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

In the Matter of the Second Amended Accusation Against:	)	
Brent Edward Silvers, M.D.	)	Case No. 800-2016-020459
Physician's and Surgeon's Certificate No. A 49201	)	
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 8, 2019.

IT IS SO ORDERED January 11, 2019.

MEDICAL BOARD OF CALIFORNIA

By: Kristina Lawson

Kristina D. Lawson, J.D., Chair
Panel B

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

In the Matter of the Second Amended Accusation against: BRENT EDWARD SILVERS, M.D., Physician's and Surgeon's Certificate No. A49201, Respondent.	Case No. 800-2016-020459 OAH No. 2017101162

PROPOSED DECISION

Matthew Goldsby, Administrative Law Judge with the Office of Administrative Hearing (OAH), heard this matter on November 19, 20, 26, 27, 28, and 29, 2018, in Los Angeles, California.

Edward Kim, Deputy Attorney General, appeared and represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

Michael J. Khouri, Attorney at Law, appeared and represented respondent Brent Edward Silvers, M.D.

The matter was taken under submission on November 30, 2018.

FACTUAL FINDINGS

Jurisdictional and Background Facts

1. On March 4, 1991, the Board issued Physician's and Surgeon's Certificate number A49201 to respondent. The certificate was active and valid through November 30, 2018.[1]

[1] The Board maintains jurisdiction over any expired licenses pursuant to Business and Professions Code section 118, subdivision (b).

2. Respondent received training and education at the California College of Podiatric Medicine in 1979, and became board-certified in podiatry. He earned Doctor of Medicine (MD) degree at Virgen Milagrosa Institute of Medicine in 1986, and completed his residency at Flushing Hospital Medical Center in New York in 1989.

3. Respondent has been in the private practice since 1994. Except as described below, respondent has no public record of discipline or civil malpractice judgments.

4. The Board has received the following complaints pertaining to respondent's certificate:

(A) On February 22, 2016, the Board received an anonymous online complaint with the following description: "Physician with alcohol abuse issues. [Respondent] has been going to the office either drunk or hung over. He is having memory lapses due to this and still treating patients. Frequency of working drunk has increased greatly over the last few months to year. Also does an in office surgical procedure and gives patients Ativan, Norco, and wine prior to their procedures. Several incidences of patients vomiting during and after procedures from this cocktail as well as severe sedation." (Ex. 5.)

(B) On March 16, 2016, the Board received two anonymous online complaints. The first stated: "Physician is actively drunk at office performing procedures and treating patient. He admits to excessive alcohol and that he is an alcoholic. You can see he is impaired and smell alcohol on him." (Ex. 5.) The second complaint alleged respondent "smells of whiskey" and "is loud, obnoxious and unprofessional to patients and staff." (Ex. 5.)

(C) On July 7, 2017, the Board received an online complaint from a consumer, identified herein as Patient A to protect her privacy. The complaint was supplemented with a copy of a Complaint for Medical Negligence filed by Patient A and her husband on August 29, 2017, in the Superior Court of California, County of Orange, in case number 30-2017-00940678-CU-MM-CJC. In summary, the civil complaint alleged that respondent required Patient A to completely disrobe for a medical procedure without any medical necessity to disrobe for the procedure and without a chaperone present during the performance of the procedure. (Ex. 43.)

5. On October 11, 2017, complainant brought the Accusation in her official capacity. Respondent filed a timely Notice of Defense.

6. On September 26, 2017, the Board issued an Interim Suspension Order No Practice, which was upheld on October 27, 2017. Respondent has complied with the terms of the Interim Suspension Order and he has tested negative for alcohol in random testing.

7. On April 26, 2018, complainant filed the First Amended Accusation. On November 16, 2018, complainant brought the Second Amended Accusation in her official capacity.

Investigations

8. On March 10, 2016, the Department of Consumer Affairs, Health Quality Investigation Unit, assigned investigator Jeremy Paris to investigate the complaints of alcohol abuse. March 28, 2016, Investigator Paris appeared at respondent's medical office and informed respondent of the complaints against him. Respondent told Investigator Paris that he "never reported to work under the influence of alcohol or drugs" and that he "used to occasionally offer patients a cup of wine prior to procedures to help them relax." (Ex. 3, pp. 003-004.) Respondent produced a urine sample for testing and signed the necessary consent forms. The urine tested negative for alcohol.

9. Investigator Paris interviewed staff members, including Deborah Marshall and Lucienne Hamilton who both reported never having seen respondent report to work under the influence of drugs or alcohol. Employee Leilani Hernandez informed Investigator Paris that she recently gave notice of her intent to quit because respondent "exhibited 'sporadic erratic' behavior," that she heard respondent say that he was hungover while at work, that she smelled alcohol while she and respondent were in the laboratory, that respondent comes to work under the influence of alcohol once per week, and that he has given patients wine on occasion along with Ativan and Norco. (Ex. 3.)

10. Alison Gracom Stirrat, a physician's assistant employed by respondent, informed Investigator Paris that she has known respondent to work under the influence of alcohol, that she smelled alcohol on him at work on multiple occasions, that she has asked him to leave work because of the strong odor of alcohol and the glassy appearance of his eyes when inebriated, and that she had chosen to resign because "his alcoholism made [her] concerned about reputation and liability issues." (Ex. 3, p. 006.) She disclosed that she had filed the complaint with the Board and that she had previously instructed staff to clean up vomit from a patient who had been given Ativan, Norco, and wine. She also observed concerning lapses in memory, although she stated "none of his memory issues seem to affect the treatment he provided to patients." (*Id.*)

11. On October 19, 2016, respondent's case was reassigned to Lucila Gojny, Investigator with the Department of Consumer Affairs. On January 24, 2017, she appeared at respondent's medical office to ask if respondent would voluntarily submit to undergo a professional competency examination, a mental examination, and a physical examination. Respondent signed voluntary agreements to submit to each examination. (Ex. 6.) Respondent gave Investigator Gojny a tour of the office and she observed no bottles of alcohol in plain view. She otherwise observed respondent's demeanor to be "coherent and professional." (Ex. 3, p. 009.)

12. Investigator Gojny ordered a three-year patient profile for respondent from the Controlled Substance Utilization Review and Evaluation System (CURES), a database compiled and maintained by the California Department of Justice of all controlled substances prescribed and dispensed in the State of California. The CURES report showed no instances of self-prescription of controlled substances. (Ex. 10.)

13. On February 27, 2017, as directed by Investigator Gojny, respondent underwent a mental evaluation by Markham Kirsten, M.D., board certified in forensic psychiatry, addiction psychiatry, and other areas of psychiatric practice. Respondent reported to Dr. Kirsten "30 years of insomnia" causing him to frequently drink "from half a glass to half a bottle" of wine every night. Respondent also reported that he "fell down the stairs while drinking" and that he was hospitalized, and that brain imaging demonstrated a subdural hematoma. Dr. Kirsten performed a mental status examination, testing respondent's cognition by the "clock test." The results showed a persistent poor spacing of numbers, errors deemed "small and not indicative of the major neurocognitive disorder." (Ex. 9B) Respondent scored 26/30 in a mini mental status exam. At the conclusion of the interview, Dr. Kirsten could not identify any "prima facia evidence" of alcohol abuse, but recommended respondent be evaluated by a neuropsychologist to rule out cognitive deficits and by a neurologist regarding possible subdural hematoma.

14. On March 3, 2017, respondent underwent a physical examination. Nehal Patel, M.D., examined respondent and concluded that respondent was physically and medically safe to continue practicing medicine. (Ex. 12.)

15. On May 26, 2017, respondent submitted to a neuropsychological evaluation by David C. Anderson, PhD., Diplomate in clinical psychology and clinical neuropsychology. During the evaluation, respondent denied any history of alcohol or other substance abuse and reported that he has "two glasses of wine three days a week in the evening." (Exhibit 13.) Dr. Anderson administered a series of standardized cognitive tests. The results of a Word Memory Test indicated a "best fit" pattern for individuals with early dementia. The results of the Montréal Cognitive Assessment (MoCA) were in the "impaired" range. (Ex. 13, p. 005.) Respondent scored in the average and low average ranges in a series of subtests of the Wechsler Adult Intelligence Scale-Fourth Edition. In memory functioning assessments, respondent scored variably in the low average range to severely impaired. In visual memory assessments, respondent scored in borderline to severely impaired ranges. In executive functioning assessments, respondent scored in the low average to impaired ranges. Dr. Anderson concluded that respondent was not competent to practice medicine due to severe memory and executive functioning deficits.

