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

In the Matter of the First Amended Accusation Against:	)	
JAMES R. VEVAINA, M.D.	)	Case No. 10-2013-233509
Physician's and Surgeon's Certificate No. A 30551	)	
Respondent	)	

DECISION AND ORDER

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 August 24, 2017.

IT IS SO ORDERED: July 25, 2017.

MEDICAL BOARD OF CALIFORNIA

Michelle Anne Bholat MD

Michelle Anne Bholat, M.D., Chair
Panel B

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

In the Matter of the First Amended Accusation Against: JAMES R. VEVAINA, M.D., Physician's and Surgeon's Certificate No. A30551, Respondent.	Case No. 10-2013-233509 OAH No. 2016080152

PROPOSED DECISION

Adam L. Berg, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on June 5, 6, and 7, 2017, in San Diego, California.

Karolyn M. Westfall, Deputy Attorney General, Department of Justice, represented complainant, Kimberly Kirchmeyer, Executive Director, Medical Board of California, Department of Consumer Affairs, State of California.

Robert Frank, Attorney at Law, represented respondent, James R. Vevaina, M.D.

The matter was submitted on June 7, 2017.

PROTECTIVE ORDER

The names of patients referred to in this matter are subject to a protective order. Any document received in this matter that contains the name of a patient shall, before any disclosure to the public, be redacted and replaced by the patient's initials. No court reporter or transcription service shall transcribe the name of the patient, but shall instead refer to the patient by his or her initials.

SEALING ORDER

Exhibits 4, 5, 6, 8, 9, 10, 12, 13, 14, 15, 16, and 17 contain confidential patient information. It is impractical to delete all of the confidential information from these exhibits. To protect privacy and prevent the inappropriate disclosure of confidential personal information, these exhibits are ordered sealed. This sealing order governs the release of documents to the public. A reviewing court, parties to this matter, their attorneys, or a government agency decision maker or designee under Government Code section 11517 may review the documents that are subject to this sealing order, provided that the documents containing confidential information remain protected from release to the public.

FACTUAL FINDINGS

1. On February 21, 1989, the board issued Physician's and Surgeon's Certificate Number A30551 to respondent. At all times relevant to these proceedings, respondent's certificate was in full force and effect. There is no history of discipline against respondent's certificate.

2. On February 1, 2017, complainant, in her official capacity, signed the first amended accusation, alleging gross negligence in the care of three patients, repeated negligent acts in the care of those patients, and failure to maintain adequate and accurate patient records. Complainant seeks the revocation or suspension of respondent's certificate.

Respondent's Background

3. Respondent received his medical degree from the University of Mumbai in 1967. He completed his internship and residency in internal medicine at Mount Sinai Hospital in New York City and Miami Beach. He completed a fellowship in pulmonary disease and intensive care at Mount Sinai Hospital in Miami Beach. He was board-certified in Internal Medicine in 1972 and Pulmonary Medicine in 1986. He is a fellow of both the American College of Physicians and American College of Chest Physicians. He has held leadership positions in the San Diego Pulmonary Society. From 1975 to 1990, he was associate director of the pulmonary laboratory at Flushings Hospital and worked in private practice. From 1991 to the present, he has been a solo practitioner in San Diego and held hospital affiliation with Sharp Memorial Hospital for the past 24 years. Approximately 95 percent of his practice is pulmonary and sleep medicine, 5 percent is internal medicine.

The Board's Expert Jonathan K. Leung, M.D.

4. Jonathan Leung, M.D., received his Doctorate of Medicine from Tulane University in 1988. He completed his internship and residency in Internal Medicine as well as a pulmonary and critical care medicine fellowship at Los Angeles County and University of Southern California Medical Center. Dr. Leung was board-certified in Internal Medicine in 1992, Pulmonary Disease in 1994, and Critical Care Medicine in 1995. He is a fellow of

the American College of Chest Physicians and member of the American Thoracic Society. Since 1996, Dr. Leung has operated a private practice in Glendora. Approximately 90 percent of his patients are pulmonology patients, the rest are internal medicine. In addition to his private practice, Dr. Leung is the medical director of the pulmonary rehabilitation program at Citrus Valley Medical Center. He has been an expert reviewer for the board since 2008 and recently became a district medical consultant, reviewing cases involving other specialties. He has sat on several peer review committees at various hospitals. He has published several articles in peer-reviewed publications and given a number of lectures. Based on his education, training, and experience, Dr. Leung was well qualified to render an expert opinion in this matter.

Respondent's Expert William Wayne Hooper, M.D.

5. William Wayne Hooper, M.D., received his Doctor of Medicine from McGill University in Montreal, Quebec, in 1975. He completed his residency in Internal Medicine at Royal Victoria Hospital, McGill University, in 1978. He completed a Pulmonary and Critical Care Medicine Fellowship at University of California at San Diego (UCSD) in 1980. In 1980 he joined the faculty at UCSD as an Assistant Clinical Professor in the Division of Pulmonology and Critical Care. Dr. Hooper joined an internal medicine group in 1982 affiliated with Scripps Memorial Hospitals. He started his own practice in 2002. He holds a number of hospital affiliations and has been a member of hospital peer-review committees. Since the mid-1980s, he has provided medical-legal consultations, primarily for malpractice defense. Based on his education, training, and experience, Dr. Hooper was well qualified to render an expert opinion in this matter.

Patient S.S.

6. Respondent treated S.S. from August 15, 2012, until May 22, 2013. Complainant alleged respondent committed gross negligence in the care and treatment of S.S. by failing to maintain adequate and accurate medical records, failing to monitor potential side effects from patient S.S.'s medications, and failing to properly dismiss patient S.S. from his care. In addition, complainant alleged respondent committed repeated negligent acts in his care and treatment of patient S.S. by failing to reconcile patient S.S.'s medications on one visit; failing to work diligently to obtain authorization approval from S.S.'s insurance company for tests and medications respondent believed were necessary for patient S.S.; and failing to promptly evaluate and teat patient S.S. for pulmonary hypertension with known patent foramen ovale.

7. Patient S.S. had a history of systemic lupus erythematous (lupus), pulmonary hypertension and suffered from a post-partum pulmonary embolism related to the lupus. In 2008, she was seen at the University of California at Los Angeles (UCLA) pulmonary hypertension clinic for evaluation and treatment. An echocardiogram revealed a patent foramen ovale, which is a hole in the heart, and elevated pulmonary artery pressure (pulmonary hypertension). She was placed on multiple medications and was taking Coumadin indefinitely due to the lupus. In 2012, S.S.'s insurance changed and she was no

longer able to be seen at UCLA. Her primary care doctor referred her to respondent for follow-up treatment of her pulmonary hypertension.

RESPONDENT'S RECORDS FOR S.S.

8. S.S. was first seen at respondent's office on August 15, 2012. Respondent was on vacation that day, and the patient was seen by Dr. Begovic, a pulmonologist at UCSD who was covering respondent's practice. In S.S.'s chart was a single-page typewritten assessment signed by Dr. Begovic on August 15, 2012. In addition, there was a typewritten four-page pulmonary consultation that was signed by respondent and also dated August 15, 2012.

S.S. was next seen at respondent's office October 17, 2012. According to the progress note[1] for this visit, she complained of being tired after walking just one block. There was no listing of her current medications. Under the "plan" section respondent wrote that he wanted to await the results of a cardiac MRI and "patent foramen ovale or patent ductus arteriosus must be determined first." On October 23, 2012, respondent faxed a letter to Dr. Hutt, who reviewed authorization requests at S.S.'s HMO, requesting a chest MRI at UCSD and thoracic surgical consult.

The next visit was November 5, 2012. S.S. complained of upper back pain, difficulty breathing, and a feeling of passing out. A list of medications was completed including Tyvaso, Letairis, Adcirca, and Remodulin[2]. The diagnosis was pulmonary hypertension and atrial septal defect. Respondent recommended an MRI of the chest, CT scan of the chest, an EKG, and an echocardiogram. Respondent wrote, "see again when authorized." On November 6, 2012, respondent faxed a request for a chest MRI to UCSD.

The last visit was on January 21, 2013. S.S. complained of back pain, pressure in her throat, and difficulty breathing. Respondent wrote that S.S.'s pulmonary hypertension was controlled, but he "believed she should be doing better." He advised her to discontinue Lasix due to low blood pressure. He recommended a sleep study. The plan section contained the following tests requested for authorization: pulmonary function test, pulmonary stress test, chest MRI, Doppler echocardiogram with bubble study, and sleep study. This progress note was faxed to S.S.'s insurer for authorizations.

A report dated March 20, 2013, indicated S.S. underwent a sleep study. The recommendation was for the primary care physician to refer to an ears, nose, and throat specialist.

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[1] Unless otherwise indicated, all of the progress notes for the three patients involved in this case were pre-printed forms that respondent and his medical assistant completed by hand.

[2] Remodulin (treprostinil) is a continuous pump therapy for treatment of pulmonary hypertension.

On May 22, 2013, respondent sent S.S. a letter stating that her case was too complicated and he would no longer serve as her pulmonologist. He wrote, "I recommend you promptly find care at UCSD Medical Center. You may contact your insurance to obtain a list of physicians currently accepting new patients. Any delay could jeopardize your health, so please act promptly." Respondent concluded that he would not provide medical care of any kind as of the date of the letter.

A handwritten note dated May 23, 2013, said S.S. was admitted to a hospital in Chula Vista. The note stated respondent spoke to an unnamed pulmonologist who referred S.S. to UCSD.

DR. LEUNG'S TESTIMONY

9. Dr. Leung testified about his understanding of the standard of care. The standard of care, according to Dr. Leung, is the level, skill, knowledge of the diagnosis and treatment of patients in the same circumstances in the same time frame of practice. The difference between a "simple" and "extreme" departure is based on degree; harm to the patient is not required for there to be an extreme departure. Dr. Leung is familiar with the standard of care for pulmonologists based on his twenty-plus years of practice, work on peer-review committees, and consultation with his colleagues. There are four other pulmonologists in his practice group, and he regularly reviews their charts and discusses cases with them.

10. Dr. Leung's testimony is summarized as follows: Dr. Leung believed respondent's medical record-keeping was an extreme departure from the standard of care. The standard of care for an initial consultation is to perform a complete history and physical examination which includes: history of the present illness; past medical history; drug allergies; current medications; social and family history; review of systems; full physical examination; and an assessment and plan. For progress notes, a physician should update any changes in medical history and medications, perform a physical exam, and provide an assessment and plan. If any of these items were not completed, the physician should document that the information was not obtained. Each page of a medical record should be identified with the patient's name, birthdate, and date of entry in order for the record to be clearly identified.

Based on the medical record, it was not possible to tell who saw the patient on the initial August 15, 2012, visit. It is permissible for a physician to co-sign a note or enter an addendum to the note. However, respondent did not do this, and it appears from respondent's consultation that he himself saw the patient. Additionally, there was a discrepancy between the two notes: Dr. Begovic advised the patient to go to Sharp emergency should her condition worsen, respondent's note indicated the patient was advised to go to UCSD.

Dr. Leung believed there was an extreme departure in the standard of care for three reasons: respondent did not properly mark all his medical records with required identifying

information, the chart was largely disorganized and the chart was not maintained in chronological order, and respondent should have clearly indicated his initial consultation was an addendum to Dr. Begovic's note, rather than appearing that respondent saw the patient for the initial consultation.

Dr. Leung admitted that he received the copy of the patient's chart from the board, and thus has no way of knowing if the original was in chronological order or why there was no apparent order to how the chart was organized.

11. Dr. Leung believed respondent committed a simple departure from the standard of care by failing to reconcile each of S.S.'s medications on each visit. No medications were listed in the progress note for October 17, 2012. Given the patient's complex medical history, respondent should have kept track of her current medications. Documenting the pulmonary medications is essential. The physician should document the dose and frequency of a medication. However, respondent failed to document the medications on only one out of four office visits, and this failure was a simple departure from the standard of care.

12. Dr. Leung believed respondent committed an extreme departure from the standard of care by failing to monitor side-effects of medications by requesting routine lab tests. S.S. was taking multiple medications (Letaris, Lasix, Remodulin, Adcirca, Plaquenil, Imuran, and prednisone) that could impair her kidneys and liver. Respondent did not request any labs for the patient, or document that such labs were being completed by another physician over the five months he treated S.S. Additionally, S.S. was on Coumadin, which requires routine monitoring. There was no documentation indicating respondent was aware of who was monitoring the patient's Coumadin. Respondent's failure to request any lab work constituted an extreme departure from the standard of care.

