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

In the Matter of the Accusation Against: HOWARD HACK, M.D. Physician and Surgeon's Certificate No. G 68575 Respondent.	Case No. 800-2015-012753 OAH No. 2016100492

DECISION AFTER REMAND

This matter was heard before Administrative Law Judge (ALJ) Marcie Larson, Office of Administrative Hearings, State of California, on January 24 through 26, 2017, in Sacramento, California.

Demond Philson, Deputy Attorney General, represented complainant Kim Kirchmeyer, Executive Director (Complainant) of the Medical Board of California (Board).

Peter Osinoff, Attorney at Law, represented Respondent Howard Hack, M.D., (Respondent) who was present at the hearing.

Evidence was received, the record was closed, and the matter was submitted for decision January 26, 2017. The ALJ issued the proposed decision on February 27, 2017. Panel A of the Board adopted the decision on March 29, 2017, with a minor typographical correction. Respondent filed a petition for reconsideration, which was denied. Respondent then filed a petition for writ of mandate with the Superior Court of California, County of Los Angeles. The Court remanded the case back to the Board to reconsider condition 12 of Respondent's order relating to non-practice while on probation, in light of the Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines, 12th Edition, 2016 (2016 Disciplinary Guidelines). The Court upheld the Board's disciplinary order in all other respects.

The Board set a hearing for May 9, 2019, and invited the parties to provide oral and written argument on the matter. The parties submitted written argument only, and did not attend the hearing. The Board having read and reviewed the administrative record and the parties' written argument, and considered the judicial directions given in this matter, hereby amends its disciplinary decision to apply the 2016 Disciplinary Guidelines to condition 12 of

Respondent's order relating to non-practice while on probation. This modification, however, will not change Respondent's circumstances. Respondent's physician's and surgeon's certificate is on probation in California, but he is not practicing medicine in California. Respondent is practicing medicine in North Dakota, a state that has not placed his license on probation. Consequently, even under the 2016 Disciplinary Guidelines, Respondent is in a non-practice status. Moreover, pursuant to condition 12 in Respondent's order, being in a non-practice status for more than two years is a violation of probation.

Standard model language for non-practice while on probation in the 2016 Disciplinary Guidelines states, in pertinent part, the following:

> **Non-practice While on Probation**
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> Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. **Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice.** A Board-ordered suspension of practice shall not be considered as a period of non-practice.
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> In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.
>
> Respondent's period of non-practice while on probation shall not exceed two (2) years.
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> ¶ . . . ¶

(Emphasis added.)

The provision, **"Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice,"** which appears in both the 11th and 12th editions of the Disciplinary Guidelines, would not be necessary if the Board intended to allow licensees to "work off" their period of probation by simply practicing in another state or jurisdiction.

The Board's primary mission pursuant to Business and Professions Code sections 2001.1 and 2229 is consumer protection. The Board cannot permit a licensee to avoid the oversight of an order of probation by practicing in a state where the licensee is not on probation. To do so would not be consistent with consumer protection. Licensees could use such an avenue to avoid the consequences of violating California's Medical Practice Act by practicing out of state for the duration of their California disciplinary order not ever having been subject to the oversight of probation as required. Consequently, while the Board is agreeable to amending condition 12 of Respondent's order to be consistent with the 2016 Disciplinary Guidelines, Respondent remains in a non-practice status.

Because Respondent has been in a non-practice status since the effective date of his disciplinary order, May 8, 2017, if this decision after remand was made retroactive to that date, Respondent would already be out of compliance with the terms and conditions of his probation, because of the two-year limitation for being in a non-practice status. Respondent has not begun to serve his three-year probation ordered by the Board, thus his probationary period has been tolled. Under the circumstances of this case, and in light of the Court's order, a new effective date is appropriate so that Respondent is not immediately facing action for a probation violation for being in a non-practice status for more than two years.

For all of the reasons stated above, the Board enters the following as its decision in this matter.

FACTUAL FINDINGS

1. On May 14, 1990, the Board issued Respondent Physician and Surgeon's Certificate No. G 68575 (certificate). The certificate was current at all times pertinent to this matter. It will expire on September 30, 2017, if not renewed.

2. On August 15, 2016, complainant, acting in her official capacity, signed and thereafter filed the Accusation against Respondent. Complainant seeks to impose discipline on Respondent's certificate, based on his alleged unprofessional conduct in connection with his treatment of three patients: R.B., N.P., and D.R.[1] Generally, complainant alleged Respondent unnecessarily performed repeated endoscopic procedures on the patients and failed to refer R.B. and N.P. to a more experienced physician to remove large colon polyps. Complainant alleged that Respondent's unprofessional conduct constituted excessive use of diagnostic procedures, gross negligence, repeated acts of negligence, and demonstrated incompetence.

[1] The patients are referred to by their initials to protect their privacy.

Complainant also alleged that Respondent failed to keep complete and accurate medical records for the care and treatment he rendered to patient R.B.

3. Respondent timely filed a Notice of Defense, pursuant to Government Code section 11506. The matter was set for an evidentiary hearing before an Administrative Law Judge of the Office of Administrative Hearings, an independent adjudicative agency of the State of California, pursuant to Government Code section 11500 et seq.

Respondent's Background

4. Respondent completed his Bachelor of Arts degree in economics at the University of Pennsylvania in 1984. He attended medical school at Washington University in St. Louis, Missouri. Respondent graduated from medical school in 1988. Thereafter, he completed an internship at the Cleveland Clinic in Ohio. Respondent returned to Washington University in 1989, to complete his residency in internal medicine at Barns Hospital. In 1990, he obtained his certificate to practice medicine in California. Respondent completed a three-year Gastroenterology fellowship at Stanford University in California, from 1991 until 1994. The fellowship program consisted of two years of clinical training and a third year that was a combination of clinical training and clinical research.

5. In 1993, Respondent was board-certified in Gastroenterology. He was recertified in 2004 and 2014. After Respondent finished his fellowship at Stanford, he returned to Milwaukee, where he was raised, and practiced Gastroenterology for 15 years at the Milwaukee Medical Clinic. Respondent was the Chairman of the Division of Gastroenterology and Chief of the Gastroenterology Department for a total of 6 years. Respondent returned to Stanford, at times, to work as a Clinical Instructor approximately two times per month. He also worked as an Assistant Clinical Professor of Medicine at the College of Wisconsin and a Clinical Associate Professor at Marquette University.

6. From 2002 until 2009, Respondent practiced Gastroenterology at the West Bend Clinic in West Bend, Wisconsin. He was a member of the Quality Assurance Committee at the West Bend Clinic. From 2009 to 2012, Respondent operated a private Gastroenterology practice in Las Vegas, Nevada. He also worked in a Locum Tenens position in Lafayette, Indiana.

7. In 2013, Respondent was recruited to practice at Feather River Hospital (Feather River) in Paradise, California. Feather River is a 100 bed rural hospital located near Chico, California. In March 2013, Respondent opened a private practice in Paradise. He performed procedures at Feather River and Skyway Surgery Center (Skyway), in Chico. Respondent was granted "provisional" staff privileges at Feather River. Despite being recruited to work at Feather River, Respondent testified that he quickly discovered that the Chief of Medicine at Feather River was not "enthusiastic" about his arrival. The Chief of Medicine would not acknowledge Respondent's presence or greet him. Their relationship did not improve over time, despite Respondent's efforts to speak with the Chief of Medicine. Respondent was also informed by his colleagues that the Chief of Medicine "hated him."

8. Respondent worked at Feather River until February 2015. During his time at Feather River, he performed thousands of procedures. Feather River reviewed all of Respondent's patient files and procedures. Respondent had no patient complaints and no complications with any of the procedures he performed. In February 2015, Feather River was in the process of determining whether Respondent would be recommended for advancement to active staff. Respondent had never experienced a delay in obtaining hospital staff privileges. Respondent testified that he did not believe that the issues the Chief of Medicine had with him were going to resolve or that his staff privileges would be handled in the normal manner in which Respondent was accustomed. As a result, effective February 25, 2015, prior to Feather River's decision, Respondent resigned his position.

Investigation Conducted by Investigator Adam Brearley

9. On March 19, 2015, the Board received an "805 Report" from Feather River. The brief statement provided by Feather River explained that Respondent was under a "focused investigation related to his gastroenterology privileges" and that prior to a decision made by the Feather River Medical Executive Committee to "recommend or deny" Respondent's advancement to active staff, he resigned.

10. On April 16, 2015, Adam Brearley, an Investigator for the Department of Consumer Affairs, was assigned to investigate the report filed by Feather River. Mr. Brearley issued an initial report dated April 5, 2016, and a supplement report dated May 12, 2016, regarding his investigation of Respondent. Mr. Brearley testified at hearing. As part of his investigation, Mr. Brearley obtained Respondent's patient records from Feather River, for any patient in which "the competence or conduct of [Respondent] was in question." Mr. Brearley provided the medical records to the Board's medical consultant Dr. Howard Slyter for review.

11. On September 10, 2015, Dr. Slyter completed his review of the medical records provided to him by Mr. Brearley. Dr. Slyter requested additional records for six patients. On September 25, 2015, Mr. Brearley provided Dr. Slyter with the medical records of six patients, including R.B., N.P. and D.R. On December 28, 2015, Respondent was interviewed by Investigator Michel Veverka. Dr. Slyter was present at the interview.

12. On January 8, 2016, Mr. Brearley sent a letter, draft report, and "selected attachments and property" to Board expert reviewer James Ostroff, M.D., who is board-certified in Gastroenterology. On March 20, 2016, Dr. Ostroff issued a report in which he opined that Respondent performed endoscopic procedures on patients R.B., N.P. and D.R., that deviated from the standard of care.

Description of Endoscopic Procedures

13. An endoscopy is a procedure conducted with a thin, flexible tube equipped with a digital camera that travels through the body's orifices and allows a doctor to examine a patient's stomach, esophagus, small intestine and colon. Endoscopic procedures include upper gastrointestinal endoscopies (upper endoscopy) and colonoscopies. An upper endoscopy involves the insertion of an endoscope through a patient's mouth to view the areas such as the

esophagus and stomach. A colonoscopy procedure involves the insertion of an endoscope through the rectum to view the colon.

14. In preparation for a colonoscopy, a patient is required to cleanse the colon of fecal material prior to the procedure. The day of the procedure, the patient is sedated with either moderate sedation or monitored anesthesia depending on the patient's needs. A doctor inserts an endoscope through the anus, which travels through the colon. The colon is shaped like an upside down U. The rectum is the starting point of the colon. The endoscope is inserted through the anus to the rectum, which is followed by the sigmoid colon, and then the descending colon located on the right side of the body. The transverse colon is the horizontal portion of the colon, followed by the ascending colon, which is located on the left side of the body. The cecum is at the end of the ascending colon, which is where a colonoscopy ends. The colonoscope contains a camera which projects an image onto a monitor for the doctor to view.

15. The American Medical Association (AMA) recommends that individuals over the age of 50 years old undergo a screening colonoscopy for colon cancer. The screening colonoscopy is a preventative measure. Approximately one-third of individuals over the age of 50 have colon polyps, which is tissue growth. The first layer of the colon is the mucosa, where the polyp tissue arises. The layer below the mucosa is the submucosa. Typically, two types of polyps are found in the colon, pedunculated and sessile polyps. A pedunculated polyp is a tissue growth that is attached to the top of a stalk. The stalk is attached to the mucosa. A sessile polyp, also referred to as a flat polyp, is flat and lies on the surface of the mucosa. If not removed, a polyp can progress into cancer. The risk of undergoing a colonoscopy includes bleeding, a perforation, and respiratory complications.

16. Polyp tissue can be removed with a snare. The snare is threaded through a hollow channel in the colonoscope. Typically, the snare is equipped with electricity and heat. The polyp tissue is removed from the colon. The tissue can be suctioned through a hollow channel in the colonoscope and caught in a trap that contains webbing, referred to as a Roth net (net). Small polyps can be removed with biopsy forceps. The polyp tissue that is removed is sent to pathology to determine if any of the tissue contains cancer or pre- cancerous cells.

17. The performance of a colonoscopy by a Gastroenterologist is a standard procedure. Gastroenterologists study the digestive system, including the stomach, small intestine, and the large intestine and some organs related to the digestive system, such as the liver, the gall bladder, the pancreas, and the salivary glands. Gastroenterologists typically care for patients with ailments in those structures. Respondent estimated that he performs approximately 1000 to 2000 colonoscopies and endoscopies per year. Over the course of his career, he has performed between 30,000 to 40,000 colonoscopies and endoscopies. During his fellowship at Stanford, Respondent was trained to remove large flat polyps from the colon that are larger than 2 centimeters (cm) in size. As part of his practice, Respondent regularly removes large flat polyps. Approximately 10 to 15 percent of his patients have flat polyps, and of those patients, Respondent removes less than 10 percent of the flat polyps in a piecemeal fashion, during multiple procedures.

Treatment History of Patient R.B.

MARCH 4, 2014 COLONOSCOPY

18. On March 4, 2014, Respondent performed a screening colonoscopy on R.B., a 67 year-old man. Respondent performed the procedure at Skyway. Respondent observed during the colonoscopy that R.B. had a 4 cm flat polyp in the proximal ascending colon, a 3 cm flat polyp in the transverse colon and a 1 cm polyp in the sigmoid colon. Respondent removed the 1 cm polyp with a snare and electrocautery, and partially removed the 4 cm flat polyp. He did not remove the 3 cm polyp in the transverse colon.

19. Respondent was only able to partially remove the 4 cm flat polyp because he did not have the "necessary endoscopic conditions to remove it in its entirety." Respondent testified that in order to remove a flat polyp, the patient needs to be comfortable and well sedated, so that Respondent can get the patient into proper position. Moderate sedation was insufficient for R.B. during the procedure. Respondent determined that R.B. needed a higher level of sedation administered by an anesthesiologist, which required monitored anesthesia. Skyway did not have a higher level of sedation available.

Skyway also had older endoscopy equipment. In contrast, Feather River was able to provide the most recent series of gastrointestinal scopes. Additionally, the technician assisting Respondent at Skyway was "less skilled" in assisting with colonoscopies. Specifically, Respondent relied upon the technician to apply abdominal pressure which allows Respondent to successfully advance the scope. Respondent was not able to perform the technical maneuvers necessary to remove the entire 4 cm flat polyp successfully at Skyway. As a result, Respondent determined that in order to remove the entire flat polyp, he needed to perform another colonoscopy on R.B. at Feather River.

MARCH 27, 2014 COLONOSCOPY

20. On March 26, 2014, Respondent conducted an examination of R.B., which he documented in R.B.'s medical record. Respondent documented R.B.'s history and physical examination. Respondent noted in R.B.'s medical record that during the March 4, 2014 colonoscopy at Skyway, he discovered a 4 cm flat polyp "in the proximal descending colon that could not be removed in its entirety endoscopically." Respondent testified that the medical record was not correct. He should have noted that the 4 cm polyp was in the "proximal ascending colon." Respondent dictated his medical notes. He failed to notice after the notes were transcribed, the mistake regarding the location of the 4 cm polyp in the history portion of R.B.'s record.

21. On March 27, 2014, Respondent performed a second colonoscopy on R.B. at Feather River. R.B. was administered monitored anesthesia. Respondent inserted the colonoscope through R.B.'s anus and advanced the scope. Respondent located the 4 cm flat polyp in the proximal ascending colon he incompletely removed during the March 4, 2014 procedure. Respondent correctly noted in the procedure notes that the flat polyp was located in

the proximal ascending colon. Respondent estimated that the remaining flat polyp in the proximal ascending colon was 25 millimeters (mm).

Respondent removed part of the 25 mm flat polyp in the proximal ascending colon with a "saline injection-lift technique using a hot snare," which Respondent also referred to as an "endoscopic mucosal resection." The endoscopic mucosal resection involves injecting liquid, such as saline, in the layer just below where the polyp arises. By injecting the polyp area with saline in the submucosa, a bubble is formed that creates a larger and thicker space. The mucosa with the polyp is brought away from the rest of the layers in the colon. This technique also provides a buffer for the lining of the colon from the electricity and heat from the snare. The snare fits around a portion of the polyp, which is cut with the snare and the polyp "flips off." Respondent explained that it is also important to remove a layer of tissue around the boarder of the polyp to ensure that no precancerous tissue is left.

22. Respondent noted that the resection of the 25 mm flat polyp in the proximal ascending colon "incomplete." The polyp was curved around a bend in the colon. Due to the size and location of the polyp, he could not position the snare around the entire polyp. Respondent removed as much of the 25 mm flat polyp that he believed was safe for the patient. Respondent testified that, particularly with flat polyps, there is a risk of bleeding. Respondent reduced the risk of bleeding and complications by removing the amount of tissue he believed was safe. He also applied a "resolution clip" to the removal site, which provided a surgical closure to the polypectomy site. Respondent also completely removed and retrieved a 5 mm sessile polyp in the distal sigmoid colon.

Respondent injected permanent carbon black ink into the submucosal space near the polypectomy site where he removed a portion of the 25 mm flat polyp, to identify that site for a future examination. Respondent testified that "there are no road markings in the colon." The ink assists him, and other doctors who may perform subsequent colonoscopies, with identification of the site in the future.

23. Respondent noted in R.B.'s medical record, that the resected tissue from the 25 mm flat polyp was "partially retrieved." Respondent indicated that there can be different reasons for incomplete retrieval of polyp tissue. Respondent testified that it is possible that the removed tissue was lost in the fluid that was present in the colon. Additionally, tissue that is suctioned can be shredded or does make it into the trap successfully. All tissue that was retrieved during R.B.'s procedure was labeled and sent to pathology for testing.

24. Respondent noted that that the estimated blood loss during the procedure was "minimal" and that the patient tolerated the procedure well. Respondent also noted that the "colonoscopy was technically difficult and complex due to poor endoscopic visualization." Respondent testified that R.B.'s bowel preparation was poor. The fecal matter was not cleaned out of his colon prior to the procedure, which made visualization of the colon more difficult. As a result, Respondent recommended that R.B. have another colonoscopy in two months to get better visualization of the colon and to review the polypectomy site. Respondent did not document any information about the 3 cm flat polyp in the transverse colon he observed

during the March 4, 2014 colonoscopy at Skyway.

25. The surgical pathology report dated March 31, 2014, indicated that approximately 0.5 cm of aggregate tissue from the 25 mm polyp in the ascending colon and 0.5 cm of a single tissue fragment from the 5 mm polyp in the sigmoid colon were submitted to pathology. The tissue from the ascending colon was diagnosed as "tubulovillous adenoma." The tissue from the sigmoid colon was diagnosed as a "Hyperplastic polyp." The report further noted as to the hyperplastic polyp in the sigmoid colon that "sections show polypoid colonic mucosa with some of the glands demonstrating serrated luminal outlines."

An adenoma has precancerous potential, regardless of the location of the adenoma. A tubulovillous adenoma is a more advanced precancerous condition and is believed to be a higher predilection for developing into cancer. Serrated adenoma is also thought to have precancerous potential and can be mistaken for a hyperplastic polyp. Respondent testified that a hyperplastic polyp in the left side of the colon does not typically have any clinical significance. However, if a hyperplastic polyp is found in any other part of the colon, the polyp could be precancerous, due to the location of the polyps in the colon

MAY 28, 2014 COLONOSCOPY

26. On May 27, 2014, Respondent conducted an examination of R.B., which he documented in R.B.'s medical record. Respondent incorrectly documented that during the March 4, 2014 colonoscopy at Skyway, he discovered a 4 cm flat polyp "in the proximal descending colon" rather than the ascending colon. However, in the same paragraph he noted that on March 27, 2014, there was a follow up colonoscopy to "remove the remainder of the proximal polyp in the ascending colon." Respondent also documented that on March 4, 2014, he identified "a 3 cm flat polyp in the transverse colon, which was removed." Respondent testified that the medical record is incorrect. Respondent should have written that the 3 cm flat polyp in the transverse colon, was not removed on March 4, 2014. Respondent reviewed the medical notes after his dictation was transcribed, but did not see the errors.

27. On May 28, 2014, Respondent performed a third colonoscopy on R.B. at Feather River. Respondent observed two flat polyps in the mid-transverse colon and in the proximal ascending colon. He noted the two polyps were 12 to 30 mm in size. Respondent testified that the polyp he identified in the proximal ascending colon was residual polyp tissue from the 4 cm polyp that removed in piecemeal fashion on March 4, and March 27, 2014. Respondent testified that the polyp in the mid-transverse colon was 3 cm polyp he first observed during the March 4, 2014 colonoscopy, which he incorrectly documented in the May 27, 2014 history that he had removed on March 4, 2014.

In the May 28, 2014 procedure notes, Respondent documented that he removed the polyps from the proximal ascending colon and mid-transverse colon, with the saline injection-lift technique, using a hot snare. The polyp resection was incomplete and the resected tissue was partially retrieved. Respondent injected the area near the polypectomy site with carbon black ink for tattooing. Respondent used four clips to prevent bleeding. Respondent testified that he was concerned that the resection of polyps in the ascending and transverse colon was

not complete and that there may be residual polyp tissue at the edge of the polyp. He noted that bowel preparation of the ascending colon was only "fair" which may have obscured his view.

28. Respondent also noted in the procedure report that the "colonoscopy was technically difficult and complex due to restricted mobility of the colon." Respondent further noted that "successful completion of the procedure was aided by using manual pressure." There was no bleeding during the procedure. Respondent recommended a follow-up colonoscopy in two months for "surveillance after piecemeal polypectomy."

29. Respondent noted in the "Patient Profile" portion of the procedure report that R.B. had a "4 cm flat serrated adenoma" in the ascending colon, which he had been removing "in a piecemeal fashion." This was an error. The 4 cm polyp in the ascending colon he partially removed on March 4 and March 27, 2914 was diagnosed as atubulovillous adenoma.

