

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

In the Matter of the Accusation)
Against:)
)
)
Vincent Luvern Anthony, M.D.)
)
Physician's and Surgeon's)
Certificate No. A 96566)
)
Respondent)
_____)

Case No. 800-2016-024564

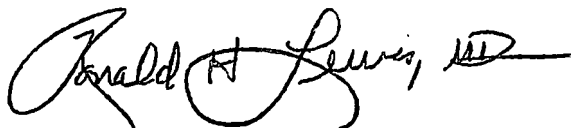
DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on March 26, 2020.

IT IS SO ORDERED February 25, 2020.

MEDICAL BOARD OF CALIFORNIA


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

1 XAVIER BECERRA
Attorney General of California
2 JUDITH ALVARADO
Supervising Deputy Attorney General
3 VLADIMIR SHALKEVICH
Deputy Attorney General
4 State Bar No. 173955
California Department of Justice
5 300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
6 Telephone: (213) 269-6538
Facsimile: (916) 731-2117
7 *Attorneys for Complainant*

8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:
13 **VINCENT LUVERN ANTHONY, M.D.**
14 **1711 West Temple Street, #7200**
Los Angeles, CA 90026
15 **Physician's and Surgeon's Certificate No.**
16 **A96566,**
17 Respondent.

Case No. 800-2016-024564
OAH No. 2019051292
**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

18
19 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
20 entitled proceedings that the following matters are true:

21 **PARTIES**

22 1. Christine J. Lally (Complainant) is the Interim Executive Director of the Medical
23 Board of California (Board). She brought this action solely in her official capacity and is
24 represented in this matter by Xavier Becerra, Attorney General of the State of California, by
25 Vladimir Shalkevich, Deputy Attorney General.

26 2. Respondent Vincent Luvern Anthony, M.D. (Respondent) is represented in this
27 proceeding by attorney Richard J. Ryan, Esq., whose address is: 500 N. Brand Blvd., Suite 950
28 Glendale, CA 91203.

1 facie basis for the charges in the Accusation, and that Respondent hereby gives up his right to
2 contest those charges.

3 9. Respondent agrees that his Physician's and Surgeon's Certificate is subject to
4 discipline and he agrees to be bound by the Board's terms as set forth in the Disciplinary Order
5 below.

6 CONTINGENCY

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

17 11. The parties understand and agree that Portable Document Format (PDF) and facsimile
18 copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile
19 signatures thereto, shall have the same force and effect as the originals.

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

23 DISCIPLINARY ORDER

24 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 96566 issued
25 to Respondent VINCENT LUVERN ANTHONY, M.D. is hereby publicly reprimanded pursuant
26 to Business and Professions Code section 2227. This Public Reprimand is issued in connection
27 with Respondent's actions as set forth in Accusation No. 800-2016-024564.

28 IT IS FURTHER ORDERED that Respondent comply with the following:

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

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

15 Respondent shall submit a certification of successful completion to the Board or its
16 designee not later than 15 calendar days after successfully completing the course, or not later than
17 15 calendar days after the effective date of the Decision, whichever is later.

18 2. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of
19 the effective date of this Decision, Respondent shall enroll in a professionalism program, that
20 meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1.
21 Respondent shall participate in and successfully complete that program. Respondent shall
22 provide any information and documents that the program may deem pertinent. Respondent shall
23 successfully complete the classroom component of the program not later than six (6) months after
24 Respondent's initial enrollment, and the longitudinal component of the program not later than the
25 time specified by the program, but no later than one (1) year after attending the classroom
26 component. The professionalism program shall be at Respondent's expense and shall be in
27 addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

28 A professionalism program taken after the acts that gave rise to the charges in the

1 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board
2 or its designee, be accepted towards the fulfillment of this condition if the program would have
3 been approved by the Board or its designee had the program been taken after the effective date of
4 this Decision.

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

8 3. VIOLATION OF THIS AGREEMENT. Failure to comply with any term or
9 condition of this Agreement is unprofessional conduct in violation of Business and Professions
10 Code section 2234. If Respondent violates this Agreement in any respect, the Board may file an
11 accusation and, after a hearing, discipline Respondent's license for unprofessional conduct in
12 violation of section 2234.