On cross examination, Dr. Leung admitted that none of the drugs respondent prescribed required serial testing according to the manufacturers' prescribing information. Although Lasix requires routine lab work, the physician prescribing the drug should order lab tests. Dr. Leung admitted that the standard of care is to assume other physicians treating the patient are also acting within the standard of care.

13. Dr. Leung believed that there was an extreme departure from the standard of care regarding respondent's dismissal of S.S. from his practice. The standard of care requires the patient receive continuity of care. The standard is for a physician to provide a letter to the patient stating the effective date and reason of the dismissal. The standard is to provide the patient with 30 days to find another physician, during which the dismissing physician is responsible for providing interim care. The letter should be sent by certified mail to ensure that the patient receives it. Respondent sent a letter to S.S. on May 23, 2013, informing her he would no longer provide her medical services because her case was too complicated. He recommended she seek care at UCSD and to contact her HMO to obtain a list of available physicians. Respondent specifically wrote that he would no longer provide care as of the effective date of the letter. Respondent committed an extreme departure from

the standard of care because he did not offer or assist S.S. in finding a new pulmonologist and failed to indicate he would provide her care for 30 days while she attempted to find a new physician. The letter should have been sent by certified mail, and respondent should have informed the patient's HMO of his termination.

14. Dr. Leung believed that respondent did not work diligently to obtain authorization from S.S.'s insurer for certain tests, physician referral, and medications. The standard of care requires physicians to help in obtaining authorization for special tests or referrals. The progress notes indicated respondent believed S.S. needed tests and referrals that required insurance authorization. Dr. Leung could not tell from the notes if respondent actually requested authorization. Although respondent appears to have requested authorization for continued use of Remodulin, there was nothing indicating he did this for the tests and referrals respondent indicated were necessary. Although respondent tried to get approvals, "he didn't try hard enough." This was a simple departure from the standard of care.

15. Finally, Dr. Leung believed respondent did not promptly evaluate and treat S.S. who was suffering from pulmonary hypertension with known patent foramen ovale. The standard of care for a pulmonologist treating a complex condition is to refer the patient to other specialists if he cannot adequately treat the condition. Due to the complexity of S.S.'s case, a team of specialists was required. UCSD is world-renowned for the treatment of pulmonary hypertension. Respondent should have immediately referred S.S. to UCSD because of the complex condition and the patient's secondary issues. UCSD is in a much better position to obtain authorizations and approvals for the needed tests, than is a sole practitioner like respondent. However, Dr. Leung admitted that he did not have any knowledge about respondent's experience in treating patients with complex conditions such as pulmonary hypertension. Dr. Leung believed respondent's failure to promptly refer S.S. to UCSD constituted a simple departure from the standard of care.

DR. HOOPER'S TESTIMONY[3]

16. Dr. Hooper disagreed with Dr. Leung that respondent departed from the standard of care in the treatment of S.S. Dr. Hooper defined "standard of care" as what most reasonable physicians would do under similar circumstances. Dr. Hooper defined "simple departure" as where an error was made that did not result in injury or death to the patient and the result was "inconsequential" to the patient's health. His definition of an "extreme departure" was where injury or death results. Thus, according to Dr. Hooper, the degree of departure from the standard of care was based on the level of harm caused to the patient.

17. Dr. Hooper's testimony is summarized as follows: As to respondent's medical recordkeeping, Dr. Hooper strongly disagreed that the standard of care in the San Diego

[3] By stipulation of the parties, Dr. Hooper was deposed on May 26, 2017, because he was unavailable to testify at the hearing. A video and transcript of his testimony were received and reviewed. His deposition testimony was considered as if he testified in person.

community is for physicians to include a patient's name, date of birth, and date of entry on every page of the medical records. Dr. Hooper has reviewed numerous charts over the years, and he has never found that this information is required to be contained on all pages. Furthermore, there has never been a mandate from any authoritative body that this information be included on every page.

Dr. Hooper did not believe there was anything inappropriate with the note respondent entered after Dr. Begovic performed the initial consultation of S.S. Dr. Hooper was under the impression that respondent indicated in his note that he reviewed Dr. Begovic's note and was in agreement with his plan. Dr. Hooper also stated that respondent cosigned Dr. Begovic's note, however, he was not sure if it was actually respondent's or Dr. Begovic's signature on the document. When asked if respondent departed from the standard of care by creating a new note dated and signed when he was not even working, Dr. Hooper said he found it "unusual" and he was "hoping" respondent reviewed everything and it was his way of starting a new patient in the practice; there was no "malicious intent" on the part of respondent.

18. Dr. Hooper disagreed with Dr. Leung that respondent failed to adequately reconcile the patient's medications. Although respondent did not list the patient's medications in one of the progress notes, this was a one-time charting oversight. In his own practice, Dr. Hooper asks his patients to provide a list of medications from other providers, but he only "tracts the drugs he is interested in from a pulmonary standpoint." Thus, the standard of care does not require a pulmonologist to list all of the drugs a patient is on at every visit. Respondent made a reasonable effort on the other dates to list the various medications she was on at that time.

Dr. Hooper did admit that a physician should make some indication or acknowledgment that the patient's medications have not changed if that was indeed the case. Dr. Hooper noted that if a patient is on some sort of drug that Dr. Hooper is unfamiliar with, he will not notate the drug. Thus, a pulmonologist need only notate pulmonary drugs or closely related drugs, such as cardiac drugs. A pulmonologist does not need to document or be concerned about unrelated drugs if they are not pertinent to pulmonology. When pressed, Dr. Hooper admitted that respondent's failure to document any medications on October 17, 2014, was a simple departure from the standard of care.

19. In his report, Dr. Hooper did not address the allegation that respondent failed to properly monitor the patient's medications for possible side-effects and request lab work. However, he testified that the main side effects of these drugs would be recognized on a physical examination of the patient or a change in the patient's vital signs. Dr. Hooper focused extensively on the care of S.S. at UCLA and what information was conveyed to respondent. It would be a simple departure from the standard of care not to check labs if there were no records about past blood tests or information on who was monitoring lab work. However, he did not believe respondent's failure to request lab work constituted an extreme departure from the standard of care.

20. Dr. Hooper believed that respondent's dismissal of S.S. comported with the standard of care. Dr. Hooper was under the assumption that respondent spoke to S.S. and advised her he could no longer care for her and that she should go to UCSD. S.S. acknowledged this and confirmed she would go to UCSD. Respondent was "justified in assuming after his conversation with S.S. there would be a seamless 'handoff of care' to UCSD." Most pulmonologists in San Diego would have transferred the patient to UCSD because of the complexity of her case. The standard of care in discharging a patient is to speak to the patient to inform him or her that the physician is no longer providing care. In his practice, Dr. Hooper would give the patient six weeks to find another doctor and advise the patient that he would be responsible for his or her medications during those six weeks. Dr. Hooper believed S.S. confirmed to respondent that she would be going to UCSD. The standard of care does not require a patient receive notice through certified mail, if there was an actual conversation and acknowledgment by the patient. Ensuring the patient was seen at UCSD was the main issue.

21. Dr. Hooper indicated in his report that respondent worked to obtain tests, referrals, and medications from S.S.'s HMO. From his understanding, respondent tried to get the patient referred to a cardiac surgeon and get an MRI. It is common for a physician to run into a bureaucratic wall when requesting authorizations from an HMO, and Dr. Hooper felt respondent tried to get authorizations.

22. Finally, Dr. Hooper believed that respondent adequately evaluated S.S. for pulmonary hypertension and patent foramen ovale. Dr. Hooper was unaware if the doctors at UCLA properly evaluated the patient, and respondent properly ordered an MRI to investigate that further. Most pulmonologists in San Diego would have referred a complicated case like S.S.'s to UCSD because of its expertise and having multiple specialists who could address her different issues. Dr. Hooper believed respondent initially felt comfortable managing S.S.'s pulmonary hypertension, although most pulmonologists would have referred the patient to UCSD.

RESPONDENT'S TESTIMONY

23. Respondent testified that in his practice he has seen numerous complex patients like S.S., and most patients come to him with complex medical problems. Respondent started keeping electronic medical records a year-and-a-half ago. Most of the problems related to his medical records were because they were incomplete. Prior to electronic medical records, his medical assistant would normally type up his handwritten notes. However, because they were often busy, sometimes the notes would not be typed. This is why a number of the records were missing "this and that." Respondent believed his patient care was excellent. Electronic records have made it much easier. After the initiation of these proceedings, on the advice of his attorney, he enrolled in a medical recordkeeping course at UCSD's Physician Assessment and Clinical Education (PACE) program.

24. Respondent said the board's copy of his chart appeared to be out of order. There was an issue in that the board did not have the entire chart, and respondent had to

provide the board with an additional copy. Respondent disagreed that the standard of care requires a physician to stamp every medical record. He noted that in a large system, such as UCSD, this is done electronically. But in a solo practice, such is not practical.

25. Respondent reviewed the note he authored October 17, 2012, where no medications were listed. Respondent said that no medications were changed during the visit. He admitted he should have written "same" indicating there were no changes in medications. Respondent felt comfortable taking S.S. on as a new patient. He has handled many patients similar to her in the past, and he thought her HMO would approve his test requests. Respondent knew he could handle her care. Dr. Begovic, who was an attending physician at UCSD performed the initial evaluation because he was covering respondent's practice that day. When he returned from his vacation, respondent discussed S.S.'s case with Dr. Begovic. Dr. Begovic gave respondent a brief typewritten note and some handwritten notes, and he asked respondent to complete the note since Dr. Begovic had not had time. Respondent just rewrote what Dr. Begovic found, and he added some changes to the assessment and plan. He only billed for one visit and he was just continuing the note that Dr. Begovic started. Respondent admitted there was a discrepancy in the two notes about what hospital S.S. should go to in an emergency.

26. Respondent said it was his understanding that S.S.'s primary care physician was responsible for ordering labs and monitoring the patient's Coumadin. Respondent could not be responsible for a drug he did not order. Furthermore, the referring doctor at UCLA never informed him that the patient was on Coumadin or told respondent he was expected to monitor it. The medications respondent prescribed do not affect the liver or kidneys or pose a significant risk to the patient. Respondent disagreed with Dr. Leung that changing the Lasix the patient received would affect the liver or kidneys requiring labs because 40 mg is a low dose.

27. Respondent said he tried as hard as he could to get the patient referred for tests regarding her patent foramen ovale and to see a cardiologist. He requested an echocardiogram, MRI of the heart, and an EKG. He noted a letter that he sent the HMO reviewing physician requesting the MRI and a cardiothoracic consult. He tried as hard as he could to get the HMO to approve the tests. He left messages with the HMO reviewing physician, and in the end, all of his referrals were authorized. S.S. was finally referred to a cardiologist a week before he dismissed her, but she did not go to the appointment. Respondent implied that this was one of the reasons for discharging the patient. However, when pressed, he could not provide any details or evidence in his chart that S.S. actually had a cardiac consult appointment or failed to appear for it.

28. Respondent said the case became too complicated because he was not receiving authorizations for the tests he requested. He had his medical assistant, who spoke Spanish, call S.S. and explain to her that her case was too complicated. He told her to go immediately to UCSD and S.S. said she would go. He then sent her a letter dismissing her from his practice. His medical assistant relayed this to S.S., and she understood what respondent told her. Respondent gave S.S. 30 days to find a new pulmonologist and told her

she could use respondent for care, but he forgot to include this in the letter. Respondent had never received any information on the proper way of discharging a patient. If he had to do it again, he would give the patient 30 days to find another doctor, during which time he would see the patient. The standard of care does not require him to work through the HMO to find a new doctor. The primary care physician is responsible for that. The day after discharging the patient, respondent learned that she had gone to Sharp Hospital in Chula Vista. A physician there indicated the patient was being transferred to UCSD.

EVALUATION

29. The standard of care requires a specialist to possess and exercise that level of knowledge and skill ordinarily possessed by members in good standing in his or her specialty in the same or similar circumstances at the time in question. The existing standard does not fault a medical professional for choosing among different methods that have been approved by the profession even if the choice later turns out to have been the wrong selection or not favored by other members of the profession. (*N.N.V. v. American Assn. of Blood Banks* (1999) 75 Cal.App.4th 1358, 1384.) Because the standard of care is a matter peculiarly within the knowledge of experts, expert testimony is required to prove or disprove that a health care professional acted within the standard of care unless negligence is obvious to a layperson. (*Johnson v. Sup. Ct.* (2006) 143 Cal.App.4th 297, 305.)

