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

In the Matter of the Accusation Against:	)	
SANGJOON JAY LEE, M.D.	)	Case No. 800-2014-009361
Physician's and Surgeon's Certificate No. C50371	)	OAH No. 2017030151
Respondent	)	

DECISION

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 February 9, 2018.

IT IS SO ORDERED January 10, 2018.

MEDICAL BOARD OF CALIFORNIA

By: Ronald H. Lewis, M.D.
Ronald Lewis, M.D., Chair
Panel A

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

In the Matter of the Accusation Against: SANGJOON JAY LEE, M.D., Physician and Surgeon's Certificate No. C 50371, Respondent.	Case No. 800-2014-009361 OAH No. 2017030151

PROPOSED DECISION

This matter was heard by Julie Cabos-Owen, Administrative Law Judge (ALJ) with the Office of Administrative Hearings (OAH), on October 9, 11 and 12, 2017, in Los Angeles, California. Complainant was represented by Richard D. Marino, Deputy Attorney General. Sangjoon Jay Lee, M.D. (Respondent) was represented by Raymond J. McMahon, with Doyle Schafer McMahon.

At the administrative hearing, the Accusation was amended at page 9, line 8, and at page 10 line 12, to change "MK" to "MC."

Additionally, at the hearing, the ALJ was provided with Exhibits 6 through 10, 13, 15 through 24, and N, containing confidential medical information which is protected from disclosure to the public. Redaction of the documents to obscure this information was not practicable and would not provide adequate privacy protection. In order to prevent the disclosure of confidential information, concurrent with the issuance of this Proposed Decision the ALJ, on her own motion, issued a Protective Order providing that Exhibits 6 through 10, 13, 15 through 24, and N shall be placed under seal following their use in preparation of the Proposed Decision. These exhibits shall remain under seal and shall not be opened, except by order of the Medical Board of California, by OAH, or by a reviewing court. 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 subject to this order provided that such documents are protected from release to the public.

Oral and documentary evidence was received, and argument was heard. The record was left open until November 20, 2017 to allow the parties to submit closing briefs. Complainant timely filed "Complainant's Closing Summation," which was marked as

Complainant's Exhibit 26 and lodged. Respondent timely filed "Respondent's Opening Post-Hearing Brief," which was marked as Respondent's Exhibit X and lodged. In response, Complainant timely filed "Complainant's Reply," which was marked as Complainant's Exhibit 27 and lodged. The record was closed, and the matter was submitted for decision on November 20, 2017.

On November 28, 2017, Respondent filed "Respondent's Reply Brief," which was marked as Respondent's Exhibit Y and lodged. However, since Exhibit Y was filed untimely, it was not considered as part of Respondent's closing argument.

FACTUAL FINDINGS

1. On December 14, 2016, Complainant Kimberly Kirchmeyer filed the Accusation in this matter while acting in her official capacity as the Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

2. On March 3, 2000, the Board issued Physician and Surgeon's Certificate Number C 50371 to Respondent. Respondent's Certificate was in full force and effect at all relevant times and was scheduled to expire on November 30, 2017.[1] The license has not been previously disciplined.

Respondent's Education and Practice; Procedural History

3. Respondent was born in Korea, and he earned his medical degree from Yonsei University School of Medicine in 1971. Thereafter, he served as a medical officer in the South Korean Army Medical School until 1974, when he moved to the Unites States. In 1979, after his internship and residency, Respondent opened a private practice in Maryland, practicing Obstetrics and Gynecology (Ob-Gyn).

4. Respondent has been board certified in Ob-Gyn since 1983.

5. In 1998, he returned to Seoul, Korea to teach at SungKyunkwan University School of Medicine and to serve as the Chairman of the Department of Ob-Gyn at Kangbuk Samsung Hospital. However, in November 2001, he returned to the United States and opened a private practice in Ob-Gyn located in Los Angeles.

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[1] If the license was not renewed, the Board retains jurisdiction over this matter pursuant to Business and Professions Code section 118, subdivision (b).

6(a). During the time Respondent practiced medicine in Los Angeles, he retained hospital privileges at the Hospital of the Good Samaritan and Hollywood Presbyterian Medical Center (HPMC).

6(b). During that time, the patient population Respondent treated was primarily lower income, Korean-speaking patients. Since Respondent spoke Korean, he was able to communicate with them in their primary language.

7. Respondent has participated in a medical practice ministry through his church for several years. Respondent traveled as a medical missionary to Mongolia in 2013 and to Haiti in 2016.

8. After returning from Mongolia in 2013, Respondent suffered from herniated disc back pain and left side sciatica which worsened after surgery in January 2014. Due to his continuing back pain, Respondent decided to retire.

9(a). Respondent's decision to retire was hastened when HPMC initiated peer review proceedings involving several of Respondent's patients, including MK, JS, HC, CK (designated as KC in the Accusation), and MC.[2]

9(b). While the HPMC peer review investigation was pending, Respondent voluntarily surrendered his clinical privileges at HPMC in October 2014.

10. Respondent retired from medical practice in December 2014. He currently has no medical office and maintains no medical insurance. However, he plans to continue volunteering his time and skill through medical missionary work.

11. As required by law, HPMC reported to the Board Respondent's surrender of his clinical privileges while under peer review investigation.

12. On October 30, 2014, the Board opened an investigation into the circumstances surrounding Respondent's surrender of his clinical privileges at HPMC. The Board obtained the HPMC records of patients MK, JS, HC, CK/aka KC, and MC, and sent a letter to Respondent requesting an interview. Respondent did not respond.

13. After being served with the Accusation and retaining an attorney, Respondent forwarded to the Board his office records for the five patients at issue in this case. Respondent also provided typewritten transcriptions of his office progress notes to clarify what he had written.

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[2] Patients' initials are used in lieu of their full names in order to protect their privacy.

Facts Re: Patient MK

14. MK was a 53-year-old woman who first visited Respondent's office on July 8, 2013, complaining of a large uterine myoma, also known as a fibroid,[3] along with severe pain and dyspareunia.[4]

Office Records for MK

15. Respondent's handwritten office records for MK were brief, contained mostly abbreviations, and were difficult to read. The findings below (Factual Findings 16 through 35) were derived by review of the records along with Respondent's uncontroverted testimony.

16. On July 8, 2013, Respondent performed a history and physical on MK. According to the patient's medical records, her vitals were taken, and her weight (129 pounds) and blood pressure (129/93) were documented. Her medical history was also taken. She had given birth to two children, one via low segment transverse Cesarean section (C-section). She had one ectopic pregnancy with a unilateral salpingo-oophorectomy.[5] Her last menstrual period was two years prior. There was no documentation of her last pap smear.[6] She had no known allergies.

17. Respondent performed and documented a physical examination and a pelvic examination. On examination, Respondent documented scar tissue from the patient's prior C-section, vaginal atrophy, and a "relaxed outlet."[7] MK also had an external posterior repair of her perineum from an episiotomy. Respondent noted a palpable tumor comparable in size to a 16 to 18 week pregnancy. Respondent's assessment was that the patient had a large

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[3] A fibroid is an area of muscle tissue which grows too rapidly and forms a ball-like mass in the uterus.

[4] Dyspareunia is genital pain from intercourse.

[5] A unilateral salpingo-oophorectomy is the removal of one fallopian tube and one ovary.

[6] A pap smear is a screening procedure to detect pre-cancerous and cancerous processes in the cervix.

[7] A "relaxed vaginal outlet" occurs when the tissues that separate the vagina from the rectum become weak or damaged, causing the pelvic organs — such as the bladder, urethra, uterus, rectum, and small intestines—to slip into, or protrude out from, the vagina.

myoma with severe pain and a relaxed outlet. He noted that a gastrointestinal (GI) workup had been negative, pointing to gynecological etiology, and that conservative treatment had failed.[8]

18. Due to the size of the tumor and the patient's severe pain, Respondent determined that the best treatment for MK was a total abdominal hysterectomy (TAH), which involved the removal of the uterus and cervix.

19(a). As was his custom and practice, Respondent and MK discussed treatment options and Respondent went through his customary informed consent discussion. He described the proposed procedure in Korean using layman's terms, and he explained the risks of the procedure. He discussed the pros and cons of surgery versus non-surgical alternatives. He then allowed the patient to decide what option she wished to select.

19(b). This discussion was not specifically documented in the office medical record.

20. Respondent and MK arrived at a treatment plan wherein they agreed that MK would undergo a TAH and posterior scar revision of her perineum.

21. After leaving Respondent's office on July 8, 2013, the patient immediately contacted Respondent, informing him that she was in severe pain and wanted to undergo surgery as soon as possible. Respondent called Hollywood Presbyterian Medical Center (HPMC) and determined they had an opening, and he scheduled the procedure for the next day.

22. The office medical record contained no documentation of any ultrasound performed on MK.

23. Although Respondent testified that the patient refused a pap smear and cancer marker tests, these offers and refusals were not documented in the office medical record.

Hospital Records for MK

24. On July 9, 2013, in the early morning, MK was admitted to HPMC with a diagnosis of "large painful uterine fibroid, dyspareunia, and scarred perineum." (Exhibit 21, p. 9; Exhibit 7, p. 86.)

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[8] Conservative treatment often involved the patient waiting until menopause and the decrease of hormonal levels to see if the myoma would shrink.

25(a). On that date, Respondent filled out a form provided by HPMC on which he documented a very abbreviated history and physical noting only a small portion of the information he obtained during his evaluation of MK at his office on July 8, 2013.

25(b). In itself, the cursory and mostly illegible chart note was inadequate.

25(c). Respondent did not provide a copy of his July 8, 2013 office history and physical note for inclusion in the HPMC medical records.

26. On July 9, 2013, MK signed HPMC forms entitled "Hysterectomy Informed Consent" acknowledging the resulting sterilization (Exhibit 7, p. 89), "Consent for Blood or Component Transfusion" (*Id.* at p. 90), and "Consent to Surgery / Special Procedures / Anesthesia)" (*Id.* at pp. 91-92). Regarding the consent for transfusion, Respondent explained that she would not likely lose blood, but in case of excessive bleeding, this consent is needed. The Consent for Blood or Component Transfusion included a statement: "The possible risks and consequences associated with transfusion have been explained to me. I understand that these risks may include: . . . transmission of infectious diseases such as hepatitis." (*Id.* at p. 90.)

27. As required by HPMC, Respondent brought the consent for surgery form to the patient's bedside with the nurse standing by, and he again conducted an informed consent discussion of the risks and benefits of the surgery to allow the patient to change her mind.

28. The consent for surgery form contained a typewritten statement: "Your physicians and surgeons have recommended the following operation or procedure." (Exhibit 7, p. 91.) That typewritten statement was followed by a blank lined section in which the following was handwritten: "abdominal hysterectomy, scar revision of perineum." (*Ibid.*) Just below the handwritten name of the procedure were the typewritten words "Lay terminology" (*Ibid.*), followed by another blank lined section. Nothing was handwritten in that section. The consent form also contained a typewritten statement: "Your signature to this form indicates that (a) you have read and understand the information provided in this form, (b) the operation or procedure set forth above has been adequately explained to you by your physician, (c) you have had a chance to ask questions, (d) you have received all the information you desire concerning the operation or procedure and anesthesia, and (e) you authorize and consent to the performance of the operation or procedure and/or administration of anesthesia." (*Id.* at p. 92.)

29. On July 9, 2013, at about 7:40 a.m., Respondent performed a TAH and reversed perineorrhaphy. The peritoneum was closed with a Vicryl suture, and the skin was closed with staples. Pathology revealed a benign leiomyoma.

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30. Respondent's physician progress notes in the hospital record from July 9, 2013 and July 10, 2013 were cursory and illegible. (Exhibit 7, p. 110.)

