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

In the Matter of the Second Amended Accusation and Petition to Revoke Probation Against: Richard Neill Sauer, M.D. Physician's and Surgeon's Certificate No. A29403 Respondent	Case No. 800-2018-047592

DECISION

The attached Proposed Decision is hereby amended, pursuant to Government Code section 11517(c)(2)(C), to correct clerical errors that do not affect the factual or legal basis of the Proposed Decision. The Proposed Decision is amended as follows:

1. Page 3, Paragraph 2, Line 1 is corrected to read "On March 15, 2017, Kimberly Kirchmeyer, former Executive Director for."
2. Page 3, Paragraph 3, Line 1 is corrected so the name reads "Ms. Kirchmeyer."
3. Page 3, Paragraph 3, Line 1 is corrected so the name reads "Ms. Kirchmeyer."
4. Page 4, Line 1 is corrected to read "December 6, 2019, Christine J. Lally, former Interim Executive Director, filed a First Amended Accusation and Petition to Revoke."
5. Page 4, Line 3 is corrected so the date reads "October 18, 2019."

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

This Decision shall become effective at 5:00 p.m. on

February 12, 2021.

IT IS SO ORDERED January 14, 2021.

MEDICAL BOARD OF CALIFORNIA

By: Kristina Lawson

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

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

In the Matter of the Second Amended Accusation and Petition to Revoke Probation against:

RICHARD NEILL SAUER, M.D., Respondent

Agency Case No. 800-2018-047592

OAH No. 2020020171

PROPOSED DECISION

Danette C. Brown, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter by telephone and video on November 2, 3, 4, 9, and 10, 2020, from Sacramento, California.

Megan O'Carroll, Deputy Attorney General, represented complainant William Prasifka, Executive Director, Medical Board of California (Board), Department of Consumer Affairs (DCA).

Albert Garcia, Attorney at Law, represented respondent Richard Neill Sauer, M.D., who was periodically present at the hearing.

Oral and documentary evidence was received. The record was held open for the parties to submit simultaneous closing briefs by November 17, 2020, and for

complainant to submit a rebuttal brief by November 19, 2020. Respondent's closing brief was received and marked as Exhibit F. Complainant's closing brief was received and marked as Exhibit 38. The record was closed and the matter was submitted for decision on November 19, 2020.

FACTUAL FINDINGS

Jurisdictional Matters and Disciplinary History

1. On July 28, 1975, the Board issued to respondent Physician and Surgeon's Certificate No. A 29403 (certificate). Pursuant to a Decision issued in Case No. 800-2017-030024, referenced below, respondent was placed on Board probation with terms and conditions, including a requirement that he cease the practice of medicine as of October 3, 2019, pending successful completion of a clinical assessment training program. Pursuant to a Decision in Case No. 800-2019-060521, also referenced below, effective October 18, 2019, the certificate was suspended pending the hearing in this matter. The license expired on October 31, 2020, and has not been renewed.[1]

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[1] Business and Professions Code section 118, subdivision (b), provides in pertinent part, that the expiration of a license issued by the Board, or its suspension "shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding . . . "

2017 ACCUSATION

2. On March 15, 2017, Christine J. Lally, former interim executive officer for the Board, acting in her official capacity, signed and thereafter filed an Accusation, Case No. 800-2014-002745, against respondent. The Accusation alleged cause to discipline respondent's license based on gross negligence, repeated negligent acts, failure to maintain adequate records, and general unprofessional conduct related to his treatment of two patients. Effective May 18, 2018, the Board revoked respondent's certificate, stayed the revocation, and placed respondent on probation for five years with terms and conditions.

2019 ACCUSATION

3. On January 23, 2019, Ms. Lally, acting in her official capacity, signed and thereafter filed a First Amended Accusation, Case No. 800-2017-030024, against respondent. The First Amended Accusation alleged cause to discipline respondent's license based on his unprofessional conduct, gross negligence, and repeated negligent acts, involving a single patient. The Board revoked respondent's certificate, but stayed the revocation and placed respondent on probation for five years. The terms and conditions of probation included a requirement that respondent cease the practice of medicine until he successfully completed a clinical training program, such as the Physician Assessment and Clinical Education Program (PACE) at the University of California San Diego School of Medicine. The Board's decision, and respondent's probation, became effective on October 3, 2019.