California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reason upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.) Relying on certain portions of an expert's opinion is entirely appropriate. A trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal. 3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.* at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal. App. 2d 762, 767.) The fact finder may also reject the testimony of a witness, even an expert, although it is not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal. 3d 875, 890.)

30. Dr. Leung believed respondent committed an extreme departure from the standard of care regarding his recordkeeping based on three reasons: respondent did not properly mark all his medical records with required identifying information, the chart was largely disorganized and not maintained in chronological order, and respondent should have clearly indicated his initial consultation was an addendum to Dr. Begovic's note, rather than appearing that respondent saw the patient for the initial consultation. Dr. Hooper believed that the records, although not perfect, were adequate and met the standard of care.

It was not established by clear and convincing evidence that failing to list the patient's name, birthdate, and date of entry on every page of the chart departed from the standard of

care. Dr. Hooper's and respondent's testimony on this issue was more convincing than that of Dr. Leung.

Next, although the copy of S.S.'s chart provided to the board was largely disorganized and out of chronological order, it was not established by clear and convincing evidence that this disorganization mirrored respondent's original chart. As such, it cannot be found that the original chart was organized in such a manner as to constitute a departure from the standard of care.

Finally, Dr. Leung believed that respondent inappropriately completed a note that made it appear he saw and evaluated S.S., when in fact Dr. Begovic, performed the consultation. Both Dr. Leung and Dr. Hooper agreed that it would have been appropriate for respondent to cosign Dr. Begovic's note, but this did not occur. Instead, respondent created a note that never mentioned Dr. Begovic or indicated respondent did not personally evaluate the patient. Dr. Leung's testimony that this departed from the standard of care was more convincing than Dr. Hooper's, who suggested the note was permissible since respondent did not have any malicious intent. Dr. Hooper was also under the impression that respondent cosigned Dr. Begovic's note, which was not the case. Any person reviewing the chart would believe that respondent evaluated the patient, rather than Dr. Begovic.

Dr. Leung believed that respondent's recordkeeping was an extreme departure from the standard of care based on these three reasons. It cannot be found that the note respondent created constituted an extreme departure in and of itself. At most it was a simple departure from the standard of care, which is to provide records that are accurate and not misleading.

31. Dr. Leung believed respondent committed an extreme departure from the standard of care by failing to request labs and monitor side-effects of S.S.'s medications. Dr. Hooper testified that the standard of care requires a pulmonologist to monitor the medications he or she prescribes to the patient. Here, based on the manufacturers' prescribing information, the medications respondent prescribed did not require routine lab work. Dr. Hooper further testified that the side effects of these drugs would be ascertainable through a physical examination and change in vital signs. Although, S.S. was on multiple medications prescribed by different specialists, clear and convincing evidence did not establish that the standard of care requires a pulmonologist to ensure that other doctors are monitoring the drugs they are prescribing. As such, respondent's failure to order any labs did not constitute a departure from the standard of care.

32. Dr. Leung believed that respondent's dismissal of the patient constituted an extreme departure from the standard of care. Respondent testified that he had his medical assistant, who spoke Spanish, speak to the patient over the phone and advise her that the case was too complicated and she should immediately go to UCSD. Respondent testified that he told the patient she would have 30 days to find a new pulmonologist during which time he would continue to see her during the transition. Respondent's testimony on this matter was not credible. First, it conflicts with what was contained in the letter to S.S., which stated he "would not provide medical care of any kind as of the date of the letter." Additionally, the

very next day, S.S. went to a hospital in Chula Vista, not UCSD, which undercuts his claim that he told her to go to UCSD immediately. Respondent had not seen S.S. since January 2012. He dismissed her in May, because he said her HMO was not authorizing procedures and she failed to attend a consultation once it was authorized. However, there was no evidence establishing S.S. did not attend an appointment, and respondent's attempt to shift blame to the patient was disingenuous.

Dr. Hooper believed that respondent's actions met the standard of care because he felt all the important information was conveyed to the patient verbally. Both experts agreed that the important part of discharging a patient is to maintain the continuity in care. As Dr. Hooper's opinion was based on information deemed not credible, his opinion is given little weight. Instead, clear and convincing evidence established respondent committed an extreme departure from the standard of care in the manner he discharged the patient. Rather than taking any steps to ensure she had continuity of care, he merely instructed her to go to UCSD. S.S. suffered from serious medical conditions. Respondent provided no assistance to her or offer to see her during the transition. Complainant established that respondent's actions were an extreme departure from what would be expected of a pulmonologist in a similar situation.

33. Dr. Leung believed that respondent's failure to reconcile medications on one visit was a simple departure from the standard of care. Both Dr. Hooper and respondent agreed that respondent should have indicated at least which pulmonary medications S.S. was on at the time of the visit or that there was no change. Although the error only occurred on one occasion, complainant established that the standard of care requires documentation of a patient's medications. As this was not done, a simple departure from the standard of care was established.

34. Dr. Leung believed respondent failed to work diligently to obtain authorization and approval for tests and medications respondent believed were necessary for S.S.'s treatment. As for authorization for medication, respondent did receive authorizations for Remodulin, which S.S. received. Respondent's progress notes indicated he wanted to send S.S. for a number of tests. Respondent testified that he worked diligently to request authorizations for tests but ran into multiple denials from the HMO. This assertion was not supported by documentation in the chart, which only had several faxes to the HMO requesting authorization. However, the issue is not one of recordkeeping, but of whether respondent actually made a concerted effort to get S.S. the care he thought she needed. Thus, the burden is on complainant to prove that respondent was dilatory in his efforts such that he departed from the standard of care. This burden was not met as it was not established by clear and convincing evidence that respondent failed to diligently pursue authorizations for these tests.

35. Finally, Dr. Leung believed respondent did not promptly evaluate and treat S.S. for her pulmonary hypertension and patent foramen ovale. Respondent testified that although S.S. was a complex case, he has extensive experience in treating pulmonary hypertension. However, once he began encountering problems with receiving authorization

for tests, he decided he could no longer care for her and recommended she go to UCSD. Both Dr. Leung and Dr. Hooper agreed that UCSD is highly recognized for its treatment of pulmonary hypertension. Additionally, as a tertiary care facility, UCSD has the ability to coordinate care across multiple specialties. Both experts agreed that most San Diego pulmonologists would have referred a patient with S.S.'s medical issues to UCSD for care. However, Dr. Leung was not aware of respondent's training and experience with regard to the treatment of pulmonary hypertension. Although all agree that it would have been better for S.S. to have been referred to UCSD, which calls into question why UCLA referred such a patient to respondent in the first place, it was not established by clear and convincing evidence that respondent's actual treatment departed from the standard of care.

Patient E.E.

36. E.E. was referred to respondent by her primary care doctor after E.E. had visited the emergency room on three occasions for asthma. E.E. saw respondent on July 8, July 14, and December 11, 2014. Complainant alleged respondent committed gross and repeated negligence in the care and treatment of E.E. by failing to maintain adequate and accurate medical records, failing to adequately manage patient E.E.'s persistent asthma, failing to reconcile patient E.E.'s medications on all three visits, and performing a breast exam, without indication, without proper documentation, and without first obtaining proper informed consent.

RESPONDENT'S RECORDS FOR E.E.

37. A progress note from E.E.'s primary care doctor dated June 20, 2014, was attached to the referral and included in respondent's chart. The note indicated that E.E.'s mother had pancreatic cancer and E.E. had breast implants five years before. There was no mention of a family history of breast cancer.

At her first visit, E.E. completed a four-page initial patient history. On the form, she indicated her mother had cancer but did not specify the type. In the list of prior surgeries, E.E. did not indicate she had breast implants. E.E. also completed a four-page sleep questionnaire where she did indicate she had breast implants. Respondent's first progress note from July 8, 2014, indicated the reason for the consultation was asthma. He wrote, "the patient c/o shortness of breath and not being able to talk due to shortness of breath." Under medications, respondent listed Dulara and albuterol.[4] In the surgical history section there was no notation that E.E. had breast implants. The physical history section was pre-printed and contained items respondent could circle to indicate it was part of the physical exam. Respondent wrote "silicone implants," but neither "No masses were palpable" nor "Deferred" were circled. He wrote "minimal wheeze" for lungs and circled "Soft," "Flat," and "No organomegaly" for the abdomen. He assessed E.E. as having "mild asthma," prescribed her 10 mg of prednisone, and indicated she should return in 10 to 15 days for a pulmonary function test.

[4] Dulera (formoterol/mometasone) and albuterol are aerosol inhalers.

E.E.'s next visit was on July 14, 2014. On a progress note, respondent wrote that E.E. responded well to prednisone and her mother-in-law died from cancer. Respondent listed medications as prednisone and Symbicort.[5] In the physical exam section, respondent circled "No masses." His diagnosis was asthma and he recommended taking an unnamed steroid inhaler twice daily and follow-up in six weeks.

E.E.'s final visit was on December 22, 2014. Respondent wrote that E.E. complained of "dizzy spells and palpitations." The note indicated E.E. went to the emergency room and was given prednisone, which she finished, but was still complaining of coughing and wheezing. In the physical examination section, respondent wrote "implants without masses" and circled "soft" under abdomen. His diagnosis was asthma, and he prescribed prednisone, QVAR, and montelukast.[6] He recommended a follow-up visit in two weeks.

PATIENT E.E.'S TESTIMONY

38. E.E. is a 62-year-old female. She began having breathing problems approximately four years ago. She initially sought treatment at a local health clinic and had to go to the emergency room on several occasions. On June 14, 2014, she was seen at the health clinic. She provided information to her doctor that she had silicone breast implants and her mother had pancreatic cancer. This information was recorded in the clinic's medical records. The clinic referred E.E. to respondent for treatment of asthma. She had recently been to the emergency room where she was put on a breathing machine and prescribed prednisone.

39. When E.E. arrived at her first appointment with respondent on July 8, 2014, she completed a health survey. After her appointment, when she was leaving, she also completed a sleep disorder survey. After E.E. checked in with the receptionist, the receptionist took her to a room and took E.E.'s vital signs. The receptionist then asked E.E. to change into a gown. E.E. removed her top and changed into the gown. When respondent entered the room, E.E. was sitting on the end of the exam bed. Respondent listened to her heart and lungs and prescribed her prednisone. E.E. never discussed her medical history with respondent or told him she had silicone breast implants. He did not touch her breasts or abdomen during this exam. Respondent told E.E. to return in two weeks. E.E. testified that she had no memory of the second appointment a week later.

40. E.E. said she went to respondent hoping to get testing to determine what was wrong with her. She was disappointed with respondent's treatment of just prescribing prednisone. After the second appointment with respondent, of which she had no memory, E.E. returned to her primary care physician and went to the emergency room on three

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[5] Symbicort (budesonide/formoterol) is an aerosol inhaler.

[6] Prednisone is a corticosteroid; QVAR (beclomethasone dipropionate HFA) is an inhalation aerosol; and montelukast is a leukotriene receptor antagonist used in the treatment of asthma.

occasions because of difficulty breathing. She was told she needed to see a specialist who could perform testing to determine the underlying cause of her asthma. Because it would have been difficult to get an appointment with another pulmonologist, she called respondent and scheduled an appointment for the next day.

41. She returned to respondent's office on December 14, 2014. Her asthma was very bad and she was very distressed about her condition. A medical assistant took E.E. to an exam room and took E.E.'s vitals. Respondent entered the room almost immediately. He gave E.E. a gown and asked her to change. Respondent re-entered the room without knocking. E.E. was sitting on the edge of the bed. Respondent asked her to lie down. Respondent opened the gown and proceeded to touch her breasts. Respondent never said anything before about performing a breast exam. Respondent "caressed" her breasts, touching them both at the same time. E.E. has had annual breast exams with her gynecologist so she is familiar with having breast exams. Her gynecologist wears gloves and palpates her breasts and feels under her arm to determine if there are any discrepancies. What respondent did was completely different. E.E. could not believe what was happening. While he was touching her he asked, "Are they real?" E.E. responded that they were implants, and respondent said, "They feel and look great to me." E.E. felt very ashamed and could not believe what was happening. Respondent stopped touching her breasts and moved his hands down her abdomen, putting his hand just underneath her waistband. E.E. said it did not feel like a normal abdominal exam. E.E. was startled and jumped. Respondent stopped what he was doing, asked her to get dressed, and left the room. Respondent never explained why he was touching her breasts or abdomen. At no time did she tell respondent that she had breast cancer in her family. E.E. denied that anyone in her family has had a history of breast cancer; her mother had bowel cancer that spread to the pancreas. E.E. could not remember if respondent listened to her heart and lungs. After the appointment respondent prescribed prednisone and told her to return in two weeks.

