

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

In the Matter of the Accusation)
Against:)
)
LARRY MITCHELL ISAACS, M.D.) **Case No. 05-2013-229462**
)
Physician's and Surgeon's)
Certificate No. G 86613)
)
Respondent)
_____)

DECISION AND ORDER

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

This Decision shall become effective at 5:00 p.m. on August 8, 2016.

IT IS SO ORDERED August 1, 2016.

MEDICAL BOARD OF CALIFORNIA

By: 
Kimberly Kirchmeyer
Executive Director

1 KAMALA D. HARRIS
Attorney General of California
2 E. A. JONES III
Supervising Deputy Attorney General
3 BENETH A. BROWNE
Deputy Attorney General
4 State Bar No. 202679
California Department of Justice
5 300 So. Spring Street, Suite 1702
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7 *Attorneys for Complainant*

8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

11
12 In the Matter of the Accusation Against:

Case No. 05-2013-229462

13 **LARRY MITCHELL ISAACS, M.D.**
2 Danielle Drive
14 Goshen, NY 10924

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

15 Physician's and Surgeon's Certificate
No. G 86613

16
17 Respondent.

18
19 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
20 entitled proceedings that the following matters are true:

21 PARTIES

22 1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board
23 of California. She brought this action solely in her official capacity and is represented in this
24 matter by Kamala D. Harris, Attorney General of the State of California, by Beneth A. Browne,
25 Deputy Attorney General.

26 2. LARRY MITCHELL ISAACS, M.D. (Respondent) is represented in this proceeding
27 by attorney Thomas R. Bradford, Esq., Peterson & Bradford, LLP, whose address is 100 North
28 First Street, Suite 300, Burbank, CA 91502.

1 3. On or about August 14, 2002, the Medical Board of California issued Physician's and
2 Surgeon's Certificate No. G 86613 to Respondent. The Physician's and Surgeon's Certificate
3 expired on November 30, 2011, and has not been renewed.

4 JURISDICTION

5 4. Accusation No. 05-2013-229462 was filed before the Medical Board of California
6 (Board), Department of Consumer Affairs, and is currently pending against Respondent. The
7 Accusation and all other statutorily required documents were properly served on Respondent on
8 December 9, 2014. Respondent timely filed his Notice of Defense contesting the Accusation. A
9 copy of Accusation No. 05-2013-229462 is attached as Exhibit A and incorporated by reference.

10 ADVISEMENT AND WAIVERS

11 5. Respondent has carefully read, fully discussed with counsel and understands the
12 charges and allegations in Accusation No. 05-2013-229462. Respondent also has carefully read,
13 fully discussed with counsel, and understands the effects of this Stipulated Surrender of License
14 and Order.

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

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

24 CULPABILITY

25 8. Respondent understands that the charges and allegations in Accusation No. 05-2013-
26 229462, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and
27 Surgeon's Certificate.

28 9. Respondent admits the truth of the allegations in the Fourth Cause for Discipline. For

1 the purpose of resolving the Accusation without the expense and uncertainty of further
2 proceedings, Respondent does not contest that, at an administrative hearing, Complainant could
3 establish a *prima facie* case with respect to the remaining charges and allegations contained in
4 Accusation No. 05-2013-229462 and that he has thereby subjected his license to disciplinary
5 action. Respondent hereby gives up his right to contest that cause for discipline exists based on
6 those charges.

7 10. Respondent agrees that if he ever petitions for reinstatement of his Physician's and
8 Surgeon's Certificate No. G 86613, all of the charges and allegations contained in Accusation No.
9 05-2013-229462 shall be deemed true, correct and fully admitted by respondent for purposes of
10 that reinstatement proceeding or any other licensing proceeding involving respondent in the State
11 of California.