16. On May 23, 2017 respondent submitted to a neurologic evaluation before Martin J. Backman, M.D., Diplomate of the American Board of psychiatry and neurology. During the evaluation, respondent reported to Dr. Backman that "he may have one glass of wine at night with dinner three days a week ... [stating] this is the only time he drinks alcohol." (Exhibit 14, p. 004.) The results of this neurological exam were normal, and Dr. Backman perceived no medical condition rendering respondent unsafe to practice medicine or that would pose a threat to patient safety "provided that additional monitoring is provided." (Ex. 14, p. 006.) Dr. Backman recommended that a final determination be made after further psychological evaluation by Dr. Kirsten as to any psychologic functioning that could impact his conclusions.

17. In his report dated July 30, 2017, after reviewing the evaluations of Dr. Anderson and Dr. Backman, Dr. Kirsten diagnosed respondent with mild cognitive disorder and severe alcohol use disorder in sustained remission. Dr. Kirsten reasoned that a person with mild cognitive impairment may retain the capacity to perform basic activities of daily living, such as showering or driving a car, "but not have the capacity to take a medical history, perform a physical examination, perform foot surgery or treat an infection." (Ex. 9C.) Dr. Kirsten's final determination was that respondent was unable to practice medicine safely without any conditions.

Fitness to Practice - Medical History

18. On September 11, 2016, respondent was taken by paramedics to the emergency room following a seizure. A CT-scan of the head revealed what appeared to be "an old infarct in the left occipital lobe." (Ex. 36, p. 122.)

19. On December 7, 2016, respondent was again brought to the emergency room with an altered level of consciousness. Respondent's son had found respondent lying on the couch, unconscious, and having difficulty breathing. (Ex. 36, p. 40.) After 45 minutes, respondent remained unresponsive and the family called paramedics. (Ex. 36, p. 63.) Respondent had consumed an unknown amount of wine and vomited a red substance. He was intubated to protect his airway (Ex. 36, p. 50) and his "alcohol level was 299" (Ex. 36, p 64).

20. On June 27, 2017, respondent was hospitalized after having the six-minute convulsive seizure two days after he reportedly stopped drinking alcohol.

Fitness to Practice – Respondent's Evidence

21. Respondent presented the expert testimony of Nathan Lavid, M.D., a clinical and forensic psychiatrist and board-certified in psychiatry since 2003.

22. In Dr. Lavid's opinion, respondent is not impaired either by alcohol addiction or cognitive disorders. He bases his opinion on 21 sources of information, including the evaluation reports issued by complainant's experts, and on his own comprehensive evaluation of respondent. Dr. Lavid performed a mental status examination, interviewing respondent for over three hours. He noted that respondent exhibited memory problems and that respondent required some redirection, but overall performed "pretty good." He noted that respondent has complied with alcohol testing requirements imposed by the Board since the suspension of respondent's license, and that all tests have been negative for alcohol.

23. Dr. Lavid was unaware of respondent's history of hospitalizations in relation to alcohol use. Respondent told Dr. Lavid that he has "no plans to drink alcohol ever again." (Ex. E, p. 8.) Respondent denied the existence of any physical problems or legal issues relating to alcohol.

24. Respondent testified that he does not believe that he drank too much in the past, that he uses alcohol to help him fall asleep at night, that he has never worked under the influence of alcohol, and that he drank "a couple of glasses of wine" each night during the final week of the hearing. He further testified that he would stop drinking if abstinence was a condition to continued licensure while stating, "I am not sure how I will sleep."

Fitness to Practice – Ultimate Findings

25. The admissibility of expert evidence regarding an ultimate issue of fact is a discretionary matter for the trier of fact, to be evaluated in light of the facts of the particular case and the usefulness of the expert's opinions in arriving at the truth. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907.) In determining the credibility of multiple expert witnesses giving conflicting testimony, an administrative law judge may consider any matter that has any tendency in reason to prove or disprove the truthfulness of each witness's testimony at the hearing, including the witness's demeanor while testifying, the character of the witness's testimony, and the existence of any bias, interest, or other motive. (Evid. Code, § 780.) The testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, at 1052.)

26. In this case, Dr. Lavid's opinion is given less weight than the expert opinions presented by complainant. Dr. Lavid did not consider respondent's medical record hospitalizations relating to excessive alcohol use and his opinion was based on respondent's false representation that he no longer drinks and would never drink again, contradicted by respondent's testimony at hearing. The law does not accord to an expert's opinion the same degree of credence or integrity as it does the data underlying the opinion. (*County of Sacramento v. Workers' Comp. Appeals Bd.* (2013) 215 Cal.App.4th 785.)

27. Dr. Kirsten was credible and his opinion was based on a comprehensive evaluation over a longer period of review. Accordingly, substantial evidence exists to clearly and convincingly find that respondent is unable to safely practice medicine because his conditions of mild cognitive disorder and severe alcohol use disorder in sustained remission affect his competency.

Sexual Misconduct - Patient A

28. Respondent had been treating Patient A for approximately five years when she consulted him on May 24, 2017 about a blood draw and wellness check. At the conclusion of the consultation, respondent asked Patient A if she had undergone a bone density examination. Respondent testified that a scan is advisable for women presenting with risk factors for osteoporosis, such as being thin or over the age of 50. At the time, Patient A was 50 years of age, 65 inches tall, and thin.

29. After Patient A agreed to the examination, respondent led Patient A into an examination room with the scanning equipment and a paper gown. Respondent had invested in a Northland Excel Bone Densitometry (DEXA) machine, comprised of a 6-foot DEXA

table and an L-shaped scanning device that moves over a patient lying on the table. At the head of the table, a laptop computer was placed on a separate stand and connected to the machine. In the past, another technician performed the bone density exams. When that employee voluntarily quit working for respondent, respondent invested in the time and study to become certified in radiology. (Ex. 34.)

30. Respondent instructed Patient A to remove all metals and clothing, and he left the room. Patient A was wearing a loose-fitting boat neck cotton sundress containing no metal. Her underwear was a solid navy blue with no painted pattern and made of cotton and polyester. After Patient A removed the sundress, all jewelry, and the underwire brassiere she was wearing, she put on a paper gown and vest that was available in the examination room. She did not remove her underwear.

31. Respondent returned to the room without a chaperone. He instructed Patient A to remove her underwear for the examination. Patient A explained that she was menstruating and asked about rescheduling. In response, respondent told Patient A that the machine was already recalibrating and not to worry about coordinating the scan with her cycle.

32. After Patient A lay on her back on the scanning table, respondent placed a rectangular wedge-type foam block between the knees of Patient A to spread her legs. Respondent instructed Patient A not to move her legs during the scan. He then directed Patient A to cover her eyes with a pair of heavy goggles, which fastened behind her head. Patient A could not see anything through the goggles.

33. Patient A testified that, after the scanning began, respondent said, "I know this sounds strange but you need to be naked for this." He then removed the lower part of the gown leaving her fully exposed and naked below the waist. Patient A credibly testified that, after about 10 to 15 minutes, respondent "came over to open the paper top exposing [her] breasts," and that shortly thereafter she felt what she believed was respondent's finger push into the side of her rib cage below the breast.

34. Patient A testified that she was "terrified the entire time," that she had this feeling that "something was terribly wrong," but that she never had any reason to question respondent before this procedure.

35. After approximately 20 minutes, respondent informed Patient A that the procedure was completed. Patient A testified that she "threw over" the goggles, that she grabbed her underwear and put them on, that she dressed with her back to respondent, and that, when she turned around to face him, she observed respondent staring at her, which caused her to feel that he had been staring at her while she dressed. She heard respondent state, "You have an awfully nice figure, I am used to seeing overweight women." She had never heard of physician make a personal comment about her figure.