13 ACCEPTANCE

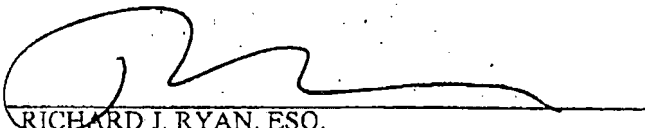
14 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
15 discussed it with my attorney, Richard J. Ryan, Esq. I understand the stipulation and the effect it
16 will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and
17 Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the
18 Decision and Order of the Medical Board of California.

19 DATED: 1/11/20


VINCENT LUVERN ANTHONY, M.D.
Respondent

21 I have read and fully discussed with Respondent Vincent Luvern Anthony, M.D. the terms
22 and conditions and other matters contained in the above Stipulated Settlement and Disciplinary
23 Order. I approve its form and content.

24 DATED: 1/12/20


RICHARD J. RYAN, ESQ.
Attorney for Respondent

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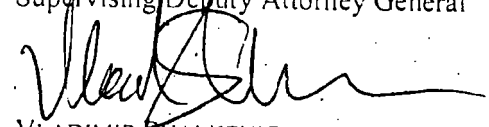
ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: 1/13/20

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH ALVARADO
Supervising Deputy Attorney General



VLADIMIR SHALKEVICH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2016-024564

1 XAVIER BECERRA
Attorney General of California
2 ROBERT MCKIM BELL
Supervising Deputy Attorney General
3 VLADIMIR SHALKEVICH
Deputy Attorney General
4 State Bar No. 173955
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5 300 South Spring Street, Suite 1702
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7 *Attorneys for Complainant*

8
9 **BEFORE THE**
10 **MEDICAL BOARD OF CALIFORNIA**
11 **DEPARTMENT OF CONSUMER AFFAIRS**
12 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 800-2016-024564

13 VINCENT LUVERN ANTHONY, M.D.

A C C U S A T I O N

14 1711 West Temple Street, #7200
15 Los Angeles, California 90026

16 Physician's and Surgeon's Certificate A 96566,

17 Respondent.

18
19 Complainant alleges:

20 **PARTIES**

21 1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official
22 capacity as the Executive Director of the Medical Board of California (Board).

23 2. On July 28, 2006, the Board issued Physician's and Surgeon's Certificate Number
24 A96566 to Vincent Luvern Anthony, M.D. (Respondent). That license was in full force and
25 effect at all times relevant to the charges brought herein and will expire on January 31, 2020,
26 unless renewed.

27 //

28 //

JURISDICTION

1
2 3. This Accusation is brought before the Board, under the authority of the following
3 laws. All section references are to the Business and Professions Code (Code) unless otherwise
4 indicated.

5 4. Section 2227 of the Code states:

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

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

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

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

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

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

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

25 5. Section 2234 of the Code, states:

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

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

3 “(b) Gross negligence.

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

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

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

14 “(d) Incompetence.

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

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

18 “(g) The practice of medicine from this state into another state or country without meeting
19 the legal requirements of that state or country for the practice of medicine. Section 2314 shall not
20 apply to this subdivision. This subdivision shall become operative upon the implementation of the
21 proposed registration program described in Section 2052.5.

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

25 6. Section 2266 of the Code states: “The failure of a physician and surgeon to maintain
26 adequate and accurate records relating to the provision of services to their patients constitutes
27 unprofessional conduct.”

28

1 **FIRST CAUSE FOR DISCIPLINE**

2 (Gross Negligence)

3 7. Respondent Vincent Luvern Anthony, M.D. is subject to disciplinary action under
4 section 2234, Subdivision (b) of the Code in that he grossly negligent in the care and treatment of
5 a single patient. The circumstances are as follows:

6 8. At all times relevant to the allegations herein, July 1 through July 3, 2016,
7 Respondent was the director of the subacute care unit at California Hospital Medical Center
8 (CHMC) in Los Angeles, California. Respondent's duties as the subacute unit director were
9 about to end, and a different physician was about to take over these duties. Respondent was
10 covering for the incoming physician through the Fourth of July, 2016, holiday.

