recommended that steroids only be administered to COVID patients who required supplemental oxygen, which Dr. Cohn testified applied to individuals with 94 percent or less oxygen saturation on room air. Dr. Cohn incorrectly asserted Patient 1 did not have 94 percent or less saturation when he was in the ED, and his oxygen saturation rate only decreased to 94 percent or less starting on January 7, four days after he was admitted. Dr. Cohn also asserted that Dr. Mantilla's statements in her progress notes regarding Patient 1's steroid treatment, i.e., "steroids per primary," were evidence that Dr. Mantilla did not endorse respondent's use of steroids.

97. Although Dr. Cohn acknowledged doctors disagree about the use of antibiotics for bacterial pneumonia, it was his opinion that secondary bacterial infections are not commonly found with COVID pneumonia and therefore antibiotics were not necessarily required to treat Patient 1. Dr. Cohn noted respondent did not perform any diagnostic testing to identify the nature of the pulmonary infiltrates to confirm the possibility of a bacterial lung infection. Additionally, although Patient 1's chest CT scan showed improvement, respondent continued to treat Patient 1 with antibiotics. Dr. Cohn opined that treating Patient 1 with antibiotics longer than five days constituted a departure from the standard of care. Dr. Cohn relied in part on Dr. Mantilla's notes that numbered the days Patient 1 received antibiotic treatment to support his opinion that Patient 1's antibiotic course should have been limited to five days. Dr. Cohn also contended respondent departed from the standard of care by failing to identify end points for the use of antibiotics and steroids to treat Patient 1's condition.

Dr. Wachtel's Opinion

98. Dr. Wachtel disagreed with Dr. Cohn's opinions regarding respondent's evaluation and management of Patient 1's pulmonary infiltrates, and maintained respondent's treatment of Patient 1's pulmonary infiltrates was consistent with the standard of care. Dr. Wachtel opined that the existence of pulmonary infiltrates with ground glass opacities in Patient 1's lungs was conclusive evidence of pneumonia, and contrary to Dr. Cohn's opinion, their presence was not consistent with past trauma to Patient 1's lungs. Dr. Wachtel further asserted that during the January 2022 Covid surge, the "overwhelming majority of possibilities" was that Patient 1 had Covid pneumonia, and if not, Patient 1's pneumonia was a super bacterial infection post-Covid. It was Dr. Wachtel's opinion that respondent's treatment decisions made clear that his differential diagnosis included both these conditions, which he treated with steroids and antibiotics, respectively, as well as aspirational pneumonia, which he addressed by ordering a swallow study.

99. Dr. Wachtel took issue with Dr. Cohn's opinion that only a five-day antibiotics course was appropriate and continuing the antibiotics past five days was contrary to Dr. Mantilla's recommendation and a departure from the standard of care. Dr. Wachtel noted Dr. Mantilla's notes did not make clear whether she intended the antibiotic course to last for five days or whether she intended to reevaluate the course of treatment after five days. Dr. Wachtel also opined it would be below the standard of care to treat a 90-year-old pneumonia patient with antibiotics for only five days; the standard of care requires seven to 10 days, particularly when the patient showed improvement after taking them. Regarding planned endpoints, Dr. Wachtel explained it was customary to reevaluate a patient's condition frequently and to decide when to stop based on the patient's progress rather than setting a predefined endpoint.

100. Dr. Wachtel opined respondent's decision to treat Patient 1 with steroids was justified and within the standard of care, even if the general guidelines indicate otherwise. Dr. Wachtel contended the guidelines are not necessarily applicable when dealing with a 90-year-old patient. It is Dr. Wachtel's experience that patients with Covid pneumonia respond well to steroids, and they constitute an appropriate treatment within the standard of care. Moreover, Dr. Wachtel asserted that in Patient 1's case, the steroids probably positively affected Patient 1's pneumonia based on the January 7 radiograph results.

101. Dr. Wachtel opined that Patient 1's condition did not necessitate a consultation from a pulmonologist, and Patient 1's failure to order a pulmonary consult was not a departure from the standard of care. Patient 1 did not have shortness of breath or a pulmonary embolism. Dr. Wachtel concluded that addressing Patient 1's respiratory issues was within respondent's scope of practice.