30. The pathology report dated May 29, 2014, indicated that two pieces of tissue were submitted in one cassette, labeled transverse colon polyp. Respondent did not label the specimens after the tissue was removed and placed in the cassette. He relied on the nurse or technician assisting with the procedure to properly label the cassettes. Respondent testified that it is possible that one of the tissue samples was from the ascending colon polyp. One sample was 0.4 cm and the other was "1.3 x 0.8 x 0.5" cm. The tissue in the single cassette was diagnosed as a tubulovillous adenoma.

NOVEMBER 26, 2014 COLONOSCOPY

31. On November 18, 2014, Respondent conduct a history and physical examination of R.B., in preparation for a follow-up colonoscopy to inspect the polypectomy sites. Respondent continued to incorrectly note in R.B.'s medical record that on March 4, 2014, a large flat "4-5" cm polyp was discovered in the proximal descending colon, rather than the ascending colon, and that a flat polyp in the transverse colon was removed on March 4, 2014. He also noted that he was not able to access the "4-5" cm flat polyp at Skyway, which was inconsistent with the previous medical notes from the March 27 and May 28, 2014 procedures, in which he wrote that he was able to partially resect the polyp during the March 4, 2014 colonoscopy at Skyway. Respondent noted that R.B. underwent colonoscopies on March 27, 2014, and May 28, 2014, "where it appeared to be the remainder of the large polyps were removed in piecemeal fashion."

32. On November 26, 2014, Respondent performed a fourth colonoscopy on R.B. at Feather River. Respondent inserted the colonoscope through the rectum to the sigmoid colon. Respondent observed a 5 mm sessile polyp in R.B.'s rectum. Respondent observed that the R.B.'s colon preparation was poor, which prevented Respondent from seeing the colon. As a result, Respondent canceled the procedure and recommended that R.B. have a follow-up procedure in two months with better preparation. Respondent resigned his position with Feather River, prior to performing the follow-up colonoscopy on R.B.

Treatment History of Patient N.P.

33. On December 18, 2013, Respondent examined N.P., an 89 year-old man who was referred to Respondent after he lost 23 pounds over an 18-month period. N.P. informed Respondent that other than losing weight, he felt well. N.P. reported that he had recently sold his appliance store business. He had three children. N.P. had lived alone since his wife had passed away 20 years ago. N.P. reported that he was active. He gardened and took care of his pool. Respondent noted that N.P. "appears well and appears younger than his stated age."

34. N.P. reported that he had a history of heartburn, but no recent symptoms. He reported an "intermittent sensation of lower esophageal dysphagia for solid foods" and that he had to drink a lot of water to swallow his food. He also reported feeling more constipated over the previous 12 months. N.P. informed Respondent that in 2001, he had colon polyps removed at Feather River. Respondent noted that blood tests taken in October 30, 2013, were "essentially normal with hemoglobin of 13.9."

35. Respondent's impressions included:

1. Involuntary weigh loss;

2. Chronic gastroesophageal reflux disease;

3. Intermittent dysphagia for solid foods, this is most likely related to a Schatzki ring with differential diagnosis also includes esophagitis and less likely esophageal cancer and history of colon polyps;

4. Weight loss. The differential diagnosis is broad, and they include hypothyroidism, celiac disease, malignancy such as colon, esophageal, or gastric cancer.

36. Respondent recommended that N.P. undergo an upper endoscopy and colonoscopy for further evaluation of his symptoms. Respondent recommended a colonoscopy because N.P. had profound weight loss, loss of appetite and constipation. Respondent determined that a colonoscopy should be used as diagnostic tool due to N.P.'s symptoms and history of colon polyps.

DECEMBER 19, 2013 PROCEDURES

37. On December 19, 2013, Respondent performed an upper endoscopy on N.P. Respondent observed that N.P. had "salmon-colored mucosa suspicious for short-segment Barrett's esophagus." Respondent testified that Barrett's esophagus is a condition which can cause cancer of the esophagus. Respondent obtained a tissue sample for a biopsy in order to obtain a definitive diagnosis. The pathology came back negative for cancer.

38. Respondent also performed a colonoscopy on N.P. Respondent observed eight polyps in the sigmoid, transverse and ascending colon, 5 to 25 mm in size. Respondent resected the eight polyps with a hot snare and retrieved the tissue. He inserted eight clips to close the polypectomy sites. Respondent also observed a 40 mm "polypoid lesion" in the distal transverse colon. Respondent was particularly concerned about the lesion because N.P. was in good health and there was no explanation for his profound weight loss. Given the size and appearance of the lesion, Respondent believed it was more likely to contain cancer.

Rather than remove the lesion which would not be indicated at the time of the colonoscopy if the lesion contained cancer, Respondent obtained samples of the lesion with cold biopsy forceps to send the sample to pathology. Respondent then injected the spot near the lesion with carbon black ink for tattooing. Respondent noted that the colonoscopy was performed "without difficulty" and that N.P. tolerated the procedure well. Respondent also noted that the estimated blood loss was minimal.

39. The pathology report dated December 20, 2013, noted that the lesion from the transverse colon was a polyp that contained "multiple tubulovillous adenoma fragments." The sample was "negative for high grade dysplasia and malignancy." The polyps in the ascending, transverse and descending colon were tubulovillous adenoma. The polyps in the sigmoid colon were hyperplastic polyps.

40. After obtaining the biopsy results, Respondent recommended to N.P. that he have the 40 mm tubulovillous adenoma polyp removed during another colonoscopy. Respondent believed that N.P. had a life of expectancy of another five years. There was no way for Respondent to predict whether the tubulovillous adenoma polyp would develop into cancer and Respondent believed that the risk of removing the polyp was very low.

MAY 14, 2014 COLONOSCOPY

41. On May 14, 2014, Respondent conducted a second colonoscopy on N.P. to remove the large flat polyp in the transverse colon. During the colonoscopy Respondent estimated that the polyp was larger than he originally estimated. Rather than 40 mm as he previously estimated, he determined that the polyp was "greater than 50" mm. He removed a portion of the polyp with a saline injection-lift technique using a hot snare. Based on Respondent's clinical experience, he removed the amount of tissue he believed was safe. The tissue was retrieved using a net. Respondent inserted five clips at the polypectomy site and injected the area near the polypectomy site with carbon black ink for tattooing.

Respondent also removed five sessile polyps from the transverse and ascending colon that were 10 to 15 mm. The polyps were removed with a hot snare. Resection and retrieval were complete. Respondent also removed four polyps that were 5 to 8 mm in size, from the rectum, and the transverse and ascending colon. The polyps were removed with "jumbo cold forceps." Resection and retrieval were complete.

42. Respondent noted that the colonoscopy was "technically difficult and complex due to inadequate bowel prep." He also noted there was minimal blood loss and that the

patient tolerated the procedure well. Respondent recommended that N.P. undergo a third colonoscopy in two to six months to remove the remainder of the flat polyp in the transverse colon.

43. The pathology report dated May 15, 2014, noted that the specimen from the ascending colon contained four "0.1-0.6" cm tissue fragments. The specimen from the transverse colon contained four fragments of polyps "0.9-1.2" cm "in greatest dimension." The polyps in the ascending colon were hyperplastic polyps and "submucosal lymphoid aggregates." The polyps in the transverse colon were fragments of tubulovillous adenoma.

SEPTEMBER 29, 2014 COLONOSCOPY

44. On September 29, 2014, Respondent performed a third colonoscopy on N.P. to remove the remainder of the 50 mm flat polyp in the transverse colon. Respondent estimated that the remaining polyp tissue was 38 mm. He removed the remaining polyp tissue with a saline injection-lift technique using a hot snare. Resection and retrieval of the tissue was complete. Three clips were successfully placed to close the polypectomy site to reduce the risk of bleeding. Respondent noted that the procedure was performed without difficulty and N.P. tolerated the procedure well. There was no bleeding during the procedure. The tissue samples were collected and sent for testing.

45. The pathology report dated September 30, 2014, described a "2.1 x 1.5 x up to 0.9" cm tissue from the transverse colon, which were diagnosed as tubulovillous adenoma.

Treatment History of Patient D.R.

46. On March 27, 2013, Respondent examined D.R., a 42 year-old woman with a history of Clostridium Difficile (C. difficile), an intestinal infection she acquired while she was in the hospital in January 2013. D.R. reported that in March 2013, she had been in the hospital for six days taking oral Vancomycin, as a result of the C. difficile infection. She had blood in her stool and diarrhea. She had also been prescribed Flagyl for several weeks. D.R. complained of continued back and abdominal pain. She was tired and did not feel well. She had diarrhea, several times per day, weight loss and acid reflux. Respondent assessed D.R. with C. difficile, GERD, and Dysphagia. He recommended she undergo an upper endoscopy and colonoscopy.

47. On April 5, 2013, Respondent performed an upper endoscopy and colonoscopy on D.R. He noted "moderate inflammation characterized by congestion (edema)" in her stomach. He also noted that the "entire examined colon appeared normal." He obtained biopsies of the stomach, rectum and the ascending, descending and sigmoid colon.

48. The pathology report dated April 8, 2013, noted no specific pathologic abnormality, except for a mild hyperplastic change in the sigmoid colon and a hyperplastic polyp in the rectum.

JUNE 7, 2013 PROCEDURES

49. On June 6, 2013, Respondent conducted a second examination of D.R. She reported that on May 19, 2013, she was seen at the Oroville Hospital (Oroville) due to abdominal pain and loose stools. She was prescribed oral Vancomycin. D.R. reported that she had lost approximately 15 pounds "over the intervening two to three months." Respondent noted that radiological studies obtained at Oroville "were remarkable for an abdominal series showing some dilated loops of small bowel." He also noted that D.R.'s stool culture for C. difficile was negative.

50. Respondent was concerned that the dilated loops of small bowel could indicate that there was an obstruction or an inflammatory bowel disease. He believed the finding were a clinically significant change from the initial examination he conducted on March 27, 2013. Respondent did not have a clear clinical explanation for D.R.'s symptoms. Her condition improved between March and April 2013, and then her symptoms returned. Respondent was concerned that D.R. may have an inflammatory bowel disease, recurring C. difficile infection or ischemic colitis. Respondent explained that the treatment for these conditions is different. Failure to properly diagnosis and treat the condition would have resulted in D.R. getting sicker or even have caused her death. As a result, he recommended that D.R. undergo another upper endoscopy and colonoscopy. The procedures would allow Respondent to view the lining of the mucosal to determine whether there were any changes to the lining that would provide information on the nature of D.R.'s condition. For example,
C. difficile colitis can present as a yellowish material on the lining of the colon. Ischemic colitis presents as patch inflammation and ulceration.

51. On June 7, 2013, Respondent performed an upper endoscopy on D.R. Her esophagus was normal. She had inflammation in the lining of her stomach. Respondent obtained biopsies. Respondent also performed a colonoscopy. He noted that the bowel preparation was poor. As a result, Respondent was not able to properly view the lining of the colon. Respondent obtained biopsies and a stool sample for testing. The pathology report dated June 10, 2013, reported no significant pathology and the stool sample was negative for C. difficile.

52. Respondent determined that biopsy results would not provide him with the information he needed concerning the nature of D.R.'s condition, because the results only related to a small area of the colon where tissue was obtained. Respondent recommended that D.R. undergo a third colonoscopy so that Respondent could exam the lining of her colon.

JULY 22, 2013 COLONOSCOPY

53. Respondent performed a third colonoscopy on D.R. on July 22, 2013. He noted that the quality of the bowel preparation was good. Respondent was able to view the lining of the colon, which appeared to be normal. Respondent obtained biopsies of the small bowel, right and left colon and rectum, which had no significant pathology. Respondent suspected that D.R. had a recurring C. difficile infection. Respondent referred D.R. to Stanford for further evaluation and treatment. Ultimately, it was determined that D.R. had a recurring C.

difficile infection.

Complainant's Expert James Ostroff, M.D.

54. Dr. Ostroff is board-certified in Gastroenterology and Internal Medicine. He is licensed by the Board to practice medicine in California. Dr. Ostroff graduated from Cornell Medical College in 1977. He completed a medical residency at New York Hospital- Cornell Medical Center in 1980. Between 1980 and 1982, Dr. Ostroff completed a two-year fellowship in Gastroenterology at the University of California, San Francisco (UCSF). In 1982, Dr. Ostroff became part of the faculty at UCSF, where he is still employed.

Dr. Ostroff is a Professor of Clinical Medicine, Clinical Pediatrics and Clinical Radiology. He is also the Chief of Endoscopy and the Director of the Gastrointestinal Consult Service at the UCSF Mt. Zion Medical Center. Dr. Ostroff specializes in endoscopic procedures. He sees patients two and one-half days per week at UCSF and the rest of the week he performs procedures. He recently started a pediatric pancreas clinic with a pediatric Gastroenterologist. Dr. Ostroff has served as an expert witness for the Board approximately ten times.

55. Following a January 8, 2016 referral from Mr. Brearley, Dr. Ostroff authored a report dated March 20, 2016, concerning his evaluation of Respondent's conduct related to the treatment of patients R.B, N.P., and D.R.[2] In the report, Dr. Ostroff listed the documents he reviewed to reach his opinions and conclusions. Dr. Ostroff reviewed in part, the certified medical records of R.B., N.P., and D.R. He also reviewed Respondent's curriculum vitae, and a transcript of Respondent's interview with the Board's investigator. Dr. Ostroff testified at hearing.

OPINIONS REGARDING PATIENT R.B.

56. Dr. Ostroff opined that the standard of care requires a doctor to recognize that the removal of large sessile polyps require specialized techniques and the presence of "adequately trained assistants as well as the presence of the correct equipment." Dr. Ostroff opined that based on his review of R.B.'s medical records, the pathology reports, and Respondent's interview with the Board's investigator, there were discrepancies concerning which polyps Respondent removed during the colonoscopy procedures and where the polyps were removed from during the procedures. Dr. Ostroff also opined that the pathology reports did not coincide with Respondent's documentation concerning the tissue that was removed. Additionally, he opined that Respondent did not have the skill to remove extremely large polyps.

57. Respondent documented during his examination of R.B. on March 26, 2014, that the first colonoscopy performed on R.B. at Skyway on March 4, 2014, revealed the 4 cm

[2] Dr. Ostroff's report references three additional patients in which he found no violations of the standard of care. Those patients are not referenced in this decision.

flat polyp in the proximal descending colon, but this could not be removed entirely by endoscopically, a 3 cm flat polyp in the transverse colon, and a 1 cm polyp in the sigmoid colon. Dr. Ostroff noted that Respondent was less comfortable performing the colonoscopy at Skyway and decided to perform a second colonoscopy at Feather. Dr. Ostroff opined that Respondent's decision to end the first colonoscopy at Skyway was a "personal judgment" that "no one could fault him" because "everyone should be comfortable about what they are doing."

58. Dr. Ostroff opined that Respondent's documentation and findings concerning the March 27, 2014 colonoscopy were inconsistent with the findings from the March 4, 2014 procedure. Specifically, Respondent failed to mention the 3 cm flat polyp in the transverse colon that was discovered during the March 4, 2014. Respondent referenced a 25 mm sessile polyp in the proximal ascending colon, rather than the proximal descending colon, and a 5 mm polyp, in the distal sigmoid colon. Dr. Ostroff noted that Respondent removed the sessile polyp by lifting up the polyp using a saline wall and removing the tissue with a snare, which he opined Respondent performed correctly.

However, in reviewing the March 31, 2014 pathology report, only approximately 0.5 cm of aggregate tissue from the ascending colon and 0.5 cm of a single tissue fragment from the sigmoid colon were submitted to pathology. Dr. Ostroff opined that only a small percentage of the 25 mm polyp from the proximal ascending colon was removed. Dr. Ostroff contended that while Respondent correctly noted in R.B.'s medical record that the polyp was incomplete and the resected tissue was partially retrieved, the tissue that was retrieved does not represent that polyp, because such a small percentage of the polyp was submitted for pathological analysis. Dr. Ostroff opined that Respondent should have retrieved more than 20 percent of his "work product."

59. Dr. Ostroff also noted that Respondent documented in R.B.'s medical records from the May 28, 2014, that R.B. had a 4 cm flat serrated adenoma in the ascending colon. However, there is no documentation from any pathology report diagnosing the tissue as a serrated adenoma. The only reference Dr. Ostroff found was in the March 31, 2014 pathology report that referenced hyperplastic polyp in the sigmoid colon that had glands demonstrating serrated luminal outlines, which is "far from a serrated adenoma." He opined that a serrated adenoma potentially has complications and may be more malignant.

Respondent documented in R.B.'s medical record that during the colonoscopy performed on May 28, 2014, two 12 to 30 mm polyps in the mid-transverse colon and proximal ascending colon were observed. Dr. Ostroff opined that Respondent failed to detect these polyps during the colonoscopy on March 27, 2014. Due the inconsistent information contained in R.B.'s medical records, it was not clear to Dr. Ostroff that polyp in the ascending colon was the 4 cm polyp he began to remove on March 4, 2014, and the 3 cm polyp in the transverse colon he identified on March 4, 2014.

Additionally, the resection of the two 12 to 30 mm polyps in the mid-transverse colon and proximal ascending colon on May 28, 2014 was incomplete and retrieval was also incomplete. The pathology report dated May 29, 2014, only referenced specimens from the

transverse colon polyp, consisting of aggregate tissue that was smaller than 3 cm. There was no tissue submitted from the ascending colon. Dr. Ostroff opined that flat polyps can be removed in a piecemeal fashion, but after a certain point, Respondent should have employed a more specialized removal of the polyps such as an endoscopic mucosal resection or a submucosal section so repeated colonoscopies did not have to be performed.

60. Dr. Ostroff also noted that R.B.'s medical records for the November 18, 2014, pre-colonoscopy examination stated that during the March 4, 2014 colonoscopy at Skyway, a 4 to 5 cm flat polyp in the proximal descending colon was discovered, but Respondent was not able to access the polyp. Dr. Ostroff opined that this note is inconsistent with previous notes in R.B.'s medical records which indicate that Respondent was able to remove part of the polyp during the March 4, 2014 procedure. Respondent also noted that a 3 cm polyp in the transverse colon was removed on March 4, 2014, however this note was inconsistent with previous medical notes, which indicated it was not removed.

61. Dr. Ostroff opined that it is not "striking" that Respondent would incompletely remove a polyp for a variety of reasons, such as safety, or that some of the fragments of the polyps are not retrieved. However, Respondent repeatedly and incompletely removed the polyps, during three attempts, with R.B. still requiring four or more colonoscopies to remove the polyps. Respondent also repeatedly lost tissue fragments. Dr. Ostroff opined that the confusion regarding which polyps were resected, the "techniques employed with a 4-5 cm" polyp and the "lack of adequate pathology specimen" over the course of three colposcopies together in aggregate represented an extreme departure. Dr. Ostroff opined that the standard of care required Respondent to refer R.B. to a "more experienced colonoscopist that specialized in large colonic polyp resection."

OPINIONS REGARDING PATIENT N.P.

62. Dr. Ostroff contended that Respondent deviated from the standard of care by performing multiple colonoscopies on N.P. Dr. Ostroff opined that endoscopic procedures can be associated with risk, particularly in the case of an elderly person. The standard of care requires that there are "clear indications" before an endoscopic procedure is performed. In the absences of "frank bleeding," a colonoscopy is "usually avoided except with profound anemia."

63. Dr. Ostroff further opined that standard of care also discourages screening colposcopies for patients older than 85, particularly patients without "alarm symptoms" such as bleeding or profound anemia. Dr. Ostroff opined that anorexia, difficulty swallowing, weight loss, or constipation are not indications for a colonoscopy. Dr. Ostroff opined that N.P.'s symptoms did not warrant a colonoscopy, because he had no iron deficiency or other nutritional deficiencies. However, Dr. Ostroff further opined that if N.P. had been in his 60's, he would have been "entitled to a colonoscopy."

64. He further contended that reducing N.P.'s risk of colon cancer by removing the polyps in a 90-year-old man was not within the accepted standard of care. Dr. Ostroff opined that the risk factor for colorectal cancer "takes a dive" around 80 years of age. Dr. Ostroff also

opined that while Respondent discovered, during the colonoscopies, that N.P. had polyps, the polyps were not causing his symptoms, were not bleeding and "likely would have gone un-noticed for the rest of his life." He further opined that it would take years for a tubulovillous adenoma polyp to become malignant. He opined that the three colonoscopies that were performed with "unsuccessful attempts to remove the largest of the polyps is far more serious than performing a single colonoscopy and then looking elsewhere for the cause of his problem." Dr. Ostroff opined that three colonoscopies were performed where there was little indication for one, and was an extreme departure from the standard of care.

65. Dr. Ostroff also contended that the performance of a colonoscopy requires "formal training including practical and didactic training." He further contended that "special training and skill is required for large sessile polyp removal and often advanced training is required under supervision." Dr. Ostroff opined that "[i]t is simply not enough to continue to remove pieces for techniques are in place that simulates a surgical trans mural resection." Dr. Ostroff opined that Respondent did not possess the skill to remove N.P.'s sessile polyps.

66. Dr. Ostroff opined that during the first colonoscopy on December 19, 2013, Respondent observed that N.P. had a number of large flat polyps, which he removed in a piecemeal fashion. He partially resected a 5 cm polyp in the proximal transverse colon, and follow-up was recommended to determine whether the polyp had any relationship to his symptoms. Dr. Ostroff contended that Respondent's decision to subject this 89-year-old man to repeated follow-up colonoscopies in order to resect asymptomatic polyps was "very questionable."

67. Dr. Ostroff contended that during the May 14, 2014 colonoscopy, Respondent removed small hyperplastic polyps which were are "more like blemishes on the colon rather than being premalignant lesions." The pathology report also indicated that only 0.1 to 0.6 cm of the large polyp in the ascending colon was retrieved. Four fragments of the polyp from the transverse colon ranging in size from 0.9 to 1.2 cm were retrieved.