36. Respondent verbally reviewed the results of the examination with Patient A immediately after the examination. Patient A testified that she "honestly didn't hear a thing" and "just wanted to leave." When she left the office, she went to her car and called her

husband and told him that something felt very wrong. She then searched "bone density scan" on a Google application on her cell phone. She testified, "What I read was not what I experienced." She called three local radiologists to inquire about the typical procedure for a bone density exam. Each provider told Patient A that a patient is allowed to wear loose fitting clothing with no metal, and that a gown is offered only if a patient wears jeans with a zipper or some other clothing with metal. Respondent asked about protection and was told it was not necessary. Respondent began to cry as she spoke to a radiologist at the University of California, Irvine. When the radiologist asked what was wrong, Patient A described her experience with respondent. The radiologist instructed Patient A to report respondent and go to the police.

37. On May 24, 2017, the same day of the examination, Patient A went to the Irvine Police Station to file a police report and Sergeant Keith Herter took her statement. Sergeant Herter sought and received Patient A's consent to cooperate with an undercover recording of a conversation with respondent. During a recorded telephone conversation, Patient A expressed to respondent that she was very uncomfortable during the bone density examination and asked why she needed to be undressed. Respondent replied, "Well you are not supposed to have anything in the way of the imaging. They used to do them with a gown on and they found the images weren't good." (Ex. 26, p. 008.) He further stated to Patient A that the goggles were needed because of the radiation and that it was for her safety. Respondent acknowledged that it was "a mistake" not to have a chaperone in the room and he apologized. When Patient A asked what respondent was doing while her eyes were closed, respondent told her that he was watching the counters and that "there is a lot of physician stuff that goes on." (Ex. 26, p. 009.) When Patient A asked respondent why she needed to expose her breasts, he informed her that it was necessary in order to capture her sternum.

38. On June 29, 2017, Sergeant Herter and Detective E. Kim went to respondent's office to investigate. Respondent demonstrated the scanning equipment and stated to Sergeant Herter, "The patient takes their clothes off but they have to put on a gown and the gown remains on the entire time of the test. . . . I get the feeling this [investigation] has to do with [Patient A] being clothed or unclothed, again she was covered the entire treatment, it is not necessary to reveal the patient." (Ex. 26, p. 011.) When Sergeant Herter explained that Patient A had reported that she did not have a gown on during the procedure, respondent stated "I don't recall that" and that he always has a female in the room with him when he does procedures on other women. (*Id.*) When the officer asked respondent if Patient A's breasts and pubic area were covered during the scan, respondent replied "As far as I know, I didn't open it, there is no reason to." (*Id.*) Respondent did not recall having a telephone conversation with Patient A concerning her discomfort for the exam.

39. During his inspection of respondent's office, Sergeant Herter looked around for camera equipment and observed no evidence to show that Patient A had been photographed during the procedure. He also could not determine that any lewd conduct had occurred. He did not perceive respondent was under the influence of alcohol.

40. Sergeant Herter determined that respondent had not committed a crime and did not arrest respondent. However, he requested that his report be reviewed by the Board "as it appears [respondent] had [Patient A] completely naked during a bone density exam when there was no medical justification for doing so." (Ex. 26, p. 014.)

Sexual Misconduct - Patient B

41. The pleadings refer to Patient B, who was not in fact a patient, but a 20-year-old medical assistant employed by respondent for two months in 2017. She served as a chaperone during at least four bone density scans. She observed that all patients were female and that respondent instructed each patient to completely disrobe for the examination. Patient B reported to Investigator Gojny that respondent explained to her that "it was necessary to do so to get 'more accurate results.'" (Ex. 3, p. 035.)

42. One day during working hours, respondent asked Patient B to help him test the bone density scanning equipment. Patient B was given a health questionnaire to complete. She was then taken to the examination room and asked to remove her clothing. In her testimony, she could not recall if anyone else was in the room, and she credibly testified that she was completely naked when she lay on the examination table.

43. Patient B testified that she felt "weird;" she told Investigator Gojny that she felt "so uncomfortable." (Ex. 3, p. 035.) However, she "did not feel he was doing anything in a sexual manner." Patient B did not complain to respondent and was unaware of any violation of her personal rights. At the conclusion of the examination, respondent left the room while patient got dressed. He returned with a printout and explained the results.

Standard of Care - in General

44. The standard of care for a given profession is a question of fact and in most circumstances must be proven through expert witnesses. *(Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997-998, 1001; *Alef v. Alta Bates Hospital* (1992) 5 Cal.App.4th 208, 215.) "Standard of care" means the use of that reasonable degree of skill, care, and knowledge ordinarily possessed and exercised by members of the profession under similar circumstances, at or about the time of the incidents in question. (*Flowers, supra*, 8 Cal.4th at pp. 997-998.)

45. As articulated in the case of *Flowers v. Torrance Memorial Hospital Medical Center*, *supra*, 8 Cal.4th 992 at page 997:

> The amount of care deemed reasonable in any particular case will vary, while at the same time the standard of conduct itself remains constant, i.e., due care commensurate with the risk posed by the conduct taking into consideration all relevant circumstances. (Citation.) "'There are no "degrees" of care as a matter of law; there are only different amounts of care, as a matter of fact....' [Citation.]" (Citation

Standard of Care – Bone Density Scan Procedures

46. Complainant presented the expert testimony of Afsaneh Maghsoudy, a board certified radiologist with professional experience and training in bone density procedures and equipment. She testified that the standard of care in conducting bone density examinations is to avoid any metal or printed material on clothing during the scanning process. Because the radiation is very limited, goggles are not necessary. Calibrating the equipment does not require human to lie on the scanning table. A proper scan does not include the sternum or the chest and there is never a reason to expose a patient's breasts during a bone density exam. Moreover, other than the presence of a pattern or design, there is no reason to remove a patient's underwear during the examination.

47. In her opinion, respondent committed an extreme departure from the standard of care by calibrating the machine with Patient A and Patient B on the table, by requiring both patients to be nude during the examination, and by failing to have a chaperone in the room during the examination.

48. Respondent testified that the bone density scan for Patient A was routine, that he typically asks women to remove the underwear because he found that "designs on underwear or some metals interfere with the scan," and that he used the foam wedge to keep her legs in the standard position. Respondent offered no evidence, such as training materials, articles, or expert testimony, to support his practices.

49. Respondent further testified that Patient A had an "odd reaction," and that she was "pathological" and "not normal." He acknowledged that she was briefly exposed, but did not feel that it was "a big deal" or a "huge event that should be life altering." He expressed compassion, but testified that he does not feel remorse because "it sounds like murder." Respondent testified that he did not recall asking Patient B to take the scan, but that "it is something [he] would do." Respondent argued that no other female patients complained about being made to undress for the bone density scans.

50. Respondent denied deriving any sexual gratification by his practice of having women exposed during the bone density examination. There was no evidence that he masturbated during any procedure involving a naked patient or that he photographed any patient without their consent. Nonetheless, respondent presented no competent medical evidence to support his practice of exposing the genitals and breasts of female patients during a bone density scan. Dr. Maghsoudy credibly testified that she could not envision any reason other than sexual gratification to explain why a male physician would instruct female patients to be completely naked during a bone density scan. Calibrating the equipment did not require a human for testing, let alone a naked 20-year-old female.

51. Clear and convincing evidence establishes that respondent committed sexual misconduct and an extreme departure from the standard of care by calibrating the machine with Patient A and Patient B on the table, by requiring both women to be nude during the examination, and by failing to have a chaperone in the room during the examination.

Standard of Care – Mixing Alcohol and Sedatives

52. Complainant presented the expert testimony of Jeffrey Rosenberg, M.D., board certified with the American Board of Plastic Surgeons with substantial professional experienced in reconstructive surgery, cosmetic surgery, trauma injuries, operation complications, and all cosmetic procedures. Dr. Rosenberg testified that the standard of care is not to mix alcohol with narcotics and sedatives prior to surgery. He explained that alcohol can potentiate sedatives and produce dangerous and unpredictable results. In preparing for surgical procedures, the standard of care is to instruct the patient to have nothing in the stomach, and any amount of alcohol in the stomach increases the risk for vomiting and aspiration. Dr. Rosenberg never heard of any surgeon serving wine to a patient while administering conscious sedation. He reasoned that even a sip of wine added unnecessary risk.