11 9. The Patient whose care and treatment is the subject of this Accusation, was a 35-year-
12 old male who previously suffered a debilitating stroke. The patient was transferred from Kindred
13 Hospital to the subacute care unit at CHMC on or about July 1, 2016 at approximately 1800
14 hours, at which time he became Respondent's patient. Respondent was made aware ahead of this
15 transfer by the CHMC subacute unit case manager. Although he was aware of the incoming
16 patient, and acknowledged that this patient became his responsibility upon admission to CHMC,
17 Respondent had none, or very limited, clinical information about him. Respondent did not
18 personally review the patient's case or the transfer orders from Kindred. Respondent did not
19 receive any communication from the transferring physician, and he did not reach out to speak
20 with the transferring physician. In a later communication to the Board investigators, Respondent,
21 through his attorney, claimed that the nursing staff at CHMC made a unilateral decision to admit
22 the patient to Respondent's care without his authorization and without a physician confirming
23 whether or not the patient was stable for transfer. These factors should have prompted
24 Respondent to visit the patient as soon as possible upon the patient's admission to CHMC.

25 10. At the time of transfer to CHMC, the patient was suffering from the effects of a major
26 stroke, which occurred approximately five months prior. He was suffering from severe
27 oropharyngeal dysphasia, characterized by lack of volitional movements and inability to swallow,
28 and was unable to manage his secretions. The patient had a history of sleep apnea, which

1 required him to breathe through a tracheostomy during night time. He received nutrition through
2 a feeding tube, and voided through a catheter.

3 11. Respondent was contacted by CHMC nursing staff, and spoke with a nurse at
4 approximately 10:00 p.m. on July 1, 2016. At that time, Respondent ordered that all of the
5 previous medical orders from the transferring facility be continued until he could visit the patient
6 and physically examine him. At the time, Respondent did not know the details of the prior orders
7 from the transferring facility. His conversation with CHMC nursing staff was no longer than
8 three minutes, and it was not documented in the patient's record. Respondent did not visit and/or
9 examine this patient on July 1, 2016.

10 12. The nursing staff at CHMC contacted Respondent several times between midnight
11 and approximately 2:00 a.m. on July 2, 2016, seeking additional orders based on the patient's
12 family requests for medications or treatments that were not included in the Kindred transfer
13 orders, or were not accurately transcribed from Kindred transfer orders. Still, Respondent did not
14 visit and examine this patient at CHMC on July 2, 2016.

15 13. On July 3, 2016, the patient had trouble breathing and his condition began to worsen.
16 CHMC nursing staff began attempts to reach Respondent to obtain an order for a breathing
17 treatment at approximately 11:20 a.m. At 11:44 a.m., before Respondent could be reached, a
18 rapid response team¹ was summoned to the patient's room. Respondent spoke to the CHMC
19 nursing staff at approximately 11:55 a.m., and ordered the patient transferred to the CHMC
20 Intensive Care Unit (ICU). The patient was transferred to the ICU, where he remained
21 Respondent's patient, with nursing staff continuing to page and update Respondent on the
22 patient's condition. Respondent, however, did not visit and examine his patient after the transfer
23 to ICU on July 3, 2016, and did not make, or attempt to make, or document making or attempting
24 to make, any arrangement to transfer the care of the patient to another physician.

25 //

26 //

27 ¹ A "rapid response team" is a patient safety intervention team summoned to the patient's
28 bedside when a patient demonstrates signs of imminent clinical deterioration.

1 14. At 1:45 p.m. on July 3, 2016, a "Code Blue"² was called for the patient. The nursing
2 staff at CHMC unsuccessfully attempted to contact Respondent at 1:45 p.m. and again at 1:47
3 p.m. A CHMC nurse left a message that the patient was "coding" with Respondent's call service
4 at 1:59 p.m. The nursing staff was able to reach Respondent by phone at 2:07 p.m. This
5 telephone call lasted 15 minutes. After the "Code Blue" was initiated, the patient was revived by
6 the code team after receiving two electrical shocks. A second "Code Blue," however, was
7 initiated at 2:13 p.m., and this time the patient could not be revived. The patient's time of death
8 was called at 3:16 p.m. on July 3, 2016. Respondent did not visit and did not examine this patient
9 at CHMC on July 3, 2016, or at any time during the patient's hospitalization at CHMC.

10 15. Respondent was the doctor of record for the patient during the patient's
11 hospitalization at CHMC. Respondent did not write any note in the patient's chart. Respondent
12 did not document an Admission History and Physical, did not document any progress note, did
13 not prepare a Transfer Summary (to ICU), did not prepare a Discharge Summary, and did not
14 prepare a Death Note. There is also no documentation of any communication with the ICU
15 medical staff upon transfer to ICU on July 3, 2016, even though Respondent's phone records
16 show that communications took place.