68. He also opined that by the third colonoscopy on September 29, 2015, there was still incomplete removal of the polyp. Respondent estimated that the large flat polyp in the transverse colon was a 38 mm polyp. It was resected and retrieved, which would suggest that the polyp was taken out, collected and submitted for pathological evaluation. However, the pathology noted that the specimen was approximately 21 mm, which is less than the size described by Respondent in the medical record. Dr. Ostroff contended that the pathology findings demonstrate that Respondent failed to remove the entire polyp.

69. Dr. Ostroff opined that it was "very likely" that N.P.'s "very large polyps" would have remained silent for the remainder of his life. However, if Respondent felt this was an important thing for N.P.'s health to have the polyps removed, Respondent should have referred N.P. to a more experienced colonoscopist to remove the polyps. Dr. Ostroff opined that Respondent did not have the skills necessary to remove very large sessile polyps and the repetitive colonoscopies were an extreme departure from the standard of care.

OPINIONS REGARDING PATIENT D.R.

70. Dr. Ostroff contended that Respondent performed one unnecessary upper endoscope procedure and two unnecessary colonoscopy procedures on D.R. Dr. Ostroff opined that endoscopic procedures can be associated with risk. There must be clear indications for the procedures. With a new patient who has conflicting symptoms, it is often necessary to perform endoscopic procedures, especially when the patient has a history of infection or a "pan-colitis" exists. Dr. Ostroff opined that "endoscopy and colonoscopy with appropriate biopsies and cultures may be indicated."

71. Dr. Ostroff opined that the first upper endoscopy and colonoscopy Respondent performed on D.R. on April 5, 2013, were "completely appropriate" and within the standard of care. D.R. was a new patient with a history of C.difficile infection and conflicting symptoms. The findings of the procedures and biopsies were normal.

72. Dr. Ostroff contended that the upper endoscopy and colonoscopy performed on June 7, 2013, and the colonoscopy performed on July 22, 2013, were unnecessary.[3] Dr. Ostroff opined that there was "nothing in the history taken by [Respondent] or those of the emergency room doctors suggesting that her symptoms or laboratory evaluation was evolving." Dr. Ostroff opined that there was high probability that D.R.'s symptoms were due to a C.difficile infection. He further contended that there were no "alarm symptoms" such as rectal bleeding or bowel obstruction. Rather, she complained of the same "general symptoms" she has been having when the first endoscopic procedures were performed. He contended that D.R.'s complaint of recurrent abdominal pain, nausea, diarrhea, weight loss of 15 pounds since the March 2013 procedures, a finding of dilated loops of small bowel, and a stool culture that was negative for C.difficile, were not indications to perform additional upper endoscopy and colonoscopy procedures.

73. Dr. Ostroff noted that the second colonoscopy visual findings were normal, except for the notation that the bowel preparation was poor. The second upper endoscopy showed the same similar mild gastritis that appeared on the first upper endoscopy. Dr. Ostroff contended that although Respondent may not have been able to view the colon during the second colonoscopy due to poor bowel preparation, Respondent obtained biopsies that were normal. Dr. Ostroff conceded that a biopsy may not detect a patchy disease in an area where a biopsy is not obtained.

74. Dr. Ostroff opined that performing a second upper endoscopy and two additional colonoscopies were repetitive and unnecessary. He also opined that performing the procedures in a short period of time after the first procedures demonstrated normal finding, was an extreme departure from the standard of care, because of both the costs and risks that

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[3] Dr. Ostroff opined that Respondent performed a third upper endoscopy on July 22, 2013. However, he was not able to find any reference to a third upper endoscopy in the medical records. He conceded that Respondent only performed two upper endoscopy procedures on D.R.

are associated with any endoscopic procedures.

Respondent's Expert Rudolph Bedford, M.D.

75. Rudolph Bedford is board-certified in Internal Medicine, with a subspecialty board certification in Gastroenterology. He is licensed by the Board to practice medicine in California. Dr. Bedford graduated from Case Western Reserve University School of Medicine in Cleveland, Ohio in 1987. He completed a medical residency at New York Hospital-Cornell Medical Center in 1990. Between 1990 and 1992, Dr. Bedford completed a two-year fellowship in Gastroenterology at the Cleveland Clinic Foundation. Between 1992 and 1993, he completed an advanced fellowship in therapeutic endoscopy at St. Luke's Hospital in Racine, Wisconsin.

In 1994, Dr. Bedford became the Director of Clinical Education for Gastroenterology and Director of Pancreatic-Billiary Services, Department of Medicine, UCLA School of Medicine. Dr. Bedford worked as an Assistant Clinical Professor in the Division of Digestive Diseases at UCLA. Since 2012, Dr. Bedford has been the Chief of Gastroenterology at St. John's Hospital, located next to UCLA. He is also a staff physician at the West Los Angeles Veterans Hospital. For the last 12 years, Dr. Bedford has also maintained a private practice. He performs approximately 1,500 to 2,000 colonoscopies per year, and approximately 500 upper endoscopies per year. Dr. Bedford has served as an expert witness rendering opinions concerning the standard of care for Gastroenterologist practicing in California

76. Dr. Bedford reviewed several documents to reach his opinions concerning Respondent's treatment of patients R.B., N.P. and D.R., including the Accusation, the investigation report prepared by Mr. Brearley, the patient records for R.B., N.P. and D.R., the expert report prepared by Dr. Ostroff and the transcript of Respondent's interview with the Board's investigator. Dr. Bedford prepared a report dated January 4, 2017, and testified at hearing.

OPINIONS REGARDING PATIENT R.B.

77. Dr. Bedford opined that Respondent did not depart from the standard of care in his treatment of R.B. He disagreed that Respondent lacked the training and experience to remove the large flat polyps from R.B. He also disagreed that the standard of care required Respondent to refer R.B. to another endoscopist. Dr. Bedford opined that it is within the judgment of a doctor whether to remove a polyp as a whole or in piecemeal fashion. Dr. Bedford opined that Respondent appropriately used his judgment and determined it was prudent to remove R.B.'s polyps in piecemeal fashion.

78. Dr. Bedford contended that all Gastroenterologists are trained to remove large polyps in a piecemeal fashion. He estimated that "well over 85 to 90 percent of Gastroenterologists within the community will attempt to remove large flat polyps in a piecemeal fashion." Dr. Bedford contended that there are a variety of reasons as to why it is difficult for a doctor to remove a large flat polyp during a single procedure. The tissue must be raised, the preparation of the colon may not be ideal and there may be difficulty getting the

scope around a corner or curve in the colon. Dr. Bedford opined that it is always better to bring a patient back for another procedure to remove a polyp in piecemeal fashion during an additional procedure for the safety of the patient.

79. Dr. Bedford opined that it was within the standard of care for Respondent to end the March 4, 2014 colonoscopy he performed on R.B. at Skyway. Dr. Bedford contended that if there are technical difficulties and Respondent cannot adequately sedate a patient, then the procedure cannot be adequately performed.

80. Dr. Bedford also opined that it was within the standard of care for Respondent to remove the 4 cm polyp from R.B.'s ascending colon in a piecemeal fashion, and that Respondent employed the proper technique to remove the polyp. Dr. Bedford opined that it was also within the standard of care for Respondent to recommend that R.B. undergo another colonoscopy after the May 28, 2014 procedure. Dr. Bedford contended that there is always a concern that there may be polyp tissue left or that there may be other polyps that were not seen during the procedure. He opined that flat polyps have a higher risk of developing into cancer so it was prudent for Respondent to make sure that he cleared the colon. Dr. Bedford also opined that the risk of performing multiple colonoscopies on a patient is "minimal." The biggest risk is perforation which occurs in 1 in every 10,000 to 20,000 patients. For a patient such as R.B., who was 67 years old with no co-morbid conditions, the risk was low.

81. Dr. Bedford also opined that Respondent's partial retrieval of polyp tissue during the March 27 and May 28, 2014 colonoscopies was not a deviation from the standard of care. Dr. Bedford opined that it can be "challenging and difficult" to retrieve every piece of a polyp that is removed. The techniques used to remove the tissue such as sucking the tissue through a channel, breaks down the tissue into smaller pieces. The pieces fall into a trap that squeeze the tissue. Dr. Bedford contended that often the tissue that is seen by the doctor and what is retrieved are different. Dr. Bedford contended that the lack of pathology samples to confirm the removal of the polyp was not significant. Rather, the more important information is Respondent's documentation of removal of the polyp.

OPINIONS REGARDING PATIENT N.P.

82. Dr. Bedford disagreed with Dr. Ostroff's opinion that a colonoscopy was not indicated for N.P. Dr. Bedford opined that N.P's. weight loss, history of polyps removed, and age, were "obvious indications for a colonoscopy." He further opined that it was "certainly not a departure from the standard of care" to perform a colonoscopy on N.P.

83. Dr. Bedford opined that it was within the standard of care to reduce N.P.'s risk of developing colon cancer by removing polyps, despite his age, especially since N.P. was otherwise relatively healthy and could be expected to live several more years." Dr. Bedford contended that someone with a history of colon polyps is more likely to develop colon cancer. Additionally, the larger the polyp, the more likely the polyp will develop into cancer. Dr. Bedford disagreed with Dr. Ostroff's opinion that patients over the age of 80 are less likely to develop cancer. Dr. Bedford opined that the older a patient is, the more likely the patient has a propensity to develop all types of cancer and colon cancer is no exception.

84. Dr. Bedford opined that it was within the standard of care for Respondent to first obtain a biopsy of the 40 to 50 mm polyp he located in N.P.'s transverse colon during the first colonoscopy, due to his concern that the polyp might be cancer. If the polyp was cancer, then it would need to be surgically removed. If the polyp was not cancer, as in N.P.'s case, then Respondent could remove the polyp endoscopically during a subsequent procedure. Dr. Bedford also opined that Respondent's judgment was correct to remove the polyp during a colonoscopy procedure, which he contended is minimally invasive and safe.

85. Dr. Bedford disagreed with Dr. Ostroff's opinion that N.P.'s polyps should not have been removed because the polyps were not giving him any symptoms and that the large tubulovillous adenoma polyp would take years to develop into cancer if at all. Dr. Bedford opined that a doctor cannot predict when a polyp will develop into cancer. N.P. could live another five to ten years. Dr. Bedford opined that it incumbent upon a doctor that sees the type of large polyp N.P. had, to remove it, regardless of his age.

86. Dr. Bedford also opined that it is within the standard of care to remove large polyps piecemeal and Respondent was not required to refer the patient to another endoscopist. Dr. Bedford disagreed with Dr. Ostroff's opinion that Respondent did not possess the necessary skills to remove very large sessile polyps. Dr. Bedford opined that "as a matter of course all academically trained Gastroenterologists are instructed on the techniques of polyp removal." Dr. Bedford further contended that all gastroenterologists are trained to remove large flat polyps piecemeal if that is what is required. He further opined that Respondents "credentials are impressive" and that anyone who has performed 30,000 to 40,000 is an expert.

87. Dr. Bedford also contended that it was within Respondent's judgement to remove the large flat polyp in piecemeal. Dr. Bedford opined that piecemeal removal of a polyp is standard of care. Dr. Bedford also contended that "[q]uite often with very large polyps, it is necessary to perform piecemeal removal over several sessions." Respondent utilized the standard procedure to remove the polyp, which is to inject a solution underneath the polyp to raise it, and then utilizing a snare to remove what has been raised. Dr. Bedford explained that quite often the saline solution that is used to raise the polyp becomes diffuse and will not keep the tissue raised for a long period of time. The doctor must constantly go back to try to raise the tissue.

At times, a doctor may be successful in getting all the tissue in one session, but typically that is not the case. It can become dangerous to be over persistent in an effort to remove an entire polyp. He opined that it is "always better" to perform additional procedures to remove a polyp safely. Bringing the patient back for additional procedures allows the doctor to have a "better frame of mind" about what needs to be done. Additionally, as in the case of N.P., Respondent tattooed the site, so that when he returned he could find the location.

88. Dr. Bedford also disagreed with Dr. Ostroff's opinion that Respondent failed to completely remove the large flat polyp in N.P.'s transverse colon. Respondent reported that the polyp was 38 mm as of the September 29, 2014, when he performed the third colonoscopy

to remove the remaining tissue. The pathology report estimated the tissue that was submitted from the transverse colon was approximately 21 mm. Dr. Bedford contended that there is "always a discrepancy" of what a doctor sees in the colon versus what is taken out. The colonoscopy magnifies the tissue approximately 30 times. The doctor must "eyeball" the size of the polyp based on the magnification. Additionally, tissue can be lost when it is sucked through the scope. Dr. Bedford opined that the significance of the large flat polyp Respondent removed from N.P.'s transverse colon was that it was over 2 cm. Thus, the polyp had an increased risk of developing into cancer. Dr. Bedford opined that the only item of importance was that Respondent removed the entire polyp.

OPINIONS REGARDING PATIENT D.R.

89. Dr. Bedford disagreed with Dr. Ostroff's opinion that the second upper endoscopy performed on June 7, 2013, was a departure from the standard of care. Dr. Bedford opined that the second upper endoscopy was indicated due to the finding of dilated loops of small bowel discovered during a radiological study on May 19, 2013. Dr. Bedford opined that a finding of dilated loops of small bowel raised the concern that there is an obstruction. An upper endoscopy is necessary to visualize the small bowel to determine whether an obstruction is causing the dilation. Dr. Bedford further opined that it was prudent to perform an upper endoscopy, which is a low risk procedure, to help determine why her symptoms are "waxing and waning."

90. Dr. Bedford also opined that the second colonoscopy performed on June 7, 2013, was indicated. D.R. reported recurrent abdominal pain, diarrhea, with a history of C.difficile, in addition to the finding of dilated loops in the small bowel. Dr. Bedford opined that it was necessary to conduct the colonoscopy to determine if her pain and symptoms that were "waxing and waning" were caused by ischemic colitis, inflammatory bowel disease or another process. Dr. Bedford explained that ischemic colitis is low blood flow to particular areas of the colon. The disease can cause a portion of the colon to die, and cause bleeding and abdominal pain. Dr. Bedford contended that it was "absolutely necessary" to diagnose ischemic colitis because the patient may require surgery.

91. Dr. Bedford also opined that it was within the standard of care for Respondent to perform a third colonoscopy on July 22, 2013, even though the biopsy results from the June 7, 2013, were normal. Dr. Bedford found that Respondent's ability to visualize the colon on June 7, 2013, was complicated due to poor preparation of the bowel. If there is stool covering the lining of the colon, Respondent would not be able to observe a condition such as ischemic colitis, or an inflammatory bowel disease. D.R. continued to have "waxing and waning" symptoms and the cause was not known. Dr. Bedford opined that it was within the clinical judgment of Respondent to proceed with a third colonoscopy for the purpose of obtaining better visualization of the colon.

92. Dr. Bedford opined that the endoscopic procedures Respondent performed on D.R. "fall well within the clinical judgement of the physician managing the patient at the time." Additionally, he opined that it was within the standard of care for Respondent to refer D.R. to Stanford for further evaluation. Dr. Bedford opined that when a physician reaches the

point where he has provided all the help he can to a patient, it is prudent to refer the patient for a second opinion.

Discussion of Accusation Allegations

PATIENT R.B.

93. Complainant alleged that the repetitive colonoscopy procedures Respondent performed on R.B. were incomplete and required expert skill, which Respondent did not possess. Complainant further alleged that Respondent failed to refer R.B. to a more experienced physician who specialized in large colonic polyp resection. Complainant alleged that Respondent's treatment of R.B. constituted an extreme departure from the standard of care, incompetence, and excessive use of diagnostic procedures. Complainant also alleged that Respondent failed to keep complete and accurate medical records concerning the care and treatment he rendered to R.B.

94. The evidence established that on March 4, 2014, Respondent performed a screening colonoscopy on R.B. at Skyway. During the procedure Respondent observed a 4 cm flat polyp in the proximal ascending colon, a 3 cm flat polyp in the transverse colon and a 1 cm polyp in the sigmoid colon. Dr. Ostroff persuasively opined that the standard of care requires the doctor to recognize that the removal of large sessile polyps requires specialized techniques and the presence of "adequately trained assistants as well as the presence of the correct equipment."

Respondent documented that he partially removed the 4 cm flat polyp and the 1 cm polyp in the sigmoid colon. Respondent appropriately recognized that in order to remove the remainder of the polyps, his patient needed a higher level of sedation. Respondent also needed better equipment, and more experienced staff, which could be provided at Feather River.

95. Both experts agreed that Respondent's decision to end the colonoscopy at Skyway and perform a second procedure at Feather River was appropriate. Dr. Ostroff opined that "no one could fault" Respondent for his decision. Dr. Bedford opined that that if there are technical difficulties and Respondent could not adequately sedate the patient, then the procedure could not be adequately performed. As a result, it was within the standard of care for Respondent to end the colonoscopy procedure at Skyway and recommend a follow- up procedure, which was conducted at Feather River on March 27, 2014.

96. On March 27, 2014, Respondent performed a second colonoscopy on R.B. During the procedure, Respondent located the 4 cm flat polyp in the proximal ascending colon that he incompletely removed during the March 4, 2013 procedure. Respondent estimated that the remaining flat polyp was 25 mm. Respondent removed a portion of the polyp using a saline injection-lift technique using a hot snare. Both experts agreed that Respondent's technique was correct.

However, removal of the 25 mm polyp was incomplete. The polyp was curved around a bend in the colon. Due to the size and location of the polyp, Respondent could not position

the snare around the entire polyp. Respondent removed as much of the flat polyp that he believed was safe for the patient. He tattooed the area near the polyp and used a clip to secure the polypectomy site. Dr. Bedford persuasively testified that it was within the standard of care for Respondent to remove the 25 mm flat polyp in a piecemeal fashion. In addition, Respondent was trained to remove large polyps in a piecemeal fashion and had significant experience over the course of his career to remove large flat polyps. The evidence established that Respondent appropriately exercised his clinical judgment that piecemeal removal of the polyp was most safe for his patient.

Respondent also documented that retrieval of the 25 mm flat polyp tissue from the proximal ascending colon was incomplete. The pathology report documented that Respondent submitted 0.5 cm of aggregate tissue from the ascending colon. Dr. Bedford persuasively testified that partial retrieval of polyp tissue was not a deviation from the standard of care. Respondent and Dr. Bedford persuasively testified that techniques used to remove the tissue, such as sucking the tissue through a channel, breaks down the tissue into smaller pieces and the pieces fall into a trap that squeeze the tissue. In addition, the amount of polyp tissue observed by the doctor during the procedure, does not always correlate to the amount of tissue submitted for pathology.

97. On May 28, 2014, Respondent performed a third colonoscopy on R.B. Respondent observed two flat polyps in the mid-transverse colon and in the proximal ascending colon. He noted the polyps were 12 to 30 mm in size. He removed the polyps with the saline injection-lift technique using a hot snare. Respondent noted that the bowel preparation was "fair." Respondent was concerned that the resection of polyps in the ascending and transverse colon was not complete and that there might be residual polyp tissue at the edge of the polyp. Dr. Bedford persuasively testified that when there is a concern that polyp tissue is left or that there may be other polyps that were not seen during the procedure, due to poor preparation, it was prudent for Respondent to conduct another colonoscopy to make sure that he cleared the colon.

98. While the evidence established that Respondent's removal of R.B.'s polyps in a piecemeal fashion was within the standard of care, there were significant errors and inconsistencies in the documentation and pathology reports for the treatment Respondent rendered to R.B. Dr. Ostroff persuasively opined that the confusion regarding which polyps were resected and the lack of adequate pathology specimens over the course of the colonoscopies, in aggregate, represented an extreme departure. Specifically, on March 26, 2014, Respondent conducted a pre-procedure examination of R.B. Respondent documented in R.B.'s medical records that during the March 4, 2014 colonoscopy at Skyway, he discovered a 4 cm flat polyp "in the proximal descending colon that could not be removed in its entirety endoscopically." This information was not correct. The polyp was located in the proximal ascending colon. This error was carried over into R.B.'s medical records for the May 28 and November 26, 2014 procedures.

99. Additionally, Respondent failed to document following the March 27, 2014 procedure any information about the 3 cm flat polyp in the transverse colon that was

discovered during the March 4, 2014 colonoscopy. In the May 27, 2014 pre-procedure records he documented that on March 4, 2014, he identified "a 3 cm flat polyp in the transverse colon, which was removed." This was incorrect. The polyp in the transfer colon was not removed until the May 28, 2014 procedure.

100. Respondent documented in R.B.'s medical records for the May 28, 2014 procedure, that R.B. had a 4 cm flat serrated adenoma in the ascending colon. However, there is no documentation from any pathology report diagnosing the tissue as a serrated adenoma. Dr. Ostroff persuasively opined that the implications of incorrectly identifying a polyp as a serrated adenoma are significant because a serrated adenoma may be more malignant. Additionally, Respondent noted that two 12 to 30 mm polyps in the transverse colon and proximal ascending colon were partially removed. Respondent testified that the polyp in the ascending colon was tissue remaining from the 4 cm polyp he began removing on March 4, 2014. However, the pathology report dated May 29, 2014, only referenced specimens from the transverse colon polyp. No tissue from the ascending colon was identified. As a result, there is no evidence to confirm that tissue was removed from the ascending colon.

101. Respondent noted in R.B.'s medical records for the November 18, 2014, pre-colonoscopy examination that during the March 4, 2014 colonoscopy at Skyway, a 4 to 5 cm flat polyp across the proximal descending colon was discovered, but Respondent was not able to access the polyp. This note is inconsistent with previous notes in R.B.'s medical records which indicate that Respondent was able to remove part of the 4 to 5 cm polyp during the March 4, 2014 procedure. Respondent again noted that a 3 cm polyp in the transverse colon was removed on March 4, 2014, which was incorrect. The polyp in the transverse colon was not removed until May 28, 2014.