42. After E.E. left the appointment she felt upset and distressed. E.E. told her husband what happened later that evening and he suggested E.E. contact a friend who was a physician. She called the friend the next day who suggested E.E. contact the medical board. E.E. could not get through to the board by telephone but filed an online complaint with the board that day. E.E. never spoke to anyone else prior to filing a complaint. E.E. has since filed a lawsuit against respondent.

43. E.E. read the transcript of the December 2016 deposition she gave for her lawsuit the week before the hearing. E.E. met with her own lawyer and the deputy attorney general approximately six weeks before the hearing. E.E. did not recall ever being seen at her family clinic for lumps in her breasts. E.E. testified at the hearing that respondent never asked her about her medical history. However, she admitted stating in her deposition that she said respondent asked her about her medical history after he listened to her heart and lungs. E.E. said she discussed her family history with the health clinic and told them that her mother had bowel and pancreatic cancer. E.E. said that if the health clinic's records said her mother had breast cancer, that it would be incorrect. E.E. was questioned about why in her deposition she said she did have a family history of breast cancer on her mother's side. E.E.

said she was very nervous during the deposition and again stated at this hearing that her mother never had breast cancer. When she initially reviewed the deposition, she scanned the first few pages she thought contained the introductions and went straight to what she thought was important. She read the deposition cover-to-cover a week before the hearing.

44. E.E. was asked why she told board investigators approximately six months after the incident that at the first visit, respondent had her lie down on the table before listening to her heart and lungs. E.E. said she might have confused the two visits, but she was sure that she was sitting on the table at the first visit. Finally, E.E. could not explain why she initially told board investigators that the abdominal exam was normal when she testified that it was not a normal exam.

DR. LEUNG'S TESTIMONY

45. Dr. Leung believed that respondent committed an extreme departure in the standard of care by failing to maintain complete and accurate medical records. The medical records lacked the minimal identification of the patient's name, birthdate, and date of entry on each page. The records Dr. Leung reviewed were not in chronological order, making it difficult to review. He concluded that these errors constituted a simple departure from the standard of care.

Dr. Leung noted that respondent did not document any information about how long the patient had asthma, what exacerbated her symptoms, her previous treatments including hospitalizations, and medications she had used. This information should have been obtained on the initial visit. Respondent listed that E.E. was on two inhalers, Dulera and albuterol, but he did not list the frequency E.E. took these medications. Respondent claimed during his subject interview that he performed a breast exam only on the initial visit. However, respondent filled out findings on all three progress notes indicating he performed breast and abdominal exams at every visit. Dr. Leung did not believe it was normal for a pulmonologist to perform a breast exam on a patient referred for asthma exacerbation. If such an exam were performed, there should be documentation as to why the exam was clinically appropriate.

On the July 14, 2014, visit respondent listed prednisone and Symbicort as the medications E.E. was taking. In the assessment section, respondent wrote that E.E. should take "steroid inhaler daily." The note did not specify which inhaler the patient should take, Symbicort or the Dulera, which was on the medication list from the visit the week prior. There was no indication in any of the records about who prescribed Symbicort.

For the final visit on December 11, 2014, respondent listed three medications. For the first, the name of the medication was omitted and only "20 mg QD" was written. He also listed QVAR twice a day and montelukast 10 mg. Respondent also indicated he performed a head-to-toe physical exam, including noting "implants without masses." The recommendation was to take medications and return in two weeks. Dr. Leung could not tell

from the record which medications respondent prescribed and the frequency they should be taken.

Dr. Leung believed that the above errors in documentation constituted an extreme departure from the standard of care. Over the three visits there were different inhalers listed but no reason why the inhalers were changed or altered. Additionally, respondent's diagnosis of "asthma" lacked specificity as to the type of asthma. A general diagnosis of "asthma" would be a proper diagnosis for an internist referring the patient to a specialist, but a pulmonologist should assess the quality of the asthma, which was not indicated in the records. Finally, in each of the three visits, respondent documented that he performed a head-to-toe examination. During his subject interview, respondent said he only performed a breast exam on the first visit. It is inappropriate for a physician to record findings for an exam he did not conduct.

46. Dr. Leung believed respondent failed to assess and treat E.E.'s asthma, which constituted an extreme departure from the standard of care. Respondent diagnosed E.E. with mild asthma and prescribed prednisone. Prednisone is reserved for more severe asthma and respondent should have considered adding an anticholinergic inhaler (such as Spiriva) and/or a leukotriene antagonist (such as montelukast) before starting the prednisone. However, Dr. Leung testified that prednisone almost always works in treating the symptoms of asthma.

47. Dr. Leung believed respondent did not reconcile the patient's medications on each visit and this constituted an extreme departure. Respondent listed three different steroid inhalers on three visits without any documentation as to why one was used or changed. Changing medications without noting the reasons was well below what an average physician would do.

48. Dr. Leung believed that performing a breast exam on the patient was an extreme departure from the standard of care. There might be a reason for a pulmonologist to perform a breast exam if the pulmonologist suspected a lung lesion; however, this is not a common practice. Dr. Leung did not know why respondent performed a breast exam on a patient being seen for asthma. The standard of care requires a physician to obtain consent by the patient before performing an exam. He could not tell from the medical records which date the exam occurred, because the chart indicated he performed a breast exam at each of the three visits. Performing an exam without consent would also be an extreme departure from the standard of care. There was no indication in the chart as to why respondent performed a breast exam.

DR. HOOPER'S TESTIMONY

49. Dr. Hooper again disagreed with Dr. Leung that the standard of care requires a pulmonologist to provide the patient's name, birthdate, and date of entry on each page of a medical record.

50. Dr. Hooper believed that respondent properly assessed and treated E.E.'s asthma. Prescribing prednisone was a reasonable choice for respondent to have used. Various medical groups have recommended doctors classify the type of asthma and describe the severity. Dr. Hooper himself does not use this system as he does not find it as accurate as a description of what is actually occurring. Classification of the asthma is not as important as the assessment itself. He does not believe it is an extreme departure, but "perhaps a mild departure" not to be more specific. He did believe that respondent's assessment of "mild asthma" on July 8, 2014, did not fit with the symptoms she was having. He believed a diagnosis of asthma with exacerbation not well controlled would have been a better diagnosis, for which prednisone would have been properly prescribed.

51. Patients are often on multiple inhalers of the same class. There were some problems with respondent's recordkeeping identifying what inhaler E.E. was on. Dr. Hooper described respondent's medication reconciliation as "sloppy" because in the July 14, 2014, progress note, he did not write down which inhaled steroid the patient should be taking daily. It was also "sloppy" for respondent not to write down how often the patient is supposed to take the medication. Dr. Hooper said he could not tell from the record how often the patient was supposed to be taking the steroid. He also could not tell what happened to the prednisone. Although he described the recordkeeping as "sloppy," he did not believe it was an "error." He noted that respondent in several areas lacked specificity. However, he believed that respondent met the bare minimum for the standard of recordkeeping. For the December 11, 2014, visit, Dr. Hooper believed that the three medications respondent listed were the medications she was on when she presented to respondent. Dr. Hooper believed that respondent meant for her to continue with the medication, which would have been appropriate treatment.

52. Dr. Hooper testified that it was his understanding from respondent's subject interview that respondent performed a breast exam of E.E. at her initial visit. Performing a breast exam would be reasonable if respondent's practice is more focused on internal medicine. It was his understanding that respondent has a different practice than Dr. Hooper in that he does more internal medicine, and an internist performing a breast and abdominal exam is normal. Dr. Hooper believed that patient E.E. informed respondent she had a family history of breast cancer and silicone breast implants. Dr. Hooper believed respondent had "certain expertise" about problems involving silicone implant rupture. Again, Dr. Hooper noted that performing a breast exam would be more reasonable in a practice focused on internal medicine instead of pulmonology. The fact that respondent performed a breast exam lead him to believe respondent's practice was more internal medicine focused than his own. Dr. Hooper noted the consent of the patient was required. However, he also said that if there is an adequate medical reason, he personally does not think a doctor needs to obtain consent before examining the breasts. He admitted that you could not tell from the chart why respondent would have conducted a breast exam. It would be "sloppy" to record "without mass," suggesting respondent performed a breast exam, if he did not in fact conduct an examination. If respondent's version of events was credible, then it would be within the standard of care of an internist upon an initial evaluation.

RESPONDENT'S TESTIMONY

53. Respondent testified that he has excellent memory and could independently recall the three appointments with E.E. Based on E.E.'s symptoms, he believed she had mild asthma. He treated her with a small dose of prednisone because in his experience prednisone is always effective. He admitted he did not document how long E.E. was to take prednisone but he thinks it was for 10 to 15 days. In E.E.'s case, prednisone worked and she got better. Respondent disagreed with Dr. Leung that he should have treated E.E. with other inhalers rather than prednisone. He disagreed with Dr. Leung that E.E. she should have been prescribed Spiriva, which respondent said is never prescribed for asthma. He said Dr. Leung has made up his own rules about the standard of care. On July 14, 2014, the patient returned for a second visit. Respondent gave her a sample of Symbicort, which is why it is listed on the medication list for the second visit. She was to continue to take the prednisone for four days, but he did not write that down. He said he told her to take Symbicort twice a day. Respondent said he wrote "asthma" as the diagnosis not to imply that her condition was worse, but because he was busy that day and he just wrote "asthma."

54. E.E. returned on December 11, 2014, much later than when respondent had requested. E.E. had been seen at the emergency room where she received prednisone. Respondent said he prescribed prednisone, montelukast, and QVAR, as listed in the medication section of his progress note. However, on cross-examination respondent said she was on prednisone and he added QVAR and montelukast. He again disagreed with Dr. Leung that his management of her asthma was below the standard of care. He said the patient was better because she never returned after the December 11, 2014 visit.

55. Respondent said E.E. completed both the medical history and sleep study forms when she arrived for her first appointment on July 8, 2014. The medical assistant took her to the exam room and took E.E.'s vitals. When respondent entered the room he saw that E.E. indicated on her form that her mother had cancer. E.E. told her that her mother had breast cancer. Respondent had seen from the health clinic records that were sent over that pancreatic cancer was listed. E.E. also told him that she had silicone implants. Respondent had experience in evaluating whether silicone implants had ruptured. In 1991, respondent examined patients to see if the implants had ruptured to determine whether they qualified for a class action lawsuit. Respondent told E.E. that 100 percent of silicone implants rupture. He also discussed with her that since her mother had breast cancer there is a genetic link. Respondent said "everyone knows you do a complete exam on the first visit when it is indicated, and it was indicated in this case." Respondent told her these implants can rupture so he should do a breast examination. E.E. said, "absolutely, go ahead doctor." Respondent gave her a gown and he left the room.

When asked if he did anything unprofessional, he said he "went out of his way to make her comfortable. I spent about 10 seconds, I just put my fingers on her breasts, I didn't touch her nipples, about 10 seconds, then I moved on to her abdomen, and moved on to her legs, and then I said you can get dressed." Respondent then left the room. During an abdominal exam, it is sometimes necessary to examine below the pant-line. Respondent

produced a billing record for that visit indicating a higher charge for the first visit than the following two visits. He charged a higher level because of the complete physical exam. Respondent also admitted he charged the higher rate for the initial consultation for each of the three patients who are the subjects of this case.

56. On the second and third visit, respondent only listened to E.E.'s lungs. Asked to explain why the progress note appeared to show that he completed another full physical exam, he said he was "carrying-over" information. He explained as an example that indicating that the teeth were normal is just for the record, since he did not actually examine the teeth. On the last visit, respondent noted in his record "implants without masses." Respondent said this was just a comment to remind him that she had implants without masses. He did not perform a breast exam on this visit. On the third visit he asked her why she did not bring the records from the emergency room or come seem him before five months and she appeared not to be happy with this.