53. In Dr. Rosenberg's opinion, respondent committed an extreme departure from the standard of care by serving alcohol to patients in combination with Ativan and Norco in preparation for surgical procedures.

54. Respondent testified that he gave alcohol to patients because alcohol is a component of many medicines, and that he offered alcohol in order to administer a lower dose of narcotics. Respondent presented no competent medical evidence to support his practices. He further testified that he threw "about five" Botox parties during which alcohol was served, which he now recognizes was wrong.

55. Clear and convincing evidence established that respondent committed an extreme departure from the standard of care by serving alcohol to patients in combination with Ativan and Norco in preparation for surgical procedures.

Record Keeping

56. During his assessment of respondent's fitness to practice, Dr. Kirsten reviewed respondent's medical records for Patient A. Dr. Kirsten testified, "My God, he was keeping terrible records. Every single entry is unedited or unproofed with errors.... I was completely flabbergasted to see that every entry was erroneous." For example, respondent made entries for a prostate exam even though Patient A is female; he made repetitive entries for a pap smear and breast exam, but never took those actions; he made an assessment for a urinary tract infection, but there was no chief complaint to support the entry; there was no objective documentation as to why he prescribed Cipro; and all records were signed on October 31, 2017, even though treatment took place on various dates dating back to 2014. (Ex. 24.)

57. Respondent testified that he kept medical records by a software program that pre-populated a patient's chart with data, requiring him to modify the chart pursuant to the facts. The implication was that the software made entries that he did not modify or delete pursuant to the facts presented by Patient A.

58. Respondent presented the expert testimony of John Heydt, M.D., a board certified physician who was appointed by the Board to monitor respondent's practice. Dr. Heydt performed random chart reviews, examining approximately 10 percent of respondent's charts per month, and met regularly with respondent to review his prescription practices, billing practices, and the general administration of his medical practice.

59. In his report to the Board dated November 5, 2018, Dr. Heydt wrote, "I have now completed 12 months of monitoring of [respondent] and [his practice]. I have found no irregularities to date in any aspect of the practice or patient care.... This month, all 20 charts were complete and I reviewed the deficient chart from last month and it was complete. I was satisfied with the system respondent had in place regarding open charts and the system worked as demonstrated by the completion of the chart from last month." (Exhibit C.) In Dr. Heydt's opinion, respondent was maintaining records and operating within the standard of care and safe to practice medicine.

Aggravating evidence

60. Investigator Lucila Gojny is a peace officer for the state of California and a trained employee of the Department of Consumer Affairs, Health Quality Investigation Unit.

61. After having completed in-person interviews with respondent on January 24, 2017, January 4, 2018, and February 14, 2018, Investigator Gojny received a telephone call from respondent with the stated purpose of verifying the place and time of another interview. When Investigator Gojny informed respondent that no further interviews were scheduled, respondent invited Investigator Gojny "to stop by" if she was ever in the area of his office.

62. Investigator Gojny testified that she was "shocked" and considered the invitation to be an inappropriate proposition considering the subject matter of her investigation.

LEGAL CONCLUSIONS

Standard and Burden of Proof

1. Complainant has the burden of proof in an administrative action seeking to suspend or revoke a professional license, and the standard is clear and convincing proof to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

2. Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

Fitness to Practice

3. The first cause for discipline alleges that respondent is subject to discipline based on his unfitness to practice.

4. If the Board determines that a licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally or physically ill affecting competency, the Board may take action by revoking the licentiate's certificate or license. (Bus. & Prof. Code, § 822, subd. (a).)

5. In this case, clear and convincing evidence established that respondent has a mild cognitive disorder and severe alcohol use disorder. The condition is adversely affecting respondent's memory and judgment. His treatment of Patient A and Patient B demonstrate his impairment, lack of judgment, and inability to safely practice medicine.

6. Cause exists to discipline respondent's license under Business and Professions Code section 2234, subdivisions (b) and (c), because his ability to practice medicine safely is impaired because a mental or physical illness affecting his competency.

Dangerous Use of Alcohol

7. The second cause for discipline alleges that respondent is subject to discipline based on his dangerous use of alcohol.

8. The Board is required to take action against any licensee who is charged with unprofessional conduct. (Bus. & Prof. Code, § 2234.)

9. Unprofessional conduct includes the use of "alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely." (Bus. & Prof. Code, § 2239, subd. (a).)

10. Unprofessional conduct includes the practice medicine while under the influence of alcohol to such an extent as to impair a physician's ability to conduct the practice of medicine with safety to the public and his or her patients. (Bus. & Prof. Code, § 2280.)

11. Compelling evidence clearly and convincingly established that respondent has practiced medicine while under the influence of alcohol. The evidence that he has fallen down stairs and was admitted to the hospital with a recorded alcohol level of 299 and in the state of lost consciousness exhibits the use of alcohol to a dangerous extent. His continued use of alcohol during the final week of hearing in spite of the disciplinary action against him for alcohol abuse exhibits an inability to resist the compulsion to consume alcohol.

12. Cause exists to discipline respondent's license under Business and Professions Code section 2234, subdivisions (b) and (c), because clear and convincing evidence

established that he engaged in unprofessional conduct based on gross negligence or repeated acts of negligence.

Negligence

13. The third and fourth causes for discipline allege unprofessional conduct based on gross negligence and repeated acts of negligence.

14. Unprofessional conduct includes gross negligence and repeated acts of negligence. (Bus. & Prof. Code, § 2234, subds. (b) and (c).)

15. The Medical Practice Act does not define "negligence." However, courts have defined negligence as a "simple departure from the standard of care." (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462.) Gross negligence includes "an extreme departure from the ordinary standard of conduct." (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941; *Van Meter v. Bent Cons. Co.* (1956) 46 Cal.2d 588, 594.) Repeated acts of negligence include "an initial act or omission followed by a separate and distinct departure from the standard of care." (Bus. & Prof. Code, § 2234, subd. (c).)

16. In this case, credible expert testimony established that respondent repeatedly committed an extreme departure from the ordinary standard of care by calibrating the machine with Patient A and Patient B on the table, by requiring both women to be nude during the examination, and by failing to have a chaperone in the room during the examination. (Factual Findings 28-51.) Respondent further committed an extreme departure from the ordinary standard of care by serving alcohol and administering narcotics to patients in preparation for surgery. (Factual Findings 52-55.)

17. Cause exists to discipline respondent's license under Business and Professions Code section 2234, subdivisions (b) and (c), because clear and convincing evidence established that he engaged in unprofessional conduct based on gross negligence or repeated acts of negligence.

Sexual Misconduct

18. The fifth cause for discipline alleges unprofessional conduct based on gross negligence, sexual abuse or misconduct, and exploitation.

19. Business and Professions Code section 726, subdivision (a), provides:

> The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed [as a physician and surgeon].

20. Business and Professions Code section 729, subdivision (a), defines sexual exploitation as follows:

> Any physician and surgeon, psychotherapist, alcohol and drug abuse counselor or any person holding himself or herself out to be a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor, who engages in an act of sexual intercourse, sodomy, oral copulation, or sexual contact with a patient or client, or with a former patient or client when the relationship was terminated primarily for the purpose of engaging in those acts, unless the physician and surgeon, psychotherapist, or alcohol and drug abuse counselor has referred the patient or client to an independent and objective physician and surgeon, psychotherapist, or alcohol and drug abuse counselor recommended by a third-party physician and surgeon, psychotherapist, or alcohol and drug abuse counselor for treatment, is guilty of sexual exploitation by a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor

21. In this case, respondent did not engage in an act of sexual intercourse, sodomy, oral copulation, or sexual contact with a patient A or Patient B. Accordingly, respondent did not engage in sexual exploitation as statutorily defined and cause does not exist to discipline respondent's license under Business and Professions Code section 729.

22. However, respondent committed gross negligence by requiring Patient A and Patient B to be naked for a bone density exam without any medical necessity. Clear and convincing evidence was presented to establish that respondent's practices constituted sexual misconduct under Business and Professions Code section 726.

23. Cause exists to discipline respondent's license under Business and Professions Code sections 726, subdivision (a), because he engaged in unprofessional conduct by engaging in acts of sexual misconduct.