2020 ACCUSATION AND PETITION TO REVOKE PROBATION

4. On September 30, 2019, Ms. Lally, acting in her official capacity, signed and thereafter filed an Accusation, Case No. 800-2018-047592, against respondent. On

December 6, 2019, she filed a First Amended Accusation and Petition to Revoke Probation, relating to respondent's care and treatment of patient P.T. and recordkeeping. On October 17, 2019, Ms. Lally petitioned for, and was granted, an interim suspension order (ISO) temporarily prohibiting respondent from practicing medicine. On November 15, 2019, following a noticed hearing, the ISO was extended until such time an accusation was filed and a decision entered on it.

5. On June 10, 2020, complainant filed a Second Amended Accusation and Petition to Revoke Probation. The Second Amended Accusation alleged seven causes for discipline of respondent's certificate: (1) gross negligence; (2) repeated negligent acts; (3) failure to maintain adequate and accurate records; (4) making a false medical record; (5) engaging in dishonest and corrupt acts; (6) engaging in the unlicensed practice of medicine; (7) and general unprofessional conduct. Additionally, Ms. Lally alleged cause to revoke probation based on respondent's alleged: (1) failure to complete a Clinical Competence Program as a condition precedent to practicing medicine (Condition 17); (2) engaging in solo practice (Condition 5); and (3) engaging in the unlicensed practice of medicine (Condition 8). Respondent timely filed a Notice of Defense. The matter was set for an evidentiary hearing before an ALJ of the OAH pursuant to Government Code section 11500 et seq.

Respondent's Care and Treatment of Patient P.T.

6. In October 2017, P.T. was a 60-year-old female who began experiencing pain and weakness in her extremities. Magnetic resonance imaging (MRI) studies from November 2017 showed a lesion on her cervical spinal cord region and white matter signal changes of the brain. A cervical spine report noted an overall finding of "sequela from prior transverse myelitis with a differential diagnosis of neuromyelitis optica."

7. Hung Hoang, M.D. was P.T.'s primary care physician (PCP), and referred P.T. to respondent for neurological care. In the referral, Dr. Hoang specified that P.T. had been diagnosed with "idiopathic transverse myelitis."[2] The referral also contained the final reports of the MRI studies taken in November 2017.

FEBRUARY 14, 2018 INITIAL VISIT

8. On February 14, 2018, P.T. presented to respondent's office for the first time. Her sister and caretaker, D.T., accompanied her. Prior to the visit, respondent did not review any of P.T.'s hospital or primary care records. After the visit, he prepared a document on his letterhead memorializing the appointment as follows:

> The patient comes in complaining of right greater than left hand tingling. This is in the median distribution. No weakness is reported.
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> The patient reports that his [*sic*] blood pressure at his [*sic*] primary physician's [*sic*] have all been in the normal range and of no concern. Examination reveals no significant weakness and a question of sensory loss in the median distribution of both hands.

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[2] Transverse myelitis is an inflammation of the spinal cord, often damaging the insulating material covering nerve cell fibers, or myelin. (https://www.mayoclinic.org/diseases-conditions/transverse-myelitis/symptoms-causes/syc-20354726.)

> At this point, the patient is on gabapentin for this and is doing reasonably well.
>
> It appears that this patient has a compressive neuropathy in both wrists. To confirm this the patient will have both upper extremities [electromyography] EMG and conduction velocity examination and further therapy will follow.

9. In a subsequent letter to Dr. Hoang, respondent noted he had evaluated P.T. for "probable neuropathy versus radiculopathy." Respondent then requested that Dr. Hoang authorize an EMG and conduction velocity examination.