Analysis

102. Complainant failed to offer sufficient evidence to show it was more likely than not that respondent's treatment of Patient 1's pulmonary infiltrates constituted a departure from the standard of care.

103. Although respondent did not document his differential diagnosis, the evidence made clear respondent was treating the possibility that Patient 1's pneumonia was Covid-related, bacterial, and/or aspirational. As a board-certified pulmonologist, Dr. Wachtel's opinion that respondent's analysis and treatment of Patient 1's pneumonia with antibiotics and steroids was appropriate considering the imaging study findings, the laboratory results, and the Covid surge at the time is entitled to greater deference than the contrary opinion of Dr. Cohn who is not a

pulmonologist and did not receive special training in critical care medicine. Dr. Wachtel's opinion that respondent did not depart from the standard of care by not ordering a pulmonary consult is entitled to greater deference for the same reasons.

104. Additionally, Dr. Cohn's reliance on Dr. Mantilla's notes to demonstrate respondent overprescribed antibiotics to treat Patient 1's pneumonia is misplaced. Nothing in the records indicated Dr. Mantilla disagreed with respondent's antibiotic treatment. Dr. Mantilla's notes did not contain an end date for Patient 1's antibiotics, and she did not stop the antibiotics until January 12, the date when Patient was discharged from SVGMC. Because Dr. Mantilla did not testify, it is impossible to know her intentions regarding Patient 1's antibiotic use. Dr. Cohn's presumption therefore that Dr. Mantilla only intended Patient 1 to receive five days of antibiotics, based on her incorrect numbering of the days Patient 1 had received antibiotics, is speculative and not persuasive.

105. Dr. Cohn's reliance on certain Covid guidelines recommending against the use of steroids for hospitalized patients who do not require supplemental oxygen was likewise not compelling for several reasons. First, there was no evidence that the undated guidelines cited by Dr. Cohn were in force during Patient 1's treatment at SGVMC. Both Dr. Wachtel and respondent testified that steroids were effectively prescribed to patients with Covid pneumonia during this period. Second, guidelines, contrary to Dr. Cohn's testimony, do not constitute the standard of care, and Dr. Wachtel asserted that treating a 90-year-old Covid patient with steroids was within the standard of care despite any recommendations otherwise. Third, the records plainly state Patient 1's oxygenation rates while he was in the ED often went below 94 percent, which Dr. Cohn cited as the cutoff for steroid use. Thus, even under the Guidelines, ordering steroids for Patient 1 might have been appropriate. Fourth, Dr.

Cohn's assertion that Dr. Mantilla distanced herself from respondent's steroid treatment by noting "steroids per primary" in her progress notes is again speculative without Dr. Mantilla's testimony. Fifth, respondent limited the course of steroid treatment to three days, and Patient 1 appeared to improve during this time. When the steroids were stopped, Patient 1's oxygenation rate decreased, and it was Dr. Mantilla ordered the steroids to be restarted. It was therefore reasonable to assume the steroids had a positive impact on Patient 1's condition.

106. Finally, although Dr. Cohn asserted respondent should have ordered a pulmonary consult for Patient 1, he did not indicate why a consult was needed. Patient 1 showed no shortness of breath or respiratory distress, and he did not have a pulmonary embolism. Dr. Wachtel, himself a pulmonologist, found Patient 1 presented no issue outside the scope of practice of a board-certified internal medicine doctor, such as respondent.

107. Based on the foregoing, Dr. Wachtel's opinions were more credible than those of Dr. Cohn. Accordingly, it was not proven that respondent's treatment of Patient 1's pulmonary infiltrates constituted a departure from the standard of care.

DOCUMENTATION

Dr. Cohn's Opinion

108. According to Dr. Cohn, the standard of care for documenting a hospitalized patient's treatment requires the treating physician's progress notes to accurately reflect the information used in the evaluation, decision making, and management of such care. A physician's progress notes should also accurately reflect what was done and be updated to reflect the patient's current state. The notes must be sufficiently complete to advance the patient's care by other medical providers. Dr.

Cohn asserted the standard of care regarding documentation did not change because of the Covid surge.