102. The evidence established that Respondent had the training, skills and knowledge to remove R.B.'s large polyps. Although four colonoscopies were performed, the first colonoscopy was appropriately ended because of various challenges Respondent encountered. The fourth colonoscopy was ended due to poor bowel preparation. Respondent completed two colonoscopy procedures to remove R.B.'s polyps. After the third colonoscopy, Respondent was concerned that there might be residual polyp tissue at the edge of the polyps in the transverse colon and in the proximal ascending colon. As a result, it was within the standard of care for Respondent to recommend a fourth colonoscopy. Complainant failed to establish that Respondent was incompetent in his care and treatment of R.B. or that he employed excessive use of diagnostic procedures.

103. While Respondent had the necessary training, skills and knowledge to remove R.B.'s large polyps, he repeatedly failed to exercise the care that was expected. Respondent repeatedly failed to accurately account for which polyps he removed and when he removed the polyps. The descriptions of the location of the polyps and the type of polyps that were removed were inconsistent and inaccurate. Additionally, there was lack of adequate pathology specimens for the removal of polyp from the ascending colon on May 28, 2014, despite Respondent's documentation that is was removed. Complainant established that the procedures that Respondent performed were incomplete and that Respondent should have

referred R.B. to another physician to complete the removal of his polyps.

104. Dr. Bedford's contention that the lack of pathology samples to confirm the removal of the polyps was not significant and that the more important information isthe Respondent's documentation of the removal of the polyp, was not persuasive, given the repeated inaccuracies in Respondent's documentation. Without proper documentation and pathology reports to test and confirm removal of potentially cancerous tissue, Respondent placed his patient at significant risk for harm. As a result, complainant established Respondent's treatment of R.B. was an extreme departure from the standard of care and a failure to keep complete and accurate medical records.

PATIENT N.P.

105. Complainant alleged that the repetitive colonoscopy procedures Respondent performed on N.P. were not indicated, that Respondent did not have the skill to remove N.P.'s large sessile polyp and that Respondent failed to refer N.P. to a more experienced physician. Complainant alleged that Respondent's treatment of N.P. constituted an extreme departure from the standard of care, incompetence, and excessive use of diagnostic procedures.

106. Dr. Ostroff persuasively opined that the standard of care requires that there are "clear indications" before an endoscopic procedure is performed. The evidence established that there were clear indications for the colonoscopies Respondent performed on N.P. Respondent recommended that N.P. undergo a colonoscopy because he had a 23 pound weight loss over 18 months. He also had a loss of appetite, constipation and colon polyps removed in 2001. Respondent determined that a colonoscopy should be used as a diagnostic tool. Dr. Bedford persuasively obtained that N.P.'s weight loss, history of polyps removed, and his age, were indications for a colonoscopy.

107. Dr. Ostroff's opinion that a colonoscopy was not indicated for N.P., was not persuasive. Dr. Ostroff contended that that N.P.'s symptoms did not warrant a colonoscopy, because he had no iron deficiency or other nutritional deficiencies. However, Dr. Ostroff opined that if N.P. had been in his 60's, with the symptoms he reported, he would have been "entitled to a colonoscopy." Dr. Ostroff's contention that there was no indication for the colonoscopy appeared to be less about the symptoms N.P. reported and more about his age.

108. Dr. Bedford persuasively opined that it was within the standard of care for Respondent to first obtain a biopsy of the 40 to 50 mm polyp he located in N.P.'s transverse colon during the first colonoscopy, due to his concern that the polyp might be cancer andthat his decision to subsequently remove the tissue was within the standard of care. Dr. Bedford also persuasively testified that it was within the standard of care to reduce N.P.'s risk of developing colon cancer by removing polyps, despite his age, especially since N.P. was otherwise relatively healthy and could be expected to live several more years.

109. Dr. Ostroff's opinion that reducing his risk of colon cancer by removing the polyps in a 90-year-old man was not within the accepted standard of care, was not persuasive. Dr. Ostroff opined that the polyps were not causing N.P.'s symptoms, were not bleeding and

"likely would have gone un-noticed for the rest of his life." He further opined that it would take years for a tubulovillous adenoma to become malignant. However, Dr. Bedford persuasively explained that a doctor cannot predict when a polyp will develop into cancer and that it incumbent upon a doctor that sees a large polyp, to remove it, regardless of the patient's age.

110. The evidence established that on May 14, 2014, Respondent conducted a colonoscopy on N.P. to remove the 40 to 50 mm polyp in the transverse colon. A portion of the polyp was removed with a saline injection-lift technique using a hot snare. Based on Respondent's clinical experience, he removed the amount of tissue he believed was safe. He tattooed the tissue near the polyp site and inserted clips. On September 29, 2014, Respondent performed a third colonoscopy on N.P. and removed the remainder of the flat polyp in the transverse colon. Dr. Bedford persuasively opined that it is within the standard of care to remove large polyps piecemeal and Respondent was not required to refer the patient to another endoscopist. The evidence established that Respondent was trained to remove large sessile polyps and it was within his clinical judgment to remove the polyp in a piecemeal fashion.

111. Dr. Ostroff's opinion that Respondent failed to remove the large sessile polyp in the transverse colon because the tissue from the September 29, 2014 procedure, was approximately 21 mm and Respondent had estimated the size of the remaining polyp tissue he removed was 38 mm, was not persuasive. Both Respondent and Dr. Bedford persuasively explained that that there can be a discrepancy in what a doctor sees from the camera in the colon versus what is taken out, for various reasons, including tissue getting lost in fluid and the effect of the suction.

112. The evidence established that Respondent appropriately used his clinical judgement, knowledge and skill to perform three colonoscopy procedures on N.P. The first colonoscopy was indicated due to his reported symptoms. The second and third colonoscopies were to remove a large sessile polyp, which Respondent competently removed. As a result, complainant failed to establish that Respondent's treatment of N.P. constituted an extreme departure from the standard of care, incompetence, or excessive use of diagnostic procedures.

PATIENT D.R.

113. Complainant alleged that the repetitive upper endoscopy and colonoscopy procedures Respondent performed on D.R. were not indicated. Complainant alleged that Respondent's treatment of D.R. constituted an extreme departure from the standard of care, incompetence, and excessive use of diagnostic procedures.

114. Both experts persuasively opined that there must be clear indications for performing endoscopic procedures. Both experts also agreed that when a new patient has conflicting symptoms it is often necessary to perform endoscopic procedures. On March 27, 2013, D.R. saw Respondent for the first time. D.R. reported that she had acquired a C. difficile infection in January 2013. Since that time, she had blood in her stool, diarrhea several times per day, weight loss and acid reflux. Respondent recommended D.R. undergo an upper

endoscopy and colonoscopy. Both experts agreed the first upper endoscopy and colonoscopy Respondent performed on D.R. on April 5, 2013, was appropriate and within the standard of care. The results of the April 5, 2013 endoscopic procedures were normal.

115. The evidence established that between April and May 2013, D.R.'s symptoms improved. On May 19, 2013, D.R. was seen at the Oroville Hospital due to abdominal pain, and loose stools. Radiological studies were taken which identified dilated loops of small bowel. D.R.'s stool culture for C. difficile was negative. D.R. was seen by Respondent on June 6, 2013. She reported to Respondent her visit to Oroville Hospital. D.R. also reported that she had lost approximately 15 pounds in the preceding two or three months. Respondent was concerned that the dilated loops of small bowel could indicate that there was an obstruction or an inflammatory bowel disease. Respondent recommended a second upper endoscopy and colonoscopy.

116. Dr. Bedford persuasively opined that Respondent's decision to conduct a second upper endoscopy and colonoscopy on June 7, 2013, was within the standard of care, based on the recurrent abdominal pain, diarrhea, with a history of C. difficile, and the finding dilated loops of small bowel. The upper endoscopy allowed Respondent an opportunity to visualize the small bowel to determine whether an obstruction was causing the dilation. The colonoscopy gave Respondent the opportunity to view the colon to determine if her pain and symptoms were caused by ischemic colitis, inflammatory bowel disease or anotherprocess.

117. Dr. Ostroff's opinion that there was "nothing in the history taken by [Respondent] or those of the emergency room doctors suggesting that her symptoms or laboratory evaluation was evolving" was not supported by the evidence. D.R. reported a significant weight loss over two to three months. Additionally, Dr. Ostroff failed to address the significance of the dilated loops in the small bowel finding.

118. In addition, Dr. Bedford pervasively opined that when Respondent was not able to view the colon during the second colonoscopy due to the poor preparation, it was within the clinical judgment of Respondent to proceed with a third colonoscopy, for the purpose of obtaining better visualization of the colon. The fact that Respondent was able to obtain biopsies did not alleviate the need to view the colon lining. Both experts agreed that a biopsy may not detect a patchy disease in an area where a biopsy is not obtained.

119. The evidence established that Respondent appropriately used his clinical judgment, knowledge and skill to conduct a second upper endoscopy and two additional colonoscopies on D.R., due to the nature of her symptoms and the radiological findings. When Respondent determined that a second opinion was needed, he appropriately referred D.R. to Stanford for treatment. As a result, complainant failed to establish that Respondent's treatment of N.P. constituted an extreme departure from the standard of care, incompetence, and excessive use of diagnostic procedures.

Additional Evidence Submitted by Respondent

120. Respondent testified that he has managed the removal of polyps from his

patients on a daily basis for decades. Respondent believes the care and treatment he rendered to patients R.B., N.P. and D.R. was appropriate and within the standard of care. Respondent testified that he can determine when a standard endoscopic mucosal resection of a large flat polyp is not going to be safe in a community setting. If he feels that removal of a polyp is beyond his expertise, or his patient needs more advanced care, he refers those patients to clinics and hospitals that have more advanced procedures and equipment.

121. Respondent acknowledged that there were inaccuracies in R.B.'s medical records. Respondent in part attributed the inaccuracies to the transcription software. On December 7, 2016, Respondent registered for a medical record keeping seminar through the University of California, Irvine School of Medicine. He intended to complete the course on January 28, 2017. Respondent also submitted evidence of numerous hours of continuing education he has completed over past several years in the areas of Gastroenterology and record keeping.

122. After Respondent resigned from Feather River, he worked at the Veteran's Hospital (VA) in Tucson, Arizona. In December 2015, Respondent began working for Altru Health System in Grand Forks, North Dakota. Respondent enjoys his position. He sees patients and performs endoscopic procedures. Respondent is also a Clinical Associate Professor of Medicine at the University of North Dakota School of Medicine. He teaches medical students in the classroom and in clinical settings. Within the last year, Respondent was also recruited to act as a co-investigator with the Dean of the North Dakota Medical School to conduct a research project regarding the effect of a particular protein in the small intestine.

CHARACTER LETTERS

123. Respondent submitted six character letters from colleagues at AltruHealth System and two letters from colleagues at the VA. The authors of the letters described Respondent as a competent doctor who is well-respected by his colleagues and who cares about the welfare of his patients.

Appropriate Discipline

124. Complainant failed to establish by clear and convincing evidence that Respondent's care and treatment of patients N.P. and D.R. constituted the excessive use of diagnostic procedures, extreme departures from the standard of care, or demonstrated incompetence. Complainant also failed to establish that Respondent's care and treatment of R.B. constituted the excessive use of diagnostic procedures or incompetence. However, complainant did establish, by clear and convincing evidence, that Respondent's treatment of R.B. constituted an extreme departure from the standard of care and failure to keep complete and accurate records.

Respondent acknowledged his mistakes in R.B.'s medical records. However, he failed to acknowledge the serious nature of the inconsistencies and inaccuracies in his charting through three of the four colonoscopies he performed. The mistakes and failures in the charts

were more than typographical errors. The charting inconsistencies and inaccuracies were repeated and significant, and raised questions regarding the substance of the actual procedures he performed. In sum, Respondent repeatedly failed to exercise the care that was expected during the course of the treatment he provided R.B. and the three colonoscopy procedures he performed. In doing so, Respondent subjected his patient to potential harm.

125. The Board's Disciplinary Guidelines provide that the minimum discipline that should be imposed, for an extreme departure from the standard of care and failure to keep complete and accurate records, is stayed revocation, with five years of probation. Respondent has been licensed to practice medicine in California since 1990. He has no record of discipline with the Board. Respondent enjoys his profession and takes an active role in educating new doctors. He is respected by his colleagues. Based on the totality of the evidence, the public protection would be served by imposing a three year term of probation, which includes completion of a medical record keeping course and appropriate education courses approved by the Board.

LEGAL CONCLUSIONS

Burden of Proof

1. Complainant has the burden of proving each of the grounds for discipline alleged in the Accusation, and must do so by clear and convincing evidence. (See, *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence is evidence that leaves no substantial doubt and is sufficiently strong to command the unhesitating assent of every reasonable mind. (See, *In re Marriage of Weaver* (1990) 224 Cal.App.3d 478.)

Cause for Discipline

2. Business and Professions Code section 2234 provides that the Board shall take action against any licensee found to have engaged in unprofessional conduct, which includes but is not limited to the following:

> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> > (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
> >
> > (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1)

including, but not limited to, a reevaluation of the diagnosis or achange 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.

3. Pursuant to Business and Profession Code sections 2234 and 725, subdivision (a), repeated acts of clearly excessive use of diagnostic procedures as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon.

4. Business and Professions Code section 2266 provides that failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

5. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care applicable in a medical professional must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal. App.4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal. App. 4th 234, 280.) The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal. App. 3rd 1040, 1052. Simple negligence is merely a departure from the standard of care.

6. Complainant established byclear and convincing evidence that Respondent's treatment of R.B. constituted an extreme departure of the standard of care, as set forth in Findings 20, 26, 29, 31, 59, 60, 61, 98 through 104, and 124. Therefore, cause was established to impose discipline on Respondent's certificate pursuant to Business and Professions Code section 2234, subdivision (b).

7. Complainant failed to establish by clear and convincing evidence that Respondent's treatment of N.P. and D.R. constituted an extreme departure of the standard of care, as set forth in Findings 105 through 113 and 124. Therefore, no cause for discipline was established pursuant to Business and Professions Code section 2234, subdivision (b), related to his treatment of N.P. and D.R.

8. Complainant alleged that Respondent's care and treatment of patients R.B., N.P. and D.R. constituted repeated acts of negligence. As set forth in Findings 105 through 113 and 124, there is no cause to impose discipline on Respondent's license based on his treatment of N.P. and D.R. Therefore, complainant failed to establish by clear and convincing evidence that Respondent engaged in repeated acts of negligence. As a result, no cause for discipline exists under Business and Professions Code section 2234, subdivision (c).

9. Complainant failed to establish by clear and convincing that Respondent was incompetent in his treatment of R.B., N.P. and D.R., as set forth in Findings 93 through 97,

105 through 113 and 124. Incompetence has been defined as "absence of qualification, ability or fitness to perform a prescribed duty or function." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040.) It is evidenced by a lack of knowledge or ability in the discharging of professional obligations. (*James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1109.) Therefore, no cause for discipline was established pursuant to Business and Professions Code sections 2234, subdivision (d).

10. Complainant failed to establish by clear and convincing evidence that Respondent engaged in the excessive use of diagnostic procedures, as set forth in Findings 93 through 97, 105 through 113 and 124. As a result, no cause for discipline was established pursuant to Business and Professions Code sections 2234 and 725.

11. Complainant established by clear and convincing evidence that Respondent failed to maintain adequate and accurate records related to his treatment of patient R.B., as set forth in Findings 20, 26, 29, 31, 59, 60, 61, 98 through 104, and 124. Therefore, cause was established exists to impose discipline on Respondent's certificate pursuant to Business and Professions Code section 2266.

Conclusion

12. The objective of an administrative proceeding relating to licensing is to protect the public. Such proceedings are not for the primary purpose of punishment. (See *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) When all the evidence is considered, Respondent's certificate should be placed on probation, for a period of three years, with appropriate terms and conditions to protect the public.

ORDER

Physician's and Surgeon's Certificate No. G 68575 issued to Respondent Howard Hack M.D. is REVOKED, but the revocation is STAYED, and Respondent is placed on probation for three years, upon the following terms and conditions:

1. Education Course: Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. Medical Record Keeping Course: Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course

provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

3. **Professionalism Program (Ethics Course):** Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

4. **Monitoring - Practice/Billing:** Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee. Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

5. **Solo Practice Prohibition:** Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that

location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

6. **Notification:** Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. **Supervision of Physician Assistants:** During probation, Respondent is prohibited from supervising physician assistants.

8. **Obey All Laws:** Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. **Quarterly Declarations:** Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. **Compliance with Probation Unit:** Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

a. Address Changes. Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a

post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

b. Place of Practice. Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

c. License Renewal. Respondent shall maintain a current and renewed California physician's and surgeon's license.

d. Travel or Residence Outside California. Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days. In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. Interview with the Board or its Designee: Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. Non-practice While on Probation: Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California, will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

13. **Completion of Probation:** Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

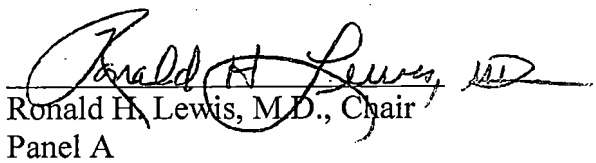
14. **Violation of Probation:** Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. **License Surrender:** Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. **Probation Monitoring Costs:** Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

The Decision shall become effective at 5:00 p.m. on June 28, 2019.

IT IS SO ORDERED this 31st day of May, 2019.



Ronald H. Lewis, M.D., Chair
Panel A
Medical Board of California

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES, CENTRAL DISTRICT

HOWARD HACK, M.D., Petitioner, vs. MEDICAL BOARD OF CALIFORNIA, DEPARTMENT OF CONSUMER AFFAIRS OF THE STATE OF CALIFORNIA, Respondent.	CASE NO.: BS 170152 [~~PROPOSED~~] **WRIT OF MANDATE** HEARING DATE: December 18, 2018 TIME: 9:30 A.M. DEPT.: 82

THE PEOPLE OF THE STATE OF CALIFORNIA

TO RESPONDENT MEDICAL BOARD OF CALIFORNIA, DEPARTMENT OF CONSUMER AFFAIRS, STATE OF CALIFORNIA:

Whereas on 2-1-, 2019, Judgment was entered in this action upon this Court's Decision, ordering the issuance of a writ of mandate, YOU ARE HEREBY COMMANDED, upon receipt of this writ, to reconsider the non-practice provision in the probationary terms and

conditions of your March 29, 2017 Decision and Order in the Matter of the Accusation Against Howard M. Hack, M.D. (Case No. 800-2015-012753, OAH No. 2016100492), in light of the 2016 version of your Disciplinary Guidelines, in accordance with the Decision of this Court on December 18, 2018.

YOU ARE FURTHER COMMANDED to file with this Court a return to this writ on or before 3-4- 2019, stating what you have done to comply.

Clerk

By

Deputy Clerk

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

In the Matter of the Accusation Against:	)	
	)	
HOWARD MARK HACK, M.D.	)	Case No. 800-2015-012753
	)	
Physician's and Surgeon's Certificate No. G 68575	)	OAH No. 2016100492
	)	
Respondent.	)	
	)	

DENIAL BY OPERATION OF LAW
PETITION FOR RECONSIDERATION

No action having been taken on the petition for reconsideration, filed by Peter R. Osinoff, Esq., on behalf of respondent, Howard Mark Hack, M.D., and the time for action having expired at 5 p.m. on May 8, 2017, the petition is deemed denied by operation of law.

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

In the Matter of the Accusation Against:	)	
	)	MBC No. 800-2015-012753
HOWARD MARK HACK, M.D.	)	
	)	OAH No. 2016100492
Physician's and Surgeon's	)	
Certificate No. G 68575	)	**ORDER GRANTING STAY**
	)	
	)	(Government Code Section 11521)
Respondent	)	

Peter R. Osinoff, Esq., on behalf of respondent, Howard Mark Hack, M.D., has filed a Petition for Reconsideration of the Decision in this matter with an effective date of April 28, 2017.

Execution is stayed until May 8, 2017.

This stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: April 25, 2017

Kimberly Kirchmeyer
Executive Director
Medical Board of California

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

In the Matter of the Accusation Against:	)	
HOWARD MARK HACK, M.D.	)	Case No. 800-2015-012753
Physician's and Surgeon's Certificate No. G 68575	)	OAH No. 2016100492
Respondent	)	

DECISION

The Proposed Decision of Marcie Larson, Administrative Law Judge, dated February 27, 2017 is attached hereto. Said decision is hereby amended, pursuant to Government Code section 11517(c)(2)(C), to correct technical or minor changes that do not affect the factual or legal basis of the proposed decision. The proposed decision is amended as follows:

1. Page 18, "Complainant's Expert Rudolph Bedford, M.D." is stricken and replaced with "Respondent's Expert Rudolph Bedford, M.D."

The Proposed Decision as amended is hereby accepted and 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 April 28, 2017.

IT IS SO ORDERED: March 29, 2017.

MEDICAL BOARD OF CALIFORNIA

Jamie Wright, JD, Chair
Panel A

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

In the Matter of the Accusation Against: HOWARD HACK, M.D. Physician and Surgeon's Certificate No. G 68575 Respondent.	Case No. 800-2015-012753 OAH No. 2016100492

PROPOSED DECISION

This matter was heard before Administrative Law Judge Marcie Larson, Office of Administrative Hearings, State of California, on January 24 through 26, 2017, in Sacramento, California.

Demond Philson, Deputy Attorney General, represented complainant Kim Kirchmeyer, Executive Director of the Medical Board of California (Board).

Peter Osinoff, Attorney at Law, represented respondent Howard Hack, M.D., who was present at the hearing.

Evidence was received, the record was closed, and the matter was submitted for decision January 26, 2017.