31. A Physician Order, dated July 10, 2013 at 11:35 a.m., indicated that Respondent had issued a telephone order for the patient to be discharged to home that day (one day post-surgery) and that the patient was told to follow up with Respondent on July 16, 2013.

32. As was his custom and practice after major surgery, with the potential for infection, the patient was given a written prescription for Cipro and instructed to call Respondent if she had any fever or redness, and at that point, Respondent "would tell [her]" what to do with the paper [prescription]" (Respondent's testimony). According to Respondent, if he determined from their telephone discussion that the patient had signs of infection, he would tell her to fill the prescription right away. However, the prescription was not to be filled until the patient spoke to Respondent.

33. Respondent testified that it was his custom and practice to go over discharge instruction with Korean-speaking patients. Respondent insisted that he explained his discharge instructions to MK and that she indicated she understood. Their discussion was not documented in the hospital medical record.

34. The patient was given written discharge instructions on July 10, 2013.

35. MK was discharged in stable condition on July 10, 2013.

Follow-up Office Records for MK

36(a). Prior to MK's discharge from HPMC, Respondent ordered that the patient be provided a staple remover kit. Respondent testified that he did not intend for the patient to remove the staples herself, that she was told to bring it to her follow up appointment with Respondent, and that Respondent, not the patient, removed the staples at his office.

36(b). There was no notation in the Respondent's office progress notes that a follow up appointment took place on July 16, 2013, nor was there any indication in any of the following progress notes that Respondent had removed the staples. Instead, there was only a handwritten note on a small piece of paper, author unknown, indicating:

> 7-16-13
> [MK]
> [patient's telephone number]
> 7-16-13 staple removed
> e-mail to Dr. Lee

photo • remove szte [the spelling of the last word was unclear]
if ok. 6 wks f/u
spoke w/ pt. Dr. Lee
(Exhibit 21, p. 20.)

36(c). It was unclear from this handwritten note whether Respondent had removed the staples himself.

37. Respondent's very sparse office progress notes, dated August 10, 2013 and August 24, 2013, were not legible. At the administrative hearing, Respondent clarified that on August 10, 2013, the progress note stated that the patient's abdomen was healing and that the patent demanded the suture "out" of her perineum, so he removed it.

Facts Re: Patient JS

38. JS was a peri-menopausal 50-year-old woman who first visited Respondent's office on November 27, 2012. She had undergone multiple procedures for the removal of fibroids and was complaining of large uterine myoma with severe bleeding, anemia, and dizziness.

Office Records for JS

39. Respondent's handwritten office records for JS were brief, contained mostly abbreviations, and were difficult to read. The findings below (Factual Findings 40 through 61) were derived by review of the records along with Respondent's uncontroverted testimony.

40. On November 27, 2012, Respondent performed a history and physical on JS. According to the patient's medical records, her vitals were taken, and her weight (160 pounds) and blood pressure (174/89) were documented. Her medical history was also taken. She had given birth to three children, and her last menstrual period was November 14, 2012. Her last pap smear was seven years prior. She had no known allergies.

41. Respondent performed and documented a physical examination and a pelvic examination. On examination, Respondent documented a myoma comparable in size to a 20 week pregnancy. Respondent noted that the patient had unsuccessfully tried acupuncture to reduce the size of the myoma and that conservative treatment had also failed. Respondent's assessment was that the patient had a large myoma.

42(a). Respondent and JS discussed treatment options and Respondent went through his customary informed consent discussion. He discussed the pros and cons of surgery versus non-surgical alternatives. Since the patient was peri-menopausal, they discussed medication and waiting until she reached menopause to see if the tumor would shrink. They also

discussed TAH as a good option for a 50-year-old who did not intend to have any more pregnancies. They also discussed a myomectomy, which is the surgical removal of only the myoma; however, this involved the risk of developing another myoma. Respondent then allowed the patient to decide what option she wished to select. The patient wanted to keep her uterus, so she elected the myomectomy. He described the proposed procedure, and he explained the risks of the procedure.

42(b). This discussion was not specifically documented in the office medical record.

43. Respondent's plan for treatment was to surgically remove the myoma. However, prior to that procedure, Respondent's plan included conducting a pap smear and an ultrasound and obtaining hemoglobin and CA-125 cancer marker blood testing.

44. A pap smear conducted on November 27, 2012 came back negative for intraepithelial lesion or malignancy. The cancer marker testing also came back within normal limits. The ultrasound showed multiple myomas.

45. The patient's surgery was scheduled for December 7, 2012.

Hospital Records for JS

46. On December 7, 2012, in the early morning, JS was admitted to HPMC with a diagnosis of "large uterine fibroid." (Exhibit 22, p. 21; Exhibit 8, p. 227.)

47(a). On that date, Respondent filled out a form provided by HPMC on which he documented an extremely abbreviated history and physical noting only a very small portion of the information he obtained during his evaluation of JS at his office on November 27, 2012.

47(b). In itself, the cursory and mostly illegible chart note was inadequate.

47(c). Respondent did not provide a copy of his November 27, 2012 office history and physical note for inclusion in the HPMC medical records.

48. On December 7, 2012, JS signed HPMC forms "Consent for Blood or Component Transfusion" (Exhibit 8, p. 214), and "Consent to Surgery / Special Procedures / Anesthesia)" (*Id.* at pp. 212-213). Regarding the consent for transfusion, Respondent explained that she would not likely lose blood, but in case of excessive bleeding, this consent is needed. The Consent for Blood or Component Transfusion included a statement: "The possible risks and consequences associated with transfusion have been explained to me. I understand that these risks may include: . . . transmission of infectious diseases such as hepatitis." (*Id.* at p. 214.)

49. As required by HPMC, Respondent brought the consent for surgery form to the patient's bedside with the nurse standing by, and he again conducted an informed consent discussion of the risks and benefits of the surgery to allow the patient to change her mind.

50. The consent for surgery form contained a typewritten statement: "Your physicians and surgeons have recommended the following operation or procedure." (Exhibit 8, p. 212.) That typewritten statement was followed by a blank lined section in which the following was handwritten: "exploratory laparotomy,[9]myomectomy." (*Ibid.*) Just below the handwritten name of the procedure were the typewritten words "Lay terminology" (*Ibid.*), followed by another blank lined section. Nothing was handwritten in that section. The consent form also contained a typewritten statement: "Your signature to this form indicates that (a) you have read and understand the information provided in this form, (b) the operation or procedure set forth above has been adequately explained to you by your physician, (c) you have had a chance to ask questions, (d) you have received all the information you desire concerning the operation or procedure and anesthesia, and (e) you authorize and consent to the performance of the operation or procedure and/or administration of anesthesia." (*Id.* at p. 213.)

51. On December 7, 2012, at about 7:30 a.m., Respondent performed exploratory laparotomy and multiple myomectomy. Due to the extent of the surgery, a Jackson-Pratt drain (JP drain)[10] was inserted due to oozing from the incision site and the possibility of fluid accumulation and infection. The peritoneum was closed with a Vicryl suture, and the skin was closed with staples.

52(a). According to a surgical pathology report, the total number of myoma removed was 27, and an intrauterine device (IUD) was also found.

52(b). Although the pathology report indicated that 27 myomas were found, the photograph of the specimens found in the medical record included a handwritten number "26." Due to the quality of the photograph, it was not possible to determine whether 26 or 27 myomas were depicted.

52(c). When Respondent examined JS in his office, he was not aware of any IUD. He did not observe any IUD on the ultrasound, and during the pelvic examination he did not observe any IUD string which would have been extending through the cervix. Additionally, he did not see any IUD either during surgery or post-operatively when he sent the specimens to pathology. During his testimony, Respondent noted that it is possible for an IUD to

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[9] Laparotomy is a surgical incision in the abdomen.

[10] A Jackson-Pratt drain is a closed suction medical device commonly used as a post-operative drain for collecting bodily fluids from surgical sites.

migrate from its original position. Respondent surmised that either the IUD had become embedded in a myoma or the pathologist's report was erroneous.

52(d). The pathologist did not testify at the administrative hearing, and the photographs of the specimens did not clearly depict the IUD.

53. Respondent's physician progress notes in the hospital record from December 7, 2012 and December 8, 2012 were cursory and illegible. (Exhibit 8, p. 229.)

54(a). During the course of the patient's post-operative hospitalization, the nurses documented the production from the JP drain. (Exhibit 8, pp. 326-328.) The drainage markedly decreased with time, as expected, eventually documented at 35.

54(b). Respondent allowed the patient to be discharged with the JP drain in place. There was no documentation in the hospital medical record regarding whether the JP drain was left in or removed prior to the patient's discharge.

55(a). On December 7, 2012 JS's hemoglobin just prior to surgery (at 6:25 a.m.) was measured at 11.8, and at 11:50 a.m. it was 9.7. On December 8, 2012 at 6:05 a.m., her hemoglobin was measured at 7.3. This was low, in light of the reference range of 12-15g/dL.

55(b). JS did not receive any blood transfusion while at HPMC.

55(c). At the administrative hearing, Respondent explained that, although JS's hemoglobin level dropped to 7.3, he did not give her a blood transfusion because on clinical assessment, she was stable with no active bleeding and normal blood pressure. According to Respondent, if the patient cannot recover quickly without transfusion, then it will be administered. Otherwise, he refrains from just "treating numbers in the [laboratory report], [rather than] the patient overall."

56. On December 8, 2012, at 9:00 a.m., as was his custom and practice, Respondent explained his discharge instructions to the patient, and she indicated she understood. This discussion was documented by the nurse in the hospital medical record. (Exhibit 8, p. 303.)

57. The patient was also given written discharge instructions on the afternoon of December 8, 2012.

58. JS was discharged in stable condition on December 8, 2012.

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59. As was his custom and practice after major surgery, with the potential for infection, the patient was given a written prescription for Cipro and instructed to call Respondent if she had any fever or redness, and at that point, Respondent "would tell [her]" what to do with the paper [prescription]" (Respondent's testimony). According to Respondent, if he determined from their telephone discussion that the patient had signs of infection, he would tell her to fill the prescription right away. However, the prescription was not to be filled until the patient spoke to Respondent.

Follow-up Office Records for JS

60. Prior to JS's discharge from HPMC, Respondent ordered that the patient be provided a staple remover kit. Respondent testified that he did not intend for the patient to remove the staples herself, that she was told to bring it to her follow up appointment with Respondent, and that Respondent, not the patient, removed the staples at his office.

61. Respondent's very sparse office progress notes, dated December 17, 2012 and January 22, 2013, were not legible. At the administrative hearing, Respondent clarified that the December 17, 2012 progress note states that the patient's JP drain and staples were removed.

Facts Re: Patient HC

62. HC was a 40-year-old woman who first visited Respondent's office on May 29, 2012, complaining of a uterine fibroid for which another physician had recommended a hysterectomy.

Office Records for HC

63. Respondent's handwritten office records for HC were brief, contained mostly abbreviations, and were difficult to read. The findings below (Factual Findings 64 through 82, and) were derived by review of the records along with Respondent's uncontroverted testimony.

64. On May 29, 2012, Respondent performed a history and physical on HC. According to the patient's medical records, her vitals were taken, and her weight (140 pounds) and blood pressure (140/90) were documented. Her medical history was also taken. She had given birth to one child, and her last menstrual period was May 14, 2012. She had no known allergies.

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65. Respondent performed and documented a physical examination and a pelvic examination. On examination, Respondent documented a palpable myoma comparable in size to a 10-12 week pregnancy. Respondent's assessment was that the patient had a large myoma with bleeding and pain.