109. Dr. Cohn opined respondent's medical record-keeping, as reflected in his progress notes and discharge summary, constituted an extreme departure from the standard of care. According to Dr. Cohn, respondent's progress notes and discharge summary were inaccurate, lacked critical information relating to lab results and imaging studies, contained no meaningful plans, and would not assist in advancing Patient 1's care if assumed by other health providers. Dr. Cohn asserted that respondent's progress notes differed only slightly throughout Patient 1's hospitalization.

110. Dr. Cohn criticized respondent's failure to include any analysis in his notes and opined that these omissions, considered together, constituted an extreme departure from the standard of care. According to Dr. Cohn, a physician reviewing the notes would not be able to discern respondent's differential diagnoses for Patient 1's confusion or pulmonary infiltrates. Nor would a physician be able to assess the nature and extent of Patient 1's confusion. Dr. Cohn maintained that respondent's notes contained no details regarding Patient 1's neurocognitive dysfunctions. Dr. Cohn asserted respondent's failure to explain his decisions to order telemetry monitoring, IV lines, and the necessity of physical restraints departed from the standard of care. Likewise, Dr. Cohn opined that respondent's failure to explain Patient 1's worsening respiratory function or his decisions about where and when to discharge Patient 1 constituted departures from the standard of care. Dr. Cohn maintained the standard of care required respondent to set forth his goals for Patient 1 or how he intended to measure Patient 1's improvement.

///

111. Dr. Cohn opined respondent's discharge summary for Patient 1 also represented an extreme departure from the standard of care. Of particular concern was respondent's failure to state that Patient 1's discharge was against respondent's clinical judgment. The discharge summary also did not indicate that Patient 1 was restrained for nearly the entirety of his hospitalization, and his oxygenation, respiratory function, and functional deficits all worsened at this time. The discharge summary indicated respondent's pneumonia was treated, but did not explain how. According to Dr. Cohn, another doctor from another hospital treating Patient 1 may only have access to the discharge summary, and respondent's discharge summary provided no comprehensive description of Patient's care and treatment at SGVMC.

Dr. Wachtel's Opinion

112. According to Dr. Wachtel, a medical record is accurate if it reports information correctly and "is adequate if it contains sufficient information to be able to identify the patient, support the diagnosis, justify the treatment course, document relevant laboratory and test results, and promote continuity of care among healthcare providers." (Exhibit C, p. B20.) Dr. Wachtel asserted that an adequate record permits another physician to pick up the patient's care where a previous provider left off without any issues.

113. Dr. Wachtel agreed with Dr. Cohn that respondent's documentation was deficient. However, he disagreed that the deficiencies in respondent's documentation constituted an extreme departure from the standard of care because they were not "so severe they impeded or could reasonably be expected to impede diagnosis or treatment." (Exhibit C, p. B20.) Dr. Wachtel opined respondent's documentation issues constituted a simple departure from the standard for documentation, which he asserted is based on the adequacy and accuracy of the records.

114. Dr. Wachtel asserted respondent provided sufficient information in his notes so that a doctor could follow what was going on with Patient 1. Dr. Wachtel acknowledged the lack of detail and respondent's omission of his thought processes were problematic, but he indicated respondent's intentions and plan could be gleaned from his orders and the treatment he provided. Dr. Wachtel did not find it inappropriate that respondent included aspects of consultants' notes in his progress notes, and asserted it was consistent with the standard of care to state "see my orders" when all Patient 1's SGVMC health records could be accessed in one place and were separated by tabs in the same electronic patient file.

115. Dr. Wachtel agreed with Dr. Cohn that relevant laboratory and test results should be included in a physician's progress notes. Dr. Wachtel also agreed respondent's discussion of the reasoning behind his discharge plans would have made his treatment easier to understand. Dr. Wachtel acknowledged Patient 1's notes contained errors but asserted those errors were not significant. However, Dr. Wachtel disagreed with Dr. Cohn that any of these omissions and errors affected Patient 1's treatment or would have affected Patient 1's care in the future.

116. Dr. Wachtel agreed with Dr. Cohn that respondent's discharge summary was deficient. He acknowledged respondent erroneously described Patient 1's condition as stable. However, he disagreed that Patient 1's hospitalization course was complicated. He asserted that Patient 1's worsening oxygenation was part of Patient 1's condition, not a complication.