57. Respondent said he did not view himself as E.E.'s primary care physician. Respondent admitted that he never documented anything about E.E.'s mother having breast cancer, despite it being significant history that led him to perform a breast exam. Respondent did not document that he discussed the risks of silicone implants with E.E. Respondent did not document that there were no ruptures or no masses. He did not document it because he did not think about it. Respondent did not ask E.E. when she last had a breast exam or monogram. He did not think this was important because silicone implants can rupture at any time. Respondent agreed the standard of care for a patient seeking treatment for asthma would be to obtain verbal consent for a breast exam. He did not document that she gave consent because, it was "a routine examination, it's not a big deal, it's a simple exam, we don't document everything. If a man comes in for a prostrate problem we don't document that we got consent to examine the prostrate." Respondent reiterated that E.E. was very comfortable with having the exam. Respondent said a medical assistant is normally in the room when he performs a breast exam, but she had suddenly disappeared so he performed the exam without her.

EVALUATION

58. Dr. Leung believed respondent committed an extreme departure from the standard of care by failing to maintain adequate and accurate medical records. Dr. Hooper believed that the records were "sloppy" but met the bare minimum for the standard of care. The biggest issue with respondent's records is that they contained no information as to why a pulmonologist, evaluating a patient for asthma, would perform a breast examination. There was no documentation as to the clinically significant reasons respondent claimed were the basis for him suggesting an exam. Additionally, respondent indicated in each of the three visits that respondent performed a head-to-toe examination, including a breast exam, when he did not in fact perform a head-to-toe exam.

Respondent's records were also unclear as to what medications E.E. was on before she came to the appointment and what respondent prescribed. Different inhalers were listed

for all three visits without any indication as to why the inhalers were changed. Although respondent said that the inhalers were of the same class and largely interchangeable, Dr. Leung believed respondent needed to document that he was changing an inhaler nonetheless. For example, respondent never documented that he gave E.E. a Symbicort sample, as he testified. Nor did he document the frequency and duration that E.E. should take the prednisone that he prescribed at the first visit. On the third visit, respondent himself was unsure if he had prescribed prednisone or whether she was advised to continue with prednisone she was already on. Finally, respondent's diagnosis of "mild asthma" on the first visit and "asthma" on the two subsequent visits did not provide any detail about the severity or nature of E.E.'s asthma that would be expected from a pulmonologist. For these reasons, Dr. Leung's conclusion that respondent's record keeping departed from the standard of care was far more persuasive than Dr. Hooper's opinion, in which he went out of his way to describe as "sloppy" but meeting the minimal requirements.

As for the degree of departure from the standard of care, Dr. Leung classified it as an extreme departure. It was not established by clear and convincing evidence that it was an extreme departure. To be sure, there were multiple errors in respondent's charting, the most serious when he failed to document clinically significant reasons why he performed a breast exam. However, Dr. Leung did not provide sufficient justification for his opinion that it constituted an extreme departure.

59. Dr. Leung believed respondent did not appropriately classify and treat E.E.'s asthma. He believed systemic prednisone should not have been the first course of treatment for a patient classified with "mild asthma" as respondent documented on the first visit. However, it appears Dr. Leung's criticism of respondent dealt more with the classification of mild asthma than treatment with prednisone. Dr. Hooper and respondent both testified that prednisone was an appropriate treatment for a patient exhibiting the symptoms identified by E.E. E.E. did appear to respond well to the prednisone, and her condition improved by the time of her next visit a week later. As previously noted, respondent did not document the nature and severity of E.E.'s asthma. Notwithstanding, it was not established by clear and convincing evidence that respondent departed from the standard of care in the actual treatment of E.E.'s asthma.

60. Dr. Leung believed respondent did not reconcile the patient's medications on each visit and this constituted an extreme departure. Respondent listed three different steroid inhalers on three visits without any documentation as to why one was used or changed. Dr. Hooper admitted respondent's charting was sloppy but did not believe it constituted a departure from the standard of care. Both experts and respondent agreed that each of the three inhalers listed for E.E. were of the same class. Additionally, there were omissions in the documentation regarding what exactly respondent prescribed. Again, it is necessary to differentiate between how respondent treated the patient and what he documented. It is determined that respondent's errors in medication reconciliation are a reflection of poor documentation and incorporated in the allegation that respondent failed to maintain adequate medical records. .

61. Finally, Dr. Leung believed that performing a breast exam, without indication, without proper documentation, and without first obtaining proper informed consent. E.E. testified that on the third visit, respondent caressed her bare breasts without consent. Respondent testified that he performed a breast exam on E.E. at the first visit, after he explained that E.E. was at risk for breast cancer because of her family history and silicone implants will rupture. That a breast "exam" occurred is not in dispute. What is disputed is the day it occurred and whether E.E. provided consent. The credibility of the two witnesses was evaluated pursuant to the factors set forth in Evidence Code section 780.[7] E.E.'s testimony was far more credible than that of respondent. There are multiple reasons compelling this conclusion.

E.E. was referred to respondent after she had been to the emergency room and primary care doctor for asthma. Although respondent is also an internist, which composes five percent of his practice, he was seeing respondent based on a pulmonary referral. Respondent contends E.E. told him her mother had breast cancer and she had silicone implants. As a result, respondent discussed with her the genetic risk of breast cancer and the likelihood that her implants would rupture. E.E. then consented to the exam, which was unremarkable for any pathology.

However, respondent cannot corroborate any of this in his records. The progress note respondent received from E.E.'s primary care doctor indicated E.E.'s mother had pancreatic cancer. Nowhere in the forms E.E. completed prior to the consultation did E.E. list a family history of breast cancer. The family history section in respondent's progress note was blank. There was no documentation that E.E. had a family history of breast cancer, the absence of which is remarkable because it was one of the reasons respondent, as a pulmonologist, justified performing a breast exam. Yet, at the second visit a week later, respondent documented that E.E.'s mother-in-law, and thus not a blood relative, died of lung cancer, which has absolutely no relevance to E.E.'s health.

Unlike the second visit, where respondent circled "no masses," respondent only wrote "silicone implants" in the physical exam section. On the third visit, when E.E. claimed respondent touched her breasts, respondent wrote "implants without masses" in the physical exam section. This would tend to indicate respondent performed the exam that day rather than on the first visit as respondent claimed. In sum, the absence of any documentation relating to why respondent would perform a breast exam on a patient complaining of asthma highly suggests that a breast exam was not performed on the third visit. Such a notation would be expected even if the pulmonologist's recordkeeping was below the standard of care in other aspects.

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[7] The factors are: the demeanor and manner of the witness while testifying; the character of the testimony; the capacity to perceive at the time the events occurred; the character of the witness for honesty; the existence of bias or other motive; other statements of the witness which are consistent or inconsistent with the testimony; the existence or absence of any fact to which the witness testified; and the attitude of the witness toward the proceeding in which the testimony has been given.

Finally, respondent testified about the exam itself and said, "I spent about 10 seconds, I just put my fingers on her breasts, I didn't touch her nipples, about 10 seconds, then I moved on to the abdomen. . . ." Although there was no expert testimony about how long a complete breast exam should take, even a layperson who has never had a breast exam could conclude that 10 seconds is an exceedingly short time to perform a complete breast exam. If in fact respondent was concerned that E.E. had a lump or ruptured implant, it was not reflected in what can, at best, be described, as a perfunctory exam.

E.E. on the other hand, told a generally consistent account of events since making her complaint on December 12, 2014. Her testimony was sincere and thoughtful. It was clear that she was uncomfortable having to relate a story that was emotionally difficult. Her demeanor while testifying did not give any indication that she was being untruthful. E.E. claimed that respondent touched her breasts at the third visit on December 11, 2014. The next day she reported the incident to the board. What motive would E.E. have to allege respondent inappropriately touched her breasts five months after respondent supposedly conducted a legitimate breast exam? Respondent believes that E.E. was unhappy with him because he chastised her about not returning earlier, not bringing medical records to the appointment, and because she wanted him to do more than just prescribe prednisone. He suggested that this would be a way for her to get a referral to another pulmonologist. However, this is rather implausible considering that there are less onerous ways of getting a referral to another doctor. While E.E. did ultimately file a civil suit against respondent, and money could be a motivating factor to allege misconduct, there would have been no reason to have waited five months – the day after her final visit – to file a complaint if the breast exam had actually occurred in July. Something happened to E.E. at the last visit that caused her to make her report to the board the next day. To claim that she would have fabricated her claim because she was unhappy with respondent's care is simply not persuasive.

E.E. credibly testified that the exam was not like any that she had before, and her testimony that he caressed her breasts rather than feeling for lumps was credible. E.E. also said she receives regular breast exams and mammograms from her gynecologist. It was apparent that she was in great distress because of her asthma when she arrived for her first appointment with respondent. Under those circumstances, it would be difficult to believe that she would want respondent to do anything other than diagnose her breathing problem.

Respondent contends that he charged more for the initial consultation than the subsequent visits because of the comprehensive exam. However, respondent charged this amount for the initial consultation of each of the three patients subject to this case. Respondent contends that E.E.'s testimony is unreliable because she testified that her mother did not have breast cancer but said the opposite during her deposition. There were also some other inconsistencies between her testimony and what she told board investigators, such as whether she was lying down during the exam at the first visit. The discrepancy between her live and deposition testimony regarding whether her mother died of breast cancer is significant because it would corroborate in part one of respondent's justifications for performing the exam. However, E.E. testified that she was extremely nervous at the deposition and she misspoke. There was no other evidence introduced to impeach her

testimony at the hearing that her mother did not have breast cancer. The few discrepancies in her account do not undermine what has been generally consistent and the most plausible version of events. Therefore, it is found that respondent performed a breast exam at the third visit, on December 11, 2014, without E.E.'s consent.

62. Turning to the ultimate question of standard of care, complainant alleged that respondent performed a breast exam without indication, without proper documentation, and without obtaining informed consent. Dr. Leung based his conclusions on E.E.'s complaint and respondent's medical records. Dr. Hooper based his conclusions on respondent's statement and belief respondent was operating as an internist. Because respondent's testimony regarding the issue is determined not to be credible, Dr. Hooper's opinion is given no weight. Clear and convincing evidence established that respondent committed an extreme departure from the standard of care when he touched E.E.'s breasts without consent.

Patient P.C.

63. Respondent treated P.C. from April 8, 2015, until October 27, 2015, after being referred to respondent by his primary care doctor for a pulmonary evaluation. Complainant alleged respondent committed gross negligence in the care and treatment of P.C. by failing to properly dismiss patient P.C. from his care. In addition, complainant alleged respondent committed negligent acts in the care and treatment of P.D. by failing to maintain adequate and accurate medical records and failing to reconcile patient P.C.'s medications on all four visits.

RESPONDENT'S MEDICAL RECORDS FOR P.C.

64. P.C.'s initial consultation with respondent occurred on April 8, 2015. Respondent wrote that the P.C. was referred for Chronic Pulmonary Obstructive Disease (COPD) and was that he was complaining of shortness of breath. Respondent indicated P.C. was on multiple medications, including two inhalers, Advair and Combivent. He diagnosed P.C. with emphysema, back surgeries, and hypertension. Respondent ordered lab work, a CT scan of the chest, and a pulmonary function test. Respondent recommended P.C. take QVAR, although the frequency was not listed and QVAR was not contained in the list of medications.

At the next office visit on May 20, 2015, respondent indicated he would treat P.C. for immune deficiency with Gammagard.[8] The only medications listed this time were prednisone, Combivent, Flovent, Spiriva, and albuertol. He diagnosed P.C. with COPD, obesity, and hypertension. The recommendation and plan were left blank.

Respondent received lab results on May 20, 2015. He continued to prescribe P.C. Gammagard injections every two weeks. The next visit was on June 24, 2015. The only medications listed in the progress note were Ventolin, Advair, and Atrovent. He again

[8] Gammagard (intravenous immune globulin) is used to treat immune deficiency.

diagnosed P.C. with COPD and immune deficiency. The plan and recommendation were again left blank. Respondent received labs on September 24, 2015, which was P.C.'s last visit. The only medications listed were Advair, Ventolin, and Atrovent. He noted that the patient was improving with therapy and recommended he return in three months. He ordered the Gammagard to be discontinued after one more month of therapy on September 24, 2015.

A patient communication sheet indicated P.C. called the office on multiple times in September and October 2015 requesting a sleep study, but respondent determined it was not necessary. On October 10, 2015, the note said P.C. called three times and said abusive words and appeared to be under the influence of alcohol. On October 27, 2015, respondent sent P.C. a discharge letter by first class mail. The letter stated that respondent "regrets to inform" him that he no longer would provide any services. A note indicated P.C. called several days later stating he would not report respondent to the board for discharging him if he would order a sleep study.

