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

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **LARRY MITCHELL ISAACS, M.D.** 2 Danielle Drive Goshen, NY 10924 Physician's and Surgeon's Certificate No. G 86613 Respondent.	Case No. 05-2013-229462 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

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

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

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

JURISDICTION

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

ADVISEMENT AND WAIVERS

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

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

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

CULPABILITY

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

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

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

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

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

CONTINGENCY

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

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

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

ORDER

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

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

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

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

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

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

ACCEPTANCE

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

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

DATED: 3/18/16

LARRY MITCHELL ISAACS, M.D.
Respondent

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

DATED: 3/23/16

THOMAS R. BRADFORD, ESQ.
Attorney for Respondent

ENDORSEMENT

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

Dated: 6/1/16

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

BENETH A. BROWNE
Deputy Attorney General
Attorneys for Complainant

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61732838

Exhibit A

Accusation No. 05-2013-229462

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **LARRY MITCHELL ISAACS, M.D.** 2 Danielle Drive Goshen, NY 10924 Physician's and Surgeon's Certificate No. G 86613 Respondent.	Case No. 05-2013-229462 **ACCUSATION**

Complainant alleges:

PARTIES

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

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

JURISDICTION

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

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

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

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

5. Section 2227 of the Code states:

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

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

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

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

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

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

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

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

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

6. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

" . . ."

7. Section 2266 of the Code provides:

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

8. Section 2305 of the Code states:

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

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence – Patient G.G.)

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

May 5, 2009 Surgery

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

B. On May 5, 2009, Respondent performed an open[2] exploratory operation and removed an abdominal structure, presumed to be G.G.'s appendix. Respondent had suspected appendicitis, but failed to carry out proper operative diagnostic tests. Even using an open approach in his surgery, Respondent failed to establish anatomical identification of the appendix as the structure arising from the cecum (bowel). Instead, Respondent assumed that the longitudinal structure was the appendix and he removed it. Pathology proved Respondent's assumption to be inaccurate and showed the removed structure to be a fallopian tube with a pyosalpinx.[3] G.G. was discharged from the hospital on May 8,

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

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

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

February 6, 2010 Surgery

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

D. Later on February 6, 2010, Respondent performed an open ventral hernia repair. It is unclear from his operative report whether he intended to treat a single hernia or double hernias. Enterotomies[9] were made which can occur during lysis[10] of adhesions altering the sterility of the wound. The wound was contaminated. Respondent used a

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

[5] Ventral means toward the front of the abdomen.

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

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

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

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

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

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

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

February 19, 2010 Surgery

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

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

February 20, 2010 Surgery: Open Exploratory Laparatomy

H. On February 20, 2010, Respondent performed another exploratory laparotomy[14] on G.G. Respondent documented that he performed a small bowel resection and reanastomosis. Specifically, small bowel in the hernia sac was considered non-viable

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

[12] Distal means away from the point of origin.

[13] An anastomosis is the connection of two anatomical structures.

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

so it was resected and a side-to-side functional end-to-side small bowel reanastomosis was performed. Additionally, Respondent described that a small area of the bowel was adherent to the abdominal wall anterolaterally[15] and he was unable to safely dissect it off. He therefore performed an entero-ascending colostomy[16] in a side-to-side functional end-to-end anastomosis. Respondent placed a drain into the space of the hernia sac and closed the midline wound.[17]

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

February 20, 2010 Surgery: Mini-Laparatomies

J. On February 20, 2010, Respondent operated on the patient again, suspecting abdominal compartment syndrome[18] due to blood loss. He performed two mini-laparotomies to exclude this possibility. If bleeding is suspected, the source should be sought. Respondent ineffectively performed laparotomies away from the source of

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

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

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

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

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

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

Subsequent CT Results

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

Subsequent Surgery

L. By March 2, 2010, G.G.'s care was transferred to another surgeon who performed yet another laparotomy with Respondent as an assistant describing what he had done, which did not make sense to the primary surgeon. After extensive separation of adhesions, a leaking distal intestinal loop was resected, a colonic anastomosis was taken down, and a mesh was removed from the abdominal wall. An end ileostomy[20] was performed, and a gastrostomy[21] was placed. The primary surgeon documented that no appendix was identified.

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

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[19] Extraluminal means outside of the intestine.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THIRD CAUSE FOR DISCIPLINE
(Incompetence – Patient G.G.)

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

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

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

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

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

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

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

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

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

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

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

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

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

FIFTH CAUSE FOR DISCIPLINE
(Out of State Discipline)

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

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

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

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

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

PRAYER

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

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

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

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3. Ordering Respondent, if placed on probation, to pay the costs of probation monitoring; and

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

DATED: December 9, 2014

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

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