117. Dr. Wachtel asserted that a physician's standard of documentation was affected by an emergency, and the Covid surge constituted an emergency. When confronted by such an emergency, it was Dr. Wachtel's opinion that a lower level of

charting was often expected and accepted. However, Dr. Wachtel also asserted that the presence of an emergency did not excuse poor documentation; it just mitigated it.

Analysis

118. Both experts agreed that respondent's progress notes and discharge summary were deficient. They differed, however, on the degree of the deficiency. Dr. Cohn opined respondent's inaccurate and inadequate recordkeeping, taken as a whole, constituted an extreme departure from the standard of care. Dr. Wachtel opined respondent's records did not affect Patient 1's care and therefore could not be evaluated under a standard of care analysis. Instead, Dr. Wachtel asserted the accuracy and adequacy of respondent's notes should be evaluated under a standard of documentation analysis, and under that analysis, respondent's deficient record keeping amounted to a simple departure.

119. Dr. Cohn's opinion on the adequacy of Patient 1's record keeping is more credible than Dr. Wachtel's opinion on this issue. Dr. Wachtel asserted in his report that recordkeeping deficiencies do not translate into standard of care violations unless they are so severe that they impede or could reasonably be expected to impede diagnosis or treatment. Here, complainant offered convincing evidence that respondent's progress notes and discharge summary could reasonably be expected to do just that.

120. As Patient 1's hospitalist and the physician with primary responsibility for Patient 1's care, respondent was responsible for explaining his course of treatment and his decisions relating to that treatment. As Dr. Wachtel acknowledged, respondent's records by themselves do not describe the extent of respondent's treatment and care of Patient 1 or respondent's evaluation and decision making regarding his treatment

decisions. The records do not evaluate or even note the latest lab results, Patient 1's functional assessments, or changes in medication.

121. Dr. Wachtel asserted that SGVMC physicians and health care providers could access Patient 1's nursing notes, lab results, and consultant notes to find the information they needed. However, even if SGVMC physicians had the time to review the hundreds of pages of SGVMC records reflecting Patient 1's treatment, those records would not provide respondent's thought processes. Moreover, physicians who did not have privileges at SGVMC likely would not have access to the SGVMC terminal, and therefore would not be able to review the records to continue Patient 1's care effectively. Those non-SGVMC physicians could not readily determine the nature of respondent's treatment, his plan of treatment, and the reasons for his decisions regarding the management of Patient 1's care from respondent's records. This is particularly true regarding respondent's discharge summary, which omitted and mischaracterized crucial facts regarding Patient 1's care.

122. Dr. Wachtel also failed to recognize that accurate and adequate recordkeeping is important outside of the hospital context. Proceedings like these and other judicial proceedings initiated to evaluate the medical practice of a physician or the physician's hospital require records that contain the treating physician's contemporaneous observations, impressions, and plans. Those records must also contain accurate recitations of facts relating to a patient's treatment.

123. Dr. Cohn's assertion that standard of care was not affected by the presence of Covid is incorrect, as the standard of care is determined in part by the circumstances under which medicine is practiced. However, while Covid may have interfered with respondent's medical record keeping, it did not excuse respondent's significant omissions and inaccuracies. Those inaccuracies and omissions made it

almost impossible to follow respondent's thought processes and treatment of Patient 1's encephalopathy and pneumonia and to ensure the effective continuity of care necessary to maintain Patient 1's health. Respondent's record keeping therefore constituted an extreme departure from the standard of care.

Character Witnesses

KAMALAKAR RAMBHATLA, M.D.

124. Kamalakar Rambhatla, M.D., has been a pulmonary critical care physician working in the San Gabriel area since 1983. Dr. Rambhatla is currently affiliated with Greater El Monte Community Hospital (El Monte Hospital), where he served two terms as Chief of Staff and is currently its Medical Director for the pulmonary department and subacute medical unit. Dr. Rambhatla is also affiliated with USC Arcadia Hospital and two long-term acute care facilities. Dr. Rambhatla was publicly reprimanded by the Board in 2021 for poor medical record keeping.