Failure to Maintain Adequate and Accurate Records

24. The sixth cause for discipline alleges unprofessional conduct based on a failure to maintain adequate and accurate medical records.

25. 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. (Bus. & Prof. Code, § 2266.)

26. The language of Business and Professions Code section 2266 must be given its plain and ordinary meaning. (*DuBois v. Workers' Comp. Appeals Bd.* (1993) 5 Cal.4th 382; *Hall v. Court Reporters Bd.* (2002) 98 Cal.App.4th 633.) Respondent's recordkeeping was flawed and, as to Patient A, replete with errors. The plain and ordinary meaning of the term "adequate" does not require perfection to comply with the statute. Dr. Heydt had more opportunity than Dr. Kirsten to observe respondent's recordkeeping, monitoring his practice over the course of 12 months and reviewing 10 percent of his charts on a regular basis.

27. Overall, clear and convincing evidence did not establish that respondent failed to maintain adequate and accurate medical records. Accordingly, cause does not exist to discipline respondent's license under Business and Professions Code section 2266.

Unprofessional Conduct

28. The seventh cause for discipline alleges general unprofessional conduct based on the allegations of the first through sixth causes for discipline.

29. Unprofessional conduct includes, but "is not limited to," the statutory definitions at Business and Professions Code section 2234. Courts have held that unprofessional conduct includes conduct which is "unbecoming a member in good standing of the medical profession," and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.) The weight of all evidence presented at hearing established that respondent engaged in conduct unbecoming a member in good standing of the medical profession, and demonstrated an unfitness to practice medicine.

30. Cause exists to discipline respondent's license under Business and Professions Code sections 2234 because he generally engaged in unprofessional conduct. (Factual Findings 8-62.)

Conclusion

31. The task in disciplinary cases is preventative, protective and remedial, not punitive. (*In re Kelley* (1990) 52 Cal.3d 487.) Imposing license discipline furthers a particular social purpose: the protection of the public. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757.)

32. In determining the level of discipline to be imposed, an administrative law judge is mandated, wherever possible, to take action that is calculated to aid in the rehabilitation of a licensee, or to order restrictions as are indicated by the evidence. (Bus. & Prof. Code, § 2229, subd. (b).) Disciplinary actions must be calculated to aid in the rehabilitation of a licensee, but only to the extent not inconsistent with public protection. (Bus. & Prof. Code, § 2229, subd. (b).) Protection of the public is the highest priority for the Board and is paramount over other interests in conflict with that objective. (Bus. & Prof. Code, §§ 2001.1, and 2229, subd. (a).)

33. In this case, respondent has complied with the terms of the Interim Suspension Order and he has tested negative for alcohol in random testing. He has a lengthy career with no prior record of discipline or civil judgments against him for professional negligence.

34. However, arguably the most important consideration in predicting future conduct is evidence of a change in attitude from that which existed at the time of the conduct in question. (*Singh v. Davi* (2012) 211 Cal.App.4th 141.) In this case, respondent has steadfastly held to his belief that he remains a competent physician, in spite of objective

signs of a decline in his executive functioning. He continues to consume alcohol while defending allegations that his alcohol consumption may be a ground for discipline, and chronically misled medical examiners about the continuation and extent of his drinking. Respondent's level of insight regarding his memory lapses and poor judgment is insufficient to prevent a recurrence through self-awareness or probationary terms.

35. Fully acknowledging the wrongfulness of past actions is an essential step towards rehabilitation. (*Seide v. Committee of Bar Examiners* (1989) 49 Cal.3d 933.) Respondent exhibited no remorse or acknowledgement of wrongdoing with respect to his treatment of Patient A, testifying that she overreacted to being unnecessarily exposed. The fact that Patient B and other patients did not complain or were unaware of the violation of their personal rights does not negate the violation that occurs when a female patient is made to expose parts of her body to a male physician for no legitimate purpose. By propositioning Investigator Gojny, the very individual investigating allegations of sexual misconduct, respondent exhibited a profound inability to control inappropriate impulses.

36. The more serious the misconduct, the stronger the evidence must be to show rehabilitation. (*In re Gossage* (2000) 23 Cal.4th 1080.) Respondent has presented insufficient evidence to indicate that he has had a sufficient change in attitude to prevent a recurrence. Probationary terms or license restrictions will not aid in respondent's rehabilitation and would have no preventative or remedial effect. Public protection is best served by revocation of respondent's license.

ORDER

The Second Amended Accusation against respondent Brent Edward Silvers, M.D., is affirmed. Physician's and Surgeon's Certificate number A49201 issued to respondent is revoked.

DATED: December 28, 2018

DocuSigned by:
Matthew Goldsby

MATTHEW GOLDSBY
Administrative Law Judge
Office of Administrative Hearings

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General
EDWARD KIM
Deputy Attorney General
State Bar No. 195729
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6000
Facsimile: (213) 897-9395
Attorneys for Complainant

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STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO NOV. 16 20 18
BY [illegible] ANALYST

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

In the Matter of the Second Amended Accusation Against: **BRENT EDWARD SILVERS, M.D.** **2 Hughes, Suite 150** **Irvine, California 92618** **Physician's and Surgeon's Certificate No. A49201,** Respondent.	Case Nos. 800-2016-020459 and 800-2017-034481 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Second Amended Accusation (hereinafter, "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 4, 1991, the Board issued Physician's and Surgeon's Certificate Number A49201 to Brent Edward Silvers, 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, 2018, unless renewed.

JURISDICTION

3. This Second Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code)

unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, 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."

7. Section 2280 of the Code states: "No licensee shall practice medicine while under the influence of any narcotic drug or alcohol to such an extent as to impair his or her ability to conduct the practice of medicine with safety to the public and his or her patients. Violation of this section constitutes unprofessional conduct and is a misdemeanor."

8. Section 822 of the Code, states:

"If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

"(a) Revoking the licentiate's certificate or license.

"(b) Suspending the licentiate's right to practice.

"(c) Placing the licentiate on probation.

"(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

"The licensing agency shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated."

9. Section 726 of the Code, states:

"(a) The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any

person licensed under this division or under any initiative act referred to in this division.

"(b) This section shall not apply to consensual sexual contact between a licensee and his or her spouse or person in an equivalent domestic relationship when that licensee provides medical treatment, other than psychotherapeutic treatment, to his or her spouse or person in an equivalent domestic relationship."

10. Section 729, subdivision (a), of the Code, states:

"(a) Any physician and surgeon, psychotherapist, alcohol and drug abuse counselor or any person holding himself or herself out to be a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor, who engages in an act of sexual intercourse, sodomy, oral copulation, or sexual contact with a patient or client, or with a former patient or client when the relationship was terminated primarily for the purpose of engaging in those acts, unless the physician and surgeon, psychotherapist, or alcohol and drug abuse counselor has referred the patient or client to an independent and objective physician and surgeon, psychotherapist, or alcohol and drug abuse counselor recommended by a third-party physician and surgeon, psychotherapist, or alcohol and drug abuse counselor for treatment, is guilty of sexual exploitation by a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor."

FACTUAL ALLEGATIONS

11. Respondent currently suffers from a mental and/or physical ailment which impairs his ability to practice medicine safely. This matter began when the Board received a complaint alleging that Respondent had been treating patients while under the influence of alcohol, had been having lapses of memory, and that he would give patients Ativan, [1] Norco, [2] and wine prior to

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[1] Lorazepam, sold under the brand name Ativan among others, is a benzodiazepine medication. It is used to treat anxiety disorders, trouble sleeping, active seizures including status epilepticus, alcohol withdrawal, and chemotherapy induced nausea and vomiting, as well as for surgery to interfere with memory formation and to sedate those who are being mechanically ventilated. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug pursuant to Business and Professions Code section 4022.