66(a). Respondent and HC discussed treatment options and Respondent went through his customary informed consent discussion. He discussed the pros and cons of surgery versus non-surgical alternatives. Since the patient was peri-menopausal, they discussed future pregnancy plans and waiting until she reached menopause to see if the tumor would shrink. They also discussed a myomectomy, which is the removal of only the myoma. Respondent then allowed the patient to decide what option she wished to select. The patient elected to undergo a myomectomy. He described the proposed procedure, and he explained the risks of the procedure.

66(b). This discussion was not specifically documented in the office medical record.

67. Respondent's plan for treatment was to surgically remove the myoma. However, prior to that procedure, Respondent's plan included conducting a pap smear and an ultrasound.

68. A pap smear conducted on May 29, 2012 came back negative for intraepithelial lesion or malignancy. The ultrasound showed a nine centimeter myoma.

69. The patient's surgery was scheduled for July 12, 2012.

Hospital Records for HC

70. On July 12, 2012, in the early morning, HC was admitted to HPMC with a diagnosis of "large uterine myoma with bleeding and pain." (Exhibit 24, p. 22-020; Exhibit 10, p. 382.)

71(a). On that date, Respondent filled out a form provided by HPMC on which he documented an extremely abbreviated history and physical noting only a very small portion of the information he obtained during his evaluation of HC at his office on May 29, 2012.

71(b). In itself, the cursory and mostly illegible chart note was inadequate.

71(c). Respondent did not provide a copy of his May 29, 2012 office history and physical note for inclusion in the HPMC medical records.

72. On July 12, 2012, HC signed HPMC forms "Consent for Blood or Component Transfusion" (Exhibit 10, p. 367), and "Consent to Surgery / Special Procedures /

Anesthesia)" (*Id.* at pp. 368-369). Regarding the consent for transfusion, Respondent explained that she would not likely lose blood, but in case of excessive bleeding, this consent is needed. The Consent for Blood or Component Transfusion included a statement: "The possible risks and consequences associated with transfusion have been explained to me. I understand that these risks may include: . . . transmission of infectious diseases such as hepatitis." (*Id.* at p. 367.)

73. As required by HPMC, Respondent brought the consent for surgery form to the patient's bedside with the nurse standing by, and he again conducted an informed consent discussion of the risks and benefits of the surgery to allow the patient to change her mind.

74. The consent for surgery form contained a typewritten statement: "Your physicians and surgeons have recommended the following operation or procedure." (Exhibit 10, p. 368.) That typewritten statement was followed by a blank lined section in which the following was handwritten: "myomectomy." (*Ibid.*) Just below the handwritten name of the procedure were the typewritten words "Lay terminology" (*Ibid.*), followed by another blank lined section. Nothing was handwritten in that section. The consent form also contained a typewritten statement: "Your signature to this form indicates that (a) you have read and understand the information provided in this form, (b) the operation or procedure set forth above has been adequately explained to you by your physician, (c) you have had a chance to ask questions, (d) you have received all the information you desire concerning the operation or procedure and anesthesia, and (e) you authorize and consent to the performance of the operation or procedure and/or administration of anesthesia." (*Id.* at p. 369.)

75. On July 12, 2012, at about 7:30 a.m., Respondent performed the myomectomy. The peritoneum was closed with a Vicryl suture, and the skin was closed with staples.

76. Respondent's physician progress notes in the hospital record from July 13 and 14, 2012 were cursory and illegible. (Exhibit 10, pp. 384-385.)

77. HC was discharged in stable condition on July 14, 2012.

78(a). On July 14, 2012, as was his custom and practice, Respondent explained his discharge instructions to the patient, and she indicated she understood.

78(b). Their discussion was not documented in the hospital medical record.

79. The patient was also given written discharge instructions on the afternoon of July 14, 2012.

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80. As was his custom and practice after major surgery, with the potential for infection, the patient was given a written prescription for Cipro and instructed to call Respondent if she had any fever or redness, and at that point, Respondent "would tell [her]" what to do with the paper [prescription]" (Respondent's testimony). According to Respondent, if he determined from their telephone discussion that the patient had signs of infection, he would tell her to fill the prescription right away. However, the prescription was not to be filled until the patient spoke to Respondent.

Follow-up Office Records for HC

81. Prior to HC's discharge from HPMC, Respondent ordered that the patient be provided a staple remover kit. Respondent testified that he did not intend for the patient to remove the staples herself, that she was told to bring it to her follow up appointment with Respondent, and that Respondent, not the patient, removed the staples at his office.

82. Respondent's very sparse office progress notes, dated July 20, 2012 and August 24, 2012, were not legible. Apparently, the patient's staples were removed on July 20, 2012.

Facts Re: Patient CK aka KC

83. CK/KC was a 53-year-old woman who first visited Respondent's office on July 26, 2012, complaining of a large uterine myoma with severe anemia and bleeding.

Office Records for CK/KC

84. Respondent's handwritten office records for CK/KC were brief, contained mostly abbreviations, and were difficult to read. The findings below (Factual Findings 85 through 104) were derived by review of the records along with Respondent's uncontroverted testimony.

85. On July 26, 2012, Respondent performed a history and physical on CK/KC. According to the patient's medical records, her vitals were taken, and her weight (112 pounds) and blood pressure (140/81) were documented. Her medical history was also taken. She had given birth to two children, and her last menstrual period was earlier in July 2012. During menstruation, she experienced severe clotting and dysmennorhea.[11] Her last pap smear was in April 2012. She had no known allergies.

86. The patient had previously used Provera to attempt to control bleeding and iron pills to maintain her blood count. On April 20, 2012, she was admitted to Olive View Medical Center and diagnosed with abnormal endometrial bleeding, uterine fibroids, and iron

[11] Dysmennorhea is pain during menstruation.

deficiency anemia (hemoglobin at 6.0). She received two transfusions. She went to the emergency room on May 10, 2012 with bleeding and shortness of breath. An ultrasound revealed a large fibroid.

87. Respondent performed and documented a physical examination and a pelvic examination. On examination, Respondent noted a myoma comparable in size to a 16 week pregnancy. Respondent's assessment was that the patient had a large fibroid with severe anemia and bleeding.

88(a). Respondent and CK/KC discussed treatment options and Respondent went through his customary informed consent discussion. He discussed the pros and cons of surgery versus non-surgical alternatives. They discussed continuing the Prover and iron pills and waiting until the patient reached menopause to see if she experienced less pain and bleeding. They also discussed a TAH, with or without a bilateral salpino oophorectomy. Respondent then allowed the patient to decide what option she wished to select.

88(b). This discussion was partially documented in the office medical record.

89. Respondent's plan for treatment included conducting a pap smear, which the patient refused, and an ultrasound and obtaining hemoglobin and CA-125 cancer marker blood testing. The ultrasound, taken July 26, 2012, showed myomas ranging from 3.17 to 4.6 centimeters.

90. The patient's surgery was scheduled for the following week. However, the following day, July 27, 2012, the patient was admitted to the HPMC emergency room with severe bleeding.

Hospital Records for CK/KC

91(a). On July 29, 2012, Respondent filled out a form provided by HPMC on which he documented an abbreviated history and physical noting only a very small portion of the information he obtained during his evaluation of HC at his office on July 26, 2012.

91(b). In itself, the cursory and mostly illegible chart note was inadequate.

91(c). Respondent did not provide a copy of his July 26, 2012 office history and physical note for inclusion in the HPMC medical records.

92. On July 28, 2012, CK/KC signed HPMC forms entitled "Hysterectomy Informed Consent" acknowledging the resulting sterilization (Exhibit 9, p. 517), "Consent for Blood or Component Transfusion" (*Id.* at p. 518), and "Consent to Surgery / Special Procedures / Anesthesia)" (*Id.* at pp. 519-520). Regarding the consent for transfusion,

Respondent explained that she would not likely lose blood, but in case of excessive bleeding, this consent is needed. The Consent for Blood or Component Transfusion included a statement: "The possible risks and consequences associated with transfusion have been explained to me. I understand that these risks may include: . . . transmission of infectious diseases such as hepatitis." (*Id.* at p. 518.)

93. As required by HPMC, Respondent brought the consent for surgery form to the patient's bedside with the nurse standing by, and he again conducted an informed consent discussion of the risks and benefits of the surgery to allow the patient to change her mind.

94. The consent for surgery form contained a typewritten statement: "Your physicians and surgeons have recommended the following operation or procedure." (Exhibit 9, p. 519.) That typewritten statement was followed by a blank lined section in which the following was handwritten: "hysterectomy." (*Ibid.*) Just below the handwritten name of the procedure were the typewritten words "Lay terminology" (*Ibid.*), followed by another blank lined section. Nothing was handwritten in that section. The consent form also contained a typewritten statement: "Your signature to this form indicates that (a) you have read and understand the information provided in this form, (b) the operation or procedure set forth above has been adequately explained to you by your physician, (c) you have had a chance to ask questions, (d) you have received all the information you desire concerning the operation or procedure and anesthesia, and (e) you authorize and consent to the performance of the operation or procedure and/or administration of anesthesia." (*Id.* at p. 520.)

95. On July 29, 2012, at approximately 1:55 p.m., Respondent performed a TAH on CK/KC. The peritoneum was closed with a Vicryl suture, and the skin was closed with staples.

96. Respondent's physician progress notes in the hospital record from July 28, 29 and 30, 2012 were cursory and illegible. (Exhibit 9, pp. 536-537.)

97(a). On July 28, 2012, at 6:05 p.m., CK/KC's hemoglobin prior to surgery was measured at 11.0. On July 29, 2012, post-operatively it was 9.1 at 3:35 p.m. This was low, in light of the reference range of 12-15g/dL.

97(b). On July 29, 2012, the patient received blood transfusions at 4:15 p.m. (one unit) and at 20:15 p.m. (two units).

97(c). On July 30, 2012, CK/KC's hemoglobin was 11.9 at 5:40 a.m. and 11.6 at 2:55 p.m.

98. CK/KC was discharged in stable condition on July 30, 2012.

99(a). On July30, 2012, as was his custom and practice, Respondent explained his discharge instructions to the patient, and she indicated she understood.

99(b). Their discussion was not documented in the hospital medical record.

100. The patient was also given written discharge instructions.

101. As was his custom and practice after major surgery, with the potential for infection, the patient was given a written prescription for Cipro and instructed to call Respondent if she had any fever or redness, and at that point, Respondent "would tell [her]" what to do with the paper [prescription]" (Respondent's testimony). According to Respondent, if he determined from their telephone discussion that the patient had signs of infection, he would tell her to fill the prescription right away. However, the prescription was not to be filled until the patient spoke to Respondent.

Follow-up Office Records for CK/KC

102. Prior to CK/KC's discharge from HPMC, Respondent ordered that the patient be provided a staple remover kit. Respondent testified that he did not intend for the patient to remove the staples herself, that she was told to bring it to her follow up appointment with Respondent, and that Respondent, not the patient, removed the staples at his office.

103. Respondent's very sparse office progress notes, dated August 4 and August 28, 2012, were not legible. Apparently, the patient's staples were removed on August 4, 2012.

Facts Re: Patient MC

104. MC was a 57-year-old woman who first visited Respondent's office on October 2, 2012, complaining of a large uterine myoma with severe bleeding.

Office Records for MC

105. Respondent's handwritten office records for MC were brief, contained mostly abbreviations, and were difficult to read. The findings below (Factual Findings 106 through 125) were derived by review of the records along with Respondent's uncontroverted testimony.

106. On October 2, 2012, Respondent performed a history and physical on MC. According to the patient's medical records, her vitals were taken, and her weight (120 pounds) and blood pressure (151/99) were documented. Her medical history was also taken. Her last menstrual period was September 30, 2012, and her last pap smear was in 2002. She had no known allergies.

107. Respondent performed and documented a physical examination and a pelvic examination. On examination, Respondent noted a myoma comparable in size to a 22 week pregnancy. Respondent's assessment was that the patient had a large fibroid which had gotten "bigger." (Exhibit 20, p. 9.)