FEBRUARY 23, 2018 EMERGENCY ROOM VISIT

10. On February 23, 2018, P.T. presented to Sutter Roseville Emergency Department with bilateral lower extremity weakness and pain. She was admitted to Sutter Roseville Hospital (Sutter) and diagnosed with multiple sclerosis (MS),[3] with a differential diagnosis of neuromyelitis optica (NMO). An MRI of her spine showed a new lesion, which the radiologist noted "suggests an active demyelinating process/myelitis." P.T. was treated with high-dose steroids, and her condition resolved. Sutter physicians observed that P.T. had a "claw hand," where the fingers curled up due to MS. P.T. was discharged on March 1, 2018. The discharge paperwork noted "Pt

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[3] MS is a potentially disabling disease of the brain and spinal cord, where the immune system attacks the protective sheath, or myelin, that covers nerve fibers and causes communication problems between the brain and the body. (https://www.mayoclinic.org/diseases-conditions/multiple-sclerosis/symptoms-causes/syc-20350269.)

does need CLOSE neurologic follow-up as NMO and Multiple Sclerosis are treated differently." (Capitalization in original.) The discharge summary included the Sutter neurologist's recommendation that P.T. continue with occupational and physical therapy, and be referred to the University of California San Francisco Neurology Department for ongoing care.

MARCH 5, 2018 VISIT

11. On March 5, 2018, P.T., accompanied by D.T., went to her scheduled appointment with respondent. P.T. was no longer able to drive due to the pain and weakness in her limbs. P.T. and D.T. brought the discharge paperwork from Sutter to show respondent that P.T. had been diagnosed with MS and/or NMO days earlier. After checking in, respondent called P.T. back to the examination room. No one took P.T.'s vital signs before or after the appointment. Respondent did not discuss the reason for the appointment or inquire about P.T.'s history. Respondent directed P.T. to lay on the examination table and thereafter performed an EMG test. Respondent did not document the temperature of P.T.'s extremities while performing the EMG, the results of which showed values consistent with mild carpal tunnel syndrome in the right extremity. When P.T. and D.T. attempted to show respondent Sutter's discharge summary, respondent refused to look at it. Instead, he instructed P.T. to bring him the MRI films from Sutter so he could review them.

12. Respondent wrote a prescription for a splint, and told P.T. to wear it as often as possible. Respondent quickly left the room without giving P.T. or D.T. a chance to ask questions or provide any further information about her recent discharge and diagnoses. Thereafter, P.T. and D.T. attempted to obtain the MRI films from Sutter. However, Sutter would only provide them with a compact disc (CD) containing the images, not the actual MRI films.

APRIL 2, 2018 VISIT

13. On April 2, 2018, P.T. returned to respondent for a follow-up appointment. Respondent refused to look at the CD of the MRI, stating that he was only able to look at the actual films. Respondent documented, "the patient complains of no change in his [*sic*] symptoms or clinical status. Examination shows no abnormality at this time." Again, no vital signs were taken before or after the appointment.

14. Respondent directed P.T. and her sister into his office instead of an examination room. He asked how P.T. was doing. P.T. explained that she continued to have difficulty walking, had weakness in her legs, and had numbness in her arms and legs. P.T. and D.T. reminded respondent that P.T. had been diagnosed with MS and transverse myelitis, but respondent did not appear to be paying attention. Instead, respondent instructed P.T. to continue wearing the splint and to return for another appointment in June. Before P.T. or D.T. could continue the conversation, respondent stood up from his desk and left the office. The entire appointment lasted five minutes.

SUBSEQUENT MEDICAL TREATMENT

15. On April 25, 2018, P.T. presented to Sutter emergency room for another exacerbation of her symptoms of MS/NMO. She was again administered steroids, and improved. Her gabapentin dose was increased. Sutter advised her to follow up with her outpatient neurologist and PCP.

16. On May 3, 2018, P.T. followed up with Dr. Hoang. He noted that P.T. required a walking stick to walk. He further noted that, although her many imaging studies from previous emergency room visits suggested MS, respondent had

diagnosed her with carpal tunnel syndrome and did not want to pursue any other diagnoses. Dr. Hoang referred P.T. to the MS clinic at the University of California, Davis.

17. On May 4, 2018, P.T. requested a referral to a different neurologist for treatment, as respondent would not consider or treat her for the diagnosis of MS. She filed a grievance with her insurance carrier, who thereafter contacted respondent. In a letter dated May 9, 2018, respondent stated he was treating P.T. for carpal tunnel syndrome and had prescribed her a splint. He continued: "[t]he patient has no signs, symptoms or laboratory studies suggestive of M.S., and her normal MRI scan was discussed with her." Further, "[t]he patient has a simple neurologic problem in her carpal tunnel syndrome and not much time was involved."