[2] Norco is a brand name for acetaminophen and hydrocodone. Other brand names include, Hycet, Lorcet, Lorcet Plus, Lortab, Maxidone, Norco, Vicodin, Vicodin ES, Vicodin HP, Zamicet, and Zydone. Hydrocodone is a semisynthetic opioid analgesic similar to but more active than codeine. It is used as the bitartrate salt or polistirex complex, and as an oral analgesic and antitussive. It is marketed, in its varying forms, under a number of brand names, including

their procedures and as a result, several patients had vomited. The Board subsequently initiated an investigation and during the investigation several witnesses were interviewed. On or about March 28, 2016, an investigator with the Department of Consumer Affairs' Division of Investigation's Health Quality Investigations Unit (HQIU) spoke to Respondent and Respondent admitted that he had occasionally offered his patients a cup of wine prior to the medical procedures that he performed on them to help them relax. At that time, Respondent also agreed to undergo mental and physical examinations by Board retained experts.

12. J.T. worked for Respondent as a medical assistant for approximately one year and six months beginning in or around January 2015 until she resigned in or around June 2016. J.T. personally observed that Respondent displayed irrational, sometimes hyper, and manic behavior. For example, J.T. witnessed Respondent randomly scrape the paint off the walls while patients were present, and say inappropriate things to his patients such as, "Don't drink the water" and "Fish fuck in water." In addition, during the time that J.T. worked for Respondent, he instructed J.T. to give his patients wine, Ativan, and Norco prior to liposuction procedures. At the end of the procedure, the patient would be unable to walk out of the room. On one particular occasion, J.T. perceived that Respondent emitted the smell of an alcoholic beverage prior to a surgical procedure. At that time, Respondent admitted he had been drinking to J.T., and she told Respondent to go home and he replied that "it was a good idea."

13. A.G. worked for Respondent from in or around January 2015 until in or around April 2016 when she resigned due to his inappropriate behavior and alcohol use. During the time A.G. worked with Respondent, she witnessed Respondent have incredible mood swings, red eyes, flushed skin, and she perceived the odor of an alcoholic beverage on his person. She also witnessed him report to work while under the influence of alcohol on multiple occasions. Respondent even admitted that he was an alcoholic at an office staff meeting. Respondent also demonstrated erratic behavior and suffered from memory issues which developed after he

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Vicodin, Hycodan (or generically Hydromet), Lorcet, Lortab, Norco, and Hydrokon, among others). Hydrocodone also has a high potential for abuse. Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I), and a dangerous drug pursuant to Business and Professions Code section 4022.

underwent a hip-replacement surgery. His memory lapses began to increase in frequency and severity over time. A.G. also learned that Respondent checked himself into the emergency department at a hospital because of his memory issues. Additionally, A.G. became aware of Respondent's practice of giving wine to his patients prior to procedures he would perform on them. She also learned that staff had to clean up vomit from a patient who had been given Ativan, Norco and wine by Respondent. A.G. also knew that Respondent had wine on his office premises. Lastly, accordingly to A.G., Respondent also suffered from periods of suicidal thoughts when he would cry and declare that he was going to kill himself.

14. L.H. worked for Respondent from in or around January 2016 until in or around April 2016 when she resigned due to his sporadic, erratic behavior. During her employment with Respondent, L.H., on more than one occasion, could smell drinking alcohol on Respondent's person while he was working at his office. Examples of Respondent's alcohol use include:

- L.H. witnessed Respondent in his office lobby sitting with patients and talking with them like it was "happy hour' and she could smell alcohol odors from him.
- L.H. witnessed Respondent come to work with bloodshot eyes and emit the odor of alcohol at approximately 9:30 a.m. when she was in the office's laboratory completing paperwork. She also heard Respondent say that he was hung over.
- L.H. smelled alcohol on Respondent on a day that he performed liposuction.
- L.H. smelled alcohol on Respondent's breath on a day that she believed that he consumed alcohol while at his medical office because he did not smell like alcohol when he came to work that morning.
- L.H. also heard Respondent say that he was hungover while at work.

15. At one point during the period beginning in or around January 2015 through April 2016, Respondent saw a female patient for a bone density examination and told her how attractive she was and asked if he could touch her inappropriately. The patient later complained about his behavior to office staff and a cosmetic sales representative.

<u>Hospitalizations of Respondent.</u>

16. Respondent was hospitalized on multiple occasions based upon his medical records

from Mission Medical Center, including, without limitation the following dates:

17. On or about September 11, 2016, paramedics brought Respondent to the emergency room following a new seizure. A CAT scan revealed an old infarct in his left occipital lobe. In addition, Respondent was advised not to drive until cleared by a neurologist and a "DMV form was filled out."

18. On or about December 7, 2016, Respondent was brought to the emergency room and hospitalized again at Mission Medical Center with an altered level of consciousness. At the time, his son had found him lying on the couch, unconscious, having difficulty breathing. He had consumed an unknown amount of wine and vomited a red substance. His wife reported that in the past, Respondent after drinking, "was obtunded for a few minutes and regained consciousness." However, he was unresponsive for 45 minutes. He received an emergent intubation for airway stabilization. While hospitalized in the ICU in critical condition it was determined that he had an elevated alcohol level (299). The recorded impressions included acute alcohol intoxication, with a history of seizure disorder and alcoholism. He also had a past medical history of memory lapses.

19. On or about June 27, 2017, Respondent was hospitalized again at Mission Medical Center. The records indicated that he had had a six-minute convulsive seizure that was due to alcohol withdrawal. He reported that he had stopped drinking for two days before he experienced the seizure. His history included drinking three glasses of wine per night. His social history included a history of alcohol abuse. It was also noted that Respondent had problems with short-term memory loss that had an abrupt onset at the time of hip surgery in 2015. The impression stated the he had, "amnestic mild cognitive impairment, first noticed after hip replacement in February 2015." In or around February 2017 he had been prescribed Aricept, medication commonly used for memory disorders with patients diagnosed with dementia. There was also a record of neuroimaging that again revealed evidence of an old infarct in his occipital lobe. The plan included that Respondent "was urged to avoid driving for the time being, until again cleared to drive."

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MEDICAL PRACTICE ACT VIOLATIONS AND SEXUAL MISCONDUCT

Patient A[3]

20. On or about May 24, 2017, Respondent saw Patient A in his office to go over blood test results. She had been his primary care patient for approximately two years and his records for Patient A contain errors and are inaccurate and inadequate. While in the office Respondent asked her if she had completed her bone density exam and told her that he would have time to complete this bone density exam on that day in the office because he was now able to conduct this exam. She agreed to undergo the exam.

21. Respondent and Patient A went to a separate room where the bone density scanner was kept. He told her that she would need to remove her clothing, including her bra. She changed into test garments, but did not remove her spandex-style underwear covering her bottom. Respondent looked at her and noticed she was still wearing her bottom underwear and told her it was not going to work with the machine, and that she needed to remove her underwear. She told Respondent that she was on her menstrual cycle, but was not wearing a tampon and if she took her bottoms off, there was a possibility of her bleeding. She told Respondent she could come back at a later time, but he told her to just continue because he had the machine calibrating. She felt very odd and uncomfortable, but agreed to continue with the exam because of Respondent's urging. When she removed her bottom underwear, Respondent did not give her a place to put it and she had to place her underwear near her head while laying on the table.

22. Patient A next was lying on her back on an exam table underneath a machine that conducts the bone density exam. While she was lying there, a small wedge-type item was in between her legs and Respondent told her keep her legs still. After lying there, Respondent gave her a thick heavy lead-style glasses to put over her eyes that completely covered her eyes and made her unable to see anything. At approximately five to ten minutes into the exam, Respondent came over to Patient A and opened her top, exposing her breasts. Respondent told her, "I'm sorry, I know it's kind of weird you have to have the gown open for this test." At the

[3] The patients' names are anonymized to address privacy. The identity of the patients is known to the Respondent and will be further provided in response to a Request for Discovery.

same time that he opened up her top, he poked her with what she thought was two fingers in the rib area approximately two times. Patient A could not see anything during the entire test due to the glasses she was wearing and she was completely naked. When the scan was complete, Respondent told her to get dressed, but did not leave the exam room while she put her clothing on. During this encounter, Respondent was in the room alone with Patient A and no chaperone was present. After the exam concluded Respondent told Patient A, "you have a nice figure, I'm used to seeing a lot of overweight people."