108(a).Respondent and discussed treatment options and Respondent went through his customary informed consent discussion. He discussed the pros and cons of surgery versus non-surgical alternatives. They discussed a TAH, with or without a bilateral salpino oophorectomy. Respondent then allowed the patient to decide what option she wished to select. The patient chose exploratory laparotomy to determine the pathology first, and then would select the best treatment option.

108(b). This discussion was partially documented in the office medical record.

108(c).Respondent testified that they also discussed the patient seeing an oncologist immediately or later, and she wanted to determine the pathology first. This discussion was not documented in the office medical record.

109. Respondent's plan for treatment included conducting a pap smear and an ultrasound and obtaining hemoglobin and CA-125 cancer marker blood testing. The pap smear results were mildly abnormal (atypical squamous cells of undetermined significance), and the ultrasound showed myomas ranging from 11.6 to 10.3 centimeters. The cancer marker was 427.4, which was quite high given the reference range of less than 30.2.

Hospital Records for MC

110(a). On October 12, 2012, Respondent filled out a form provided by HPMC on which he documented an abbreviated history and physical noting only a very small portion of the information he obtained during his evaluation of HC at his office on October 2, 2012.

110(b). In itself, the cursory and mostly illegible chart note was inadequate.

110(c). Respondent did not provide a copy of his October 2, 2012 office history and physical note for inclusion in the HPMC medical records.

111. On July 28, 2012, MC signed HPMC forms entitled "Hysterectomy Informed Consent" acknowledging the resulting sterilization (Exhibit 6, p. 643), "Consent for Blood or Component Transfusion" (*Id.* at p. 644), and "Consent to Surgery / Special Procedures / Anesthesia)" (*Id.* at pp. 641-642). Regarding the consent for transfusion, Respondent explained that she would not likely lose blood, but in case of excessive bleeding, this consent is needed. The Consent for Blood or Component Transfusion included a statement: "The possible risks and consequences associated with transfusion have been explained to me. I

understand that these risks may include: . . . transmission of infectious diseases such as hepatitis." (*Id.* at p. 644.)

112. As required by HPMC, Respondent brought the consent for surgery form to the patient's bedside with the nurse standing by, and he again conducted an informed consent discussion of the risks and benefits of the surgery to allow the patient to change her mind.

113. The consent for surgery form contained a typewritten statement: "Your physicians and surgeons have recommended the following operation or procedure." (Exhibit 6, p. 642.) That typewritten statement was followed by a blank lined section in which the following was handwritten: "total abdominal hysterectomy. Possible biopsy and removal of ovarian tumor." (*Ibid.*) Just below the handwritten name of the procedure were the typewritten words "Lay terminology" (*Ibid.*), followed by another blank lined section. Nothing was handwritten in that section. The consent form also contained a typewritten statement: "Your signature to this form indicates that (a) you have read and understand the information provided in this form, (b) the operation or procedure set forth above has been adequately explained to you by your physician, (c) you have had a chance to ask questions, (d) you have received all the information you desire concerning the operation or procedure and anesthesia, and (e) you authorize and consent to the performance of the operation or procedure and/or administration of anesthesia." (*Id.* at p. 641.)

114(a).On October 12, 2012, at approximately 1:05 p.m., Respondent performed an extensive operative procedure, including a TAH and right salpingo oophorectomy, appendectomy, excision of tumors, and omentectomy[12] on MC. According to Respondent's operative report:

> [When the peritoneum was opened,] immediately there was cauliflower-looking cancer tumor was protruding through the peritoneal incision. . . . [When he] eventually saw the pelvic cavity, [the] uterus was enlarged with 12 weeks large with [a] fungating mass on the fundus. It looked like the tumor was perforated and ruptured already, but there was no active bleeding in that area [other than] bleeding from the right adnexa. . . . Right side tumor was removed by hand . . . [The] tumor was embedded around the ovary; therefore, the right salpingo-oophorectomy was attempted and there was bleeding. . . . [S]upracervical hysterectomy was done. . . . Another tumor was attached to the right side, which eventually attached to appendix. . . . [and the] specimen was removed as appendectomy. Omentum also had multiple tumors, so . . . [Respondent] excised all the tumors. . . . Blood was transfused because

[12] The omentum is an apron of fatty tissue which forms part of the lining of the abdominal cavity. An omentectomy is the excision of all or part of the omentum.

> of hypotensive with 80 systolic and blood loss was about 1000 mL. . . .
> [A JP drain was placed.
> The peritoneum was closed with a Vicryl suture, and the skin was closed with staples.]

(Exhibit 6, pp. 658-659.)

114(b). The operation concluded at 2:35 p.m., and the anesthesia administration ended at 3:30 p.m. Due to the patient's low blood pressure during surgery, the anesthesiologist and Respondent agreed that MC should go to the Intensive Care Unit (ICU) post-operatively, so that she would have one-to-one care and would have her blood pressure monitored hourly. The operative report noted that the anesthesiologist "will watch the patient in ICU overnight." (Exhibit 6, p.659.)

115. At the administrative hearing, Respondent recalled the operation, noting that he had confirmed a uterine cancer diagnosis after observing that the cancer had ruptured the uterus and spread to the omentum and peritoneum. Respondent recalled collecting fluid and sending it to cytology STAT to check for malignant cells. He also sent the omentum to pathology. Pathology identified adenocarcinoma and the presence of malignant cells.

116. Respondent's physician progress notes in the hospital record from October 13, 14 and 15, 2012 were cursory and illegible. (Exhibit 6, pp. 662 and 660.)

117(a). On October 12, 2012, at 3:15 p.m., MC's hemoglobin was measured at 9.2. This was low, in light of the reference range of 12-15g/dL.

117(b). On October 12, 2012, the patient received blood transfusions at 4:50 p.m. (two units) and at 10:15 p.m. (two units).

117(c). After post-operative transfusions, MC's hemoglobin stabilized and was at 13.6 (October 13, 2012, at 8:00 a.m.), 12.8 (October 13, 2012, at 4:30 p.m.), 12.3 (October 14, 2012, at 6:05 a.m.) and 12.4 at (October 15, 2012, at 6:30 a.m.).

118. During the course of the patient's post-operative hospitalization, the nurses documented the production from the JP drain and contacted Respondent to inform him of JP drainage amount and color. (E.g., Exhibit 6, p. 827.) The drainage decreased with time.

119. On October 12, 2012, at 3:15 p.m., MC's white blood cell (WBC) count was measured at 12.4. This was high, in light of the reference range of 4.8-10.8 K/uL. By October 14 and 15, 2012, her WBC rose to 13. (On October 13, 2012, at 8:00 a.m., it was 12.9; on October 14, 2012, at 6:05 a.m., it was 13.8; and on October 15, 2012, at 6:30 a.m., it was 13.4.)

120(a). On October 14, 2012, at 8:12 a.m., a nursing note indicated that MC had bowel sounds present and had a bowel movement on that date. (Exhibit 6, pp. 829 and 886.)

120(b). According to an October 14, 2012 abdominal x-ray report, MC was experiencing abdominal distention, and the findings from the x-ray were "mild to moderate dilation of the small and large bowel loops indicating postop ileus,"[13] and "gaseous dilation of the stomach." (Exhibit 6, p. 762.)

120(c). On October 14, 2012, a 11:30 p.m., the patient "vomited greenish vomitus." (Exhibit 6, p. 838.) According to the nursing notes, on October 15, 2012 at midnight, the nurse "called Dr. Banks to inform him that patient vomited greenish vomitus 400 cc in amount. Patient refused Zofran IV. No order given." (*Ibid.*) At 3:37 a.m., the nursing notes stated, "no vomiting, no nausea, no pain." (*Ibid.*)

120(d). On October 15, 2012, at 7:21 a.m., a nursing note indicted "no bowel movement post op no bowel sounds." (Exhibit 6, p. 840.) This was contrary to the October 14, 2012 nursing note. Another nursing note on October 15, 2012 at 7:21 a.m. indicated, "Physician aware of post op ileus." (Exhibit 6, p. 898.)

120(e). An October 15, 2012 x-ray report noted that MC was experiencing abdominal pain. The report indicated the following findings: "Mildly dilated loops of colon are seen. Air-filled loops of small bowel are seen as well, not significantly dilated. Air-fluid levels are seen within both the small and large bowel loops. Findings are more consistent with benign postoperative ileus. No definite obstruction is seen." (Exhibit 6, p. 763.)

121. MC was discharged on October 15, 2012 at 5:26 p.m.

122. At the administrative hearing, Respondent explained why the patient was discharged despite the finding consistent with benign postoperative ileus. He noted that ileus is decreased peristalsis, and that it was benign. The October 15, 2012 x-ray was taken because MC had vomited but she improved and was discharged in stable condition.

123(a). Respondent's discharge instructions, including disposal of JP drain contents, were explained to the patient, and she indicated she understood.

123(b). This discussion was partially documented in the hospital medical record in the nursing notes (Exhibit 6, p. 899) and in Respondent's discharge summary, which stated, "Follow-up: Appointment within one week. Instruction was given for the emptying of

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[13] An ileus is the inability of the intestine to contract normally and move waste out of the body. This can lead to buildup and potential intestinal obstruction.

Jackson-Pratt and the patient will be followed up in my office with the pathology." (Exhibit 6, p. 638.)

Follow-up Office Records for MC

124. Prior to CK/KC's discharge from HPMC, Respondent ordered that the patient be provided a staple remover kit. Respondent testified that he did not intend for the patient to remove the staples herself, that she was told to bring it to her follow up appointment with Respondent, and that Respondent, not the patient, removed the staples at his office.

125. Respondent's very sparse office progress notes, dated October 20 and December 17, 2012, were mostly illegible. At the administrative hearing, Respondent clarified his notes, confirming that the patient was "doing well" and had experienced bowel movements daily. The patient's staples were removed on October 20, 2012. Respondent sent MC's records to an oncologist for follow up on January 2, 2013.

The Experts – Standard of Care

126. Complainant offered the testimony of Steven Freedman, M.D., to establish the standard of care in this case. Dr. Freedman received his medical degree from Eastern Virginia Medical School in 1978. He completed an Ob-Gyn residency in 1982 at Western Pennsylvania Hospital and is board certified in Ob-Gyn. Dr. Freedman is licensed to practice medicine in California and has been a medical expert reviewer for the Board since 2010.

127. Respondent offered the testimony of Howard Mandel, M.D., to establish the standard of care in this case. Dr. Mandel received his medical degree from New York University in 1981. He completed an Ob-Gyn residency at Cedars Sinai Medical Center in 1984 and is board certified in Ob-Gyn. Dr. Mandel is licensed to practice medicine in California. He has operated a private practice in Ob-Gyn since 1985.

128. Drs. Freedman and Mandel were equally qualified to testify as experts on the standard of care in this case. Any additional weight given to one expert's testimony over the other's was based on the content of their testimonies and bases for their opinions, as set forth more fully below.

129. Drs. Freedman and Mandel both agreed that surgery was indicated in all five cases and that Respondent's performance of the surgical procedures met the standard of care. Dr. Freedman agreed that that the medical treatment at HPMC rendered by Respondent fell within the standard of care with the exception of patient MC (addressed in greater detail below).

130. Prior to his expert review and preparation of an expert report, Dr. Freedman was provided with only HPMC's hospital records for the five patients and not with Respondent's office records for any of the patients. Respondent had provided the records to the Board at a later point, and Dr. Freedman reviewed them prior to the hearing. His opinions regarding the added information are addressed below.