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

15 CONTINGENCY

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

26 13. The parties understand and agree that Portable Document Format (PDF) and facsimile
27 copies of this Stipulated Surrender of License and Order, including Portable Document Format
28 (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

1 14. In consideration of the foregoing admissions and stipulations, the parties agree that
2 the Board may, without further notice or formal proceeding, issue and enter the following Order:

3 **ORDER**

4 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 86613, issued
5 to Respondent LARRY MITCHELL ISAACS, M.D., is surrendered and accepted by the Medical
6 Board of California.

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

11 2. Respondent shall lose all rights and privileges as a Physician and Surgeon in
12 California as of the effective date of the Board's Decision and Order.

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

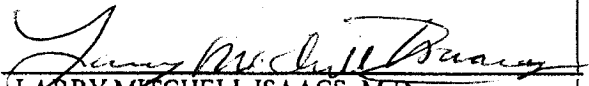
15 4. If Respondent ever files an application for licensure or a petition for reinstatement in
16 the State of California, the Board shall treat it as a petition for reinstatement. Respondent must
17 comply with all the laws, regulations and procedures for reinstatement of a revoked license in
18 effect at the time the petition is filed, and all of the charges and allegations contained in
19 Accusation No. 05-2013-229462 shall be deemed to be true, correct and admitted by Respondent
20 when the Board determines whether to grant or deny the petition.

21 5. If Respondent should ever apply or reapply for a new license or certification, or
22 petition for reinstatement of a license, by any other health care licensing agency in the State of
23 California, all of the charges and allegations contained in Accusation, No. 05-2013-229462 shall
24 be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of
25 Issues or any other proceeding seeking to deny or restrict licensure.

26 **ACCEPTANCE**

27 I have carefully read the above Stipulated Surrender of License and Order and have fully
28 discussed it with my attorney, Thomas R. Bradford, Esq. I understand the stipulation and the

1 effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated
2 Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound
3 by the Decision and Order of the Medical Board of California.

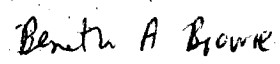
4
5 DATED: 3/18/16 _____ 
6 LARRY MITCHELL ISAACS, M.D.
Respondent

7 I have read and fully discussed with Respondent LARRY MITCHELL ISAACS, M.D. the
8 terms and conditions and other matters contained in this Stipulated Surrender of License and
9 Order. I approve its form and content.

10 DATED: 3/23/16 _____ 
11 THOMAS R. BRADFORD, ESQ.
12 Attorney for Respondent

13 ENDORSEMENT

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

16 Dated: 6/1/16 _____ Respectfully submitted,
17 KAMALA D. HARRIS
18 Attorney General of California
19 E. A. JONES III
20 Supervising Deputy Attorney General
21 
22 BENETH A. BROWNE
23 Deputy Attorney General
24 *Attorneys for Complainant*

25 LA2014613805
26 61732838

Exhibit A

Accusation No. 05-2013-229462

1 KAMALA D. HARRIS
Attorney General of California
2 E. A. JONES III
Supervising Deputy Attorney General
3 BENETH A. BROWNE
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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO December 9 20 14
BY R. FIRDAUS ANALYST

9 **BEFORE THE**
10 **MEDICAL BOARD OF CALIFORNIA**
11 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

12 In the Matter of the Accusation Against:

Case No. 05-2013-229462

13 **LARRY MITCHELL ISAACS, M.D.**

14 2 Danielle Drive
Goshen, NY 10924

ACCUSATION

15 Physician's and Surgeon's Certificate
16 No. G 86613

17 Respondent.

18 Complainant alleges:

19 **PARTIES**

20 1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official
21 capacity as the Executive Director of the Medical Board of California, Department of Consumer
22 Affairs.

23 2. On or about August 14, 2002, the Medical Board of California issued Physician's and
24 Surgeon's Certificate Number G 86613 to LARRY MITCHELL ISAACS, M.D. (Respondent).
25 Respondent's medical license expired on November 30, 2011, and he is not currently permitted to
26 practice medicine in California.