DR. LEUNG'S TESTIMONY

65. Dr. Leung indicated that respondent completed the majority of the necessary items in each of his progress notes, with the exception that he did not list all medications at each follow-up visit. He also documented performing a physical examination on two visits, including a breast exam where he indicated no masses, which presumably was not done. The notes also indicated a discrepancy in relation to P.C.'s cigarette and alcohol history. Two of the notes failed to identify a plan. Dr. Leung also noted the medical records lacked the minimal identification of the patient's name, birthdate, and date of entry. Finally, Dr. Leung noted that the chart was disorganized. Dr. Leung concluded that these deficiencies were a simple departure from the standard of care.

66. Dr. Leung believed respondent did not reconcile medications on each visit. The initial medication list was extensive and appeared to have additions and deletions. On subsequent visits, the list of inhalers changed without any indication as to the reason. There was also no indication how often P.C. was using the inhalers. Dr. Leung believed this constituted a simple departure from the standard of care.

67. Dr. Leung did not believe respondent meet the standard of care for discharging P.C. He did not inform him as to the reason for the discharge and provide him a period in which the patient could find a new doctor. Dr. Leung was not aware if respondent had any additional communications with P.C. regarding the discharge. Even if respondent had a phone call with P.C. where respondent told him he was discharging him, this did not meet the standard of care. Dr. Leung believed this was an extreme departure because it indicated no concern for the safety of the patient. Dr. Leung said the requirements for discharging a patient are the same even if the patient is difficult, as P.C. was apparently.

DR. HOOPER'S TESTIMONY

68. Dr. Hooper believed respondent's recordkeeping met the standard of care for the community. He again disagreed that there was a requirement to include the patient's name, birthdate, and date of entry on each page of the record. Additionally, Dr. Hooper did not believe that a specialist needs to document medications on subsequent visits that are not part of the medical condition the specialist is treating. He believed respondent was thorough in documenting P.C.'s medications on the initial visit. However, he admitted that QVAR was not on the list and may have been something respondent prescribed without documenting. Nor could Dr. Hooper tell the frequency of the QVAR respondent ordered. Dr. Hooper felt it was "sloppy" for respondent not to have noted what medications P.C. would be continued on or indicating "no change." Although Dr. Hooper believed respondent's documentation was sloppy, he felt it met the standard of care.

Dr. Hooper believed a one-time discrepancy in two of the notes regarding P.C.'s drug and alcohol use may not have been a discrepancy, rather simply what was reported by the patient.

69. Dr. Hooper believed that the discharge of P.C. met the standard of care. He noted that it appeared that P.C. was quite volatile and disruptive, and respondent had an interest in protecting himself and his staff. If respondent had a conversation with the patient, where he outlined that the patient had a specified number of weeks to find a new doctor, it would not be required for this to be reiterated in a formal letter. Dr. Hooper believed there was a conversation between respondent and P.C. where this was explained. Dr. Hooper disagreed with Dr. Leung that the discharging doctor should contact the patient's HMO to find him a new doctor. He felt the standard of care was met if the physician informed the patient's primary care physician that he would no longer be seeing the patient and the patient should be referred to someone else. Dr. Hooper admitted that a physician would be departing from the standard of care if he did not provide the patient with a window to find a new pulmonologist.

RESPONDENT'S TESTIMONY

70. Respondent addressed Dr. Leung's contention that he did not document a plan of care in two of his progress notes. He said that the plan for P.C. was contained elsewhere in his notes when he indicated he was continuing the patient on Gammagard and would be re-checking the Immunoglobulin-G (IgG) level. Respondent also noted P.C. should see a neurologist for leg numbness. In another note, he indicated that he would request a hepatitis test because P.C. was a heavy alcoholic, although the "plan" section was left blank. Again, he said the notes would normally have been typed out by his medical assistant, but he did not have a medical assistant at that time.

71. Respondent believed he reconciled P.C.'s medications on the first visit on April 8, 2015. His medical assistant wrote down the list of P.C.'s medications, and respondent added additional medications. Respondent noted that P.C.'s mother had breast cancer. The physical exam section indicated respondent conducted a full head-to-toe exam,

including circling "no masses" under the section labelled "breasts." Respondent said this was not inaccurate because "examining with a stethoscope my hands were around his breasts so I would have felt if there was a mass." Respondent recommended that P.C. take QVAR, but the frequency was not listed, nor was it clear if respondent prescribed this medication.

On the May 20, visit, respondent documented prednisone, Combivent, Flovent, Spiriva, and albuterol. Respondent said he was only prescribing P.C. prednisone; P.C.'s primary care physician was prescribing the other medications. Respondent said he now has electronic records so by "one click of the mouse" the medication list appears. Respondent explained why QVAR was not listed in the medications because the primary care doctor must have prescribed Flovent, which is also a steroid. Respondent said he did not discuss any of the changes with P.C.'s primary care doctor.

On June 24, respondent said his condition improved and P.C. had no complaints. Respondent only listed Ventolin, Advair, and Atrovent. Although the plan section was blank, he noted that he would continue with the Gammagard therapy.

Respondent said the only prescription he wrote was for prednisone 5 mg once a day that was written on May 20, 2015. Although it was noted in the progress note for May 20, 2015, the frequency was not noted nor was there any indication that respondent was prescribing the prednisone. Respondent testified that he believed it was for 15 days, but he was not sure. A July 24, 2015, refill request in the chart indicated respondent increased the prednisone to twice a day, doubling the quantity from 30 to 60 tablets. There was no note indicating the reason for the increase in frequency.

On the September 24, 2015, visit, prednisone was not listed in the medications and respondent said he must have finished the course. The progress note indicated he conducted a full physical exam, including a breast exam. Respondent said he did not check the breasts, but circled "no masses" "because it was there" on the form. He explained that it is similar to electronic medical records where items are repeated and automatically populated. Respondent admitted it is his responsibility to make changes to the electronic record to indicate if something was not performed. In the plan section respondent wrote "may need echocardiogram." Respondent said he did not order it because P.C.'s primary care physician was treating him for hypertension. He said it was a routine recommendation and he assumed the primary care doctor was doing this, although respondent did not speak to him.

72. Respondent said when P.C. drank he became abusive and nasty. The day respondent discharged him, P.C. called four times that day causing respondent to leave the exam room to take the phone calls. The first time P.C. called he had questions about his IgG therapy. He called an hour later asking about something else. Respondent left his patient to answer the questions. The fourth time respondent told P.C. he could not care for him any longer, and he needed to go back to his primary care physician and get a referral for another pulmonologist. He said it was unreasonable for respondent to have been called out of an exam room four times in one day. If he had it to do differently he would have sent him a letter by certified mail, he would have given him 30 days to find a new doctor, and he would have called the primary care doctor and told him to refer P.C. to another pulmonologist.

Respondent disagreed that discharging the patient in this manner was below the standard of care because he assumed the patient would go back to his primary care doctor who would care for the patient and refer P.C. to a new pulmonologist. He said if a patient had an emergency he could have gone to the emergency room.

73. Respondent believed his care of P.C. was above the standard of care because he diagnosed the immune deficiency that was missed by seven other pulmonologists.

74. With regard to all three patients, respondent said he fixed his documentation issues a year ago when he went to electronic medical records. He enrolled in the PACE recordkeeping course on the advice of his attorney, but he "does not think he needs it."

EVALUATION

75. Dr. Leung believed respondent committed a simple departure from the standard of care by failing to maintain adequate and accurate medical records. He believed respondent inappropriately documented performing a physical examination on two occasions, including a breast exam where he indicated no masses, which presumably was not done. The notes also indicated a discrepancy in relation to P.C.'s cigarette and alcohol history. Two of the notes failed to identify a plan. Dr. Leung also noted the medical records lacked the minimal identification of the patient's name, birthdate, and date of entry. Finally, Dr. Leung noted that the chart was disorganized and not in chronological order. Dr. Hooper again admitted that some of respondent's charting was sloppy, but overall it met the standard of care.

As with E.E., respondent documented items in the physical assessment that he did not actually assess, such as performing a breast exam. Although there was a discrepancy in P.C.'s alcohol and tobacco use in two of the notes, it was not established that this was an error in documentation. Likewise, respondent's failure to provide a plan in the "plan" section was immaterial because his plan for P.C. was contained elsewhere. Like the other patients, the lack of patient identifiers on every page and the fact that the copy of the chart Dr. Leung reviewed was disorganized were not established to be violations of the standard of care.

Dr. Leung believed respondent failed to properly reconcile medications at each visit. It was established that respondent did not accurately reconcile the patient's medications, and it was often unclear, even to respondent, what respondent medication he prescribed and the dosage. Moreover, respondent doubled the frequency of prednisone without any explanation as to the reason.

For each of these reasons, clear and convincing evidence established respondent committed a simple departure from the standard of care in his documentation of P.C.'s treatment.

76. Dr. Leung believed that the manner in which respondent discharged P.C. constituted a gross deviation from the standard of care. Dr. Hooper believed that there was no violation, but again assumed, without any factual basis, that respondent gave P.C. time to find a new pulmonologist. Respondent testified that P.C. was abusive and he told him over the phone that he would no longer see him. Respondent did not give P.C. any transition or assist in any manner in ensuring continuity of care. Respondent's testimony on the matter reflected his belief that he could simply assume the patient would be handled by the primary care doctor without any responsibility placed on respondent. Although respondent has every right to discharge a difficult patient, the manner in which respondent did this was an extreme departure from the standard of care.

LEGAL CONCLUSIONS

1. The main purpose of disciplinary licensing schemes is protection of the public through the prevention of future harm and the improvement and rehabilitation of the licensee. (*Griffiths v. Sup. Ct.* (2002) 96 Cal.App.4th 757, 772.) The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea v. Bd. of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) Administrative proceedings before the board are not designed to punish but to afford protection to the public upon the rationale that respect and confidence of the public is merited by eliminating from the ranks of practitioners those who are dishonest, immoral, disreputable, or incompetent. (*Fahmy v. Medical Bd. of California* (1995) 38 Cal.App.4th 810, 817.)

Burden and Standard of Proof

2. Complainant bears the burden of proof of establishing that the charges in the accusation are true. (Evid. Code § 115.) The standard of proof in an administrative action seeking to suspend or revoke a professional license is "clear and convincing evidence." (*Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; it requires sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Sup. Ct.* (2005) 130 Cal.App.4th 586, 594.)

Relevant Statutes and Regulations

3. Business and Professions Code section 2227, subdivision (a), provides:

> 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.

4. Under Business and Professions Code section 2234, the board shall take action against any licensee who is charged with unprofessional conduct which includes:

(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.

5. Business and Professions Code section 2266 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.

Relevant Decisional Authority

6. Ordinary or simple negligence has been defined as a departure from the standard of care. It is a "remissness in discharging known duties." (*Keen v. Prisinzano* (1972) 23 Cal.App.3d 275, 279; *Kearl v. Bd. of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1055-1056.) Repeated negligent acts mean one or more negligent acts; it does not require a "pattern" of negligent acts or similar negligent acts to be considered repeated. (*Zabetian v. Medical Bd. of California* (2000) 80 Cal.App.4th 462, 468.)

7. "Gross negligence" long has been defined in California as either a "want of even scant care" or "an extreme departure from the ordinary standard of conduct." (*Gore v. Bd of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 195-198; *City of Santa Barbara v. Sup. Ct.* (2007) 41 Cal.4th 747, 753-754.)

Causes Exists to Discipline Respondent's License

FIRST CAUSE FOR DISCIPLINE – GROSS NEGLIGENCE

8. Cause exists to discipline respondent's license pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b). Respondent committed gross negligence in the care and treatment of patient S.S. when he discharged the patient from his care in a manner that was an extreme departure from the standard of care. Respondent committed gross negligence in the care and treatment of E.E. when he performed a breast exam, without indication, without proper documentation, and without first obtaining proper informed consent, which was an extreme departure from the standard of care. Respondent committed gross negligence in the care and treatment of patient P.C. when he discharged the patient from his care in a manner that was an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE – REPEATED NEGLIGENCE

9. Cause exists to discipline respondent's license pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c). Respondent committed repeated negligent acts in the care and treatment of patient S.S. by failing to maintain adequate and accurate medical records; failing to properly dismiss S.S. from his care; and failing to properly reconcile S.S.'s medications. Respondent committed repeated negligent acts in the care and treatment of patient E.E. by failing to maintain adequate and accurate medical records and performing a breast exam, without indication, without proper documentation, and without first obtaining proper informed consent. Respondent committed repeated negligent acts in the care and treatment of patient P.C. by failing to maintain adequate and accurate medical records and failing to properly dismiss P.C. from his care.