FACTUAL FINDINGS

1. On May 14, 1990, the Board issued respondent Physician and Surgeon's Certificate No. G 68575 (certificate). The certificate was current at all times pertinent to this matter. It will expire on September 30, 2017, if not renewed.

2. On August 15, 2016, complainant, acting in her official capacity, signed and thereafter filed the Accusation against respondent. Complainant seeks to impose discipline on respondent's certificate, based on his alleged unprofessional conduct in connection with

his treatment of three patients: R.B., N.P., and D.R.[1] Generally, complainant alleged respondent unnecessarily performed repeated endoscopic procedures on the patients and failed to refer R.B. and N.P. to a more experienced physician to remove large colon polyps. Complainant alleged that respondent's unprofessional conduct constituted excessive use of diagnostic procedures, gross negligence, repeated acts of negligence, and demonstrated incompetence. Complainant also alleged that respondent failed to keep complete and accurate medical records for the care and treatment he rendered to patient R.B.

3. Respondent timely filed a Notice of Defense, pursuant to Government Code section 11506. The matter was set for an evidentiary hearing before an Administrative Law Judge of the Office of Administrative Hearings, an independent adjudicative agency of the State of California, pursuant to Government Code section 11500 et seq.

Respondent's Background

4. Respondent completed his Bachelor of Arts degree in economics at the University of Pennsylvania in 1984. He attended medical school at Washington University in St. Louis, Missouri. Respondent graduated from medical school in 1988. Thereafter, he completed an internship at the Cleveland Clinic in Ohio. Respondent returned to Washington University in 1989, to complete his residency in internal medicine at Barns Hospital. In 1990, he obtained his certificate to practice medicine in California. Respondent completed a three-year Gastroenterology fellowship at Stanford University in California, from 1991 until 1994. The fellowship program consisted of two years of clinical training and a third year that was a combination of clinical training and clinical research.

5. In 1993, respondent was board-certified in Gastroenterology. He was recertified in 2004 and 2014. After respondent finished his fellowship at Stanford, he returned to Milwaukee, where he was raised, and practiced Gastroenterology for 15 years at the Milwaukee Medical Clinic. Respondent was the Chairman of the Division of Gastroenterology and Chief of the Gastroenterology Department for a total of 6 years. Respondent returned to Stanford, at times, to work as a Clinical Instructor approximately two times per month. He also worked as an Assistant Clinical Professor of Medicine at the College of Wisconsin and a Clinical Associate Professor at Marquette University.

6. From 2002 until 2009, respondent practiced Gastroenterology at the West Bend Clinic in West Bend, Wisconsin. He was a member of the Quality Assurance Committee at the West Bend Clinic. From 2009 to 2012, respondent operated a private Gastroenterology practice in Las Vegas, Nevada. He also worked in a Locum Tenens position in Lafayette, Indiana.

7. In 2013, respondent was recruited to practice at Feather River Hospital (Feather River) in Paradise, California. Feather River is a 100 bed rural hospital located near Chico, California. In March 2013, respondent opened a private practice in Paradise. He

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[1] The patients are referred to by their initials to protect their privacy.

performed procedures at Feather River and Skyway Surgery Center (Skyway), in Chico. Respondent was granted "provisional" staff privileges at Feather River. Despite being recruited to work at Feather River, respondent testified that he quickly discovered that the Chief of Medicine at Feather River was not "enthusiastic" about his arrival. The Chief of Medicine would not acknowledge respondent's presence or greet him. Their relationship did not improve over time, despite respondent's efforts to speak with the Chief of Medicine. Respondent was also informed by his colleagues that the Chief of Medicine "hated him."

8. Respondent worked at Feather River until February 2015. During his time at Feather River, he performed thousands of procedures. Feather River reviewed all of respondent's patient files and procedures. Respondent had no patient complaints and no complications with any of the procedures he performed. In February 2015, Feather River was in the process of determining whether respondent would be recommended for advancement to active staff. Respondent had never experienced a delay in obtaining hospital staff privileges. Respondent testified that he did not believe that the issues the Chief of Medicine had with him were going to resolve or that his staff privileges would be handled in the normal manner in which respondent was accustomed. As a result, effective February 25, 2015, prior to Feather River's decision, respondent resigned his position.

Investigation Conducted by Investigator Adam Brearley

9. On March 19, 2015, the Board received an "805 Report" from Feather River. The brief statement provided by Feather River explained that respondent was under a "focused investigation related to his gastroenterology privileges" and that prior to a decision made by the Feather River Medical Executive Committee to "recommend or deny" respondent's advancement to active staff, he resigned.

10. On April 16, 2015, Adam Brearley, an Investigator for the Department of Consumer Affairs, was assigned to investigate the report filed by Feather River. Mr. Brearley issued an initial report dated April 5, 2016, and a supplement report dated May 12, 2016, regarding his investigation of respondent. Mr. Brearley testified at hearing. As part of his investigation, Mr. Brearley obtained respondent's patient records from Feather River, for any patient in which "the competence or conduct of [respondent] was in question." Mr. Brearley provided the medical records to the Board's medical consultant Dr. Howard Slyter for review.

11. On September 10, 2015, Dr. Slyter completed his review of the medical records provided to him by Mr. Brearley. Dr. Slyter requested additional records for six patients. On September 25, 2015, Mr. Brearley provided Dr. Slyter with the medical records of six patients, including R.B., N.P. and D.R. On December 28, 2015, respondent was interviewed by Investigator Michel Veverka. Dr. Slyter was present at the interview.

12. On January 8, 2016, Mr. Brearley sent a letter, draft report, and "selected attachments and property" to Board expert reviewer James Ostroff, M.D., who is board-certified in Gastroenterology. On March 20, 2016, Dr. Ostroff issued a report in which he

opined that respondent performed endoscopic procedures on patients R.B., N.P. and D.R., that deviated from the standard of care.

Description of Endoscopic Procedures

13. An endoscopy is a procedure conducted with a thin, flexible tube equipped with a digital camera that travels through the body's orifices and allows a doctor to examine a patient's stomach, esophagus, small intestine and colon. Endoscopic procedures include upper gastrointestinal endoscopies (upper endoscopy) and colonoscopies. An upper endoscopy involves the insertion of an endoscope through a patient's mouth to view the areas such as the esophagus and stomach. A colonoscopy procedure involves the insertion of an endoscope through the rectum to view the colon.

14. In preparation for a colonoscopy, a patient is required to cleanse the colon of fecal material prior to the procedure. The day of the procedure, the patient is sedated with either moderate sedation or monitored anesthesia depending on the patient's needs. A doctor inserts an endoscope through the anus, which travels through the colon. The colon is shaped like an upside down U. The rectum is the starting point of the colon. The endoscope is inserted through the anus to the rectum, which is followed by the sigmoid colon, and then the descending colon located on the right side of the body. The transverse colon is the horizontal portion of the colon, followed by the ascending colon, which is located on the left side of the body. The cecum is at the end of the ascending colon, which is where a colonoscopy ends. The colonoscope contains a camera which projects an image onto a monitor for the doctor to view.

15. The American Medical Association (AMA) recommends that individuals over the age of 50 years old undergo a screening colonoscopy for colon cancer. The screening colonoscopy is a preventative measure. Approximately one-third of individuals over the age of 50 have colon polyps, which is tissue growth. The first layer of the colon is the mucosa, where the polyp tissue arises. The layer below the mucosa is the submucosa. Typically, two types of polyps are found in the colon, pedunculated and sessile polyps. A pedunculated polyp is a tissue growth that is attached to the top of a stalk. The stalk is attached to the mucosa. A sessile polyp, also referred to as a flat polyp, is flat and lies on the surface of the mucosa. If not removed, a polyp can progress into cancer. The risk of undergoing a colonoscopy includes bleeding, a perforation, and respiratory complications.

16. Polyp tissue can be removed with a snare. The snare is threaded through a hollow channel in the colonoscope. Typically, the snare is equipped with electricity and heat. The polyp tissue is removed from the colon. The tissue can be suctioned through a hollow channel in the colonoscope and caught in a trap that contains webbing, referred to as a Roth net (net). Small polyps can be removed with biopsy forceps. The polyp tissue that is removed is sent to pathology to determine if any of the tissue contains cancer or pre-cancerous cells.

17. The performance of a colonoscopy by a Gastroenterologist is a standard procedure. Gastroenterologists study the digestive system, including the stomach, small intestine, and the large intestine and some organs related to the digestive system, such as the liver, the gall bladder, the pancreas, and the salivary glands. Gastroenterologists typically care for patients with ailments in those structures. Respondent estimated that he performs approximately 1000 to 2000 colonoscopies and endoscopies per year. Over the course of his career, he has performed between 30,000 to 40,000 colonoscopies and endoscopies. During his fellowship at Stanford, respondent was trained to remove large flat polyps from the colon that are larger than 2 centimeters (cm) in size. As part of his practice, respondent regularly removes large flat polyps. Approximately 10 to 15 percent of his patients have flat polyps, and of those patients, respondent removes less than 10 percent of the flat polyps in a piecemeal fashion, during multiple procedures.

Treatment History of Patient R.B.

MARCH 4, 2014 COLONOSCOPY

18. On March 4, 2014, respondent performed a screening colonoscopy on R.B., a 67 year-old man. Respondent performed the procedure at Skyway. Respondent observed during the colonoscopy that R.B. had a 4 cm flat polyp in the proximal ascending colon, a 3 cm flat polyp in the transverse colon and a 1 cm polyp in the sigmoid colon. Respondent removed the 1 cm polyp with a snare and electrocautery, and partially removed the 4 cm flat polyp. He did not remove the 3 cm polyp in the transverse colon.

19. Respondent was only able to partially remove the 4 cm flat polyp because he did not have the "necessary endoscopic conditions to remove it in its entirety." Respondent testified that in order to remove a flat polyp, the patient needs to be comfortable and well sedated, so that respondent can get the patient into proper position. Moderate sedation was insufficient for R.B. during the procedure. Respondent determined that R.B. needed a higher level of sedation administered by an anesthesiologist, which required monitored anesthesia. Skyway did not have a higher level of sedation available.

Skyway also had older endoscopy equipment. In contrast, Feather River was able to provide the most recent series of gastrointestinal scopes. Additionally, the technician assisting respondent at Skyway was "less skilled" in assisting with colonoscopies. Specifically, respondent relied upon the technician to apply abdominal pressure which allows respondent to successfully advance the scope. Respondent was not able to perform the technical maneuvers necessary to remove the entire 4 cm flat polyp successfully at Skyway. As a result, respondent determined that in order to remove the entire flat polyp, he needed to perform another colonoscopy on R.B. at Feather River.

MARCH 27, 2014 COLONOSCOPY

20. On March 26, 2014, respondent conducted an examination of R.B., which he documented in R.B.'s medical record. Respondent documented R.B.'s history and physical

examination. Respondent noted in R.B.'s medical record that during the March 4, 2014 colonoscopy at Skyway, he discovered a 4 cm flat polyp "in the proximal descending colon that could not be removed in its entirety endoscopically." Respondent testified that the medical record was not correct. He should have noted that the 4 cm polyp was in the "proximal ascending colon." Respondent dictated his medical notes. He failed to notice after the notes were transcribed, the mistake regarding the location of the 4 cm polyp in the history portion of R.B.'s record.

21. On March 27, 2014, respondent performed a second colonoscopy on R.B. at Feather River. R.B. was administered monitored anesthesia. Respondent inserted the colonoscope through R.B.'s anus and advanced the scope. Respondent located the 4 cm flat polyp in the proximal ascending colon he incompletely removed during the March 4, 2014 procedure. Respondent correctly noted in the procedure notes that the flat polyp was located in the proximal ascending colon. Respondent estimated that the remaining flat polyp in the proximal ascending colon was 25 millimeters (mm).

Respondent removed part of the 25 mm flat polyp in the proximal ascending colon with a "saline injection-lift technique using a hot snare," which respondent also referred to as an "endoscopic mucosal resection." The endoscopic mucosal resection involves injecting liquid, such as saline, in the layer just below where the polyp arises. By injecting the polyp area with saline in the submucosa, a bubble is formed that creates a larger and thicker space. The mucosa with the polyp is brought away from the rest of the layers in the colon. This technique also provides a buffer for the lining of the colon from the electricity and heat from the snare. The snare fits around a portion of the polyp, which is cut with the snare and the polyp "flips off." Respondent explained that it is also important to remove a layer of tissue around the boarder of the polyp to ensure that no precancerous tissue is left.

22. Respondent noted that the resection of the 25 mm flat polyp in the proximal ascending colon "incomplete." The polyp was curved around a bend in the colon. Due to the size and location of the polyp, he could not position the snare around the entire polyp. Respondent removed as much of the 25 mm flat polyp that he believed was safe for the patient. Respondent testified that, particularly with flat polyps, there is a risk of bleeding. Respondent reduced the risk of bleeding and complications by removing the amount of tissue he believed was safe. He also applied a "resolution clip" to the removal site, which provided a surgical closure to the polypectomy site. Respondent also completely removed and retrieved a 5 mm sessile polyp in the distal sigmoid colon.

Respondent injected permanent carbon black ink into the submucosal space near the polypectomy site where he removed a portion of the 25 mm flat polyp, to identify that site for a future examination. Respondent testified that "there are no road markings in the colon." The ink assists him, and other doctors who may perform subsequent colonoscopies, with identification of the site in the future.

23. Respondent noted in R.B.'s medical record, that the resected tissue from the 25 mm flat polyp was "partially retrieved." Respondent indicated that there can be different

reasons for incomplete retrieval of polyp tissue. Respondent testified that it is possible that the removed tissue was lost in the fluid that was present in the colon. Additionally, tissue that is suctioned can be shredded or does make it into the trap successfully. All tissue that was retrieved during R.B.'s procedure was labeled and sent to pathology for testing.

24. Respondent noted that that the estimated blood loss during the procedure was "minimal" and that the patient tolerated the procedure well. Respondent also noted that the "colonoscopy was technically difficult and complex due to poor endoscopic visualization." Respondent testified that R.B.'s bowel preparation was poor. The fecal matter was not cleaned out of his colon prior to the procedure, which made visualization of the colon more difficult. As a result, respondent recommended that R.B. have another colonoscopy in two months to get better visualization of the colon and to review the polypectomy site. Respondent did not document any information about the 3 cm flat polyp in the transverse colon he observed during the March 4, 2014 colonoscopy at Skyway.

25. The surgical pathology report dated March 31, 2014, indicated that approximately 0.5 cm of aggregate tissue from the 25 mm polyp in the ascending colon and 0.5 cm of a single tissue fragment from the 5 mm polyp in the sigmoid colon were submitted to pathology. The tissue from the ascending colon was diagnosed as "tubulovillous adenoma." The tissue from the sigmoid colon was diagnosed as a "Hyperplastic polyp." The report further noted as to the hyperplastic polyp in the sigmoid colon that "sections show polypoid colonic mucosa with some of the glands demonstrating serrated luminal outlines."

An adenoma has precancerous potential, regardless of the location of the adenoma. A tubulovillous adenoma is a more advanced precancerous condition and is believed to be a higher predilection for developing into cancer. Serrated adenoma is also thought to have precancerous potential and can be mistaken for a hyperplastic polyp. Respondent testified that a hyperplastic polyp in the left side of the colon does not typically have any clinical significance. However, if a hyperplastic polyp is found in any other part of the colon, the polyp could be precancerous, due to the location of the polyps in the colon

MAY 28, 2014 COLONOSCOPY

26. On May 27, 2014, respondent conducted an examination of R.B., which he documented in R.B.'s medical record. Respondent incorrectly documented that during the March 4, 2014 colonoscopy at Skyway, he discovered a 4 cm flat polyp "in the proximal descending colon" rather than the ascending colon. However, in the same paragraph he noted that on March 27, 2014, there was a follow up colonoscopy to "remove the remainder of the proximal polyp in the ascending colon." Respondent also documented that on March 4, 2014, he identified "a 3 cm flat polyp in the transverse colon, which was removed." Respondent testified that the medical record is incorrect. Respondent should have written that the 3 cm flat polyp in the transverse colon, was not removed on March 4, 2014. Respondent reviewed the medical notes after his dictation was transcribed, but did not see the errors.

27. On May 28, 2014, respondent performed a third colonoscopy on R.B. at Feather River. Respondent observed two flat polyps in the mid-transverse colon and in the proximal ascending colon. He noted the two polyps were 12 to 30 mm in size. Respondent testified that the polyp he identified in the proximal ascending colon was residual polyp tissue from the 4 cm polyp that removed in piecemeal fashion on March 4, and March 27, 2014. Respondent testified that the polyp in the mid-transverse colon was 3 cm polyp he first observed during the March 4, 2014 colonoscopy, which he incorrectly documented in the May 27, 2014 history that he had removed on March 4, 2014.

In the May 28, 2014 procedure notes, respondent documented that he removed the polyps from the proximal ascending colon and mid-transverse colon, with the saline injection-lift technique, using a hot snare. The polyp resection was incomplete and the resected tissue was partially retrieved. Respondent injected the area near the polypectomy site with carbon black ink for tattooing. Respondent used four clips to prevent bleeding. Respondent testified that he was concerned that the resection of polyps in the ascending and transverse colon was not complete and that there may be residual polyp tissue at the edge of the polyp. He noted that bowel preparation of the ascending colon was only "fair" which may have obscured his view.

28. Respondent also noted in the procedure report that the "colonoscopy was technically difficult and complex due to restricted mobility of the colon." Respondent further noted that "successful completion of the procedure was aided by using manual pressure." There was no bleeding during the procedure. Respondent recommended a follow-up colonoscopy in two months for "surveillance after piecemeal polypectomy."

29. Respondent noted in the "Patient Profile" portion of the procedure report that R.B. had a "4 cm flat serrated adenoma" in the ascending colon, which he had been removing "in a piecemeal fashion." This was an error. The 4 cm polyp in the ascending colon he partially removed on March 4 and March 27, 2914 was diagnosed as a tubulovillous adenoma.

30. The pathology report dated May 29, 2014, indicated that two pieces of tissue were submitted in one cassette, labeled transverse colon polyp. Respondent did not label the specimens after the tissue was removed and placed in the cassette. He relied on the nurse or technician assisting with the procedure to properly label the cassettes. Respondent testified that it is possible that one of the tissue samples was from the ascending colon polyp. One sample was 0.4 cm and the other was "1.3 x 0.8 x 0.5" cm. The tissue in the single cassette was diagnosed as a tubulovillous adenoma.

NOVEMBER 26, 2014 COLONOSCOPY

31. On November 18, 2014, respondent conduct a history and physical examination of R.B., in preparation for a follow-up colonoscopy to inspect the polypectomy sites. Respondent continued to incorrectly note in R.B.'s medical record that on March 4, 2014, a large flat "4-5" cm polyp was discovered in the proximal descending colon, rather

than the ascending colon, and that a flat polyp in the transverse colon was removed on March 4, 2014. He also noted that he was not able to access the "4-5" cm flat polyp at Skyway, which was inconsistent with the previous medical notes from the March 27 and May 28, 2014 procedures, in which he wrote that he was able to partially resect the polyp during the March 4, 2014 colonoscopy at Skyway. Respondent noted that R.B. underwent colonoscopies on March 27, 2014, and May 28, 2014, "where it appeared to be the remainder of the large polyps were removed in piecemeal fashion."

32. On November 26, 2014, respondent performed a fourth colonoscopy on R.B. at Feather River. Respondent inserted the colonoscope through the rectum to the sigmoid colon. Respondent observed a 5 mm sessile polyp in R.B.'s rectum. Respondent observed that the R.B.'s colon preparation was poor, which prevented respondent from seeing the colon. As a result, respondent canceled the procedure and recommended that R.B. have a follow-up procedure in two months with better preparation. Respondent resigned his position with Feather River, prior to performing the follow-up colonoscopy on R.B.

Treatment History of Patient N.P.

33. On December 18, 2013, respondent examined N.P., an 89 year-old man who was referred to respondent after he lost 23 pounds over an 18-month period. N.P. informed respondent that other than losing weight, he felt well. N.P. reported that he had recently sold his appliance store business. He had three children. N.P. had lived alone since his wife had passed away 20 years ago. N.P. reported that he was active. He gardened and took care of his pool. Respondent noted that N.P. "appears well and appears younger than his stated age."

34. N.P. reported that he had a history of heartburn, but no recent symptoms. He reported an "intermittent sensation of lower esophageal dysphagia for solid foods" and that he had to drink a lot of water to swallow his food. He also reported feeling more constipated over the previous 12 months. N.P. informed respondent that in 2001, he had colon polyps removed at Feather River. Respondent noted that blood tests taken in October 30, 2013, were "essentially normal with hemoglobin of 13.9."

35. Respondent's impressions included:

1. Involuntary weigh loss;

2. Chronic gastroesophageal reflux disease;

3. Intermittent dysphagia for solid foods, this is most likely related to a Schatzki ring with differential diagnosis also includes esophagitis and less likely esophageal cancer and history of colon polyps;

4. Weight loss. The differential diagnosis is broad, and they include hypothyroidism, celiac disease, malignancy such as colon, esophageal, or gastric cancer.

36. Respondent recommended that N.P. undergo an upper endoscopy and colonoscopy for further evaluation of his symptoms. Respondent recommended a colonoscopy because N.P. had profound weight loss, loss of appetite and constipation. Respondent determined that a colonoscopy should be used as diagnostic tool due to N.P.'s symptoms and history of colon polyps.

DECEMBER 19, 2013 PROCEDURES

37. On December 19, 2013, respondent performed an upper endoscopy on N.P. Respondent observed that N.P. had "salmon-colored mucosa suspicious for short-segment Barrett's esophagus." Respondent testified that Barrett's esophagus is a condition which can cause cancer of the esophagus. Respondent obtained a tissue sample for a biopsy in order to obtain a definitive diagnosis. The pathology came back negative for cancer.