27 **JURISDICTION**

28 3. This Accusation is brought before the Medical Board of California (Board),

1 Department of Consumer Affairs, under the authority of the following laws. All section
2 references are to the Business and Professions Code unless otherwise indicated.

3 4. Section 2229 of the Code states, in subdivision (a):

4 "Protection of the public shall be the highest priority for the Division of Medical Quality,¹
5 the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality
6 Hearing Panel in exercising their disciplinary authority."

7 5. Section 2227 of the Code states:

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

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

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

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

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

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

21 "(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical
22 review or advisory conferences, professional competency examinations, continuing education
23 activities, and cost reimbursement associated therewith that are agreed to with the board and
24 successfully completed by the licensee, or other matters made confidential or privileged by

25
26
27 ¹ Pursuant to Business and Professions Code section 2002, the "Division of Medical
28 Quality" or "Division" shall be deemed to refer to the Medical Board of California.

1 existing law, is deemed public, and shall be made available to the public by the board pursuant to
2 Section 803.1."

3 6. Section 2234 of the Code, states:

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

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

9 "(b) Gross negligence.

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

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

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

20 "(d) Incompetence.

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

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

24 "..."

25 7. Section 2266 of the Code provides:

26 "The failure of a physician and surgeon to maintain adequate and accurate records relating
27 to the provision of services to their patients constitutes unprofessional conduct."

28 8. Section 2305 of the Code states:

1 The revocation, suspension, or other discipline, restriction or limitation imposed by another
2 state upon a license or certificate to practice medicine issued by that state, or the revocation,
3 suspension, or restriction of the authority to practice medicine by any agency of the federal
4 government, that would have been grounds for discipline in California of a licensee under this
5 chapter [Chapter 5, the Medical Practice Act] shall constitute grounds for disciplinary action for
6 unprofessional conduct against the licensee in this state.

7 **FIRST CAUSE FOR DISCIPLINE**

8 (Gross Negligence – Patient G.G.)

9 9. Respondent is subject to disciplinary action under section 2234, subdivision (b), of
10 the Code, in that Respondent engaged in gross negligence in his care and treatment of Patient
11 G.G. The circumstances are as follows:

12 **May 5, 2009 Surgery**

13 A. G.G. was 40 years old when she was admitted to the Henry Mayo
14 Newhall Memorial Hospital, in Valencia, California on May 4, 2009, with lower
15 abdominal pain with some localization in the right lower quadrant, presumed to be
16 appendicitis.

17 B. On May 5, 2009, Respondent performed an open² exploratory operation
18 and removed an abdominal structure, presumed to be G.G.'s appendix. Respondent had
19 suspected appendicitis, but failed to carry out proper operative diagnostic tests. Even using
20 an open approach in his surgery, Respondent failed to establish anatomical identification of
21 the appendix as the structure arising from the cecum (bowel). Instead, Respondent
22 assumed that the longitudinal structure was the appendix and he removed it. Pathology
23 proved Respondent's assumption to be inaccurate and showed the removed structure to be
24 a fallopian tube with a pyosalpinx.³ G.G. was discharged from the hospital on May 8,

25 ² An open approach means that the abdomen was surgically opened, as opposed to
26 laparoscopic procedures, where it is not.

27 ³ A pyosalpinx is a circumstance where a fallopian tube becomes filled (and often
28 distended) with pus. It can be treated non-operatively.

1 2009. Respondent failed to advise G.G. that he had removed a fallopian tube, not her
2 appendix.

3 **February 6, 2010 Surgery**

4 C. On February 6, 2010, shortly after midnight, G.G. returned to the hospital
5 complaining of abdominal pain. An abdominal pelvic CT scan⁴ was performed. A
6 preliminary report by the radiologist suggested a large ventral⁵ abdominal hernia⁶ in the
7 right lower quadrant measuring approximately 11 cm and containing small bowel loops.
8 Another CT scan was performed at 5:03 a.m. It indicated a large abdominal wall hernia in
9 the anterolateral aspect of the upper right pelvis, containing numerous loops of non-dilated
10 small bowel. Stranding in the mesentery⁷ in the region of the hernia suggested vascular
11 congestion (enlarged blood vessels) or mild incarceration.⁸ Additionally, it suggested a 4.3
12 cm cyst on G.G.'s right ovary.