18. On May 15, 2018, P.T. returned to her PCP with worsening symptoms. She was no longer able to walk, even with a cane, and was wheelchair-bound. Dr. Hoang documented:

> [S]he was suspected of having M.S. and she was initially referred to a neurologist who insisted that she has carpal tunnel synd. We have tried to refer her to a MS clinic and UCD-MC for further evaluation, however it was denied.

Dr. Hoang further noted, "she needs urgent neurological referral" due to the rapid progression of her symptoms, and "she requests to be referred to another neurologist different than the first one."

19. On or about May 25, 2018, P.T. received a determination letter from the insurer advising that P.T. had received appropriate care from respondent. In the letter, the insurer reported that respondent asserted he had discussed P.T.'s normal MRI with her, which P.T. and D.T. knew to be false. The letter further stated that respondent

would discuss the MRI "films" of P.T.'s thoracic MRI with her at her next appointment in June. Because P.T. and D.T. knew that they would not be able to bring the actual films to respondent, they canceled the appointment.

20. On June 19, 2018, P.T. presented to Dr. Hoang with further deterioration of her neurological symptoms. She experienced a sharp headache in addition to worsening of her previous symptoms of weakness and balance disturbances. She also had difficulty remaining upright in her wheelchair. Dr. Hoang noted that P.T. had been referred to a different neurologist, but the referral was still pending.

JULY 14, 2018 EMERGENCY ROOM VISIT

21. On July 14, 2018, P.T. presented to Sutter emergency room with extreme weakness. She could not move parts of her body, and had difficulty breathing and swallowing. Under "History of Present Illness," the emergency room physician noted that P.T. had initially presented to the emergency room in September 2017, and had subsequent visits and admissions in 2018, during which the neurology department diagnosed her with atypical MS. The emergency room physician further noted that P.T. followed up from her hospital discharges with an outpatient neurologist who did not treat her for the MS. She was diagnosed with having an acute exacerbation of her untreated MS. The MRI studies showed further demyelinating disease. The neurologist concluded that her laboratory results and symptoms were consistent with NMO.

22. Sutter administered steroids, but this time P.T. did not respond. The hospital team then attempted to treat her with plasmapheresis.[4] However, this

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[4] Plasmapheresis is a method of removing blood plasma from the body by withdrawing blood, separating it into plasma and cells, and transfusing the cells back

treatment also failed. By July 27, 2018, P.T. was not improving, and was in extreme pain despite increasing amounts of morphine. After a family discussion with her treatment team, P.T. changed to hospice care and died two days later. Her official cause of death was cardiopulmonary arrest due to MS exacerbation.

D.T.'s Complaint to the Board

23. On August 21, 2018, D.T. filed an online written complaint to the Board regarding respondent's care and treatment of P.T. Specifically, the complaint alleged: (1) P.T. presented to respondent with a recent diagnosis of transverse myelitis and MS; (2) respondent did not listen to P.T.'s complaints and refused to review pertinent medical records; (3) respondent did not perform a physical examination; and (4) respondent misdiagnosed P.T. with carpal tunnel syndrome. On July 29, 2018, P.T. died due to complications from her conditions.

24. On October 16, 2018, Sean Cogan, Investigator, Health Quality Investigation Unit, DCA, was assigned to investigate the complaint. Investigator Cogan requested and received P.T.'s certified medical records from Sutter, respondent, and Dr. Hoang. He also interviewed D.T. and respondent, and summarized those interviews in his investigation report. Finally, he retained a medical expert to review and offer an opinion regarding the case.

25. On November 27, 2018, respondent called the telephone number he had on file for P.T., purportedly to inquire why she missed her last appointment. D.T. answered, and told respondent that P.T. had died. Respondent then asked D.T. if she

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into the bloodstream. It is performed to remove antibodies in treating autoimmune conditions. (https://www.healthline.com/health/plasmapheresis.)

had filed a complaint with the Board a month earlier. D.T. confirmed that she had filed the complaint, and respondent asked her to withdraw it. D.T. refused. After the call, which lasted approximately 18 minutes, D.T. immediately wrote a letter to the Board documenting the call and respondent's request that she withdraw her complaint. D.T. was very distressed by the call and having to discuss her sister's care with respondent.