125. Dr. Rambhatla has known respondent since respondent was the emergency room director at El Monte Hospital. After respondent transitioned to internal medicine and family practice, respondent requested Dr. Rambhatla to provide pulmonary consults for many of his patients. As the consulting physician, Dr. Rambhatla had many occasions to review respondent's charts and speak to respondent about his patients. Additionally, as a member of the El Monte Medical Executive Committee between 2019 and 2023, he was aware of respondent's probation.

126. Dr. Rambhatla testified that the Medical Executive Committee at El Monte Hospital did not have any issues or concerns regarding respondent's medical practice while he was on probation and has no current concerns. Dr. Rambhatla

practiced during the height of the Covid pandemic. He shared Covid patients with respondent and found his care to be competent and adequate. He also confirmed respondent's observations regarding the difficulty of administering patient care during the Covid surge.

127. Based on Dr. Rambhatla's review of respondent's progress notes, Dr. Rambhatla believed respondent was abreast of what was going on with his patients. Dr. Rambhatla never had an issue with respondent's documentation after respondent completed probation. He noted El Monte Hospital's issue with respondent involving his "cutting and pasting" information in his charts. Dr. Rambhatla asserted respondent is a good communicator whose patients have a high opinion of him. Dr. Rambhatla considers respondent to be a conscientious, approachable, knowledgeable, and valuable member of the El Monte Hospital staff. At the hearing, Dr. Rambhatla stated he was unaware of any complaints by any patients or patients' family members regarding respondent's care and treatment of his patients.

SUKHPAL GILL, M.D.

128. Sukhpal Gill, M.D., has been a practicing nephrologist in Arcadia for the last 30 years. He has no record of Board discipline. He is the medical director of several dialysis facilities and also practices at USC Arcadia Hospital and Huntington Hospital. Dr. Gill has known respondent for 15 years. Dr. Gill described respondent as a competent doctor with good communication skills and who is respectful to the nurses and the hospital staff.

129. Dr. Gill met respondent when respondent was an ED physician in the same hospital where Dr. Gill once worked. After respondent stopped practicing emergency medicine, he frequently called on Dr. Gill for nephrology consults. As a

result of these consults, Dr. Gill has reviewed respondent's charts and communicated with respondent about their patients. Dr. Gill found respondent's notes to be short but precise, and respondent to be well-informed about his patients. He stated respondent's records were similar to those of other internal medicine physicians, but acknowledged that each doctor charts differently.

DEVESH PATEL, M.D.

130. Devesh Patel is a board-certified ID physician. He currently works at LA Community Hospital, Norwalk Community Hospital, Adventist White Memorial Hospital, and San Dimas Community Hospital. He has known respondent for 15 years and has often worked as a consultant for respondent at Norwalk Community Hospital, San Dimas Community Hospital, and LA Community Hospital. Dr. Patel was aware of respondent's probation.

131. Dr. Patel often consulted as an ID physician on respondent's Covid cases. Dr. Patel described respondent as honest, ethical, and morally strong. He asserted respondent's medical records were similar to records prepared by other internal medicine physicians. In the Covid cases he has worked on with respondent, Dr. Patel found respondent to be competent.

Costs

132. Complainant requests respondent be ordered to reimburse the Board for the reasonable prosecution costs incurred in this matter in the total amount of $45,288.25, which consists of $39,393.25 already billed, plus a good faith estimate of an additional $5,895. Complainant also requests respondent be ordered to reimburse the Board for expert costs totaling $1,950 and investigative costs totaling $9,540.50. The total costs claimed are $56,778.75.

133. Respondent did not present any evidence regarding his income or expenses.

LEGAL CONCLUSIONS

1. Complainant has the burden to prove its alleged causes for discipline by clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

2. The Medical Practice Act governs the rights and responsibilities of the holder of a physician's and surgeon's certificate. (§§ 2000 et seq.) The state's obligation and power to regulate the professional conduct of its health practitioners are well settled. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 577.) Protection of the public is the highest priority for the Board in exercising its disciplinary authority and is paramount over other interests in conflict with that objective. (§§ 2001.1, 2229, subd. (a).) However, an administrative law judge must, "wherever possible, take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence." (§ 2229, subd. (c).)

3. The Board is required to take action against any licensee who is charged with unprofessional conduct. (§ 2234.) Unprofessional conduct includes violation of any provision of the Medical Practice Act, gross negligence, and repeated negligent acts. (§ 2234, subds. (a), (b), & (c).)