13 D. Later on February 6, 2010, Respondent performed an open ventral hernia
14 repair. It is unclear from his operative report whether he intended to treat a single hernia or
15 double hernias. Enterotomies⁹ were made which can occur during lysis¹⁰ of adhesions
16 altering the sterility of the wound. The wound was contaminated. Respondent used a

17
18 ⁴ CT means "computed tomography," an imaging method which uses x-rays to
create pictures of cross-sections of the body.

19 ⁵ Ventral means toward the front of the abdomen.

20 ⁶ A hernia is a condition where an organ bulges through connective tissue that normally
21 protects it and keeps it in place. A hernia sack is the bulge including layers of connective tissue
along with the herniated organ.

22 ⁷ The mesentery is the peritoneal (relating to the peritoneum, the serous membrane that
23 lines the abdominal and pelvic cavities and covers most abdominal viscera) fold attaching the
small intestine to the posterior (toward the back) body wall.

24 ⁸ A hernia is incarcerated if the herniated tissue becomes trapped in the hernial sack,
25 whereas in a reducible hernia, herniated material can move freely in and out of the hernial sack.

26 ⁹ An enterotomy is a surgical incision into an intestine, intentional or unintentional.

27 ¹⁰ Lysis means destruction or decomposition under the influence of a specific agent or
mobilization of an organ by division of restraining adhesions.

1 synthetic non-absorbable mesh. The use of mesh in a contaminated wound is controversial
2 as the risk of infection of the mesh is high, especially when using a synthetic non-
3 absorbable material as was used here. Furthermore, Respondent failed to employ
4 adequately sized mesh. The mesh Respondent used was only ½ inch wide, whereas the
5 standard of care requires that mesh overlap the hernia by 3 centimeters (1.2 inches) on each
6 side.

7 E. Six days later, a ventral hernia was noted on x-rays, suggesting an early
8 recurrence due to inadequate repair, or a missed hernia not diagnosed at surgery.

9 **February 19, 2010 Surgery**

10 F. By February 19, 2010, a CT scan of the abdomen showed a large right-
11 side Spigelian¹¹ hernia with dilated loops of small bowel, subtle inflammatory changes
12 surrounding the distal¹² small bowel and some subcutaneous gas laterally.

13 G. Respondent noted that on February 19, 2010, he performed an open
14 ventral hernia repair via a midline incision as well as a small bowel resection with a side-
15 to-side functional end-to-end distal small bowel anastomosis¹³ and "attempted repair of
16 recurrent ventral hernia." He had no assistant. Respondent's operative description that he
17 performed a small bowel resection and reanastomosis had no resemblance to the surgery
18 performed.

19 **February 20, 2010 Surgery: Open Exploratory Laparotomy**

20 H. On February 20, 2010, Respondent performed another exploratory
21 laparotomy¹⁴ on G.G. Respondent documented that he performed a small bowel resection
22 and reanastomosis. Specifically, small bowel in the hernia sac was considered non-viable

23 ¹¹ A Spigelian hernia is a lateral ventral hernia. It is a small extrusion of bowel that
24 protrudes through a weakness between the muscle fibers of the abdominal wall.

25 ¹² Distal means away from the point of origin.

26 ¹³ An anastomosis is the connection of two anatomical structures.

27 ¹⁴ A laparotomy is a surgical procedure involving a large incision through the abdominal
28 wall to gain access into the abdominal cavity.