38. Respondent also performed a colonoscopy on N.P. Respondent observed eight polyps in the sigmoid, transverse and ascending colon, 5 to 25 mm in size. Respondent resected the eight polyps with a hot snare and retrieved the tissue. He inserted eight clips to close the polypectomy sites. Respondent also observed a 40 mm "polypoid lesion" in the distal transverse colon. Respondent was particularly concerned about the lesion because N.P. was in good health and there was no explanation for his profound weight loss. Given the size and appearance of the lesion, respondent believed it was more likely to contain cancer.

Rather than remove the lesion which would not be indicated at the time of the colonoscopy if the lesion contained cancer, respondent obtained samples of the lesion with cold biopsy forceps to send the sample to pathology. Respondent then injected the spot near the lesion with carbon black ink for tattooing. Respondent noted that the colonoscopy was performed "without difficulty" and that N.P. tolerated the procedure well. Respondent also noted that the estimated blood loss was minimal.

39. The pathology report dated December 20, 2013, noted that the lesion from the transverse colon was a polyp that contained "multiple tubulovillous adenoma fragments." The sample was "negative for high grade dysplasia and malignancy." The polyps in the ascending, transverse and descending colon were tubulovillous adenoma. The polyps in the sigmoid colon were hyperplastic polyps.

40. After obtaining the biopsy results, respondent recommended to N.P. that he have the 40 mm tubulovillous adenoma polyp removed during another colonoscopy. Respondent believed that N.P. had a life of expectancy of another five years. There was no way for respondent to predict whether the tubulovillous adenoma polyp would develop into cancer and respondent believed that the risk of removing the polyp was very low.

MAY 14, 2014 COLONOSCOPY

41. On May 14, 2014, respondent conducted a second colonoscopy on N.P. to remove the large flat polyp in the transverse colon. During the colonoscopy respondent estimated that the polyp was larger than he originally estimated. Rather than 40 mm as he previously estimated, he determined that the polyp was "greater than 50" mm. He removed a portion of the polyp with a saline injection-lift technique using a hot snare. Based on respondent's clinical experience, he removed the amount of tissue he believed was safe. The tissue was retrieved using a net. Respondent inserted five clips at the polypectomy site and injected the area near the polypectomy site with carbon black ink for tattooing.

Respondent also removed five sessile polyps from the transverse and ascending colon that were 10 to 15 mm. The polyps were removed with a hot snare. Resection and retrieval were complete. Respondent also removed four polyps that were 5 to 8 mm in size, from the rectum, and the transverse and ascending colon. The polyps were removed with "jumbo cold forceps." Resection and retrieval were complete.

42. Respondent noted that the colonoscopy was "technically difficult and complex due to inadequate bowel prep." He also noted there was minimal blood loss and that the patient tolerated the procedure well. Respondent recommended that N.P. undergo a third colonoscopy in two to six months to remove the remainder of the flat polyp in the transverse colon.

43. The pathology report dated May 15, 2014, noted that the specimen from the ascending colon contained four "0.1-0.6" cm tissue fragments. The specimen from the transverse colon contained four fragments of polyps "0.9-1.2" cm "in greatest dimension." The polyps in the ascending colon were hyperplastic polyps and "submucosal lymphoid aggregates." The polyps in the transverse colon were fragments of tubulovillous adenoma.

SEPTEMBER 29, 2014 COLONOSCOPY

44. On September 29, 2014, respondent performed a third colonoscopy on N.P. to remove the remainder of the 50 mm flat polyp in the transverse colon. Respondent estimated that the remaining polyp tissue was 38 mm. He removed the remaining polyp tissue with a saline injection-lift technique using a hot snare. Resection and retrieval of the tissue was complete. Three clips were successfully placed to close the polypectomy site to reduce the risk of bleeding. Respondent noted that the procedure was performed without difficulty and N.P. tolerated the procedure well. There was no bleeding during the procedure. The tissue samples were collected and sent for testing.

45. The pathology report dated September 30, 2014, described a "2.1 x 1.5 x up to 0.9" cm tissue from the transverse colon, which were diagnosed as tubulovillous adenoma.

Treatment History of Patient D.R.

46. On March 27, 2013, respondent examined D.R., a 42 year-old woman with a history of Clostridium Difficile (C. difficile), an intestinal infection she acquired while she was in the hospital in January 2013. D.R. reported that in March 2013, she had been in the hospital for six days taking oral Vancomycin, as a result of the C. difficile infection. She had blood in her stool and diarrhea. She had also been prescribed Flagyl for several weeks. D.R. complained of continued back and abdominal pain. She was tired and did not feel well. She had diarrhea, several times per day, weight loss and acid reflux. Respondent assessed D.R. with C. difficile, GERD, and Dysphagia. He recommended she undergo an upper endoscopy and colonoscopy.

47. On April 5, 2013, respondent performed an upper endoscopy and colonoscopy on D.R. He noted "moderate inflammation characterized by congestion (edema)" in her stomach. He also noted that the "entire examined colon appeared normal." He obtained biopsies of the stomach, rectum and the ascending, descending and sigmoid colon.

48. The pathology report dated April 8, 2013, noted no specific pathologic abnormality, except for a mild hyperplastic change in the sigmoid colon and a hyperplastic polyp in the rectum.

JUNE 7, 2013 PROCEDURES

49. On June 6, 2013, respondent conducted a second examination of D.R. She reported that on May 19, 2013, she was seen at the Oroville Hospital (Oroville) due to abdominal pain and loose stools. She was prescribed oral Vancomycin. D.R. reported that she had lost approximately 15 pounds "over the intervening two to three months." Respondent noted that radiological studies obtained at Oroville "were remarkable for an abdominal series showing some dilated loops of small bowel." He also noted that D.R.'s stool culture for C. difficile was negative.

50. Respondent was concerned that the dilated loops of small bowel could indicate that there was an obstruction or an inflammatory bowel disease. He believed the finding were a clinically significant change from the initial examination he conducted on March 27, 2013. Respondent did not have a clear clinical explanation for D.R.'s symptoms. Her condition improved between March and April 2013, and then her symptoms returned. Respondent was concerned that D.R. may have an inflammatory bowel disease, recurring C. difficile infection or ischemic colitis. Respondent explained that the treatment for these conditions is different. Failure to properly diagnosis and treat the condition would have resulted in D.R. getting sicker or even have caused her death. As a result, he recommended that D.R. undergo another upper endoscopy and colonoscopy. The procedures would allow respondent to view the lining of the mucosal to determine whether there were any changes to the lining that would provide information on the nature of D.R.'s condition. For example, C. difficile colitis can present as a yellowish material on the lining of the colon. Ischemic colitis presents as patch inflammation and ulceration.

51. On June 7, 2013, respondent performed an upper endoscopy on D.R. Her esophagus was normal. She had inflammation in the lining of her stomach. Respondent obtained biopsies. Respondent also performed a colonoscopy. He noted that the bowel preparation was poor. As a result, respondent was not able to properly view the lining of the colon. Respondent obtained biopsies and a stool sample for testing. The pathology report dated June 10, 2013, reported no significant pathology and the stool sample was negative for C. difficile.

52. Respondent determined that biopsy results would not provide him with the information he needed concerning the nature of D.R.'s condition, because the results only related to a small area of the colon where tissue was obtained. Respondent recommended that D.R. undergo a third colonoscopy so that respondent could exam the lining of her colon.

JULY 22, 2013 COLONOSCOPY

53. Respondent performed a third colonoscopy on D.R. on July 22, 2013. He noted that the quality of the bowel preparation was good. Respondent was able to view the lining of the colon, which appeared to be normal. Respondent obtained biopsies of the small bowel, right and left colon and rectum, which had no significant pathology. Respondent suspected that D.R. had a recurring C. difficile infection. Respondent referred D.R. to Stanford for further evaluation and treatment. Ultimately, it was determined that D.R. had a recurring C. difficile infection.

Complainant's Expert James Ostroff, M.D.

54. Dr. Ostroff is board-certified in Gastroenterology and Internal Medicine. He is licensed by the Board to practice medicine in California. Dr. Ostroff graduated from Cornell Medical College in 1977. He completed a medical residency at New York Hospital-Cornell Medical Center in 1980. Between 1980 and 1982, Dr. Ostroff completed a two-year fellowship in Gastroenterology at the University of California, San Francisco (UCSF). In 1982, Dr. Ostroff became part of the faculty at UCSF, where he is still employed.

Dr. Ostroff is a Professor of Clinical Medicine, Clinical Pediatrics and Clinical Radiology. He is also the Chief of Endoscopy and the Director of the Gastrointestinal Consult Service at the UCSF Mt. Zion Medical Center. Dr. Ostroff specializes in endoscopic procedures. He sees patients two and one-half days per week at UCSF and the rest of the week he performs procedures. He recently started a pediatric pancreas clinic with a pediatric Gastroenterologist. Dr. Ostroff has served as an expert witness for the Board approximately ten times.

55. Following a January 8, 2016 referral from Mr. Brearley, Dr. Ostroff authored a report dated March 20, 2016, concerning his evaluation of respondent's conduct related to

the treatment of patients R.B, N.P., and D.R.[2] In the report, Dr. Ostroff listed the documents he reviewed to reach his opinions and conclusions. Dr. Ostroff reviewed in part, the certified medical records of R.B., N.P., and D.R. He also reviewed respondent's curriculum vitae, and a transcript of respondent's interview with the Board's investigator. Dr. Ostroff testified at hearing.

OPINIONS REGARDING PATIENT R.B.

56. Dr. Ostroff opined that the standard of care requires a doctor to recognize that the removal of large sessile polyps require specialized techniques and the presence of "adequately trained assistants as well as the presence of the correct equipment." Dr. Ostroff opined that based on his review of R.B.'s medical records, the pathology reports, and respondent's interview with the Board's investigator, there were discrepancies concerning which polyps respondent removed during the colonoscopy procedures and where the polyps were removed from during the procedures. Dr. Ostroff also opined that the pathology reports did not coincide with respondent's documentation concerning the tissue that was removed. Additionally, he opined that respondent did not have the skill to remove extremely large polyps.

57. Respondent documented during his examination of R.B. on March 26, 2014, that the first colonoscopy performed on R.B. at Skyway on March 4, 2014, revealed the 4 cm flat polyp in the proximal descending colon, but this could not be removed entirely by endoscopically, a 3 cm flat polyp in the transverse colon, and a 1 cm polyp in the sigmoid colon. Dr. Ostroff noted that respondent was less comfortable performing the colonoscopy at Skyway and decided to perform a second colonoscopy at Feather. Dr. Ostroff opined that respondent's decision to end the first colonoscopy at Skyway was a "personal judgment" that "no one could fault him" because "everyone should be comfortable about what they are doing."

58. Dr. Ostroff opined that respondent's documentation and findings concerning the March 27, 2014 colonoscopy were inconsistent with the findings from the March 4, 2014 procedure. Specifically, respondent failed to mention the 3 cm flat polyp in the transverse colon that was discovered during the March 4, 2014. Respondent referenced a 25 mm sessile polyp in the proximal ascending colon, rather than the proximal descending colon, and a 5 mm polyp, in the distal sigmoid colon. Dr. Ostroff noted that respondent removed the sessile polyp by lifting up the polyp using a saline wall and removing the tissue with a snare, which he opined respondent performed correctly.

However, in reviewing the March 31, 2014 pathology report, only approximately 0.5 cm of aggregate tissue from the ascending colon and 0.5 cm of a single tissue fragment from the sigmoid colon were submitted to pathology. Dr. Ostroff opined that only a small percentage of the 25 mm polyp from the proximal ascending colon was removed. Dr.

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[2] Dr. Ostroff's report references three additional patients in which he found no violations of the standard of care. Those patients are not referenced in this decision.

Ostroff contended that while respondent correctly noted in R.B.'s medical record that the polyp was incomplete and the resected tissue was partially retrieved, the tissue that was retrieved does not represent that polyp, because such a small percentage of the polyp was submitted for pathological analysis. Dr. Ostroff opined that respondent should have retrieved more than 20 percent of his "work product."

59. Dr. Ostroff also noted that respondent documented in R.B.'s medical records from the May 28, 2014, that R.B. had a 4 cm flat serrated adenoma in the ascending colon. However, there is no documentation from any pathology report diagnosing the tissue as a serrated adenoma. The only reference Dr. Ostroff found was in the March 31, 2014 pathology report that referenced hyperplastic polyp in the sigmoid colon that had glands demonstrating serrated luminal outlines, which is "far from a serrated adenoma." He opined that a serrated adenoma potentially has complications and may be more malignant.

Respondent documented in R.B.'s medical record that during the colonoscopy performed on May 28, 2014, two 12 to 30 mm polyps in the mid-transverse colon and proximal ascending colon were observed. Dr. Ostroff opined that respondent failed to detect these polyps during the colonoscopy on March 27, 2014. Due the inconsistent information contained in R.B.'s medical records, it was not clear to Dr. Ostroff that polyp in the ascending colon was the 4 cm polyp he began to remove on March 4, 2014, and the 3 cm polyp in the transverse colon he identified on March 4, 2014.

Additionally, the resection of the two 12 to 30 mm polyps in the mid-transverse colon and proximal ascending colon on May 28, 2014 was incomplete and retrieval was also incomplete. The pathology report dated May 29, 2014, only referenced specimens from the transverse colon polyp, consisting of aggregate tissue that was smaller than 3 cm. There was no tissue submitted from the ascending colon. Dr. Ostroff opined that flat polyps can be removed in a piecemeal fashion, but after a certain point, respondent should have employed a more specialized removal of the polyps such as an endoscopic mucosal resection or a submucosal section so repeated colonoscopies did not have to be performed.

60. Dr. Ostroff also noted that R.B.'s medical records for the November 18, 2014, pre-colonoscopy examination stated that during the March 4, 2014 colonoscopy at Skyway, a 4 to 5 cm flat polyp in the proximal descending colon was discovered, but respondent was not able to access the polyp. Dr. Ostroff opined that this note is inconsistent with previous notes in R.B.'s medical records which indicate that respondent was able to remove part of the polyp during the March 4, 2014 procedure. Respondent also noted that a 3 cm polyp in the transverse colon was removed on March 4, 2014, however this note was inconsistent with previous medical notes, which indicated it was not removed.

61. Dr. Ostroff opined that it is not "striking" that respondent would incompletely remove a polyp for a variety of reasons, such as safety, or that some of the fragments of the polyps are not retrieved. However, respondent repeatedly and incompletely removed the polyps, during three attempts, with R.B. still requiring four or more colonoscopies to remove the polyps. Respondent also repeatedly lost tissue fragments. Dr. Ostroff opined that the

confusion regarding which polyps were resected, the "techniques employed with a 4-5 cm" polyp and the "lack of adequate pathology specimen" over the course of three colposcopies together in aggregate represented an extreme departure. Dr. Ostroff opined that the standard of care required respondent to refer R.B. to a "more experienced colonoscopist that specialized in large colonic polyp resection."

OPINIONS REGARDING PATIENT N.P.

62. Dr. Ostroff contended that respondent deviated from the standard of care by performing multiple colonoscopies on N.P. Dr. Ostroff opined that endoscopic procedures can be associated with risk, particularly in the case of an elderly person. The standard of care requires that there are "clear indications" before an endoscopic procedure is performed. In the absences of "frank bleeding," a colonoscopy is "usually avoided except with profound anemia."

63. Dr. Ostroff further opined that standard of care also discourages screening colposcopies for patients older than 85, particularly patients without "alarm symptoms" such as bleeding or profound anemia. Dr. Ostroff opined that anorexia, difficulty swallowing, weight loss, or constipation are not indications for a colonoscopy. Dr. Ostroff opined that N.P.'s symptoms did not warrant a colonoscopy, because he had no iron deficiency or other nutritional deficiencies. However, Dr. Ostroff further opined that if N.P. had been in his 60's, he would have been "entitled to a colonoscopy."

64. He further contended that reducing N.P.'s risk of colon cancer by removing the polyps in a 90-year-old man was not within the accepted standard of care. Dr. Ostroff opined that the risk factor for colorectal cancer "takes a dive" around 80 years of age. Dr. Ostroff also opined that while respondent discovered, during the colonoscopies, that N.P. had polyps, the polyps were not causing his symptoms, were not bleeding and "likely would have gone un-noticed for the rest of his life." He further opined that it would take years for a tubulovillous adenoma polyp to become malignant. He opined that the three colonoscopies that were performed with "unsuccessful attempts to remove the largest of the polyps is far more serious than performing a single colonoscopy and then looking elsewhere for the cause of his problem." Dr. Ostroff opined that three colonoscopies were performed where there was little indication for one, and was an extreme departure from the standard of care.

65. Dr. Ostroff also contended that the performance of a colonoscopy requires "formal training including practical and didactic training." He further contended that "special training and skill is required for large sessile polyp removal and often advanced training is required under supervision." Dr. Ostroff opined that "[i]t is simply not enough to continue to remove pieces for techniques are in place that simulates a surgical trans mural resection." Dr. Ostroff opined that respondent did not possess the skill to remove N.P.'s sessile polyps.

66. Dr. Ostroff opined that during the first colonoscopy on December 19, 2013, respondent observed that N.P. had a number of large flat polyps, which he removed in a

piecemeal fashion. He partially resected a 5 cm polyp in the proximal transverse colon, and follow-up was recommended to determine whether the polyp had any relationship to his symptoms. Dr. Ostroff contended that respondent's decision to subject this 89-year-old man to repeated follow-up colonoscopies in order to resect asymptomatic polyps was "very questionable."

67. Dr. Ostroff contended that during the May 14, 2014 colonoscopy, respondent removed small hyperplastic polyps which were are "more like blemishes on the colon rather than being premalignant lesions." The pathology report also indicated that only 0.1 to 0.6 cm of the large polyp in the ascending colon was retrieved. Four fragments of the polyp from the transverse colon ranging in size from 0.9 to 1.2 cm were retrieved.

68. He also opined that by the third colonoscopy on September 29, 2015, there was still incomplete removal of the polyp. Respondent estimated that the large flat polyp in the transverse colon was a 38 mm polyp. It was resected and retrieved, which would suggest that the polyp was taken out, collected and submitted for pathological evaluation. However, the pathology noted that the specimen was approximately 21 mm, which is less than the size described by respondent in the medical record. Dr. Ostroff contended that the pathology findings demonstrate that respondent failed to remove the entire polyp.

69. Dr. Ostroff opined that it was "very likely" that N.P.'s "very large polyps" would have remained silent for the remainder of his life. However, if respondent felt this was an important thing for N.P.'s health to have the polyps removed, respondent should have referred N.P. to a more experienced colonoscopist to remove the polyps. Dr. Ostroff opined that respondent did not have the skills necessary to remove very large sessile polyps and the repetitive colonoscopies were an extreme departure from the standard of care.

OPINIONS REGARDING PATIENT D.R.

70. Dr. Ostroff contended that respondent performed one unnecessary upper endoscope procedure and two unnecessary colonoscopy procedures on D.R. Dr. Ostroff opined that endoscopic procedures can be associated with risk. There must be clear indications for the procedures. With a new patient who has conflicting symptoms, it is often necessary to perform endoscopic procedures, especially when the patient has a history of infection or a "pan-colitis" exists. Dr. Ostroff opined that "endoscopy and colonoscopy with appropriate biopsies and cultures may be indicated."

71. Dr. Ostroff opined that the first upper endoscopy and colonoscopy respondent performed on D.R. on April 5, 2013, were "completely appropriate" and within the standard of care. D.R. was a new patient with a history of C.difficile infection and conflicting symptoms. The findings of the procedures and biopsies were normal.

72. Dr. Ostroff contended that the upper endoscopy and colonoscopy performed on June 7, 2013, and the colonoscopy performed on July 22, 2013, were unnecessary. [3] Dr. Ostroff opined that there was "nothing in the history taken by [respondent] or those of the emergency room doctors suggesting that her symptoms or laboratory evaluation was evolving." Dr. Ostroff opined that there was high probability that D.R.'s symptoms were due to a C.difficile infection. He further contended that there were no "alarm symptoms" such as rectal bleeding or bowel obstruction. Rather, she complained of the same "general symptoms" she has been having when the first endoscopic procedures were performed. He contended that D.R.'s complaint of recurrent abdominal pain, nausea, diarrhea, weight loss of 15 pounds since the March 2013 procedures, a finding of dilated loops of small bowel, and a stool culture that was negative for C.difficile, were not indications to perform additional upper endoscopy and colonoscopy procedures.

73. Dr. Ostroff noted that the second colonoscopy visual findings were normal, except for the notation that the bowel preparation was poor. The second upper endoscopy showed the same similar mild gastritis that appeared on the first upper endoscopy. Dr. Ostroff contended that although respondent may not have been able to view the colon during the second colonoscopy due to poor bowel preparation, respondent obtained biopsies that were normal. Dr. Ostroff conceded that a biopsy may not detect a patchy disease in an area where a biopsy is not obtained.

74. Dr. Ostroff opined that performing a second upper endoscopy and two additional colonoscopies were repetitive and unnecessary. He also opined that performing the procedures in a short period of time after the first procedures demonstrated normal finding, was an extreme departure from the standard of care, because of both the costs and risks that are associated with any endoscopic procedures.

Complainant's Expert Rudolph Bedford, M.D.

75. Rudolph Bedford is board-certified in Internal Medicine, with a subspecialty board certification in Gastroenterology. He is licensed by the Board to practice medicine in California. Dr. Bedford graduated from Case Western Reserve University School of Medicine in Cleveland, Ohio in 1987. He completed a medical residency at New York Hospital-Cornell Medical Center in 1990. Between 1990 and 1992, Dr. Bedford completed a two-year fellowship in Gastroenterology at the Cleveland Clinic Foundation. Between 1992 and 1993, he completed an advanced fellowship in therapeutic endoscopy at St. Luke's Hospital in Racine, Wisconsin.