First Cause for Discipline – Gross Negligence

4. The Accusation alleges respondent was grossly negligent in the care and treatment of Patient 1 because respondent's treatment of Patient 1's delirium and weakness and respondent's documentation of his care and treatment of Patient 1 each constituted an extreme departure from the standard of care.

5. The Medical Practice Act does not define "negligence." Generally, negligence is conduct that falls below the standard established by law for the protection of others against unreasonable risk of harm. (*Flowers supra,* 8 Cal.4th at p. 997; Restatement (Second) of Torts § 282 (1965).) It is well settled the standard of care for physicians is the reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of the medical profession under similar circumstances." (*Avivi v. Centro Medico Urgente Medical Center* (2008) 159 Cal.App.4th 463, 470; *Brown v. Colm* (1974) 11 Cal.3d 639, 643.) Gross negligence includes "they want of even scant care or an extreme departure from the ordinary standard of conduct." (*Van Meter v. Bent Const. Co.* (1956) 46 Cal.2d 588, 594.)

6. Complainant failed to prove by clear and convincing evidence that respondent's treatment of Patient 1's delirium and weakness constitutes an extreme departure from the standard of care, as set forth in Factual Findings 12 through 40, 50 through 59, and 66 through 93. Cause therefore does not exist to discipline respondent's certificate for gross negligence under section 2234, subdivision (b), based on respondent's care and treatment of Patient 1's delirium and weakness.

7. Complainant proved by clear and convincing evidence that respondent's documentation of his treatment and care of Patient 1 was an extreme departure from the standard of care, as set forth in Factual Findings 41 through 49, 60 through 62, and

108 through 123. Cause therefore exists to discipline respondent's certificate for gross negligence under section 2234, subdivision (b), based on respondent's deficiencies in his medical record keeping.

Second Cause for Discipline – Repeated Negligent Acts

8. The Accusation alleges respondent engaged in repeated negligent acts in his care and treatment of Patient 1, consisting of his grossly negligent acts set forth in the first cause for discipline and his care and his negligent treatment of Patient 1's pulmonary infiltrates. Section 2234, subdivision (c), states that repeated negligent acts require "two or more negligent acts or omissions."

9. Complainant did not prove by clear and convincing evidence respondent engaged in two or more negligent acts in his care and treatment of Patient 1. Complainant proved respondent was grossly negligent in his record keeping; however, complainant did not prove respondent was grossly negligent in his care and treatment of Patient 1's delirium or weakness. (Legal Conclusions 6 & 7.) Complainant also did not prove respondent was negligent in his treatment of Patient 1's pulmonary infiltrates as set forth in Factual Findings 12 through 40, 50 through 59, 66 through 72, and 94 through 107. Cause therefore does not exist to discipline respondent's certificate for repeated acts of negligence in his care and treatment of Patient 1.

Third Cause for Discipline – Failure to Keep Adequate and Accurate Records

10. The Accusation alleges respondent is subject to disciplinary action under section 2266 because respondent failed to keep adequate and accurate records of his care and treatment of Patient 1. Section 2266 provides that the failure of a physician to

maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

11. Complainant proved by clear and convincing evidence that respondent engaged in unprofessional conduct because his medical recordkeeping of Patient 1's care and treatment was inaccurate and inadequate as set forth in Factual Findings 41 through 49, 60 through 62, and 108 through 123. Cause therefore exists to discipline respondent's certificate for violating section 2266.

Disposition

12. The record reflects respondent's charting of his care and treatment of Patient 1 was grossly deficient. Respondent was placed on probation in 2019 in part because of his poor charting, and he took a medical reporting course to correct his charting issues as a condition of that probation. Respondent therefore should have been especially sensitive to the importance of accurate and adequate records while treating Patient 1. Yet many of the problems noted in respondent's charting of Patient 1's care echo the documentation problems alleged in respondent's earlier case, such as the failure to document a treatment plan, the failure to document a physical examination, and omitting important aspects of the patient's presentation. Respondent's record keeping therefore has not shown improvement in response to his probation.