26. Board investigators interviewed respondent on May 3, 2019, during which respondent claimed he had conducted a "focused examination" of P.T. When asked whether P.T. had attempted to inform him of her MS diagnosis, respondent said:

> I remember vaguely that the caregiver, um, had brought up the idea of the MS, but . . . and I reviewed the record and saw no evidence that someone had diagnosed the patient with that.

27. In addition, respondent acknowledged that he had called and spoken with D.T. shortly after receiving the request for P.T.'s medical records from the Board. He claimed that the purpose of the call was to inquire about how P.T. was doing, since she had canceled her last appointment with him. When asked whether he requested D.T. to withdraw her Board complaint, he responded:

> I may have talked to one of the family members that if they complain about anything, it's a huge hassle, and, uh, yeah, if she remembers that, that is probably what I called about.

Practice of Medicine with a Suspended License

28. On October 3, 2019, respondent attended a Board probationary intake interview to discuss the terms of his probation pursuant to Case No. 800-2017-030024,

including the requirement he cease practicing as of that date. Probation Condition 17 stated, in pertinent part:

> Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after respondent's initial enrollment. Respondent shall not practice medicine until respondent has successfully completed the program and has been so notified by the Board or its designee in writing.

29. Board Probation Condition 5 stated, in pertinent part:

> 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.

30. Board Probation Condition 8 stated, in pertinent part:

> 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, payment and other orders.

31. The Board's probation department staff warned respondent that he must stop practicing medicine immediately. Further, respondent must successfully complete the clinical assessment program and be contacted by the Board before he may resume medical practice. Respondent told the probation staff that he had already shut down his practice and closed his office.

32. On October 10, 2019, Board probation inspectors visited respondent's medical office. As he looked through the window into the waiting room, an inspector observed respondent wearing a white laboratory coat. He took two individuals back to the examination rooms. The inspectors went to the front desk and met with receptionist Leda Aguirre. They asked to speak with respondent and requested the patient sign-in sheets. Ms. Aguirre could not produce the sign-in sheets because they were thrown away at the end of each day. While waiting, an inspector saw respondent remove his white laboratory coat. Office staff Kimberly Klantz then escorted the inspectors to respondent's office. They asked respondent why he was there, since respondent knew he was not permitted to practice medicine, and he previously represented to Board staff that he had already closed his practice. Respondent stated he was present at his office acting as a "technician." He also asserted he was using neurological machines, which did not require a college degree, and there was no prohibition to him working with the machines as a technician.

33. When asked about patients the inspectors observed in his waiting room, respondent stated that the patients were not waiting to see him, but were waiting to be seen by his partner, Richard Chun, M.D. Respondent then stated Dr. Chun was at lunch, and did not know when he would return. When asked about walking with patients, respondent claimed that: he was doing "emergency refills" for his patients only; he had to refill patient prescriptions because he could not abandon them

suddenly and leave them without care; and, he was required to complete his neurological consultations or his patients would be harmed. When the inspectors reminded respondent this constituted the practice of medicine, respondent retorted he was "saving lives." The inspectors requested respondent's patient sign-in sheets, and respondent agreed to fax them to the probation office during the lunch hour.

34. As they were leaving, the inspectors learned from Ms. Klantz that Dr. Chun had not been in the office all day, and that she had not seen Dr. Chun at the office for some time.

35. One of the inspectors stayed and met Investigator Roberto Moya from the Division of Investigation, Health Quality Investigation Unit, in the parking lot. They entered respondent's office after the lunch hour, and observed people in the waiting room different than those waiting earlier. They talked to respondent again, and asked respondent how many prescriptions he had filled since October 4, 2019. Respondent stated that he filled three or four prescriptions per day, and completed a couple of consultations each day. He specified that he was acting as a neurologist in those consultations, and not as a doctor.

36. During the lunch hour, respondent did not fax his sign-in sheets to the probation office as promised. Respondent told Investigator Moya and the probation inspector that he was too busy gathering information for his clinical assessment by the PACE Program.

37. On October 18, 2019, complainant successfully petitioned for an ISO, prohibiting respondent from practicing any aspect of medicine, or holding himself out as practicing or being available to practice medicine, within the state of California. Respondent was further prohibited from being present in any location or office which

is maintained for the practice of medicine, or where medicine is practiced, except as a patient or visitor of family or friends.