In 1994, Dr. Bedford became the Director of Clinical Education for Gastroenterology and Director of Pancreatic-Billiary Services, Department of Medicine, UCLA School of

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[3] Dr. Ostroff opined that respondent performed a third upper endoscopy on July 22, 2013. However, he was not able to find any reference to a third upper endoscopy in the medical records. He conceded that respondent only performed two upper endoscopy procedures on D.R.

Medicine. Dr. Bedford worked as an Assistant Clinical Professor in the Division of Digestive Diseases at UCLA. Since 2012, Dr. Bedford has been the Chief of Gastroenterology at St. John's Hospital, located next to UCLA. He is also a staff physician at the West Los Angeles Veterans Hospital. For the last 12 years, Dr. Bedford has also maintained a private practice. He performs approximately 1,500 to 2,000 colonoscopies per year, and approximately 500 upper endoscopies per year. Dr. Bedford has served as an expert witness rendering opinions concerning the standard of care for Gastroenterologist practicing in California

76. Dr. Bedford reviewed several documents to reach his opinions concerning respondent's treatment of patients R.B., N.P. and D.R., including the Accusation, the investigation report prepared by Mr. Brearley, the patient records for R.B., N.P. and D.R., the expert report prepared by Dr. Ostroff and the transcript of respondent's interview with the Board's investigator. Dr. Bedford prepared a report dated January 4, 2017, and testified at hearing.

OPINIONS REGARDING PATIENT R.B.

77. Dr. Bedford opined that respondent did not depart from the standard of care in his treatment of R.B. He disagreed that respondent lacked the training and experience to remove the large flat polyps from R.B. He also disagreed that the standard of care required respondent to refer R.B. to another endoscopist. Dr. Bedford opined that it is within the judgment of a doctor whether to remove a polyp as a whole or in piecemeal fashion. Dr. Bedford opined that respondent appropriately used his judgment and determined it was prudent to remove R.B.'s polyps in piecemeal fashion.

78. Dr. Bedford contended that all Gastroenterologists are trained to remove large polyps in a piecemeal fashion. He estimated that "well over 85 to 90 percent of Gastroenterologists within the community will attempt to remove large flat polyps in a piecemeal fashion." Dr. Bedford contended that there are a variety of reasons as to why it is difficult for a doctor to remove a large flat polyp during a single procedure. The tissue must be raised, the preparation of the colon may not be ideal and there may be difficulty getting the scope around a corner or curve in the colon. Dr. Bedford opined that it is always better to bring a patient back for another procedure to remove a polyp in piecemeal fashion during an additional procedure for the safety of the patient.

79. Dr. Bedford opined that it was within the standard of care for respondent to end the March 4, 2014 colonoscopy he performed on R.B. at Skyway. Dr. Bedford contended that if there are technical difficulties and respondent cannot adequately sedate a patient, then the procedure cannot be adequately performed.

80. Dr. Bedford also opined that it was within the standard of care for respondent to remove the 4 cm polyp from R.B.'s ascending colon in a piecemeal fashion, and that respondent employed the proper technique to remove the polyp. Dr. Bedford opined that it was also within the standard of care for respondent to recommend that R.B. undergo another

colonoscopy after the May 28, 2014 procedure. Dr. Bedford contended that there is always a concern that there may be polyp tissue left or that there may be other polyps that were not seen during the procedure. He opined that flat polyps have a higher risk of developing into cancer so it was prudent for respondent to make sure that he cleared the colon. Dr. Bedford also opined that the risk of performing multiple colonoscopies on a patient is "minimal." The biggest risk is perforation which occurs in 1 in every 10,000 to 20,000 patients. For a patient such as R.B., who was 67 years old with no co-morbid conditions, the risk was low.

81. Dr. Bedford also opined that respondent's partial retrieval of polyp tissue during the March 27 and May 28, 2014 colonoscopies was not a deviation from the standard of care. Dr. Bedford opined that it can be "challenging and difficult" to retrieve every piece of a polyp that is removed. The techniques used to remove the tissue such as sucking the tissue through a channel, breaks down the tissue into smaller pieces. The pieces fall into a trap that squeeze the tissue. Dr. Bedford contended that often the tissue that is seen by the doctor and what is retrieved are different. Dr. Bedford contended that the lack of pathology samples to confirm the removal of the polyp was not significant. Rather, the more important information is respondent's documentation of removal of the polyp.

OPINIONS REGARDING PATIENT N.P.

82. Dr. Bedford disagreed with Dr. Ostroff's opinion that a colonoscopy was not indicated for N.P. Dr. Bedford opined that N.P's. weight loss, history of polyps removed, and age, were "obvious indications for a colonoscopy." He further opined that it was "certainly not a departure from the standard of care" to perform a colonoscopy on N.P.

83. Dr. Bedford opined that it was within the standard of care to reduce N.P.'s risk of developing colon cancer by removing polyps, despite his age, especially since N.P. was otherwise relatively healthy and could be expected to live several more years." Dr. Bedford contended that someone with a history of colon polyps is more likely to develop colon cancer. Additionally, the larger the polyp, the more likely the polyp will develop into cancer. Dr. Bedford disagreed with Dr. Ostroff's opinion that patients over the age of 80 are less likely to develop cancer. Dr. Bedford opined that the older a patient is, the more likely the patient has a propensity to develop all types of cancer and colon cancer is no exception.

84. Dr. Bedford opined that it was within the standard of care for respondent to first obtain a biopsy of the 40 to 50 mm polyp he located in N.P.'s transverse colon during the first colonoscopy, due to his concern that the polyp might be cancer. If the polyp was cancer, then it would need to be surgically removed. If the polyp was not cancer, as in N.P.'s case, then respondent could remove the polyp endoscopically during a subsequent procedure. Dr. Bedford also opined that respondent's judgment was correct to remove the polyp during a colonoscopy procedure, which he contended is minimally invasive and safe.

85. Dr. Bedford disagreed with Dr. Ostroff's opinion that N.P.'s polyps should not have been removed because the polyps were not giving him any symptoms and that the large tubulovillous adenoma polyp would take years to develop into cancer if at all. Dr. Bedford

opined that a doctor cannot predict when a polyp will develop into cancer. N.P. could live another five to ten years. Dr. Bedford opined that it incumbent upon a doctor that sees the type of large polyp N.P. had, to remove it, regardless of his age.

86. Dr. Bedford also opined that it is within the standard of care to remove large polyps piecemeal and respondent was not required to refer the patient to another endoscopist. Dr. Bedford disagreed with Dr. Ostroff's opinion that respondent did not possess the necessary skills to remove very large sessile polyps. Dr. Bedford opined that "as a matter of course all academically trained Gastroenterologists are instructed on the techniques of polyp removal." Dr. Bedford further contended that all gastroenterologists are trained to remove large flat polyps piecemeal if that is what is required. He further opined that respondents "credentials are impressive" and that anyone who has performed 30,000 to 40,000 is an expert.

87. Dr. Bedford also contended that it was within respondent's judgement to remove the large flat polyp in piecemeal. Dr. Bedford opined that piecemeal removal of a polyp is standard of care. Dr. Bedford also contended that "[q]uite often with very large polyps, it is necessary to perform piecemeal removal over several sessions." Respondent utilized the standard procedure to remove the polyp, which is to inject a solution underneath the polyp to raise it, and then utilizing a snare to remove what has been raised. Dr. Bedford explained that quite often the saline solution that is used to raise the polyp becomes diffuse and will not keep the tissue raised for a long period of time. The doctor must constantly go back to try to raise the tissue.

At times, a doctor may be successful in getting all the tissue in one session, but typically that is not the case. It can become dangerous to be over persistent in an effort to remove an entire polyp. He opined that it is "always better" to perform additional procedures to remove a polyp safely. Bringing the patient back for additional procedures allows the doctor to have a "better frame of mind" about what needs to be done. Additionally, as in the case of N.P., respondent tattooed the site, so that when he returned he could find the location.

88. Dr. Bedford also disagreed with Dr. Ostroff's opinion that respondent failed to completely remove the large flat polyp in N.P.'s transverse colon. Respondent reported that the polyp was 38 mm as of the September 29, 2014, when he performed the third colonoscopy to remove the remaining tissue. The pathology report estimated the tissue that was submitted from the transverse colon was approximately 21 mm. Dr. Bedford contended that there is "always a discrepancy" of what a doctor sees in the colon versus what is taken out. The colonoscopy magnifies the tissue approximately 30 times. The doctor must "eyeball" the size of the polyp based on the magnification. Additionally, tissue can be lost when it is sucked through the scope. Dr. Bedford opined that the significance of the large flat polyp respondent removed from N.P.'s transverse colon was that it was over 2 cm. Thus, the polyp had an increased risk of developing into cancer. Dr. Bedford opined that the only item of importance was that respondent removed the entire polyp.

OPINIONS REGARDING PATIENT D.R.

89. Dr. Bedford disagreed with Dr. Ostroff's opinion that the second upper endoscopy performed on June 7, 2013, was a departure from the standard of care. Dr. Bedford opined that the second upper endoscopy was indicated due to the finding of dilated loops of small bowel discovered during a radiological study on May 19, 2013. Dr. Bedford opined that a finding of dilated loops of small bowel raised the concern that there is an obstruction. An upper endoscopy is necessary to visualize the small bowel to determine whether an obstruction is causing the dilation. Dr. Bedford further opined that it was prudent to perform an upper endoscopy, which is a low risk procedure, to help determine why her symptoms are "waxing and waning."

90. Dr. Bedford also opined that the second colonoscopy performed on June 7, 2013, was indicated. D.R. reported recurrent abdominal pain, diarrhea, with a history of C.difficile, in addition to the finding of dilated loops in the small bowel. Dr. Bedford opined that it was necessary to conduct the colonoscopy to determine if her pain and symptoms that were "waxing and waning" were caused by ischemic colitis, inflammatory bowel disease or another process. Dr. Bedford explained that ischemic colitis is low blood flow to particular areas of the colon. The disease can cause a portion of the colon to die, and cause bleeding and abdominal pain. Dr. Bedford contended that it was "absolutely necessary" to diagnose ischemic colitis because the patient may require surgery.

91. Dr. Bedford also opined that it was within the standard of care for respondent to perform a third colonoscopy on July 22, 2013, even though the biopsy results from the June 7, 2013, were normal. Dr. Bedford found that respondent's ability to visualize the colon on June 7, 2013, was complicated due to poor preparation of the bowel. If there is stool covering the lining of the colon, respondent would not be able to observe a condition such as ischemic colitis, or an inflammatory bowel disease. D.R. continued to have "waxing and waning" symptoms and the cause was not known. Dr. Bedford opined that it was within the clinical judgment of respondent to proceed with a third colonoscopy for the purpose of obtaining better visualization of the colon.

92. Dr. Bedford opined that the endoscopic procedures respondent performed on D.R. "fall well within the clinical judgement of the physician managing the patient at the time." Additionally, he opined that it was within the standard of care for respondent to refer D.R. to Stanford for further evaluation. Dr. Bedford opined that when a physician reaches the point where he has provided all the help he can to a patient, it is prudent to refer the patient for a second opinion.

Discussion of Accusation Allegations

PATIENT R.B.

93. Complainant alleged that the repetitive colonoscopy procedures respondent performed on R.B. were incomplete and required expert skill, which respondent did not

possess. Complainant further alleged that respondent failed to refer R.B. to a more experienced physician who specialized in large colonic polyp resection. Complainant alleged that respondent's treatment of R.B. constituted an extreme departure from the standard of care, incompetence, and excessive use of diagnostic procedures. Complainant also alleged that respondent failed to keep complete and accurate medical records concerning the care and treatment he rendered to R.B.

94. The evidence established that on March 4, 2014, respondent performed a screening colonoscopy on R.B. at Skyway. During the procedure respondent observed a 4 cm flat polyp in the proximal ascending colon, a 3 cm flat polyp in the transverse colon and a 1 cm polyp in the sigmoid colon. Dr. Ostroff persuasively opined that the standard of care requires the doctor to recognize that the removal of large sessile polyps requires specialized techniques and the presence of "adequately trained assistants as well as the presence of the correct equipment."

Respondent documented that he partially removed the 4 cm flat polyp and the 1 cm polyp in the sigmoid colon. Respondent appropriately recognized that in order to remove the remainder of the polyps, his patient needed a higher level of sedation. Respondent also needed better equipment, and more experienced staff, which could be provided at Feather River.

95. Both experts agreed that respondent's decision to end the colonoscopy at Skyway and perform a second procedure at Feather River was appropriate. Dr. Ostroff opined that "no one could fault" respondent for his decision. Dr. Bedford opined that that if there are technical difficulties and respondent could not adequately sedate the patient, then the procedure could not be adequately performed. As a result, it was within the standard of care for respondent to end the colonoscopy procedure at Skyway and recommend a follow-up procedure, which was conducted at Feather River on March 27, 2014.

96. On March 27, 2014, respondent performed a second colonoscopy on R.B. During the procedure, respondent located the 4 cm flat polyp in the proximal ascending colon that he incompletely removed during the March 4, 2013 procedure. Respondent estimated that the remaining flat polyp was 25 mm. Respondent removed a portion of the polyp using a saline injection-lift technique using a hot snare. Both experts agreed that respondent's technique was correct.

However, removal of the 25 mm polyp was incomplete. The polyp was curved around a bend in the colon. Due to the size and location of the polyp, respondent could not position the snare around the entire polyp. Respondent removed as much of the flat polyp that he believed was safe for the patient. He tattooed the area near the polyp and used a clip to secure the polypectomy site. Dr. Bedford persuasively testified that it was within the standard of care for respondent to remove the 25 mm flat polyp in a piecemeal fashion. In addition, respondent was trained to remove large polyps in a piecemeal fashion and had significant experience over the course of his career to remove large flat polyps. The

evidence established that respondent appropriately exercised his clinical judgment that piecemeal removal of the polyp was most safe for his patient.

Respondent also documented that retrieval of the 25 mm flat polyp tissue from the proximal ascending colon was incomplete. The pathology report documented that respondent submitted 0.5 cm of aggregate tissue from the ascending colon. Dr. Bedford persuasively testified that partial retrieval of polyp tissue was not a deviation from the standard of care. Respondent and Dr. Bedford persuasively testified that techniques used to remove the tissue, such as sucking the tissue through a channel, breaks down the tissue into smaller pieces and the pieces fall into a trap that squeeze the tissue. In addition, the amount of polyp tissue observed by the doctor during the procedure, does not always correlate to the amount of tissue submitted for pathology.

97. On May 28, 2014, respondent performed a third colonoscopy on R.B. Respondent observed two flat polyps in the mid-transverse colon and in the proximal ascending colon. He noted the polyps were 12 to 30 mm in size. He removed the polyps with the saline injection-lift technique using a hot snare. Respondent noted that the bowel preparation was "fair." Respondent was concerned that the resection of polyps in the ascending and transverse colon was not complete and that there might be residual polyp tissue at the edge of the polyp. Dr. Bedford persuasively testified that when there is a concern that polyp tissue is left or that there may be other polyps that were not seen during the procedure, due to poor preparation, it was prudent for respondent to conduct another colonoscopy to make sure that he cleared the colon.

98. While the evidence established that respondent's removal of R.B.'s polyps in a piecemeal fashion was within the standard of care, there were significant errors and inconsistencies in the documentation and pathology reports for the treatment respondent rendered to R.B. Dr. Ostroff persuasively opined that the confusion regarding which polyps were resected and the lack of adequate pathology specimens over the course of the colonoscopies, in aggregate, represented an extreme departure. Specifically, on March 26, 2014, respondent conducted a pre-procedure examination of R.B. Respondent documented in R.B.'s medical records that during the March 4, 2014 colonoscopy at Skyway, he discovered a 4 cm flat polyp "in the proximal descending colon that could not be removed in its entirety endoscopically." This information was not correct. The polyp was located in the proximal ascending colon. This error was carried over into R.B.'s medical records for the May 28 and November 26, 2014 procedures.

99. Additionally, respondent failed to document following the March 27, 2014 procedure any information about the 3 cm flat polyp in the transverse colon that was discovered during the March 4, 2014 colonoscopy. In the May 27, 2014 pre-procedure records he documented that on March 4, 2014, he identified "a 3 cm flat polyp in the transverse colon, which was removed." This was incorrect. The polyp in the transfer colon was not removed until the May 28, 2014 procedure.

100. Respondent documented in R.B.'s medical records for the May 28, 2014 procedure, that R.B. had a 4 cm flat serrated adenoma in the ascending colon. However, there is no documentation from any pathology report diagnosing the tissue as a serrated adenoma. Dr. Ostroff persuasively opined that the implications of incorrectly identifying a polyp as a serrated adenoma are significant because a serrated adenoma may be more malignant. Additionally, respondent noted that two 12 to 30 mm polyps in the transverse colon and proximal ascending colon were partially removed. Respondent testified that the polyp in the ascending colon was tissue remaining from the 4 cm polyp he began removing on March 4, 2014. However, the pathology report dated May 29, 2014, only referenced specimens from the transverse colon polyp. No tissue from the ascending colon was identified. As a result, there is no evidence to confirm that tissue was removed from the ascending colon.

101. Respondent noted in R.B.'s medical records for the November 18, 2014, pre-colonoscopy examination that during the March 4, 2014 colonoscopy at Skyway, a 4 to 5 cm flat polyp across the proximal descending colon was discovered, but respondent was not able to access the polyp. This note is inconsistent with previous notes in R.B.'s medical records which indicate that respondent was able to remove part of the 4 to 5 cm polyp during the March 4, 2014 procedure. Respondent again noted that a 3 cm polyp in the transverse colon was removed on March 4, 2014, which was incorrect. The polyp in the transverse colon was not removed until May 28, 2014.

102. The evidence established that respondent had the training, skills and knowledge to remove R.B.'s large polyps. Although four colonoscopies were performed, the first colonoscopy was appropriately ended because of various challenges respondent encountered. The fourth colonoscopy was ended due to poor bowel preparation. Respondent completed two colonoscopy procedures to remove R.B.'s polyps. After the third colonoscopy, respondent was concerned that there might be residual polyp tissue at the edge of the polyps in the transverse colon and in the proximal ascending colon. As a result, it was within the standard of care for respondent to recommend a fourth colonoscopy. Complainant failed to establish that respondent was incompetent in his care and treatment of R.B. or that he employed excessive use of diagnostic procedures.

103. While respondent had the necessary training, skills and knowledge to remove R.B.'s large polyps, he repeatedly failed to exercise the care that was expected. Respondent repeatedly failed to accurately account for which polyps he removed and when he removed the polyps. The descriptions of the location of the polyps and the type of polyps that were removed were inconsistent and inaccurate. Additionally, there was lack of adequate pathology specimens for the removal of polyp from the ascending colon on May 28, 2014, despite respondent's documentation that is was removed. Complainant established that the procedures that respondent performed were incomplete and that respondent should have referred R.B. to another physician to complete the removal of his polyps.

104. Dr. Bedford's contention that the lack of pathology samples to confirm the removal of the polyps was not significant and that the more important information is the

respondent's documentation of the removal of the polyp, was not persuasive, given the repeated inaccuracies in respondent's documentation. Without proper documentation and pathology reports to test and confirm removal of potentially cancerous tissue, respondent placed his patient at significant risk for harm. As a result, complainant established respondent's treatment of R.B. was an extreme departure from the standard of care and a failure to keep complete and accurate medical records.

PATIENT N.P.

105. Complainant alleged that the repetitive colonoscopy procedures respondent performed on N.P. were not indicated, that respondent did not have the skill to remove N.P.'s large sessile polyp and that respondent failed to refer N.P. to a more experienced physician. Complainant alleged that respondent's treatment of N.P. constituted an extreme departure from the standard of care, incompetence, and excessive use of diagnostic procedures.

106. Dr. Ostroff persuasively opined that the standard of care requires that there are "clear indications" before an endoscopic procedure is performed. The evidence established that there were clear indications for the colonoscopies respondent performed on N.P. Respondent recommended that N.P. undergo a colonoscopy because he had a 23 pound weight loss over 18 months. He also had a loss of appetite, constipation and colon polyps removed in 2001. Respondent determined that a colonoscopy should be used as a diagnostic tool. Dr. Bedford persuasively obtained that N.P.'s weight loss, history of polyps removed, and his age, were indications for a colonoscopy.

107. Dr. Ostroff's opinion that a colonoscopy was not indicated for N.P., was not persuasive. Dr. Ostroff contended that that N.P.'s symptoms did not warrant a colonoscopy, because he had no iron deficiency or other nutritional deficiencies. However, Dr. Ostroff opined that if N.P. had been in his 60's, with the symptoms he reported, he would have been "entitled to a colonoscopy." Dr. Ostroff's contention that there was no indication for the colonoscopy appeared to be less about the symptoms N.P. reported and more about his age.

108. Dr. Bedford persuasively opined that it was within the standard of care for respondent to first obtain a biopsy of the 40 to 50 mm polyp he located in N.P.'s transverse colon during the first colonoscopy, due to his concern that the polyp might be cancer and that his decision to subsequently remove the tissue was within the standard of care. Dr. Bedford also persuasively testified that it was within the standard of care to reduce N.P.'s risk of developing colon cancer by removing polyps, despite his age, especially since N.P. was otherwise relatively healthy and could be expected to live several more years.

109. Dr. Ostroff's opinion that reducing his risk of colon cancer by removing the polyps in a 90-year-old man was not within the accepted standard of care, was not persuasive. Dr. Ostroff opined that the polyps were not causing N.P.'s symptoms, were not bleeding and "likely would have gone un-noticed for the rest of his life." He further opined that it would take years for a tubulovillous adenoma to become malignant. However, Dr. Bedford persuasively explained that a doctor cannot predict when a polyp will develop into

cancer and that it incumbent upon a doctor that sees a large polyp, to remove it, regardless of the patient's age.