THIRD CAUSE FOR DISCIPLINE-FAILURE TO MAINTAIN ADEQUATE AND ACCURATE RECORDS

10. Cause exists to discipline respondent's license pursuant to Business and Professions Code sections 2227 and 2234 and 2226 in that he failed to maintain adequate and accurate records regarding his care and treatment of patients S.S., E.E., and P.C.

Disciplinary Guidelines

11. California Code of Regulations, title 16, section 1361, provides that when reaching a decision on a disciplinary action, the board must consider and apply the "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (12th Edition/2016). Under the Guidelines:

> The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board- ordered rehabilitation, the age of the case, and evidentiary problems,

> Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

12. Under the Disciplinary Guidelines, the minimum discipline for gross negligence, repeated negligence, and failure to maintain adequate medical records is a stayed revocation for five years. The maximum discipline is revocation. Among the conditions of probation, the guidelines recommend a clinical competence assessment program, a practice monitor, and solo practice prohibition.

Appropriate Level of Discipline

13. Respondent argued that if violations were established, a public reprimand would be appropriate because respondent has taken efforts to improve his recordkeeping, including enrolling in a PACE recordkeeping course. Complainant requested that respondent be placed on probation for five years, with conditions including completion of a recordkeeping course, a practice monitor, and chaperone for female patients.

14. Rehabilitation is a "state of mind" and the law looks with favor upon rewarding with the opportunity to serve, one who has achieved "reformation and regeneration." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.) Fully acknowledging the wrongfulness of past actions is an essential step towards rehabilitation. (*Seide v. Committee of Bar Examiners* (1989) 49 Cal.3d 933, 940.)

Respondent exhibited poor recordkeeping for each of the three patients. Respondent made several attempts to minimize this misconduct, for example, blaming the fact that his medical assistant did not have the time to type up his notes. His explanation for why he documented performing a physical exam when he did not perform one was essentially that he circled the items just because they were there and he did it for billing purposes. Several times he said that certain information was missing because he was busy. Explaining why he indicated he performed a breast exam on P.C., respondent said it was not inaccurate because he would have felt masses when he was listening to the patient's lungs. Respondent contends that using electronic medical records has solved his prior deficiencies, and he does not believe that he will learn anything from a recordkeeping course. Given some of respondent's explanations, his belief that electronic records are a panacea is concerning.

Similarly, the manner in which he discharged S.S. and P.C. reflected an absence of genuine concern regarding their safety. In justifying his discharge of S.S., respondent said she missed appointments and did not go to a consultation; not surprisingly, there is no documentation of any of this in the chart. Respondent's testimony that he told S.S. he would care for her for 30 days during the transition was not credible and was contradicted by his own letter and the fact that S.S. went to the hospital the next day. Although respondent said

he would do things differently now, he continued to give the impression that he owed little, if any, responsibility to discharged patients.

Respondent has practiced medicine for almost 50 years. He appeared knowledgeable and technically competent. However, the absence of meaningful introspection regarding the treatment of his patients vitiates any claim that he has a clear understanding of his deficiencies as to indicate that reoccurrence is unlikely.

The most serious violation involves the examination of E.E.'s breasts without her consent. Although sexual misconduct was not alleged by complainant, respondent's actions were nevertheless highly inappropriate, and respondent was not credible in recounting the event. His failure to accept responsibility - other than admitting he should have better documented the exam - weighs heavily in favor of revocation. On the other hand, respondent has an unblemished disciplinary history and complainant's recommendation of probation is afforded some deference.

Although it is a close decision, the public will be protected by placing respondent's certificate on probation for five years, with requirements that he complete educational, medical recordkeeping, and ethics courses; complete a professional boundaries program; obtain a practice monitor; and have a chaperone while treating female patients. The additional optional conditions recommended in the guidelines are not appropriate for the circumstances of this case and are therefore not required for public protection. It is hoped that the probation requirements will remediate some of respondent's deficiencies and ensure that respondent practices in a safe and professional manner.

ORDER

Certificate No. A30551 issued to respondent, James R. Vevaina, M.D., is revoked pursuant to Legal Conclusion 8, 9, and 10, separately and for all of them. However, revocation is stayed, and respondent is placed on probation for five years upon the following terms and condition

1. 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.

2. Medical Record Keeping Course. Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

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

4. Professional Boundaries Program. Within 60 calendar days from the effective date of this Decision, respondent shall enroll in a professional boundaries program approved in

advance by the board or its designee. Respondent, at the program's discretion, shall undergo and complete the program's assessment of respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24 hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the Decision, Accusation and any other information that the board or its designee deems relevant. The program shall evaluate respondent at the end of the training and the program shall provide any data from the assessment and training as well as the results of the evaluation to the board or its designee.

Failure to complete the entire program not later than six (6) months after respondent's initial enrollment shall constitute a violation of probation unless the board or its designee agrees in writing to a later time for completion. Based on respondent's performance in and evaluations from the assessment, education, and training, the program shall advise the board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that respondent can practice medicine safely. Respondent shall comply with program recommendations. At the completion of the program, respondent shall submit to a final evaluation. The program shall provide the results of the evaluation to the board or its designee. The professional boundaries program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

The program has the authority to determine whether or not respondent successfully completed the program.

A professional boundaries 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.

5. Practice Monitoring. 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(s) 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 and 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.

6. Third Party Chaperone. During probation, respondent shall have a third party chaperone present while consulting, examining or treating female patients. Respondent shall, within 30 calendar days of the effective date of the Decision, submit to the board or its designee for prior approval name(s) of persons who will act as the third party chaperone.

If respondent fails to obtain approval of a third party chaperone 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 chaperone is approved to provide monitoring responsibility.

Each third party chaperone shall sign (in ink or electronically) and date each patient medical record at the time the chaperone's services are provided. Each third party chaperone shall read the Decision(s) and the Accusation(s), and fully understand the role of the third party chaperone.

Respondent shall maintain a log of all patients seen for whom a third party chaperone is required. The log shall contain the: 1) patient initials, address and telephone number; 2) medical record number; and 3) date of service. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the board or its designee, and shall retain the log for the entire term of probation.

Respondent is prohibited from terminating employment of a board-approved third party chaperone solely because that person provided information as required to the board or its designee.

If the third party chaperone 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 of the person(s) who will act as the third party chaperone. If respondent fails to obtain approval of a replacement chaperone within 30 calendar days of the resignation or unavailability of the chaperone, 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 chaperone is approved and assumes monitoring responsibility.

Respondent shall provide written notification to respondent's patients that a third party chaperone shall be present during all consultations, examination, or treatment with female patients. Respondent shall maintain in the patient's file a copy of the written notification, shall make the notification available for immediate inspection and copying on the premises at all times during business hours by the board or its designee, and shall retain the notification for the entire term of probation.

7. 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.

8. Supervision of Physician Assistants and Advanced Practice Nurses. During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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; and Quarterly Declarations.

14. 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.

15. 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.

16. 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 or her 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.

17. 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.

Dated: July 5, 2017

DocuSigned by:

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ADAM L. BERG
Administrative Law Judge
Office of Administrative Hearings

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO February 1 2017
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **James R. Vevaina, M.D.** **8929 University Center Lane, #100** **San Diego, CA 92122** **Physician's and Surgeon's Certificate No. A30551,** Respondent.	Case No. 10-2013-233509 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about February 21, 1989, the Medical Board issued Physician's and Surgeon's Certificate No. A30551 to James R. Vevaina, M.D. (respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2018, unless renewed.

JURISDICTION

3. This First Amended Accusation, which supersedes the Accusation filed on June 23, 2016, in the above-entitled matter, is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded and ordered to complete relevant educational courses, or have such other action taken in relation to discipline as the Board or an administrative law judge deems proper.

5. 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:

"...

"(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.

"...."

6. Section 2266 of the Code states:

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent has subjected his Physician's and Surgeon's Certificate No. A30551 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of patients S.S., E.E., and P.C., as more particularly alleged hereinafter:

PATIENT S.S.

8. Sometime in or around 2007, patient S.S. was diagnosed with systemic lupus erythematous.[1] Patient S.S. then developed persistent shortness of breath and began treatment at the University of California Los Angeles Medical Center (UCLA). Between in or around 2008 through 2012, patient S.S. was treated by Dr. S.S. in the pulmonary hypertension clinic at UCLA. An echocardiogram performed on patient S.S. revealed patent foramen ovale[2] with small right to left shunt, severely dilated right atrium, normal left ventricle, and very elevated pulmonary artery pressure. Dr. S.S. diagnosed patient S.S. with pulmonary hypertension,[3] and prescribed her multiple medications, which included but were not limited to, Letairis,[4] Adcirca,[5] Remodulin,[6]

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[1] Systemic lupus erythematous is an autoimmune disease in which the body's immune system mistakenly attacks healthy tissue.

[2] Patent foramen ovale is a hole in the heart that did not close the way it should after birth.

[3] Pulmonary hypertension is high blood pressure that affects arteries in the lungs and in the heart.

[4] Letairis (ambrisentan) is used to treat pulmonary arterial hypertension. It works by preventing the thickening of blood vessels, especially those in the lungs and heart, and lowers blood pressure in the lungs, helping the heart pump blood more efficiently.

[5] Adcirca (tadalafil) is used to treat pulmonary arterial hypertension. It works by relaxing the muscles found in the walls of blood vessels and increases blood flow to particular areas of the body.

and Coumadin.[7] While being treated with these medications, patient S.S. remained in stable condition.

9. At some point during her treatment at UCLA, patient S.S.'s insurance changed, causing her to be unable to continue receiving treatment at UCLA. Patient S.S. was then referred to respondent for treatment for pulmonary hypertension. Patient's last visit at UCLA was on or about January 26, 2012.

10. On or about August 15, 2012, patient S.S., then 29 years old, attended her first appointment at respondent's office. Respondent was not in the office on that date, so patient S.S. met with Dr. A.B., who was filling in for respondent in his absence. After a physical examination, Dr. A.B. diagnosed patient S.S. with pulmonary hypertension, advised patient S.S. to continue with her current medications, suggested additional imaging may be necessary, and requested a follow-up visit in two (2) weeks. The single-page medical record for this visit stating the assessment, problem list, and plan, was signed and dated by Dr. A.B. A separate four-page pulmonary consultation was also signed and dated by respondent on August 15, 2012.

11. On or about August 29, 2012, patient S.S. was seen by respondent in his office. Patient S.S. complained of tiredness. The medical record for this date contains a list of medications, but does not contain an assessment or plan.

12. On or about October 17, 2012, patient S.S. was seen by respondent in his office. Patient S.S. continued to complain of tiredness. The medical record for this date does not list any medications. Respondent diagnosed patient S.S. with pulmonary hypertension, ruled out patent ductus arteriosis,[8] and recommended an MRI of the chest to rule out patent foramen ovale.

13. On or about October 23, 2012, respondent submitted an urgent letter to Community

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(...continued)

[6] Remodulin (treprostinil) is a continuous pump therapy used to treat pulmonary arterial hypertension.

[7] Coumadin (warfarin sodium) is a medication used to treat blood clots and/or to prevent new clots from forming in the body.

[8] Patent ductus arteriosus is a persistent opening between two major blood vessels leading from the heart.

Health Group, requesting authorization for patient S.S. to receive an MRI of the chest at UCSD, as well as a thoracic surgical consultation with Dr. P.T.

14. On or about November 5, 2012, patient S.S. was seen by respondent in his office. Patient S.S. complained of back pain for two weeks, and dyspnea with a feeling of passing out. Respondent completed a list of medications in the medical chart for this date. Respondent diagnosed patient S.S. with pulmonary hypertension and atrial septal defect, and recommended an MRI of the chest, CT scan of the chest, and an echocardiogram.

15. On or about January 21, 2013, patient S.S. was seen for the last time by respondent in his office. Respondent completed a list of medications in the medical chart for this date. Patient S.S. continued to complain of back pain and dyspnea, and complained of pressure in her throat. Respondent diagnosed patient S.S. with pulmonary hypertension and patent foramen ovale, and recommended a pulmonary function test, a pulmonary stress test, an MRI of the chest with contrast, a Doppler echocardiogram with bubble study, and a sleep study.