Standard of Care – Admission History & Physical Documents (MK, JS, HC, CK/KC, & MC) and Preoperative Evaluations (MC and CK/KC)

131. In his expert report, Dr. Freedman noted the applicable standard of care for admission documentation as follows:

> The standard of care for admitting surgeons is to provide a history and physical for the patient. The history details the patient's chief complaint along with a history of the present illness. This would include the work-up of the problem with appropriate labs and radiologic studies. Previous surgical procedures must be documented. The relevant past medical history should be detailed. For gynecologic surgery previous pregnancies and female procedures must be described in detail. Differential diagnosis and treatment options are then discussed.

(Exhibit 13, p. 967.)

132. Dr. Freedman also noted the applicable standard of care for pre-operative evaluations was "to evaluate the problem with the pelvic exam and appropriate diagnostic studies." (Exhibit 13, p. 967.)

133. In his report and in his testimony at hearing, Dr. Freedman opined that these standards of care were not followed. Regarding the admission documentation, Dr. Freedman opined:

> In each case, very brief notes were written on a standardized form. These notes were not legible. They did not provide the information of SOAP[[14]]notations. No vital signs are listed. Laboratory findings and ultrasound results are not provided. There was minimal documentation of the physical exam and the pelvic exams, in particular, are absent. Diagnosis and treatment options were not provided.

(Exhibit 13, p. 967.)

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[14] SOAP is the formatting of history and physical documentation to address subjective information, objective findings, an assessment of the diagnoses, and a plan for treatment.

134. Dr. Freeman correctly noted that there was virtually no evidence in the hospital charts that an appropriate evaluation had been performed.

135. Dr. Freedman pointed out that, in the hospital history and physical for each patient, there were no vital signs, which should be included even if a nurse is documenting it somewhere else in the medical record. He noted that the pelvic examinations were not detailed and there was no indication that any ultrasound was done. He explained that the reason for requiring such a pre-operative evaluation is that the surgeon should know what to expect before "entering the abdomen." Although using the SOAP format is not required, documenting SOAP information is essential to convey to other care providers what was found and to ensure proper patient care.

136. Dr. Freedman concluded that, "The routine failure to provide a history and physical that documents the information necessary to properly care for a patient undergoing surgery is an extreme departure from the [standard of care]." (Exhibit 13, p. 967.) He also opined that, since there was no evidence of preoperative pelvic examinations or testing in the hospital records, "The consistently inadequate pre-operative evaluations represents an extreme departure from the standard of care." (*Id.* at p. 968.)

137. After reviewing Respondent's additional office records, Dr. Freedman stated that his opinions had not changed. He noted that his opinion regarding whether Respondent met the standard of care "might have been mitigated by knowledge that the patient was referred by other physicians who prepared a history and physical, but this was not present in the hospital records." Dr. Freedman denied that it would be sufficient for the surgeon to include a note saying "review the history and physical of the general practitioner." Rather, the admitting surgeon would "still need expand on" the gynecological issues. Dr. Freedman did not address whether it would be sufficient for a gynecological surgeon to refer to his own detailed history and physical conducted prior to hospital admission. When specifically reviewing Respondent's history and physical note from patient MK's initial office visit, Dr. Freedman acknowledged that he would "generously stat[e]" that it was "an adequate history and physical."

138. Despite reviewing Respondent's office records, Dr. Freedman remained critical of Respondent's lack of hospital documentation of preoperative ultrasounds. He noted that, regarding patients MC and CK/KC, there were no records provided regarding any ultrasound being conducted, and "the fact that [the ultrasounds] were not done constituted departures from the standard of care," an extreme departure for MC, and a simple departure for CK/KC. The assertion that ultrasounds "were not done" was without merit since the evidence established that ultrasounds were performed on both MC and CK/KC.

139. Dr. Freedman later admitted that in Respondent's office records "in a few cases there was reference to ultrasound examination." However, he then noted that the ultrasound

report "was not provided" in the hospital records, and this was a departure from the standard of care. When asked if the failure to send the ultrasound reports to hospital was an extreme departure from the standard of care, he answered "no." Given the foregoing, Dr. Freedman's ultimate opinion was unclear regarding the alleged inadequacy of Respondent's preoperative evaluations of MC and CK/KC.

140. Dr. Mandel credibly opined that the office histories and physicals and preoperative workups for all five patients were appropriate and within the standard of care.

141. In this case, Respondent conducted appropriate history and physicals and preoperative examinations, including pelvic examinations and ultrasound testing, at his office. His lapse was failing to provide adequate documentation of his history and physicals and preoperative valuations and testing in the hospital records. This may have been as simple as including a copy of his office preoperative history and physicals in the hospital records. Respondent's inadequate documentation in the hospital records constitutes a failure to maintain adequate records (see Factual Finding 181). However, Dr. Freedman did not explain how five separate instances of inadequate documentation in the hospital records can be transformed into combined gross negligence.[15] Consequently, Complainant did not establish, by clear and convincing evidence, that Respondent's inadequate documentation cumulatively rose to the level of gross negligence.

142. Regarding the Respondent's preoperative evaluation and the history and physical for each of his patients, the opinions of Dr. Mandel were more persuasive than those of Dr. Freedman. Therefore, the opinions of Dr. Mandel, set forth in Factual Finding 140, are adopted as facts herein.

Standard of Care – Informed Consent (Patients MK, JS, HC, CK/KC, and MC)

143. Informed consent is the process of a physician explaining to the patient the risks and benefits of a procedure and any alternative treatments available. This enables the patient to make an educated decision about how to proceed with her treatment. Informed consent is required for every surgical patient, and the physician must document that the information was conveyed.

144(a). According to Dr. Freedman, informed consent for surgery is given three times. First, the physician must obtain informed consent in the office by explaining the procedures to the patient and have her sign consent documents. The patient is then "given informed consent again" at the hospital by nursing staff with written advice by the physician. Informed consent

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[15] Gross negligence is defined as "the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196-197.)

is "then taken a third time in the surgical suite" by physicians. Dr. Freedman noted that physicians and hospitals have their own separate requirements for obtaining informed consent.

144(b). Dr. Freedman acknowledged that each of the five patient's hospital records contained signed "hospital-type informed consent forms" which "described the surgery in medical terms." However, he maintained that these forms "did not document discussions that may or may not have been had with the physician regarding the risks, benefits, and alternatives." Given that the patients' signed surgery consents included a statement that "the operation or procedure set forth above has been adequately explained to you by your physician," Dr. Freedman conceded that the "standardized hospital form implies" that the informed consent discussion had occurred. However, he insisted that there was no evidence that the alternatives, risks and benefits had been explained to the patient in lay terminology. He contended that the reason the hospital's informed consent form contained a section for "lay terminology" was so that the "patient understands and does not rely on the nurse to translate medical jargon." Dr. Freedman opined that Respondent's informed consent was inadequate because there was a lack of lay terminology on the consent form and a lack of a Korean language translator. He concluded that the standard of care for informed consent was not met, which constituted simple departures from the standard of care.

144(c).Dr. Freedman was apparently unaware that Respondent had engaged in informed consent discussions in Korean and had used layman terms when at the patients' initial office visits, likely because these discussions were either not documented in the patients' office records (MK, JS, and HC) or only partially documented in the patients' office records (CK/KC and MC).

145. Dr. Mandel testified that informed consent, by definition, is a process, not a document. However, the process of informed consent must be documented. Dr. Mandel noted that Respondent obtained informed consent from his patients in his office and in the hospital, and the HPMC consent forms described the procedures and confirmed that the patients' informed consent was given. The HPMC consent forms are similar to forms customarily used in California hospitals and are adequate documentation of informed consent given by the patients for surgical procedures. Dr. Mandel opined that no additional information is required to demonstrate the patients gave informed consent. Dr. Mandel concluded that Respondent met the standard of care for obtaining the patients' informed consent.

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146. Regarding the Respondent's process of obtaining the patients' informed consent, the opinions of Dr. Mandel were more persuasive than those of Dr. Freedman. Therefore, the opinions of Dr. Mandel, set forth in Factual Finding 145, are adopted as facts herein. Consequently, Complainant did not establish, but clear and convincing evidence, that Respondent's process of obtaining the patients' informed consent constituted acts of simple negligence.

147. Although Dr. Mandel's credible testimony established that Respondent's process of obtaining informed consent was within the standard of care, Respondent's failure to adequately document this process in the patients' office records constitutes a failure to maintain adequate records (see Factual Finding 181).

Standard of Care – Cipro Prescriptions (Patients MK, JS, HC, and CK/KC)

148(a). In his expert report, Dr. Freedman noted the applicable standard of care for prescribing antibiotics "is to prescribe antibiotics as treatment for a medical condition. The choice of medication, its dosage, and the duration of treatment are dictated by the nature and severity of the condition being treated." (Exhibit 13, p. 969.)

148(b). Dr. Freedman criticized Respondent's practice of giving post-op patients Cipro prescriptions, noting: "There is no documentation of an infection or other condition which would warrant the use of a strong antibiotic for an extended period of time. This method of prescribing antibiotics creates resistant bacteria as well as possibly masking post-op infections/complications." (Exhibit 13, p. 969.) He opined that the "inappropriate prescription of antibiotics reflects a lack of medical knowledge and is a simple departure from the [standard of care]." (*Ibid.*)

148(c). Dr. Freedman's opinions were based on the assumption that Respondent's patients were filling and taking the prescribed Cipro. Dr. Freedman was unaware Respondent had instructed his patients to contact him before filling the Cipro prescriptions. This misunderstanding apparently arose because Respondent failed to document the directions he had given his patients.

149. Dr. Mandel noted that each of the patients was given a written prescription for Cipro to have filled if necessary. He credibly opined that this was appropriate and within the standard of care. Dr. Mandel pointed out that patients who have in-dwelling catheters and undergo radical pelvic surgery, such as those involved in this case, have a high incidence of urinary tract infection. Dr. Mandel testified that it is not uncommon for a physician to preemptively give such patients a written prescription to be filled as needed to save the physician from having to later call in the prescription and to ensure a patient's prompt access to antibiotics.

150. Regarding the Respondent's Cipro prescriptions, the opinions of Dr. Mandel were more persuasive than those of Dr. Freedman. Therefore, the opinions of Dr. Mandel, set forth in Factual Finding 149, are adopted as facts herein. Consequently, Complainant did not establish, but clear and convincing evidence, that Respondent's Cipro prescriptions constituted acts of simple negligence.

151. Although Dr. Mandel's credible testimony established that Respondent's Cipro prescriptions, with instructions for possible filling if necessary, were within the standard of care, Respondent's failure to adequately document this plan to have the patients fill the prescriptions only if necessary constitutes a failure to maintain adequate records (see Factual Finding 181).

Standard of Care – J.P. Drain (Patient JS)

152(a). Dr. Freedman noted that the purpose of a JP drain "is to drain blood or accumulating serosanguinous fluid[,] the amount of which must be quantified, noted and followed carefully." (Exhibit 13, p. 969.) Dr. Freedman stated that the applicable standard of care after placement of JP drains requires "documentation of their clinical course." (Exhibit 13, p. 969.)

152(b). Dr. Freedman opined that the "failure to document the production of the [JP drain] or its removal represents a simple departure from the [standard of care]." (*Ibid.*)

153. Dr. Freedman testified that he looked carefully through JS's entire hospital chart for documentation of drainage from the JP drain and he could not find any. This assertion was incorrect. As found in JS's hospital chart, the nurses documented the production from the JP drain. When this documentation was pointed out, Dr. Freedman then clarified, "I meant that at the time of discharge" the standard of care requires the physician to document the presence of the drain, the final drainage level, color and consistency, and the plan for its removal. He maintained that although the nursing notes reported the drainage levels, he did not see that in Respondent's report. This criticism of lack of documentation in Respondent's discharge report is quite different from Dr. Freedman's initial criticism that that there was no documentation of the drainage from the JP drain. Additionally, Dr. Freedman was aware that Respondent removed the JP drain at the patient's first post-operative visit and documented that removal.