110. The evidence established that on May 14, 2014, respondent conducted a colonoscopy on N.P. to remove the 40 to 50 mm polyp in the transverse colon. A portion of the polyp was removed with a saline injection-lift technique using a hot snare. Based on respondent's clinical experience, he removed the amount of tissue he believed was safe. He tattooed the tissue near the polyp site and inserted clips. On September 29, 2014, respondent performed a third colonoscopy on N.P. and removed the remainder of the flat polyp in the transverse colon. Dr. Bedford persuasively opined that it is within the standard of care to remove large polyps piecemeal and respondent was not required to refer the patient to another endoscopist. The evidence established that respondent was trained to remove large sessile polyps and it was within his clinical judgment to remove the polyp in a piecemeal fashion.

111. Dr. Ostroff's opinion that respondent failed to remove the large sessile polyp in the transverse colon because the tissue from the September 29, 2014 procedure, was approximately 21 mm and respondent had estimated the size of the remaining polyp tissue he removed was 38 mm, was not persuasive. Both respondent and Dr. Bedford persuasively explained that that there can be a discrepancy in what a doctor sees from the camera in the colon versus what is taken out, for various reasons, including tissue getting lost in fluid and the effect of the suction.

112. The evidence established that respondent appropriately used his clinical judgement, knowledge and skill to perform three colonoscopy procedures on N.P. The first colonoscopy was indicated due to his reported symptoms. The second and third colonoscopies were to remove a large sessile polyp, which respondent competently removed. As a result, complainant failed to establish that respondent's treatment of N.P. constituted an extreme departure from the standard of care, incompetence, or excessive use of diagnostic procedures.

PATIENT D.R.

113. Complainant alleged that the repetitive upper endoscopy and colonoscopy procedures respondent performed on D.R. were not indicated. Complainant alleged that respondent's treatment of D.R. constituted an extreme departure from the standard of care, incompetence, and excessive use of diagnostic procedures.

114. Both experts persuasively opined that there must be clear indications for performing endoscopic procedures. Both experts also agreed that when a new patient has conflicting symptoms it is often necessary to perform endoscopic procedures. On March 27, 2013, D.R. saw respondent for the first time. D.R. reported that she had acquired a C. difficile infection in January 2013. Since that time, she had blood in her stool, diarrhea several times per day, weight loss and acid reflux. Respondent recommended D.R. undergo an upper endoscopy and colonoscopy. Both experts agreed the first upper endoscopy and

colonoscopy respondent performed on D.R. on April 5, 2013, was appropriate and within the standard of care. The results of the April 5, 2013 endoscopic procedures were normal.

115. The evidence established that between April and May 2013, D.R.'s symptoms improved. On May 19, 2013, D.R. was seen at the Oroville Hospital due to abdominal pain, and loose stools. Radiological studies were taken which identified dilated loops of small bowel. D.R.'s stool culture for C. difficile was negative. D.R. was seen by respondent on June 6, 2013. She reported to respondent her visit to Oroville Hospital. D.R. also reported that she had lost approximately 15 pounds in the preceding two or three months. Respondent was concerned that the dilated loops of small bowel could indicate that there was an obstruction or an inflammatory bowel disease. Respondent recommended a second upper endoscopy and colonoscopy.

116. Dr. Bedford persuasively opined that respondent's decision to conduct a second upper endoscopy and colonoscopy on June 7, 2013, was within the standard of care, based on the recurrent abdominal pain, diarrhea, with a history of C. difficile, and the finding dilated loops of small bowel. The upper endoscopy allowed respondent an opportunity to visualize the small bowel to determine whether an obstruction was causing the dilation. The colonoscopy gave respondent the opportunity to view the colon to determine if her pain and symptoms were caused by ischemic colitis, inflammatory bowel disease or another process.

117. Dr. Ostroff's opinion that there was "nothing in the history taken by [respondent] or those of the emergency room doctors suggesting that her symptoms or laboratory evaluation was evolving" was not supported by the evidence. D.R. reported a significant weight loss over two to three months. Additionally, Dr. Ostroff failed to address the significance of the dilated loops in the small bowel finding.

118. In addition, Dr. Bedford pervasively opined that when respondent was not able to view the colon during the second colonoscopy due to the poor preparation, it was within the clinical judgment of respondent to proceed with a third colonoscopy, for the purpose of obtaining better visualization of the colon. The fact that respondent was able to obtain biopsies did not alleviate the need to view the colon lining. Both experts agreed that a biopsy may not detect a patchy disease in an area where a biopsy is not obtained.

119. The evidence established that respondent appropriately used his clinical judgment, knowledge and skill to conduct a second upper endoscopy and two additional colonoscopies on D.R., due to the nature of her symptoms and the radiological findings. When respondent determined that a second opinion was needed, he appropriately referred D.R. to Stanford for treatment. As a result, complainant failed to establish that respondent's treatment of N.P. constituted an extreme departure from the standard of care, incompetence, and excessive use of diagnostic procedures.

Additional Evidence Submitted by Respondent

120. Respondent testified that he has managed the removal of polyps from his patients on a daily basis for decades. Respondent believes the care and treatment he rendered to patients R.B., N.P. and D.R. was appropriate and within the standard of care. Respondent testified that he can determine when a standard endoscopic mucosal resection of a large flat polyp is not going to be safe in a community setting. If he feels that removal of a polyp is beyond his expertise, or his patient needs more advanced care, he refers those patients to clinics and hospitals that have more advanced procedures and equipment.

121. Respondent acknowledged that there were inaccuracies in R.B.'s medical records. Respondent in part attributed the inaccuracies to the transcription software. On December 7, 2016, respondent registered for a medical record keeping seminar through the University of California, Irvine School of Medicine. He intended to complete the course on January 28, 2017. Respondent also submitted evidence of numerous hours of continuing education he has completed over past several years in the areas of Gastroenterology and record keeping.

122. After respondent resigned from Feather River, he worked at the Veteran's Hospital (VA) in Tucson, Arizona. In December 2015, respondent began working for Altru Health System in Grand Forks, North Dakota. Respondent enjoys his position. He sees patients and performs endoscopic procedures. Respondent is also a Clinical Associate Professor of Medicine at the University of North Dakota School of Medicine. He teaches medical students in the classroom and in clinical settings. Within the last year, respondent was also recruited to act as a co-investigator with the Dean of the North Dakota Medical School to conduct a research project regarding the effect of a particular protein in the small intestine.

CHARACTER LETTERS

123. Respondent submitted six character letters from colleagues at Altru Health System and two letters from colleagues at the VA. The authors of the letters described respondent as a competent doctor who is well-respected by his colleagues and who cares about the welfare of his patients.

Appropriate Discipline

124. Complainant failed to establish by clear and convincing evidence that respondent's care and treatment of patients N.P. and D.R. constituted the excessive use of diagnostic procedures, extreme departures from the standard of care, or demonstrated incompetence. Complainant also failed to establish that respondent's care and treatment of R.B. constituted the excessive use of diagnostic procedures or incompetence. However, complainant did establish, by clear and convincing evidence, that respondent's treatment of R.B. constituted an extreme departure from the standard of care and failure to keep complete and accurate records.

Respondent acknowledged his mistakes in R.B.'s medical records. However, he failed to acknowledge the serious nature of the inconsistencies and inaccuracies in his charting through three of the four colonoscopies he performed. The mistakes and failures in the charts were more than typographical errors. The charting inconsistencies and inaccuracies were repeated and significant, and raised questions regarding the substance of the actual procedures he performed. In sum, respondent repeatedly failed to exercise the care that was expected during the course of the treatment he provided R.B. and the three colonoscopy procedures he performed. In doing so, respondent subjected his patient to potential harm.

125. The Board's Disciplinary Guidelines provide that the minimum discipline that should be imposed, for an extreme departure from the standard of care and failure to keep complete and accurate records, is stayed revocation, with five years of probation. Respondent has been licensed to practice medicine in California since 1990. He has no record of discipline with the Board. Respondent enjoys his profession and takes an active role in educating new doctors. He is respected by his colleagues. Based on the totality of the evidence, the public protection would be served by imposing a three year term of probation, which includes completion of a medical record keeping course and appropriate education courses approved by the Board.

LEGAL CONCLUSIONS

Burden of Proof

1. Complainant has the burden of proving each of the grounds for discipline alleged in the Accusation, and must do so by clear and convincing evidence. (See, *Ettinger v. Board of* Medical *Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence is evidence that leaves no substantial doubt and is sufficiently strong to command the unhesitating assent of every reasonable mind. (See, *In re Marriage of Weaver* (1990) 224 Cal.App.3d 478.)

Cause for Discipline

2. Business and Professions Code section 2234 provides that the Board shall take action against any licensee found to have engaged in unprofessional conduct, which includes but is not limited to the following:

> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the

applicable standard of care shall constitute repeated negligent acts.

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

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

(d) Incompetence.

3. Pursuant to Business and Profession Code sections 2234 and 725, subdivision (a), repeated acts of clearly excessive use of diagnostic procedures as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon.

4. Business and Professions Code section 2266 provides that failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

5. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care applicable in a medical professional must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal. App.4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal. App. 4th 234, 280.) The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal. App. 3rd 1040, 1052. Simple negligence is merely a departure from the standard of care.

6. Complainant established by clear and convincing evidence that respondent's treatment of R.B. constituted an extreme departure of the standard of care, as set forth in Findings 20, 26, 29, 31, 59, 60, 61, 98 through 104, and 124. Therefore, cause was established to impose discipline on respondent's certificate pursuant to Business and Professions Code section 2234, subdivision (b).

7. Complainant failed to establish by clear and convincing evidence that respondent's treatment of N.P. and D.R. constituted an extreme departure of the standard of

care, as set forth in Findings 105 through 113 and 124. Therefore, no cause for discipline was established pursuant to Business and Professions Code section 2234, subdivision (b), related to his treatment of N.P. and D.R.

8. Complainant alleged that respondent's care and treatment of patients R.B., N.P. and D.R. constituted repeated acts of negligence. As set forth in Findings 105 through 113 and 124, there is no cause to impose discipline on respondent's license based on his treatment of N.P. and D.R. Therefore, complainant failed to establish by clear and convincing evidence that respondent engaged in repeated acts of negligence. As a result, no cause for discipline exists under Business and Professions Code section 2234, subdivision (c).

9. Complainant failed to establish by clear and convincing that respondent was incompetent in his treatment of R.B., N.P. and D.R., as set forth in Findings 93 through 97, 105 through 113 and 124. Incompetence has been defined as "absence of qualification, ability or fitness to perform a prescribed duty or function." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040.) It is evidenced by a lack of knowledge or ability in the discharging of professional obligations. (*James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1109.) Therefore, no cause for discipline was established pursuant to Business and Professions Code sections 2234, subdivision (d).

10. Complainant failed to establish by clear and convincing evidence that respondent engaged in the excessive use of diagnostic procedures, as set forth in Findings 93 through 97, 105 through 113 and 124. As a result, no cause for discipline was established pursuant to Business and Professions Code sections 2234 and 725.

11. Complainant established by clear and convincing evidence that respondent failed to maintain adequate and accurate records related to his treatment of patient R.B., as set forth in Findings 20, 26, 29, 31, 59, 60, 61, 98 through 104, and 124. Therefore, cause was established exists to impose discipline on respondent's certificate pursuant to Business and Professions Code section 2266.

Conclusion

12. The objective of an administrative proceeding relating to licensing is to protect the public. Such proceedings are not for the primary purpose of punishment. (See *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) When all the evidence is considered, respondent's certificate should be placed on probation, for a period of three years, with appropriate terms and conditions to protect the public.

ORDER

Physician's and Surgeon's Certificate No. G 68575 issued to respondent Howard Hack M.D. is REVOKED, but the revocation is STAYED, and respondent is placed on probation for three years, upon the following terms and conditions:

1. Education Course: Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

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

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

3. Professionalism Program (Ethics Course). Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at respondent's expense

and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

4. Monitoring - Practice/Billing. Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee. Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's

practices are within the standards of practice of medicine whether respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

5. Solo Practice Prohibition. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the respondent's practice setting changes and the respondent is no longer practicing in a setting in compliance with this Decision, the respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

6. Notification. Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or

the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. Supervision of Physician Assistants. During probation, respondent is prohibited from supervising physician assistants.

8. Obey All Laws. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. Quarterly Declarations. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. Compliance with Probation Unit. Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

a. Address Changes. Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

b. Place of Practice. Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

c. License Renewal. Respondent shall maintain a current and renewed California physician's and surgeon's license.

d. Travel or Residence Outside California. Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days. In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. Interview with the Board or its Designee. Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. Non-practice While on Probation. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine. Respondent's period of non-practice while on probation shall not exceed two (2) years. Periods of non-practice will not apply to the reduction of the probationary term. Periods of non-practice will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

13. Completion of Probation. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

14. Violation of Probation. Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. License Surrender. Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his or her license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed

appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. Probation Monitoring Costs. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

DATED: February 27, 2017

DocuSigned by:
Marcie Larson
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MARCIE LARSON
Administrative Law Judge
Office of Administrative Hearings

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO August 15 2016
BY: [illegible] ANALYST

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

In the Matter of the Accusation Against: **Howard Mark Hack, M.D.** 27469 Latigo Bay View Dr. Malibu, CA 90265 Physician's and Surgeon's Certificate No. G 68575 Respondent.	Case No. 800-2015-012753 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about May 14, 1990, the Medical Board issued Physician's and Surgeon's Certificate Number G 68575 to Howard Mark Hack, 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 September 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, states, in pertinent part:

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

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

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

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

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

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

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 725 of the Code, states, in pertinent part:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon..."

6. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

"(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."

7. 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.

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FIRST CAUSE FOR DISCIPLINE

[Bus. & Prof. Code §2234(b)]

(Unprofessional Conduct/Gross Negligence)

8. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he was grossly negligent in the care and treatment of patients RB, NP, and DR. The circumstances are as follows:

9. On or about March 19, 2015, the California Medical Board received an 805 Report from Feather River Hospital stating that Respondent was under focused investigation related to his gastroenterology privileges. The report stated that prior to Feather River Hospital's Medical Executive Committee making a decision on whether to recommend or deny advancement to active staff, Respondent resigned from medical staff.

10. On or about September 25, 2015, the Board received medical records from Patients RB, NP, and DR. An expert reviewer from the Board reviewed Respondent's treatment of the identified patients and found that his actions constituted extreme departures from the standard of care based upon the following:

Patient RB

11. Patient RB was a 67-year-old man with several colonic polyps[1]. On March 4, 2014, Respondent performed a colonoscopy[2] and described a 25 mm polyp in the ascending colon in one account, then a 4-5 cm polyp in another account associated with a transverse colon polyp and a sigmoid polyp. Three colonoscopies were performed on or around the following dates: March 27, May 28, and another in November 2014, wherein Respondent attempted to remove the polyps. During an investigative interview conducted by the Board's investigator, Respondent claimed that he was not able to complete his work because both the equipment and staff were not adequate. Respondent was unsure where the polyps were and which ones he removed. Patient

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[1] A polyp is an extra piece of tissue that grows inside your body. Colonic polyps grow in the large intestine, or colon.

[2] Colonoscopy is a procedure that enables an examiner (usually a gastroenterologist) to evaluate the inside of the colon. The colonoscope is a four foot long, flexible tube about the thickness of a finger with a camera and a source of light at its tip. The tip of the colonoscope is inserted into the anus and then is advanced slowly, under visual control, into the rectum and through the colon usually as far as the cecum, which is the first part of the colon.

RB's pathology reports were not consistent with the removal of the polyps and there is no record in the pathology reports that is consistent with the removal of a 4-5 cm sessile polyp. The pathology reports do not confirm that very large polyps were removed in their entirety.

12. The repetitive procedures implemented by Respondent were incomplete and required expert skill. Respondent failed to refer Patient RB to a more experienced physician that specialized in large colonic polyp resection resulting in extreme departures from the standard of care.

Patient NP

13. Patient NP was an 89-year-old man with anorexia, dysphagia, weight loss and slight anemia with a history of colonic polyps. Respondent evaluated him on or around December 18, 2013, and suggested that an upper endoscopy[3] and colonoscopy be performed to clarify his medical condition. Patient NP underwent an upper endoscopy showing gastritis and possible Barrett's esophagus. Respondent performed three colonoscopies on Patient NP. A colonoscopy was performed on December 19, 2013, that revealed numerous sigmoid, transverse and ascending colon polyps between 5 and 25 mm in size and a 40 mm lesion in the transverse colon. The second and third colonoscopies occurred on May 24, and September 19, 2014. The two additional colonoscopies took place to access and manage the transverse colon lesion. The submitted pathology was not consistent with a completely resected specimen. The Surgical pathology report dated September 29, 2014 describes a 2.1 x 1.5 x 0.9 cm polyp while the endoscopy report speaks of a flat polyp 3.8 cm (38 mm) in size.

14. The symptom complex of Patient NP did not warrant any colonoscopies. The polyps that were subsequently found did not cause Patient NP's symptoms. Patient NP was subjected to three colonoscopies with unsuccessful attempts to remove the largest of the polyps. The three colonoscopies were performed where there was little indication constituting departures from the standard of care.

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[3] An upper endoscopy is a procedure used to visually examine your upper digestive system with a tiny camera on the end of a long, flexible tube.

15. Respondent performed the procedures pursuing numerous polyps including a large sessile polyp in the transverse repeatedly. Respondent did not possess the skills to remove it but subjected Patient NP unnecessarily to repeated colonoscopies. Respondent should have referred Patient NP to a more experienced physician. Respondent's failure to refer the patient to another physician with the requisite skill and expertise was a departure from the standard of care. Each of the repetitive unwarranted colonoscopies Respondent performed on Patient NP were extreme departures from the standard of care.

Patient DR

16. Patient DR saw Respondent in March 2014 with complaints of weight loss, diarrhea, abdominal tenderness, anorexia and fatigue. Patient DR had been treated for a Clostridium difficile[4] infection. She was cared for by Respondent, and was seen in the emergency department on more than one occasion. Patient DR's complaints included diarrhea and inability to produce a stool. While under the care of Respondent, Patient DR had three upper endoscopies and three colonoscopies performed on her (April 5, 2013, June 7, 2013 and July 22, 2013). All pathological specimens obtained from the endoscopies were normal or had no direct clinical significance to her illness. During this period one Clostridium difficile toxin was reported positive on June 7, 2013.

17. Patient DR had a history of a Clostridium difficile infection and appeared to have a recurrence. The first colonoscopy and endoscopy were normal and there was nothing in the history taken by Respondent or those of the emergency room doctors to suggest that her symptoms or laboratory evaluation was evolving. The biopsies done on the subsequent unnecessary procedures on June 7, 2013 and July 22, 2013, were again normal. The first endoscopy and colonoscopy could fall within the standard of care. Patient DR, however, was subjected to unnecessary subsequent colonoscopies and endoscopies after normal findings resulted from the initial procedures. Each of the subsequent unnecessary colonoscopies and endoscopies were extreme departures from the standard of care.

[4] Clostridium difficile is a bacterium that causes inflammation of the colon resulting in diarrhea and more serious intestinal conditions such as colitis.

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18. Respondent performed the procedures correctly although the procedures were unnecessary. The endoscopies and colonoscopies were not needed. The repetitive unnecessary procedures were extreme departures from the standard of care.

19. Respondent's care and treatment of patients RB, NP, and DR, as described above, together and separately, constitutes gross negligence in the practice of medicine and is unprofessional conduct in violation of section 2234(b) of the Code and thereby provides cause for discipline to Respondent's license.

SECOND CAUSE FOR DISCIPLINE
[Bus. & Prof. Code §2234(c)]
(Unprofessional Conduct/Repeated Negligent Acts)

20. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence in the care and treatment of patients RB, NP, and DR. The circumstances are as follows:

21. Paragraphs 9 through 19 above, are repeated here as if fully set forth.

22. Respondent's care and treatment of patients RB, NP, and DR as described above, constitutes repeated acts of negligence in the practice of medicine and is unprofessional conduct in violation of section 2234(c) of the Code and thereby provides cause for discipline to Respondent's license.

THIRD CAUSE FOR DISCIPLINE
[Bus. & Prof. Code §2234(d)]
(Unprofessional Conduct/Incompetence)

23. Respondent is subject to disciplinary action under section 2234(d) of the Code in that he was incompetent in the care and treatment of patients RB, NP, and DR. The circumstances are as follows:

24. Paragraphs 9 through 22 above, are repeated here as if fully set forth.

25. Respondent's care and treatment of patients RB, NP, and DR, as described above, constitutes incompetence in the practice of medicine and is unprofessional conduct in violation of section 2234(d) of the Code and thereby provides cause for discipline to Respondent's license.

FOURTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code §§725 and 2234]

(Unprofessional Conduct/Excessive Use of Diagnostic Procedures)

26. Respondent is subject to disciplinary action under sections 725 and 2234 of the Code in that he repeatedly performed clearly excessive diagnostic procedures in the care and treatment of patients RB, NP, and DR. The circumstances are as follows:

27. Paragraphs 9 through 25 above, are repeated here as if fully set forth.

28. Respondent's care and treatment of patients RB, NP, and DR, as described above, constitutes clearly excessive use of diagnostic procedures and is unprofessional conduct in violation of section 725 of the Code and thereby provides cause for discipline to Respondent's license.

FIFTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code §2266]

(Inadequate Record Keeping)

29. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to keep complete and/or accurate medical records of the care and treatment he rendered to patient RB The circumstances are as follows:

30. Paragraphs 9 through 28 above, are repeated here 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 G 68575, issued to Howard Mark Hack, M.D.;

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

3. Ordering Howard Mark Hack, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: August 15, 2016

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

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