1 so it was resected and a side-to-side functional end-to-side small bowel reanastomosis was
2 performed. Additionally, Respondent described that a small area of the bowel was
3 adherent to the abdominal wall anterolaterally¹⁵ and he was unable to safely dissect it off.
4 He therefore performed an entero-ascending colostomy¹⁶ in a side-to-side functional end-
5 to-end anastomosis. Respondent placed a drain into the space of the hernia sac and closed
6 the midline wound.¹⁷

7 I. Respondent's operative description that he resected more small bowel and
8 created an "enteroascending colostomy" as a "small bowel was adherent to the anterior
9 abdominal wall anterolaterally" had no resemblance to the surgery performed.

10 **February 20, 2010 Surgery: Mini-Laparatomies**

11 J. On February 20, 2010, Respondent operated on the patient again,
12 suspecting abdominal compartment syndrome¹⁸ due to blood loss. He performed two mini-
13 laparotomies to exclude this possibility. If bleeding is suspected, the source should be
14 sought. Respondent ineffectively performed laparotomies away from the source of

15 ¹⁵ Anterolateral means situated in front and to one side.

16 ¹⁶ A colostomy is a surgical procedure in which the large intestine or colon is extracted
17 through an incision in the anterior abdominal wall and sutured into place.

18 ¹⁷ In the Operative Report, the "Pre-operative Diagnosis" was "Hemoperitoneum." The
19 "Post-operative Diagnosis" was "Intestinal torsion secondary to ventral hernia with
20 reincarceration." The "Operation" was "Exploratory laparotomy, small bowel resection,
21 enterocolotomy, or anastomosis, between distal small bowel and the ascending colon, and
22 placement of drain in the hernia sac."

23 The Operative Report stated that after the previous laparotomy incision was opened, "[an]
24 area of torsion of small intestine was found in the old hernia space which had been disrupted and
25 transudative fluid was removed with pool suction, the area of torsed small bowel was reduced
26 from the hernia sac and then it was resected as it was felt to be nonviable and a side-to-side
27 functional end-to-end anastomosis. (sic) A small area of the bowel was adherent to the abdominal
28 wall anterolaterally and was unable to be safely dissected off. The decision was made to perform
29 an enteroascending colotomy (sic) which was done with 55 GIAs in a side-to-side functional end-
30 to-end fashion. All these anastomoses were then reinforced with a 3-0 silk on a pop-off needle in
31 a Lembert fashion. After this was done the drain 10 mm Jackson -Pratt was placed into the space
32 of the hernia sac and attention became directed towards closure."

33 ¹⁸ Abdominal compartment syndrome occurs when the abdomen becomes subject to
34 increased pressure. Specific cause of abdominal compartment syndrome is not known, although
35 some causes can be sepsis and severe abdominal trauma.

1 suspected bleeding, however. Respondent suspected high intra-abdominal pressure. In
2 that circumstance, the midline wound should have been re-opened and a temporary closure
3 allowing abdominal wall expansion should have been performed. Such reoperation could
4 have been a good opportunity to inspect the prior surgeries. Following the surgery, G.G.
5 continued in the intensive care unit in critical condition.

6 **Subsequent CT Results**

7 K. By February 23, 2010, a CT scan of the abdomen revealed a ventral
8 hernia with small bowel within it. By February 26, 2010, a CT scan showed a right
9 anterolateral defect with multiple loops of small bowel and contrast present within the
10 loops of small bowel in and out of the hernia sac. Multiple foci of gas appeared
11 extraluminally.¹⁹ In essence, Respondent had left a portion of G.G.'s intestine unconnected
12 to the rest of her intestine, and created an environment which allowed infection to occur.

13 **Subsequent Surgery**

14 L. By March 2, 2010, G.G.'s care was transferred to another surgeon who
15 performed yet another laparotomy with Respondent as an assistant describing what he had
16 done, which did not make sense to the primary surgeon. After extensive separation of
17 adhesions, a leaking distal intestinal loop was resected, a colonic anastomosis was taken
18 down, and a mesh was removed from the abdominal wall. An end ileostomy²⁰ was
19 performed, and a gastrostomy²¹ was placed. The primary surgeon documented that no
20 appendix was identified.