154. Dr. Mandel pointed out that the nursing notes documented the production from the JP drain, which was markedly decreasing every day as expected. It is customary for the nursing staff to monitor and document this information in the hospital record, and the physician can look at the nursing notes to see the JP drain production. Consequently, there was documentation of the JP drain production in the hospital records. Discharge of JS after the production had declined to 35 was appropriate. Thereafter, Respondent documented the removal of the JP drain in his office notes, which was appropriate.

155. Regarding the Respondent's follow-up on the JP drain, the opinions of Dr. Mandel were more persuasive than those of Dr. Freedman. Therefore, the opinions of Dr. Mandel, set forth in Factual Finding 154, are adopted as facts herein. Consequently, Complainant did not establish, but clear and convincing evidence, that Respondent's follow up on the JP drain constituted simple negligence.

156. Although Dr. Mandel's credible testimony established that Respondent's follow-up on the JP drain was within the standard of care, Respondent's failure to adequately document in the hospital records that the JP drain was left in at the patient's discharge constitutes a failure to maintain adequate records (see Factual Finding 181).

Standard of Care – Transfusions (Patients CK/KC and MC)

157. In his expert report, Dr. Freedman addressed the standard of care for blood transfusions as follows:

> The [standard of care] is to transfuse patients whose recovery depends on it. Blood transfusion requires informed consent, including the risk of hepatitis, in addition to immunologically mediated reactions.
>
> [T]he average patient will remain asymptomatic until Hb levels fall to 6-8 mg., easily tolerating a 500 cc blood loss. Transfusion is recommended for a falling Hb of less than 8 or symptomatic anemia. Symptoms include orthostatic changes, tachycardia, or not responding to fluid therapy. . . . [¶] . . . [¶]
>
> Transfusions of blood products risk incompatibility reactions along with immunologic reactions. The process itself puts the patient at risk for Hepatitis.

(Exhibit 13, pp. 970-971.)

158. Dr. Freedman noted that blood transfusion is an invasive procedure with its own risks, and therefore requires informed consent. Dr. Freedman asserted that such informed consent was not documented, testifying that he could find no informed consent for blood transfusion in the patients' hospital charts. This assertion was not borne out by the evidence, since all five patients' hospital records contained signed informed consents for blood transfusion. Freedman later acknowledged that he had not seen the informed consent forms when he reviewed the patients' records. He admitted that his testimony about patients not receiving informed consent for blood transfusion was inaccurate.

159(a). Dr. Freedman's report criticized Respondent's use of blood transfusion for patient MC, stating:

> Intraoperative drops in blood pressure, as seen in [MC] are treated with fluids or medical support. Transfusion is not recommended as treatment for asymptomatic patients with [hemoglobin (Hb)] of 8-10. . . . [MC's] first documented Hb was 11.0 after receiving 3 units of packed cells pre-operatively. She was again transfused with 2 units when her Hb fell to 9.1. Hemoglobin levels have been shown to rise almost 1 mg for every unit transfused.

(Exhibit 13, pp. 970-971)

159(b). Based on the facts set forth in his report, Dr. Freedman was apparently leveling his criticism at Respondent's care of CK/KC, not MC. This is clarified in the Accusation (p.8, paras. 13T, and 13U, and p. 11, para. 15D), which correctly notes that CK/KC was the patient whose first documented Hb was 11.0 but fell to 9.1 after which she received two transfusions. (See Factual Finding 97.)

159(c). In his report, Dr. Freedman also noted that patient MK "was transfused twice to achieve a Hb of 12.5." (Exhibit 13, p. 971.) This was incorrect, since patient MK never received any blood transfusions. Dr. Freedman apparently meant patient MC, who received two transfusions, with an ultimate Hb level of 12.4. (See Factual Finding 117.)

159(d). Addressing both of the patients' transfusions, Dr. Freedman opined, "Theoretically these patients were transfused with 2 or more units [than] they required. [JS] on the other hand was noted to have a Hb falling to 7.3. There was no evidence that she was transfused." (Exhibit 13, p. 971.) This comparative analysis of Respondent transfusing two patients, but not JS, was confusing. It was unclear whether Dr. Freedman was attempting to support his criticism of MC's and CK/KC's transfusions by pointing out that a patient with a lower hemoglobin had not received transfusion, or whether Dr. Freedman was criticizing the failure to transfuse patient JS, or both. In any event, Dr. Freedman's comparative analysis is not persuasive since the determination of whether Respondent met the standard of care should be based on the presentation of each individual patient.

160. Dr. Freedman testified that, due to the risks involved, physicians try not to give transfusions unless patient wellbeing requires it. In his opinion, a patient would require transfusion when her hemoglobin falls to a range between 6 to 8. However, as noted in Dr. Freedman's report, transfusion is not recommended for asymptomatic patients with an Hb between 8 to 10. Consequently, Dr. Freedman concluded that the transfusions for patient MC and CK/KC were unnecessary.

161. In his report, Dr. Freedman concluded, "There appears to be a lack of medical knowledge regarding the appropriate use of blood transfusions in surgical patients. Patients underwent excessive transfusions, which is a simple departure from the [standard of care]." (Exhibit 13, p. 971.)

162. Dr. Mandel credibly testified that the medical care Respondent rendered to patients MC and CK/KC, including the blood transfusions, were appropriate and within the standard of care. Dr. Mandal noted that there were minimal risks from transfusion for the two patients who would instead benefit, recover faster, and be discharged earlier. Dr. Mandel did not address Dr. Freedman's numerical cut-offs for transfusion (i.e., transfusion warranted for Hb between 6 to 8 without symptomology or between 8-10 with symptomology). Rather, Dr. Mandel discussed the two patients' specific circumstances and asserted that their transfusions were warranted for their wellbeing.

163. Regarding MC, Dr. Mandel noted that she had a "fairly aggressive cancer" with the involvement of several internal organs. Thus, maximizing the surgical ability to remove the cancer resulted in large amount of bleeding. Dr. Mandel opined that the transfusion of two units of blood for MC was reasonable and prudent, particularly given that the patient would require chemotherapy which would lower her blood count. According to Dr. Mandel, it is better for the transfusion to be given "sooner rather than later" to maximize the patient's blood count going into chemotherapy for "long term survival."

164. Regarding CK/KC, Dr. Mandal noted that patients commonly enter the recovery room having lost blood. The goal is to be preemptive to "avoid bad things from happening," so the additional transfusions after surgery were reasonable, particularly for a woman her age who was severely anemic and would benefit from transfusion.

165. Regarding the Respondent's administration of blood transfusions, the opinions of Dr. Mandel were equally as persuasive as those of Dr. Freedman. Consequently, Complainant did not establish, but clear and convincing evidence, that Respondent committed negligence or that he lacked medical knowledge regarding his administration of blood transfusions.

Standard of Care – Postoperative Care (Patients MK, JS, HC, CK/KC, and MC)

166. In his expert report and in his testimony, Dr. Freedman stated that the standard of care for post-operative care is to discharge patients "when their surgical condition has resolved or stabilized." (Exhibit 13, p. 970.) Dr. Freedman further noted that the patient's "clinical course must be documented," including notations regarding "diet, medications, activity, and plans for follow-up care." (*Ibid.*)

167. Dr. Freedman opined, "The pattern in which patients were discharged represents an extreme departure from the [standard] of care, as ongoing problems were not addressed or demonstrated to have resolved, with no documentation of follow-up plans." (Exhibit 13, p. 970.) Dr. Freedman expounded on this conclusion, stating:

> [MK] was discharged on day one [after] TAH on Cipro with no notation of follow-up care or mention of her staples.
> [JS] was discharged on day one even though she had a JP tube due to oozing without mention of a cessation of drainage or removal of the tube. Her Hb was 7.3 at the time of her discharge. There was no documentation regarding her staples or Rx with Cipro.
> [HC] was discharged on day one with staples in place and no follow-up notation.
> [CK/KC] was discharged on day one even though she required multiple transfusions.
> [MK] was discharged one day after her ICU admission even though she suffered from a post-op ileus, and a rising WBC with a left shift, indicating a probable ongoing infectious process.

(Exhibit 13, p. 970.)

168. Dr. Freedman testified that in each case, the patient was "discharged early," noting that the average hospital stay for a hysterectomy is three days. However, he also noted that "discharge on day one can be acceptable if the patient is stable on discharge and follow-up care has been arranged." As set forth in the Factual Findings above, and as discussed by Dr. Mandel below, each of the five patients was stable on discharge and follow-up care had been arranged (although not adequately documented).

169. Dr. Freedman's universal criticism for all five patients' postoperative care was that after undergoing major surgery, discharge "on day one may not be prudent," although it "may not be below the standard of care if there are no comorbid conditions." As set forth in the Factual Findings above, and as discussed by Dr. Mandel below, none of the five patients had any comorbid conditions that would weigh against their discharge, and their discharge was not below the standard of care.

170. Dr. Freedman opined that Respondent's postoperative care for each of the patients constituted simple negligence, and collectively constituted an extreme departure from the standard of care. Dr. Freedman did not expound on how the five instances of alleged simple negligence can be transformed into combined gross negligence. As discussed below, since no instances of simple negligence were established in any of the five patients' postoperative care, it follows that no combined gross negligence was established as well.

171. Regarding all five patients, the evidence established that Respondent explained his discharge instructions to his patients and they indicated they understood. The records indicated that the patients were given written discharge instructions. Prior to each patient's discharge from HPMC, Respondent ordered that the patient be provided a staple remover kit, which the patient was told to bring to her follow up appointment with Respondent. Respondent also provided them with written prescriptions for Cipro (standard of care for

which was addressed in Factual Findings 148 through 151). As noted above, Respondent failed to document in the hospital records his discharge discussion with patient, the plan for removal of the staples, and his instructions to the patient for possible filling of Cipro prescriptions.

172(a). Specifically regarding patient HC, Dr. Freedman noted in his report that HC was discharged on "day one." (Exhibit 13, p. 970.) Dr. Freedman later admitted that this assertion in his report was mistaken and contrary to the evidence which established that HC was admitted on July 12, 2012, and discharged on July 14, 2012 (i.e., day two).

172(b). Dr. Freedman further pointed out that HC was discharged with staples in place. However, he acknowledged, "that can be normal, but the issue is that lack of documentation."

173. Dr. Mandel testified credibly that the care Respondent provided HC during her hospitalization was within the standard of care, that the patient was given appropriate discharge instructions for follow-up, that she was stable for discharge, and that Respondent committed no negligence in his treatment of HC.

174. Specifically regarding patient MK, the analysis of the experts was virtually the same as for patient HC. (MK was discharged on day one rather than day two.) Dr. Mandel's credible testimony established that the care Respondent provided MK during her hospitalization was within the standard of care, that the patient was given appropriate discharge instructions for follow-up, that she was stable for discharge, and that Respondent committed no negligence in his treatment of MK.

175. Specifically regarding patient CK/KC, the analysis of the experts was virtually the same as for patients MK and HC, except for the analysis of the blood transfusions provided to CK/KC (addressed above in Factual Findings 157 through 165). Dr. Mandel's credible testimony established that the care Respondent provided CK/KC during her hospitalization was within the standard of care, that the patient was given appropriate discharge instructions for follow-up, that she was stable for discharge, and that Respondent committed no negligence in his treatment of CK/KC.