23. Later, when asked by Patient A during a phone call, "is there any reason why I needed to be undressed?" Respondent replied, "Well you are not supposed to have anything in the way of the imaging. They used to do them with a gown on and they found the images weren't good. They used to not cover the eyes but it is a low dose of radiation and you wouldn't want to be exposed, so they do cover the eyes but the gown they try not to have in the way." Patient A then stated, "You know I actually asked a friend who had a bone density exam and they actually had their clothes on, and as far as me having clothes off, I have always had a nurse or someone else in the room, and there was no one in the room with us." And, Respondent replied, "That was a mistake, I apologize for that, I agree with you, that was an oversight. I do them for a long time and I didn't think of it." Patient A then stated, "From what I understood, you don't have to be undressed at all for it, or your eyes covered." And Respondent replied, "I am certified in radiology and the exposure to radiation should have your eyes covered and if I was any closer to it I would have my eyes covered as well. When I use lasers I use eye protection." Patient A also asked, "And while my eyes were covered, what were you doing? What goes on with the test?" And Respondent stated, "Well I have to watch the counters and what goes on with the scan, that's what I am supposed to watch, there is a lot of physician stuff that goes on. It sounds like I made you uncomfortable and I apologize. I hope you come back and talk to me about it and I do so much of this kind of thing I didn't give it a second thought and I should have had someone else in the room and for that I apologize." Patient stated, "There was no one else in the room." And Respondent replied, "That was an oversight." Patient A asked Respondent, "Why I was undressed and my top was exposed and my breasts?" And Respondent, replied "Well you have to

do the sternum and that's the way it is supposed to be." Patient A asked Respondent, "So everyone is naked, correct, for the test for you?" And Respondent replied, "Yes, but I always have a woman in the room."

24. On or about June 29, 2017, Respondent was questioned by City of Irvine police officers about his bone density exam of Patient A. He showed the officers the bone density scanner machine and stated, "I get the feeling this has to do with her being clothed or un-clothed, again she was covered the entire treatment, it is not necessary to reveal the patient." However, at that point in his conversation with the police, there was no mention to Respondent about Patient A being clothed or un-clothed. Respondent also explained to the police that a patient obviously has to get undressed to put on a gown and he stated that he leaves the room when a patient undresses to put a gown on. Respondent stated that it was standard for everyone to wear a gown for the procedure. When asked about whether a patient was required to wear any other protection, he stated they do not because it is such a low dose of radiation. When asked whether a patient had to wear anything on their eyes, Respondent stated they usually do protect the eyes with opaque goggles, and he showed the police a type of ceramic goggle similar in shape to what a person wears at a tanning salon. Respondent then told the police that he just got out of the hospital because he had a bad fall and motioned towards the left forearm area. When asked if he remembers whether Patient A was unclothed in the room without a gown, he replied, that he did not recall and that he always has a female in the room with him when he does procedures on other women. The officer then asked Respondent if there is ever a time when the bone density exam is done when a patient is not wearing a gown and he stated, "no." The officer further asked, "So you would never do a bone density exam without a gown on?" Respondent replied, "it is not necessary" and began motioning towards his own body and placed his hand above his nipple line and said "the gown goes to here and I even put it up here on men." The officer then asked Respondent if Patient A's breasts would have been covered and if her pubic area would have been covered, and he replied, "as far as I know, I didn't open it, there is no reason to." Respondent then asked the officer if the complaint was whether Patient A thought she was exposed and the officer replied in the affirmative. Respondent then stated, "if she was, I don't remember it." The

officer then asked Respondent if it would have been out of the ordinary for Patient A to be exposed, and Respondent stated it would have been, but stated he was not 100% sure. The officer then asked Respondent if he has to touch a patient at all while the test is being performed, and Respondent stated that he did not have to touch them. When asked if he touched Patient A at all, Respondent stated, "not that I recall." When confronted about Patient A's reporting that Respondent touched her in the rib area during the test, Respondent stated, "I don't recall." Respondent then stated to the police, "if she was dis-robed I don't recall it and I'm not sure why she would have been, I usually keep the gown on." A police officer asked Respondent if he had since spoke to Patient A about the exam and he stated, "not that I recall, if it was something like this I would have remembered, this is kinda scary." The officer then asked Respondent if he photographed Patient A while she was naked and the test was being administered, and he stated he did not. The officer then asked Respondent again if he had spoken to Patient A about the exam and he stated, "I don't recall, if she had some kind of complaint like this, I would have remembered and she did not speak to me about this." The officer then confronted Respondent about his conversation with Patient A about the bone density scan and asked for honesty. However, Respondent immediately stated, "I don't recall, I have been in the hospital, I don't recall talking to her." The officer repeatedly asked Respondent about his conversation with Patient A about the scan, and he continued to assert a lack of memory. He stated, "I don't remember; this is not dishonesty, I just got out of the hospital." The officer then told Respondent that he seemed to be functioning fine and that his mental capacity must be fine if he was still practicing medicine after getting out of the hospital. The officer asked Respondent about the discrepancy between his answers to the officer and what he told Patient A about the scan encounter and her being naked. And, Respondent stated, "I'm not sure, I don't think anything inappropriate happened." Respondent continued to state how his memory was "pretty shot" because he just got out of the hospital, but he would not lay her naked on the table. He further stated he has a mental problem and he just got out of the hospital.

SUBJECT INTERVIEW

25. On or about February 14, 2018, Respondent was interviewed by a Department of

Consumer Affairs investigator. During this interview, Respondent stated that he dismantled and disposed of his bone density scanner machine, and Respondent also displayed many indicia of mental illness, including without limitation, that he could not remember the last names of his employees; he could not remember the year he graduated from medical school; he could not remember when he completed his residency training; he could not remember the name of his bone density scanner, or how long he had owned it; he could not remember when (the year or season) he was hospitalized at Mission Hospital; he could not remember his conversations with Irvine police officers described above; and he could not remember if he showed the police his bone density scanner machine. When asked if he commented on Patient A's figure, Respondent replied,

> "Yes, of course. That's my job. That's something like, you look like you're in good shape. Again, there's two reasons for that. One, it brings up diet, exercise. The other thing I've explained before how do you bring up do you want liposuction? If she said, oh, thank you. That means she's fine with her – um – physical attributes. Leave it alone. If she says well, yeah, I'm kind of out of shape. Here's some fat. It opens up a discussion for lipo. That was the purpose. Number One, general health. It looked like you're in good shape. It was not a solicitation of any sexual intent. Um - it was strictly business. A. Do you need to watch your weight? Do I need to talk to you about diet? B. Are you a candidate for liposuction so I can pay my car payment?"

In addition, when asked if he had any falls or injuries in the last few years that could have impaired him, he stated that he did have a fall down the stairs about a year prior.

Patient B

26. Patient B, is a young female who was approximately 21 years old and worked at Respondent's medical office for approximately four months in or around 2017 (two months as a trainee intern and then two months as a medical assistant). Respondent's records for Patient B contain errors and are inaccurate and inadequate. During the last two months when she worked at Respondent's office, Patient B chaperoned at least four bone density scans performed by him on female patients. Each of these patients, who were all female (and generally ranged in age from

their thirties to their forties), was completely nude during the bone density exams performed by Respondent pursuant to his instructions to each of them. Respondent also requested that Patient B allow herself to be scanned in order to "check" the machine to ensure it was working correctly. Patient B was completely nude when Respondent performed the bone density exam on her pursuant to his instructions.

27. There is no need to be completely nude for a bone density exam. In order to calibrate a bone density machine, there is also no need to radiate a patient and use a human being. Bone density scanners can be calibrated and tested without the actual scanning of a human being.