21 10. Respondent engaged in gross negligence in his care and treatment of G.G. in his
22 management of G.G.'s incarcerated ventral hernia between February 19 and February 20, 2010,

23 _____
24 ¹⁹ Extraluminal means outside of the intestine.

25 ²⁰ An end ileostomy refers to a stoma (surgical opening) constructed by bringing the end
26 of small intestine (the ileum) out onto the surface of the skin and to the surgical procedure which
27 creates this opening. Intestinal waste passes out of it and is collected in an artificial external
28 pouching system.

²¹ A gastrostomy is an artificial external opening into the stomach.

1 when he performed life-threatening urgent surgeries on G.G. and:

2 (1) Failed to clearly and correctly identify the anatomy;

3 (2) Failed to provide operative descriptions that had any resemblance to what was
4 performed;

5 (3) Misidentified the transverse colon as the ascending colon; and

6 (4) Erroneously re-anastomosed the small bowel to itself rather than to its distal
7 segment;

8 11. Respondent engaged in gross negligence in his cumulative errors in his care and
9 treatment of G.G. on May 5, 2009; February 6, 2010; February 19, 2010; and February 20, 2010,
10 as described above and below.

11
12 **SECOND CAUSE FOR DISCIPLINE**
(Repeated Negligent Acts – Patient G.G.)

13 12. Respondent is subject to disciplinary action under section 2234, subdivision (c), of
14 the Code, in that Respondent engaged in repeated negligent acts in the care and treatment of a
15 patient. The circumstances are as follows:

16 A. The facts and circumstances as alleged in paragraphs 9A through 9L are incorporated
17 here as if fully set forth.

18 B. In his management of G.G.'s incarcerated ventral hernia between February 19 and
19 February 20, 2010, Respondent was negligent when he performed life-threatening urgent
20 surgeries on G.G. and:

21 (1) Failed to clearly and correctly identify the anatomy;

22 (2) Failed to provide operative descriptions that had any resemblance to what was
23 performed;

24 (3) Misidentified the transverse colon as the ascending colon;

25 (4) Erroneously re-anastomosed the small bowel to itself rather than to its distal
26 segment.

27 C. Respondent was negligent in his care and treatment of G.G. in managing her lower
28

1 abdominal pain on or around May 5, 2009, when he:

2 (1) Failed to carry out proper operative diagnostic tests;

3 (2) Failed to anatomically identify the appendix and establish that it was the
4 structure arising from the cecum;

5 (3) Misdiagnosed appendicitis in a female patient by assuming any longitudinal
6 structure is the appendix.

7 D. Respondent was negligent in his care and treatment of G.G. in managing her ventral
8 hernia on or about February 6, 2010, when he performed an open ventral hernia repair and:

9 (1) Failed to clarify whether he was treating a single hernia or double hernias;

10 (2) Made enterotomies which can occur unintentionally during lysis of adhesions
11 altering the sterility of the wound;

12 (3) Used a synthetic non-absorbable material mesh in a contaminated wound
13 despite the high risk of infection;

14 (4) Used an inadequate size of mesh only ½ inch wide;

15 (5) Inadequately repaired a hernia and/or failed to diagnose a hernia at surgery.

16 E. Respondent was negligent in his care and treatment of Respondent on or about
17 February 20, 2010, in managing what he suspected was compartment syndrome due to bleeding
18 as follows:

19 (1) Respondent was negligent when he performed two mini-laparotomies to
20 exclude bleeding but performed them away from the suspected source of the bleeding;

21 (2) Respondent was negligent when he suspected high intra-abdominal pressure,
22 but failed to re-open the midline wound and perform a temporary closure allowing
23 abdominal wall expansion, using the re-operation as an opportunity to inspect the prior
24 surgeries.