176(a). Specifically regarding patient JS, the analysis of the experts was virtually the same as for patients MK and HC, except for the analysis of the JP drain (addressed above in Factual Findings 152 through 156) and except for the added issue of the IUD noted by the pathologist. Dr. Freedman's criticism involves Respondent's failure to identify the presence of the IUD preoperatively, intra-operatively, and post-operatively. Dr. Freedman acknowledged that it is not typical for a 50-year-old woman to have an IUD, but "it does happen." He asserted that an IUD is ideally removed vaginally during an office visit. According to Dr. Freedman, the presence of an IUD should be noted preoperatively, since it is

"something which may have been responsible for the pain and bleeding." However, he also acknowledged that some IUDs contain progesterone to control bleeding, and that he did not know what type of IUD was identified by the pathologist. Dr. Freedman opined that, even if the string of the IUD was not visible during pre-operative pelvic examination, "it would easily be identified on ultrasound." Dr. Freedman opined that Respondent's failure to document the presence of the IUD was a simple departure from the standard of care.

176(b). Dr. Mandel credibly disagreed with Dr. Freedman's assertions. Dr. Mandel noted that the IUD was not readily visible in the pathology photograph of the materials removed during the surgery. Dr. Mandel pointed out that the IUD was encased within one of the removed masses and that he was able to see it only because he was told it was there. He noted that the masses were taking over the patient's pelvis and abdomen, so it is not surprising that the IUD was enveloped by the fibroids and not visible when removed during surgery. Given its presentation, the IUD could not have been removed pre-operatively in Respondent's office. Dr. Mandel also noted that when fibroids grow rapidly, they can steal blood flow from their "competitor" fibroids, causing one to "die" and its core to calcify. When viewed on an ultrasound, these calcium deposits will cause a "shadow effect." An IUD is purposefully made of a texture which will create the same shadow effect. Consequently, although an ultrasound was performed on JS, if she had an IUD enveloped by fibroids, it could have looked like the calcification in an old fibroid.

177. Dr. Mandel's credible testimony established that the care Respondent provided JS during her hospitalization was within the standard of care, that the patient was given appropriate discharge instructions for follow-up, that she was stable for discharge, and that Respondent committed no negligence in his treatment of JS.

178(a). Specifically regarding patient MC, the analysis of the experts was virtually the same as for patients MK and HC, except for the analysis of blood transfusions provided to MC (addressed above in Factual Findings 157 through 165) and except for the added issue of postoperative ileus.

178(b). Dr. Freedman noted in his report that "[MK] was discharged one day after her ICU admission even though she suffered from a post-op ileus, and a rising WBC with a left shift, indicating a probable ongoing infectious process." (Exhibit 13, p. 970.) Dr. Freedman acknowledged in his testimony that his report was mistaken, and that these fact pertained to patient MC. Additionally, the assertion that MC was discharged one day after ICU admission was contrary to the evidence which established that MC was admitted on October 12, 2012, and discharged on October 15, 2012 at 5:26 p.m.

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178(c). Dr. Freedman asserted that there was clinical suspicion of ileus confirmed by x-ray. He maintained that a patient's ileus should be resolved prior to discharge. Dr. Freedman acknowledged that ileus can resolve over the course of 12 to 24 hours and that resolution can occur by way of a bowel movement.

179(a). Dr. Mandel acknowledged that MC had a suspected ileus. However, he noted that the patient had a bowel movement and normal bowel sounds and was passing flatus on October 14, 2012. This indicates that the patient's intestinal system was working appropriately. A later ultrasound on October 15, 2012 noted "[f]indings are more consistent with benign postoperative ileus. No definite obstruction is seen." Dr. Mandel also noted that although the patient vomited once on the evening of October 14, 2012, the patient was offered Zofran, a powerful anti-nausea medicine, and she refused it. Nurses' notes later noted that the patient was no longer experiencing nausea.

179(b). Dr. Mandel's credible testimony established that the care Respondent provided MC during her hospitalization was within the standard of care, that the patient was given appropriate discharge instructions for follow-up, that she was stable for discharge, and that Respondent committed no negligence in his treatment of MC.

180. Complainant did not establish, by clear and convincing evidence, that Respondent committed negligence in his postoperative care of patients MK, JS, HC, CK/KC, and MC.

Failure to Maintain Adequate Records (Patients MK, JS, HC, CK/KC, and MC)

181. As noted above, Respondent's records were sparse and illegible. (Factual Findings 15, 19, 23, 25, 30, 33, 36, 37, 39, 42, 47, 53, 61, 66, 71, 76, 82, 88, 91, 96, 103, 105, 108, 110, 116, 125, 141, 147, 151, 156, and 172. This constituted a failure to maintain adequate records as required by Business and Professions Code section 2266.

Disciplinary Considerations - Respondent's Rehabilitation and Character Evidence

182. On August 15, 2017, respondent enrolled and paid to participate in the University of California San Diego, Physician Assessment and Clinical Education (PACE) Program, Medical Recordkeeping Course, which was scheduled to start on October 19, 2017.

183. Respondent has the support of numerous friends and colleagues who testified and submitted letters on his behalf. They collectively characterized him as a professional, caring, and dedicated physician.

LEGAL CONCLUSIONS

Causes for Discipline[16]

1. Cause does not exist to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (b), in that Complainant failed to establish, by clear and convincing evidence, that Respondent committed gross negligence in his care of patients MK, JS, HC, CK/KC, and MC, as set forth in Factual Findings 1 through 181.

2. Cause does not exist to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), in that Complainant failed to establish, by clear and convincing evidence, that Respondent committed repeated negligent acts in his care of patients in his care of patients MK, JS, HC, CK/KC, and MC, as set forth in Factual Findings 1 through 181.

3. Cause does not exist to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (d), in that Complainant failed to establish, by clear and convincing evidence, that Respondent demonstrated incompetence in his care of patients MK, JS, HC, CK/KC, and MC, as set forth in Factual Findings 1 through 181.

4. Cause exists to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code sections 2234, subdivision (a), and 2266, in that Respondent engaged in unprofessional conduct when he failed to maintain adequate records in his care of patients MK, JS, HC, CK/KC, and MC, as set forth in Factual Findings 1 through 181.

Analysis re: Level of Discipline

5(a). Complainant established that Respondent engaged in a failure to maintain accurate records by his sparse and illegible progress notes in his office records and hospital records, as well as his failure to sufficiently document his informed consent discussions and

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[16] The standard of proof which must be met to establish the charging allegations is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This means the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

his post-op follow-up plans. The remaining question is the nature of the discipline to be imposed against Respondent's certificate for his violations.

5(b). Business and Professions Code section 2229, provides, in pertinent part:

> (a) Protection of the public shall be the highest priority for the Division of Medical Quality, . . . and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.
>
> (b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, [or] the division, . . . shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee . . . .

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

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, . . . and who is found guilty, or who has entered into a stipulation for disciplinary action with the division, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the division.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the division.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the division.
>
> (4) Be publicly reprimanded by the division.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the division or an administrative law judge may deem proper.

5(d). The area of concern in this case involves Respondent's global deficiency in maintaining adequate records. Although he has retired from active medical practice, Respondent intends to continue volunteering as a medical missionary, and he may likely be required to generate patient medical records in that capacity. Respondent has already enrolled in the PACE medical recordkeeping course to remedy his recordkeeping deficiency. Given that protection of the public is the primary purpose of the Board, Respondent has

demonstrated his desire to work in conjunction with the Board on its paramount goal of patient safety.

5(e). In this case, cause for discipline exists, and the Board must acknowledge, to both the public and the medical community, that the acts and omissions of Respondent were not in compliance with the Business and Profession Code. In light of Respondent's 17-year history of licensure without prior discipline, his benevolent service as a medical missionary and his intent to continue that service, and his demonstrated willingness to improve his recordkeeping skills, a public reprimand with a required recordkeeping course will best protect the public without imposing overly harsh and punitive discipline on Respondent.

ORDERS

1. Respondent is hereby reprimanded within the meaning of Business and Professions Code section 2227, subdivision (a)(4).

2. Medical Record Keeping Course: Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in a medical record keeping course 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 months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education 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.

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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.

DATED: December 15, 2017

DocuSigned by:
Julie Cabos-Owen
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JULIE CABOS-OWEN
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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO October 14, 2016
BY [illegible] ANALYST

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

In the Matter of the Accusation Against: **Sangjoon Jay Lee, M.D.** **P.O. Box 76120** **Los Angeles, CA 90076** **Physician's and Surgeon's Certificate No. C 50371,** Respondent.	Case No. 800-2014-009361 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about March 3, 2000, the Board issued Physician's and Surgeon's Certificate Number C 50371 to Sangjoon Jay Lee, 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 November 30, 2017, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code 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, or such other action taken in relation to discipline as the Board 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:

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314

shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

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."

APPLICABLE STANDARD OF CARE

7. Regarding hospital admissions, the standard of care for admitting surgeons is to provide a history and physical for the patient. The history details the patient's chief complaint along with a history of the present illness. This would include the work-up of the problem with appropriate labs and radiologic studies. Previous surgical procedures must be documented. The relevant past medical history should be detailed. For gynecologic surgery, previous pregnancies and female procedures must be described in detail. Differential diagnosis and treatment options are then discussed.

8. Regarding blood transfusions, the standard of care is to transfuse patients whose recovery depends upon it. Blood transfusion requires informed consent, including the risk of hepatitis, in addition to immunologically mediated reactions.

9. Regarding pelvic region surgery, the standard of care requires a pelvic examination and appropriate diagnostic studies.

10. Regarding informed consent, the standard of care is to explain in layman's terms the risks and benefits, along with alternative treatments, of all possible surgical procedures. The informed consent must be documented.

11. Regarding the prescribing of antibiotics and, in particular, Cipro, the standard of care requires prescribing antibiotics as treatment for certain medical conditions. However, the choice of medication, its dosage, and the duration of treatment are dictated by the nature and severity of the condition being treated.

12. Regarding postoperative care for surgical interventions, the standard of care requires follow-up and documentation of the patients' clinical course. The standard of care is is to discharge post-op patients with no current co-morbid problems, when their surgical condition has resolved or stabilized. The clinical course must be documented. Discharge is accompanied by the notation of diet, medications, activity, and plans for follow-up care.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

13. Respondent Sangjoon Jay Lee, M.D. is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that he committed gross negligence during his care, treatment and management of five patients: M.K., J.S., H.C., K.C., and M.C.,[1] as follows:

A. Hollywood Presbyterian Medical Center (HPMC) initiated peer review proceedings involving Respondent, an obstetrician and gynecologist, and 10 female patients, including M.K., J.S., H.C., K.C., and M.C. On October 14, 2014, Respondent resigned during the course of the investigation. Thereafter, on October 30, 2014, HPMC filed a report with the Medical Board of California (Board), pursuant to Business and Professions section 805.

B. Representatives of the Board contacted Respondent and asked that he submit to an interview to discuss his care, treatment and management of Patients M.K., J.S., H.C., K.C., and M.C. Respondent declined. Certified medical records for the Patient M.K., J.S., H.C., K.C., and M.C. were obtained and reviewed.

Patient M.K.

C. M.K. was a 52-year-old who complained of painful fibroids and dyspareunia[2]

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[1] In order to protect their privacy rights, all patient references are by initials only. The true names of the patient are known to Respondent and will be provided to Respondent pursuant to his timely request for discovery.

[2] Dyspareunia is persistent or recurrent genital pain that occurs just before, during or after intercourse.

related to a scarred perineum. She underwent a hysterectomy and a "reverse cosmetic perineorrhaphy.[3]" She was discharged , on day one, on Cipro and analgesics. Pathology revealed a benign leiomyoma.

Patient J.S.

D. J.S. was a 50-year-old who underwent multiple myomectomies, the surgical removal of fibroids from the uterus. A Jackson-Pratt drain[4] was inserted due to oozing. Pathology revealed 27 benign fibroids as well as an intrauterine device (IUD). She was discharged, on day one, on analgesics and Cipro, with a hemoglobin of 7.3.