13. However, respondent treated and cared for Patient 1 under extraordinarily difficult and unprecedented conditions, and those conditions cannot be ignored. Respondent placed his own health at risk each time he came to the hospital, and because he feared exposure, respondent did not linger at the hospital after visiting his patients. Providing detailed records was not respondent's utmost priority.

As Dr. Wachtel noted, under the emergency conditions brought about by Covid during this time, ordinary protocols and procedures were upended, and a lower level of detail in charting is accepted.

14. The Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (Guidelines) recommend that for cases where cause for discipline was established based on gross negligence or inadequate medical record keeping, the minimum discipline is five years of probation, and the maximum discipline is revocation. In determining the appropriate discipline, the Board urges that mitigation evidence be considered.

15. The evidence established that the 2022 Covid surge significantly impacted the practice of medicine in Southern California, including recording keeping, and therefore it is a significant mitigating factor. However, while the Covid surge may excuse some of respondent's record keeping deficiencies, it does not completely absolve them. Correct and complete medical records are crucial to providing insight into a doctor's thinking and ensuring effective continuity of care. Correct and complete records are also essential to review a physician's actions outside a medical setting and to protect a physician if any false claim arises.

16. At hearing, respondent acknowledged the gaps in his records and provided proof that he has already taken a second medical record keeping course to further improve his charting. Respondent's peers also did not cite problems understanding respondent's medical records. Under these circumstances and in the absence of gross negligence in respondent's care and treatment of Patient 1's medical condition, revocation of respondent's certificate is unduly punitive. Although the Guidelines recommend a five-year period of probation in a case of poor record keeping, the mitigating circumstances of Covid warrant a reduced probation period.

Thus, placing respondent on three years of probation, with a regular record review by a practice monitor to ensure respondent's records satisfy the statutory requirements, should be adequate to protect the public.

Costs

17. The ALJ may direct a Board licensee found to have committed a violation or violations of the Medical Practice Act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. (§ 125.3, subd. (a).) In *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32 (*Zuckerman*), the California Supreme Court set forth factors to be considered in determining the reasonableness of the costs sought. 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 or her 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. (*Id.*, at p. 45.)

18. Complainant requests reimbursement of $56,778.75 of prosecution and enforcement. As set forth in the Factual Findings, $5,895 of that amount consists of estimated costs. An agency is permitted to obtain estimated costs only when a record of actual costs is not available. Specifically, section 125.3, subdivision (c), states that "[a] certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available . . . shall be prima facie evidence of reasonable costs....." In addition, "[w]hen the agency presents an estimate of actual costs incurred, its Declaration shall explain the reason actual cost information is not available." (Cal. Code Regs., tit. 1, § 1042, subd. (b)(3).) Complainant did not explain why actual cost information was not available at the time of hearing to justify the additional estimated

costs. For these reasons, complainant cannot recover the $5,895 in estimated costs. The total recoverable costs therefore are $50,883.75.

19. As to the *Zuckerman* factors, respondent prevailed on two of complainant's claims and presented a colorable challenge to the proposed discipline. Respondent did not present any evidence regarding his financial ability to pay the requested costs. It is therefore appropriate to reduce the amount of costs by two thirds, to a total of $16,961.25.

ORDER

Physician and Surgeon's Certificate Number A 41589 issued to respondent Nagasamudra S. Ashok, M.D., is revoked pursuant to Causes for Discipline I and III, separately and for all of them. However, the revocation is stayed, and respondent is placed on probation for three years, upon the following terms and conditions:

1. Notification

Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

2. Supervision of Physician Assistants and Advanced Practice Nurses

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

3. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

4. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

5. General Probation Requirements

Compliance with Probation Unit.

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number,

Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

6. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

///

7. Non-practice while on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years. Periods of non-practice will not apply to the reduction of the probationary term. Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and

conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

8. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

9. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

10. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the

surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

11. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

12. Education Course

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

///

///

13. 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.

14. 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.

15. Monitoring – Practice

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be

expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

///

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine, whether respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

///

///

///

17. Costs

Respondent shall pay $16,961.25 to the Board in reimbursement for its costs of investigation and enforcement based on a payment plan approved by the Board.

DATE: 06/27/2025

CINDY F. FORMAN
Administrative Law Judge
Office of Administrative Hearings