17 16. Respondent completed the Death Certificate for this patient, and declared that the
18 patient's proximate cause of death was "septic shock." This is in disagreement with the Code
19 Team's documented conclusion that the patient's death was caused by a massive pulmonary
20 embolism. Without any clinical documentation from Respondent, it is impossible to understand
21 his rationale for choosing septic shock as the cause of the patient's death. Respondent did not
22 document any reason why he drew a conclusion that was different from that of the Code Team.

23 17. The call logs provided by Respondent support the reports by the nurses and the
24 patient's family that Respondent does not return calls every time he is paged. Respondent
25 himself, through his attorney, stated that he tells the nurses to page him every 15 minutes until he
26

27 ² A "Code Blue" is an emergency situation announced in a hospital or institution in which
28 a patient is in cardiopulmonary arrest, requiring a team of providers (sometimes called a 'code
team') to rush to the specific location and begin immediate resuscitative efforts.

1 responds. Having this as a personal standard is potentially unsafe for the patients. It discourages
2 communication between doctor and nurses.

3 18. After the patient's transfer to the ICU, Respondent's failure to visit and examine him
4 at the CHMC ICU, or alternatively, to arrange and document the transfer of the patient's care to
5 another doctor, constitutes an extreme departure from the standard of care under the
6 circumstances described in paragraphs 8 through 17 herein.

7 19. Respondent's failure to make any documentation in the patient's chart under the
8 circumstances described in paragraphs 8 through 17 herein, constitutes a separate and distinct
9 extreme departure from the standard of care.

10 **SECOND CAUSE FOR DISCIPLINE**

11 (Repeated Negligent Acts)

12 20. Respondent Vincent Luvern Anthony, M.D. is subject to disciplinary action under
13 section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in the care
14 and treatment of his patient. The circumstances are as follows:

15 21. The allegations of paragraphs 8 through 17 are incorporated herein by reference.

16 22. Respondent's failure to visit and examine the patient prior to the patient's transfer to
17 the ICU at CHMC under the circumstances described in paragraphs 8 through 17 herein,
18 constitutes a departure from the standard of care.

19 23. After the patient's transfer to ICU, Respondent's failure to visit and examine him at
20 the CHMC ICU, or alternatively, to arrange and document the transfer of the patient's care to
21 another doctor, constitutes a departure from the standard of care under the circumstances
22 described in paragraphs 8 through 17 herein.

23 24. Respondent's failure to make any documentation in the patient's chart under the
24 circumstances described in paragraphs 8 through 17 herein, constitutes a departure from the
25 standard of care.

26 25. Respondent's failure to document the reasons for his conclusion that the patient's
27 proximate cause of death was septic shock constitutes a departure from the standard of care.

28

1 26. Respondent's failure to promptly communicate with the CHMC nursing staff,
2 requiring them to page him every 15 minutes until he responds, is a simple departure from the
3 standard of care.

4 **THIRD CAUSE FOR DISCIPLINE**

5 (Failure to Maintain Adequate and Accurate Records)

6 27. Respondent Vincent Luvern Anthony, M.D. is subject to disciplinary action under
7 section 2266 of the Code in that he failed to maintain adequate and accurate medical records in
8 his care and treatment of the patient. The circumstances are as follows:

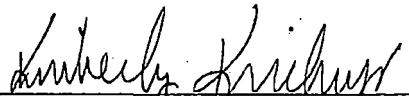
9 28. The allegations of paragraphs 8 through 17 are incorporated herein by reference.

10 **PRAYER**

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

- 13 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 96566,
14 issued to Vincent Luvern Anthony, M.D.;
- 15 2. Revoking, suspending or denying approval of his authority to supervise physician
16 assistants and advanced practice nurses;
- 17 3. If placed on probation, ordering him to pay the Board the costs of probation
18 monitoring; and
- 19 4. Taking such other and further action as deemed necessary and proper.

20
21 DATED: April 23, 2019

22 
23 KIMBERLY KIRCHMEYER
24 Executive Director
25 Medical Board of California
26 Department of Consumer Affairs
27 State of California

28 *Complainant*

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