NEUROPSYCHOLOGICAL EVALUATION

28. On or about May 26, 2017, D.A., Ph.D. performed a neuropsychological evaluation of Respondent. [4] Respondent specifically denied a history of alcohol abuse or other substance abuse to the evaluator. The evaluator administered several tests on Respondent which revealed that he was impaired or performing in the lower range of his same age peers, including without limitation, the Montreal Cognitive Assessment (MoCA)(which was designed as a rapid screening instrument for mild cognitive dysfunction) and the Wisconsin Card Sort Test (WCST-CV-4); WAIS IV Matrix Reasoning Test and the WAIS-IV Working Memory Index (WMI). Respondent's performance on the WCST-CV-4 was in the impaired range for his age and education. Respondent's working memory and mental processing speed were in the low average range for his age and he demonstrated severe verbal/auditory memory and non-verbal visual memory impairment. Moreover, Respondent also demonstrated significant impairment in executive functioning ability for his age and education. In addition, Dr. D.A. reviewed Respondent's Medical Records. According to D.A., Ph.D., based on the current neuropsychological evaluation results and his review of Respondent's Medical Records, Respondent is not competent to practice medicine, at the present

[4] Neuropsychologists perform the "study of brain behavior relationships and use a battery of psychological and neuropsychological tests that are standardized in order to elicit observations of relevancy of various aspects of the brain in terms of cognitive and intellectual function." (*Huntoon v. TCI Cablevision of Colorado, Inc.* (1998) 969 P.2d 681 [majority of jurisdictions have found that neuropsychologists may give opinions on the physical cause of organic brain injury].) These tests seek to identify any deficits in attention, memory, perception, language, visuospatial skills, executive functions, cognition, and other associated conditions that may be present. (Taylor, *Neurolaw and Traumatic Brain Injury: Principles For Trial Lawyers* (2015) 84 UMKC L. Rev. 397.)

time, due to a significant neurocognitive disorder and severe memory and executive functioning deficits.

NEUROLOGICAL EVALUATION

29. On or about May 23, 2017, Dr. M.B. performed a neurological evaluation of Respondent. At that time, Respondent stated to Dr. M.B. that his drinking was minimal and occurred only three nights a week. Based upon these facts, Dr. M.B. found that Respondent may have had excessive alcohol intake in the past, and his alcohol use may have interfered with his ability to safely practice medicine, but at the time of his evaluation in May 2017 with Dr. M.B., he did not appear to be consuming a significant amount of alcohol and Respondent reported to Dr. M.B. that his issues had resolved. However, Dr. M.B. opined that Respondent was required to be subjected to random alcohol testing. More recently, Dr. M.B. re-evaluated his initial findings regarding Respondent based upon additional records, including the neuropsychological evaluation of Dr. D.A. and the medical records of Mission Hills regarding Respondent's three hospitalizations for seizure activity. Based upon that review, Dr. M.B. found that Respondent was not safe to practice medicine due to his chronic substance use compounded with the after effects of a traumatic brain injury complicated by the development of a subdural hematoma, and that he should not be allowed to drink any alcoholic beverages as well as avoid the use of any substances (such as sedatives) that may interfere with cognition and that he should be required to complete a formal alcohol rehabilitation program.

MENTAL EVALUATION

30. On or about February 27, 2017, Dr. M.K. performed a mental evaluation of Respondent. Respondent admitted to Dr. M.K. that he frequently drank "from half a glass to half a bottle" of wine every night "episodically." When asked at several different times about his alcohol use, Respondent repetitively denied any use of alcohol prior to or during work hours. Respondent also told Dr. M.K., that he "fell down the stairs while drinking; [his] wife panicked and had [him] go to Mission Hospital (Mission Viejo)." He stated that he had brain imaging which demonstrated a "subdural" hematoma but he did not know if this was a recent event or chronic, nor where it was located in his brain. After this initial review, Dr. M.K. concluded that

Respondent had to be evaluated by a neuropsychologist to rule out cognitive deficits, and that he should be subjected to frequent random urine and blood toxicology screens, and that he be followed regularly by a psychiatrist due to his chronic insomnia, anxiety and alcohol bingeing, and that he be treated by a substance abuse counselor with frequent reports back to the Medical Board. After Dr. M.K. reviewed the findings of Respondent's neuropsychology evaluation, Dr. M.K. further found that Respondent was impaired and he could not safely practice medicine. Respondent exhibited "executive functioning deficits." In addition, based upon his more recent review of Respondent's medical records from his three hospitalizations and other materials referred to above, Dr. M.K. found that Respondent continues to be impaired. And, that while Respondent might appear to be quite articulate, and to a casual observer he might not appear to have any psychiatric disorder, doctors must possess a higher level of cognitive resources than members of the general public. The damage or injury to the public resulting from an error in the practice of medicine is more serious for a physician than a member of the general public. Medical tasks require long term memory and planning. Respondent's performance during his February 2018 interview with the Medical Board investigator reflects his ongoing problems with memory and he also admitted that he continued to drink alcoholic beverages at night. Thus, his alcohol use disorder was no longer in remission. Furthermore, he exhibited a lack of judgment and lack of impulse control when he had his female patient undress in front of him without the presence of a chaperone when he performed a DEXA bone density examination on her. Respondent suffers from ongoing cognitive deficits, including memory and executive functioning deficits. If Respondent continues his solo practice he will continue to make the same errors as he did when requiring a woman to undress for the DEXA scan. Furthermore, if the past is any indication of the future, Respondent's prior three crises due to heavy alcohol intake and seizures, will reoccur and his cognitive function will decline.

FIRST CAUSE FOR DISCIPLINE

(Unable to Practice Safely Due to Mental/Physical Illness)

31. Respondent is subject to discipline pursuant to Code section 822 in that his ability to practice medicine safely is impaired because he is mentally and/or physically ill in a manner

affecting competency. The circumstances of Respondent's illnesses are as follows:

32. The allegations in paragraphs 11 through 30 inclusive, above are incorporated herein by reference as if fully set forth.

33. Respondent's on-going memory lapses and mental issues, including, without limitation, in connection with his interactions with investigators and Patient A and Patient B demonstrate his impairment, lack of judgement, and inability to safely practice medicine.

SECOND CAUSE FOR DISCIPLINE

(Dangerous Use of Alcohol and/or Impairment and/or Practicing Under the Influence)

34. Respondent is subject to disciplinary action under Code sections 2239 and 2280 in that he used alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to himself or others or to the public, or to the extent that such use impaired his ability to practice medicine safely, and/or he practiced medicine while under the influence of any narcotic drug or alcohol to such an extent as to impair his ability to conduct the practice of medicine with safety to the public and his patients. The circumstances are as follows:

35. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

36. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he committed gross negligence. The circumstances are as follows:

37. The allegations of the First and Second Causes for Discipline are incorporated herein by reference as if fully set forth.

38. In or around January 2015, and thereafter, Respondent committed gross negligence each time he gave a patient, prior to a medical procedure, wine together with dangerous drugs, including without limitation, Ativan and Norco.

39. In or around 2017, Respondent committed gross negligence each time he a performed bone density exam on a nude female patient.

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FOURTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

40. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that Respondent committed repeated negligent acts. The circumstances are as follows:

41. The allegations of the First, Second and Third Causes for Discipline are incorporated herein by reference as if fully set forth.

42. Each of the alleged acts of gross negligence set forth above in the Third Cause for Discipline is also a negligent act.

43. In addition, Respondent was negligent when he remained in an examination room when Patient A was dressing, undressing and/or changing into her gown.

FIFTH CAUSE FOR DISCIPLINE

(Sexual Abuse, Misconduct or Exploitation)

Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), and/or section 726 and/or 729 in that Respondent committed gross negligence and/or sexual abuse and/or misconduct and or exploitation. The facts and circumstances are as follows:

44. The allegations of the First, Second, Third and Fourth Causes for Discipline are incorporated herein by reference as if fully set forth.

45. In or around 2017, Respondent committed gross negligence and/or sexual abuse and/or sexual misconduct and/or sexual exploitation each time he performed a bone density exam on a nude female patient.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Medical Records)

46. Respondent is subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate and accurate records related to the provision of medical services to patients. The circumstances are as follows:

47. The allegations of the First, Second, Third, Fourth and Fifth Causes for Discipline are incorporated herein by reference as if fully set forth.

SEVENTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

48. Respondent is subject to disciplinary action under Code section 2234, in that his actions and/or omissions represent unprofessional conduct, generally. The circumstances are as follows:

49. The allegations of the First, Second, Third, Fourth, Fifth and Sixth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

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 A49201, issued to Brent Edward Silvers, M.D.;

2. Revoking, suspending or denying approval of Brent Edward Silvers, M.D.'s authority to supervise physician assistants and advance practice nurses;

3. Ordering Brent Edward Silvers, 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: November 16, 2018

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

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