25 F. Respondent was negligent in his care and treatment of G.G. in his failure to keep
26 timely, accurate and legible medical records. Specifically, Respondent's handwritten
27 consultations and notes are illegible, thereby precluding good interdisciplinary communication
28 with other physicians and medical staff. Additionally, the illegibility made it difficult to assess

1 the care Respondent gave and to ascertain if Respondent received daily visits from Respondent or
2 his coverage.

3 **THIRD CAUSE FOR DISCIPLINE**
4 (Incompetence – Patient G.G.)

5 13. Respondent is subject to disciplinary action under section 2234, subdivision (d), of
6 the Code, in that Respondent was incompetent in the care and treatment of a patient. The
7 circumstances are as follows:

8 A. Paragraphs 9A through 9L are incorporated herein as if fully set forth.

9 B. Respondent demonstrated a lack of knowledge in general surgery;

10 C. Respondent demonstrated a lack of knowledge in his erroneous diagnosis of G.G. as
11 having an appendicitis when she did not have an appendix at the time of the surgery;

12 D. Respondent demonstrated a lack of knowledge in each intervention with his lack of
13 adequate anatomical identification of anatomical structure prior to his rendering surgical
14 treatment;

15 E. Respondent demonstrated a lack of knowledge in that each surgical treatment he
16 rendered further compromised G.G. and caused her condition to worsen;

17 F. Respondent demonstrated a lack of knowledge by his cumulative errors made in
18 surgical management rendering him incompetent in providing general surgical care.

19 **FOURTH CAUSE FOR DISCIPLINE**
20 (Inadequate Records – Patient G.G.)

21 14. Respondent is subject to disciplinary action under section 2266 of the Code, in that
22 Respondent failed to maintain adequate and accurate records of the medical services he provided.
23 The circumstances are as follows:

24 A. The facts and circumstances set forth in paragraphs 9A through 9L above are
25 incorporated herein as if fully set forth.

26 B. Respondent's handwritten consultations and notes are illegible.

27 C. Respondent's operative description in documentation of the February 19, 2010,
28 surgery bore no resemblance to what was performed.

1 D. Respondent's operative description in documentation of the February 20, 2010,
2 surgery bore no resemblance to what was performed.

3
4 **FIFTH CAUSE FOR DISCIPLINE**
(Out of State Discipline)

5 15. Respondent is subject to disciplinary action under Code section 2305 based on his
6 surrender of his medical license in Louisiana. The circumstances are as follows:

7 A. On September 5, 2013, Respondent executed a Stipulation and
8 Agreement for Voluntary Surrender of Medical License ("Stipulation") to resolve an
9 investigation into his conduct with respect to the erroneous removal of a healthy kidney
10 from a patient, as well as Respondent's failure to maintain adequate records regarding
11 same.

12 B. In addition, the Stipulation reflects that Respondent's privileges to
13 perform surgery were suspended by the hospital where the surgery was performed, thus
14 also supporting the discipline to which Respondent agreed.

15 C. Paragraph 3 of the Stipulation further permanently barred Respondent
16 from practicing medicine in Louisiana.

17 16. Because the actions which resulted in the Stipulation would have been grounds for
18 discipline in California of Respondent's medical licensee, they constitute grounds for disciplinary
19 action for unprofessional conduct against Respondent.

20 **PRAYER**

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

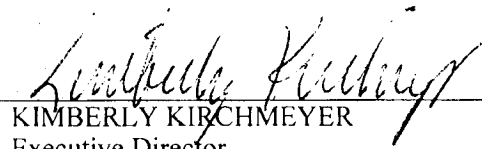
23 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 86613,
24 issued to Respondent;

25 2. Revoking, suspending or denying approval of Respondent's authority to supervise
26 physician assistants pursuant to section 3527 of the Code;

27 ///

- 1 3. Ordering Respondent, if placed on probation, to pay the costs of probation
2 monitoring; and
3 4. Taking such other and further action as deemed necessary and proper.
4

5 DATED: December 9, 2014



KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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