Patient H.C.

E. H.C. was a 40-year-old primapara who underwent removal of an 8 cm fibroid. Pathology was benign. She was discharged, on day one, with staples in place.

Patient K.C.

F. K.C. was a 53-year-old, who was admitted for bleeding and was transfused three units of blood. K.C. was taken for total abdominal hysterectomy [TAH]. During that procedure, she received another transfusion of blood. The patient's post operative hemoglobin was 11.9. Patient K.C. was transfused twice to achieve a hemoglobin[5] level of 12.5. Pathology identified a 7 cm adenomyoma. K.C. was discharged on day one.

Patient M.C.

G. M.C. was a 57-year-old nullipara who was admitted for a large pelvic mass on October 12, 2012. M.C. gave consent for a TAH and right ovarian biopsy. A laparotomy was performed which showed a fungating mass extended through the base of the uterus

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[3] Perineorrhaphy includes plastic surgery procedures used to correct clinical conditions (damage, defect, deformity) of the vagina and the anus.

[4] A Jackson-Pratt Drain (also known as a JP Drain) is a closed-suction medical device that is commonly used as a post-operative drain for collecting bodily fluids from surgical sites. The device consists of an internal drain connected to a grenade-shaped bulb via plastic tubing

[5] Hemoglobin (sometimes abbreviated as Hb) is a complex protein found in red blood cells that contains an iron molecule. Its primary purposes are to carry oxygen from the lungs to the body tissues, exchange the oxygen for carbon dioxide, and return the carbon dioxide to the lungs and where it is exchanged for oxygen

(fundus); a mass surrounding the right ovary and involving the appendix; and, multiple tumors in the omentum. [6] She was twice transfused 2 units of packed red blood cells (PRBC) and admitted to the intensive care unit (ICU) for two days. Her Hb stabilized at about 12.5.[7] Her white count rose to 13 with a left shift. Patient M.C. experienced a postopeartive ileus which was documented by x-ray on October 14, 2012. Pathology identified an adenocarcinoma of unknown origin, with vascular involvement and positive washings. Patient M.C. was discharged on day three, even though nursing documented the patient had vomited 400 cc of green fluid and that "MD (is) aware of the post-op ileus."

Medical Records

H. In each of the five cases, Respondent had only brief notes written on a standardized form. The notes were illegible and did not provide the information of SOAP notations[8]. No vital signs are listed. Laboratory findings and ultrasound results are not provided. There was minimal documentation of the physical exam and the pelvic exams, In particular, are absent. Diagnosis and treatment options were not provided.

Care, Treatment and Management Rendered

I. Patient M.C. presented with a pelvic mass. Evaluation should have included a pelvic examination, including a pap smear[9] and pelvic ultrasound. The ultrasound findings may have warranted further examination with MRI, tumor markers, and endometrial biopsy. Patients, such as M.C., with large pelvic masses would routinely benefit from further evaluation by ultrasound and possible CT scan. However, Respondent did not perform an ultrasound or, in the alternative, failed to document that he did so.

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[6] The omentum as fatty tissue that insulates the abdominal organs.

[7] Hb is a protein in red blood cells that carries oxygen throughout the body.

[8] SOAP is an acronym for subjective, objective, assessment, and plan. SOAP is a method of documentation employed by health care providers to write out notes in a patient's chart.

[9] The PAP smear, also known as the Papanicolaou test named after the doctor who found that is was it could detect cervical cancer is a method of cervical screening used to detect potentially pre-cancerous and cancerous processes in the cervix (opening of the uterus or womb).

The history and physical must provide insight into the rate of growth of the mass, its consistency and contour, and any associated tenderness. Endometrial biopsy would evaluate abnormal bleeding and uterine masses prior to laparotomy. A menopausal woman with an expanding pelvic mass with or without vaginal bleeding, warrants a Gynecologic Oncology consultation.

J. Regarding Patient M.K., menorrhagia can be treated hormonally, then evaluated with biopsy prior to surgical intervention. In each case presented, it is essential to perform a pelvic ultrasound and its results documented and followed. Respondent, however, failed to do this or, in the alternative, failed to document that he had done so.

K. Regarding Patient J.S., her intrauterine device (IUD) was not mentioned--neither Its pre-op location nor its mode of removal, an important fact given that the patient had undergone an abdominal myomectomy. Respondent's failure to document the presence or absence of the IUD constitutes departure from the standard of care in vaginal removal could represent possible surgical contamination. Removal during the myomectomy would involve transection of the endometrial cavity and future fertility and treatment.

L. Regarding Patient C.K., Respondent failed to perform or, in the alternative, document any work-up of a large mass that was found to extend through the patient's uterus.

M. Respondent's discharge summaries state that post-op patients were routinely given analgesics and Cipro 500 mg B.I.D. x20. However, there is no documentation of an infection or other condition which would warrant the use of a strong antibiotic for an extended period of time. This method of prescribing antibiotics creates resistant bacteria as well as possibly masking post-op infections/complications.

N. Regarding Patient J.S., the purpose of the JP drain is to drain blood or accumulating serosanguinous fluid; the amount of which must be quantified, noted, and followed carefully. Respondent failed to do this or, in the alternative, failed to document that he had done so.

O. Regarding Patient M.K., she was discharged on day one s/p TAH on Cipro with no notation of follow-up care or mention of her staples.

P. Regarding Patient J.S., she was discharged on day one even though she had a J.P. tube due to oozing without mention of a cessation of drainage or removal of the tube. Her Hb was 7.3 at the time of her discharge. There was no documentation regarding her staples or Cipro prescription.

Q. Regarding Patient H.C., she was discharged on day one with staples in place and no follow-up notation.

R. Regarding Patient C.K., she was discharged on day one even though she required multiple transfusions.

S. Regarding Patient M.K., she was discharged one day after her ICU admission even though she suffered from a post-op ileus, and a rising WBC with a left shift, indicating a probable ongoing infectious process.

T. Regarding Respondent's use of blood transfusions, the average patient will remain asymptomatic until Hb levels fall to 6-8 mg., easily tolerating a 500 cc blood loss. Transfusion is recommended for a falling Hb of less than 8 or symptomatic anemia. Symptoms include orthostatic changes, tachycardia, or not responding to fluid therapy. Intraoperative drops in blood pressure, as seen with Patient C.K., are treated with fluids or medical support. Transfusion is not recommended as treatment for asymptomatic patients with Hb of 8-10.

U. Patient C.K.'s first documented Hb was 11.0 after receiving 3 units of packed red blood cells pre-operatively. She was again transfused with 2 units when her Hb fell to 9.1. Hemoglobin levels have been shown to rise almost 1mg for every unit transfused. Theoretically these patients were transfused with 2 or more units then they required. Patient J.S., on the other hand, was noted to have a Hb falling to 7.3. There was no evidence that she was transfused. There was no documentation of her vital signs, an examination, or plans to follow her unstable condition.

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V. Transfusions of blood products risk incompatibility reactions along with immunologic reactions. The process itself, puts the patient at risk for Hepatitis.

W. The following acts and omission, considered individually and collectively, constitute extreme departures from the standard of care:

1) The routine failure to provide a history and physical that documents the information necessary to properly care for a patient undergoing surgery is an extreme departure from the standard of care.

2) As to Patients M.K. and K.C., there is no evidence of pre-op pelvic exams or testing, including but not limited to CT and ultrasound. The consistently inadequate preoperative evaluations represents an extreme departure from the standard of care.

3) The pattern in which patients were discharged represents an extreme departure from the standard of care, as ongoing problems were not addressed or demonstrated to have resolved, with no documentation of follow-up plans.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

14. Respondent Sangjoon Jay Lee, M.D. is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that he committed gross negligence during his care, treatment and management of five patients: M.K., J.S., H.C., K.C., and M.C., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 13, above, as though fully set forth.

B. The following acts and omissions constitute departures from the standard of care:

1) The failure to document the production of the J.P. tube or its removal represents a simple departure from the SOC.

2) The informed consent for each patient is deficient or improperly documented. In each case, the medical term for the procedure is documented; however, there is no evidence of a conversation that informed the patient of the nature of the procedure, it's risks, it's benefits, and possible complications. Further, no alternative

treatments were detailed. The lack of demonstrable informed consent is a simple departure from the standard care.

3) Patients underwent excessive transfusions, a simple departure from the standard of care. Respondent's repeated inappropriately excessive transfusions demonstrates a lack of medical knowledge regarding the appropriate use of blood transfusions in surgical patients.

4) As to all patients, the inappropriate prescription of antibiotics reflects a lack of medical knowledge and a simple departure from the standard of care.

5) The routine failure to provide a history and physical that documents the information necessary to properly care for a patient undergoing surgery is an extreme departure from the standard of care.

6) As to Patients M.K. and K.C., there is no evidence of pre-op pelvic exams or testing. Respondent's consistently inadequate preoperative evaluations represents not only a departure, but an extreme departure, from the standard of care.

7) The pattern in which patients were discharged represents an extreme departure from the standard of care, as ongoing problems were not addressed or demonstrated to have resolved, with no documentation of follow-up plans.

8) Respondent failed to document the etiology, location, and extant of Patients M.K. and C.K. vaginal scarring and the resultant pain.

9) Regarding Patient J.S., Respondent's failure to document the presence or absence of the IUD constitutes departure from the standard of care in vaginal removal could represent possible surgical contamination.

10) Regarding Patient M.C., discharging her without addressing that the patient had vomited 400 cc of green fluid and that the patient a had a postoperative ileus or lack of movement in the intestines constitutes departure from the standard of care.

11) Patients underwent excessive transfusions, a simple departure from the standard of care.

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THIRD CAUSE FOR DISCIPLINE

(Incompetence)

15. Respondent Sangjoon Jay Lee, M.D. is subject to disciplinary action under Business and Professions Code section 2234, subdivision (d), in that he demonstrated incompetence during his care, treatment and management of five patients: M.K., J.S., H.C., K.C., and M.C., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraphs 13 and 14, above, as though fully set forth.

B. Regarding transfusions, the standard of care is to transfuse patients whose recovery depends upon it.

C. Blood transfusion requires informed consent, including advising of the risk of hepatitis.

D. The average patient will remain asymptomatic until Hb levels fall to 6-8 mg., easily tolerating a 500 cc blood loss. Transfusion Is recommended for a falling Hb of less than 8 or symptomatic anemia. Symptoms include orthostatic changes, tachycardia, or not responding to fluid therapy, as well as intraoperative drops in blood pressure, as in the case of C.K. who was transfused twice to achieve a Hb of 12.5. This patient's first documented Hb was 11.0 after receiving 3 units of packed cells pre-operatively. She was again transfused with 2 units when her Hb fell to 9.1. Yet, Patient J.S. was noted that her Hb fell to 7.3 but she was not transfused or, in the alternative, Respondent failed to document the transfusion.

E. Respondent failed to demonstrate the requisite knowledge regarding transfusing patients.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

16. Respondent Sangjoon Jay Lee, M.D. is subject to disciplinary action under Business and Professions Code section 2266 in that he failed to maintain adequate and accurate medical records pertaining to the provision of medical services to five patients: M.K., J.S., H.C., K.C. , and M.C., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 13, above, as though fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

17. Respondent Sangjoon Jay Lee, M.D. is subject to disciplinary action under Business and Professions Code section 2234 in that he committed unprofessional conduct, generally, during his care, treatment and management of five patients: M.K., J.S., H.C., K.C., and M.C., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 13, above, as though fully set forth.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number C 50371, issued to Sangjoon Jay Lee, M.D.;

2. Revoking, suspending or denying approval of Sangjoon Jay Lee, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Sangjoon Jay Lee, 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: October 14, 2016

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

Complainant

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