16. On or about May 22, 2013, respondent sent a letter to patient S.S. via regular mail to inform her that he would no longer be able to provide medical services to her because her case was "too complicated." Respondent recommended patient S.S. find care at UCSD Medical Center, and further stated that he would not be providing patient S.S. medical care of any kind as of the date of the letter.

17. Between on or about August 15, 2012, and on or about January 21, 2013, many pages of respondent's medical records for patient S.S. lack identification of the patient's name, the patient's date of birth, and the date of entry.

18. Respondent committed gross negligence in his care and treatment of patient S.S. which included, but was not limited to the following:

(a) Paragraphs 8 through 17, above, are hereby incorporated by reference as if fully set forth herein;

(b) Failing to maintain adequate and accurate medical records;

(c) Failing to monitor potential side effects from patient S.S.'s medications; and

(d) Failing to properly dismiss patient S.S. from his care.

PATIENT E.E.

19. On or about June 20, 2014, patient E.E., a then 59 year old female with a history of breathing problems and heart palpitations, received a pulmonology referral from her physician at Family Health Centers to see respondent for treatment for asthma.

20. On or about July 8, 2014, patient E.E. attended her first appointment with respondent at his office for treatment for asthma. At this visit, patient E.E. completed initial intake documents, wherein she included a history of breast implants. During the initial consultation, respondent indicated in the medical record for patient E.E. that she "complained of shortness of breath and not able to talk due to shortness of breath." Prior to the physical examination, respondent requested patient E.E. disrobe from the waist up and to put on a gown he provided. Respondent then left the room. When respondent returned to the room, he opened patient E.E.'s gown and used his stethoscope to listen to patient E.E.'s chest and lungs. Upon completion of the physical examination, respondent documented in patient E.E's medical record that she had silicone implants, lungs with minimal wheezes, soft and flat abdomen with no organomegaly and regular cardiac rhythm. Respondent's assessment and diagnosis was "mild asthma." Respondent prescribed patient E.E. prednisone[9] 10mg, and requested a follow-up visit in 10 to 15 days.

21. On or about July 14, 2014, patient E.E. returned to respondent's office for her scheduled follow-up appointment. Following his physical examination, respondent noted patient E.E. "responded well to prednisone." Respondent documented in patient E.E.'s medical record that he noted no breast masses, lungs with no crackles or adventitious sound, soft abdomen, and regular cardiac rhythm. Respondent diagnosed patient E.E. with asthma, but did not qualify the severity. Respondent recommended patient E.E. take her inhaler steroid twice daily, and to return for a follow-up visit in six (6) weeks.

22. On or about December 11, 2014, patient E.E. presented to respondent's office for the last time with complaints of "dizzy spells and palpitations." Patient E.E. had recently been to the

[9] Prednisone is a corticosteroid that prevents the release of substances in the body that cause inflammation, and is used to treat many different conditions, including but not limited to, allergic disorders, skin conditions, ulcerative colitis, arthritis, lupus, psoriasis, or breathing disorders.

emergency room for coughing and wheezing, and was given prednisone, which she finished. Prior to the physical examination, respondent requested patient E.E. disrobe from the waist up and to put on a gown he provided. Respondent then left the room. When respondent returned to the room, he opened patient E.E.'s gown and began examining patient E.E.'s breasts. While touching her breasts, respondent told patient E.E. that her breasts were beautiful and asked if her breasts were real. Patient E.E. told respondent that her breasts were implants. Respondent then used his stethoscope to listen to patient E.E.'s chest and lungs. Following his physical examination, respondent documented in patient E.E's medical record that she had breast implants with no masses, lung wheezes, soft abdomen, and regular cardiac rhythm. Respondent diagnosed patient E.E. with asthma, but did not qualify the severity. Respondent prescribed patient E.E. prednisone, QVAR,[10] and montelukast,[11] recommended allergy testing, and requested a follow-up visit in two (2) weeks. Respondent did not order any labs during this visit.

23. Between on or about July 8, 2014, and on or about December 11, 2014, many pages of respondent's medical records for patient E.E. lacked identification of the patient's name, the patient's date of birth, and the date of entry.

24. Respondent committed gross negligence in his care and treatment of patient E.E. which included, but was not limited to the following:

(a) Paragraphs 19 through 23, above, are hereby incorporated by reference as if fully set forth herein;

(b) Failing to maintain adequate and accurate medical records;

(c) Failing to adequately manage patient E.E.'s persistent asthma;

(d) Failing to reconcile patient E.E.'s medications on all three visits; and

(e) Performing a breast exam, without indication, without proper documentation, and without first obtaining proper informed consent.

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[10] QVAR (beclomethasone) is used to prevent and control symptoms (wheezing and shortness of breath) caused by asthma. This medication belongs to a class of drugs known as corticosteroids. It works directly in the lungs to make breathing easier by reducing the irritation and swelling of the airways.

[11] Montelukast (brand name Singulair) is a leukotriene receptor antagonist used for the maintenance treatment of asthma and to relieve symptoms of seasonal allergies.

PATIENT P.C.

25. In or around 2015, patient P.C., a then 59 year old male with a history of bronchitis, asthma, pneumonia, sinusitis, and hypertension, received a pulmonology referral to respondent from his primary physician. Patient P.C. had a history of heavy smoking and alcohol use, as well as reported treatment from seven (7) prior pulmonology specialists since approximately 2010.

26. On or about April 8, 2015, patient P.C. attended his first appointment at respondent's office. Respondent conducted a physical examination, and noted significant findings, including blood pressure of 170/100, oxygen saturation of 90%, weight of 302 lbs., and lungs sound that was decreased, but reasonably clear. Respondent diagnosed patient P.C. with emphysema, back surgeries, and hypertension. Respondent advised the patient to take "P-Val," and ordered pulmonary function tests (PFT), an electrocardiogram (EKG), and chest x-ray (CXR). The medical record for this date contains a list of medications that was modified multiple times, but which included Advair[12] and Combivent.[13]

27. On or about April 8, 2015, a lab report revealed that patient P.C. had a low immunoglobulin (Ig) G level. Respondent requested a repeat test, and on or about April 15, 2015, the result also revealed a low level.

28. On or about April 30, 2015, respondent ordered patient P.C. to receive Gammagard[14] subcutaneous injections every two (2) weeks, with twelve (12) refills. Unspecified labs were to be done every three (3) months.

29. On or about May 19, 2015, pulmonary function tests revealed patient P.C. had severe reduction in flow, which was compatible with severe Chronic Obstructive Pulmonary Disease (COPD).

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[12] Advair contains a combination of fluticasone and salmeterol. It is used to prevent asthma attacks attacks, and to prevent flare-ups or worsening of COPD associated with chronic bronchitis and/or emphysema.

[13] Combivent is a metered-dose inhaler containing a combination of albuterol and ipratropium. It is used as an inhaled medication to prevent bronchospasm in people with COPD who are also using other medicines to control their condition.

[14] Gammagard is used to strengthen the body's natural defense system to lower the risk of infection in persons with a weakened immune system.

30. On or about May 20, 2015, patient P.C. was seen by respondent in his office. Respondent conducted a physical examination, and noted significant findings, including blood pressure of 149/70, oxygen saturation of 90%, weight of 309 lbs., Mallempati grade 3 oral cavity,[15] and clear lung examination. Respondent diagnosed patient P.C. with COPD, obesity, and hypertension. The medical record for this date contains no recommendation and plan, and the list of medications included Prednisone, Combivent, Flovent,[16] Spiriva,[17] and Albuterol.[18]

31. On or about May 20, 2015, a lab report revealed that patient P.C. continued to have a low Ig G level.

32. On or about June 24, 2015, patient P.C. was seen by respondent in his office. Respondent conducted a physical examination, and noted significant findings, including blood pressure of 140/80, oxygen saturation of 99%, weight of 305 lbs., and decreased lung sounds. Respondent diagnosed patient P.C. with COPD and immunodeficiency. The medical record for this date contains no recommendation and plan, and the list of medications included Ventolin, Advair, and Atrovent.[19]

33. On or about September 24, 2015, patient P.C. was seen by respondent in his office. Respondent conducted a physical examination, and noted significant findings, including blood pressure of 151/86, oxygen saturation of 95%, weight of 309 lbs., Mallempati grade 2 oral cavity, and decreased lung sounds. Respondent diagnosed patient P.C. with COPD, immunodeficiency,

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[15] Mallampati classification is a rough estimate of the tongue size relative to the oral cavity, and is used as an independent predictor of obstructive sleep apnea.

[16] Flovent (fluticasone) is a steroid that prevents the release of substances in the body that can cause inflammation. It is used to prevent asthma attacks.

[17] Spiriva (tiotropium) is a is a bronchodilator that relaxes muscles in the airways and increases air flow to the lungs. It is used to prevent bronchospasm (narrowing of the airways in the lungs) in people with COPD.

[18] Albuterol (ventolin) is a bronchodilator that relaxes muscles in the airways and increases air flow to the lungs. It is used to treat or prevent bronchospasm in people with reversible obstructive airway disease.

[19] Atrovent (ipratropium) is a bronchodilator that relaxes muscles in the airways and increases air flow to the lungs. It is used to prevent bronchospasm, or narrowing airways in the lungs, in people with bronchitis, emphysema, or COPD.

and malignant hypertension. The medical record for this date contains an assessment that includes, "patient improving on therapy," and a recommendation for a return visit in three (3) months, with a possible need for an EKG. The list of medications for this visit included Advair, Ventolin, and Atrovent.

34. On or about September 24, 2015, a lab report revealed that patient P.C. had an Ig G level within normal limits.

35. On or about September 28, 2015, patient P.C. contacted respondent's office by phone and requested a sleep study. When the receptionist informed patient P.C. that respondent did not think one was necessary, patient P.C. became angry and made rude comments about respondent.

36. On or about September 29, 2015, respondent ordered Gammagard be discontinued after one (1) more month of therapy.

37. On or about October 26, 2015, patient P.C. contacted respondent's office by phone several times, and made rude comments about respondent and the receptionist.

38. On or about October 27, 2015, respondent sent a letter to patient C.R. via regular mail to inform him that he can no longer provide any services. The letter did not contain a reason for the discharge, nor an offer to assist in the continuity of care.

39. Between on or about April 8, 2015, and on or about October 27, 2015, many pages of respondent's medical records for patient P.C. lacked identification of the patient's name, the patient's date of birth, and the date of entry.

40. Respondent committed gross negligence in his care and treatment of patient P.C. which included, but was not limited to failing to properly dismiss patient P.C. from his care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

41. Respondent has further subjected his Physician's and Surgeon's Certificate No. A30551 to disciplinary action under section 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in in his care and treatment of patients S.S., E.E., and P.C., as more particularly alleged hereinafter:

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Patient S.S.

42. Respondent committed repeated negligent acts in his care and treatment of patient S.S., which included but was not limited to, the following:

(a) Paragraphs 8 through 18, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Failing to reconcile patient S.S.'s medications on one visit;

(c) Failing to work diligently to obtain authorization approval from patient S.S.'s insurance company for tests and medications respondent believed were necessary for patient S.S; and

(d) Failing to promptly evaluate and treat patient S.S. for pulmonary hypertension with known patent foramen ovale.

Patient E.E.

43. Respondent committed repeated negligent acts in his care and treatment of patient E.E., which included but was not limited to, paragraphs 19 through 24, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

Patient P.C.

44. Respondent committed repeated negligent acts in his care and treatment of patient P.C., which included but was not limited to, the following:

(a) Paragraphs 25 through 40, above, are hereby incorporated by reference and realleged as if fully set forth herein.

(b) Failing to maintain adequate and accurate medical records; and

(c) Failing to reconcile patient P.C.'s medications on all four (4) office visits.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

45. Respondent has further subjected his Physician's and Surgeon's Certificate No. A30551 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records regarding his care and treatment

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of patients S.S., E.E., and P.C., as more particularly alleged in paragraphs 8 through 40, above, which are hereby incorporated by reference as if fully set forth herein.

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 No. A30551, issued to respondent James R. Vevaina, M.D.;

2. Revoking, suspending, or denying approval of respondent James R. Vevaina, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering respondent James R. Vevaina, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: February 1, 2017

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

SD2016701260