38. From October 4, 2019, through February 2020, respondent visited his office at least weekly and was in frequent contact with his office staff by telephone to provide directions on patient care and instructions for Dr. Chun to provide care to respondent's patients. Respondent also allowed his staff to authorize refills of controlled prescriptions under his name and his Drug Enforcement Administration (DEA) number. On October 16, 2019, Bel Air Pharmacy in Antelope, California received a telephone request from respondent's office to authorize a refill of clonazepam for Patient 2.[5] Bel Air Pharmacy refilled the prescription under respondent's DEA number with a notation that the telephone authorization was provided by Ms. Aguirre, respondent's receptionist. The medication was dispensed on October 16, 2019.

39. On October 21, 2019, Anderson Bros. Pharmacy in Sacramento, California received a telephone prescription for phenobarbital for Patient 3 under respondent's DEA number. The prescription noted that authorization was provided by Ms. Aguirre. The medication was dispensed on October 22, 2019.

40. In February 2020, Investigator Cogan interviewed Ms. Klantz and Ms. Aguirre at respondent's medical office. Both acknowledged that calling and authorizing refill prescriptions in respondent's name had been the custom and practice in the office for a long time, and that respondent was aware of this process. After his suspension, respondent directed Ms. Klantz and Ms. Aguirre to obtain authorizations for refills from Dr. Chun. However, Dr. Chun would only prescribe to patients that he

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[5] Other patients will be identified by numbers, beginning with Patient 2.

saw himself, and would not authorize prescriptions or refills over the telephone as was respondent's practice. Ms. Klantz initially denied that respondent had been at the office recently, but later admitted that he came to the office weekly to check his mail.

41. On February 25, 2020, Investigator Cogan interviewed Dr. Chun at respondent's office. Dr. Chun stated that when respondent was suspended from the practice of medicine, respondent asked for his help by seeing a limited number of respondent's patients for the purpose of continuing their medications. Dr. Chun agreed, and saw two to four patients once a week on Tuesdays for a half hour. He observed respondent present at the office two weeks prior to the interview. Dr. Chun is not a neurologist, is not respondent's medical partner, and has his own medical practice at a different location.

Respondent's Evidence

RESPONDENT'S TESTIMONY

42. In 1974, respondent completed his medical degree at the University of Iowa, College of Medicine. Thereafter, he completed an internship at United Hospitals in St. Paul, Minnesota. In 1975, he was licensed by the Board. In 1978, respondent completed a three-year residency in neurology at the University of California, Davis. In 1981, he became board-certified in Neurology and Psychiatry. Respondent recently attended a World MS meeting in Stockholm, Sweden, and a global MS meeting in Budapest, Hungary, where new advances in MS were discussed. Respondent previously served as a medical evaluator for the Board, though he admitted he last evaluated a case for the Board "many years ago."

TREATMENT OF P.T.

43. Respondent has treated demyelinating conditions and other forms of demyelinating disease for 42 years. He was asked to attend the global meeting in Budapest because of his expertise, stating, "my community thinks I am an expert." He explained that NMO is a rare demyelinating disease which can affect certain areas of the brain and spinal cord. Ninety-eight percent of NMO consists of "relapsing and remitting that's throughout the literature and obvious."

44. Respondent admitted receiving the November 2017 cervical spine report, and acknowledged that "differential considerations include demyelinating disease such as [NMO] although no significant optic nerve abnormality is seen on the brain MRI." Respondent also conceded he knew P.T. had a "past lesion involving the cervical spinal cord, which had improved on serial MRI scans." However, he asserted this past condition "had apparently been followed by another physician," and Dr. Hoang had referred P.T. to respondent specifically, and for the sole purpose of "an evaluation of her complaint of hand numbness."

45. Respondent recalled the February 14, 2018 initial appointment with P.T and "her caregiver." However, he did not recall whether D.T. identified herself as P.T.'s sister. He did not indicate in his medical notes whether he took any vital signs prior to or during the appointment. He did not notice that P.T. had difficulty in ambulating. He conducted an EMG test and prepared a report. He recalled discussing that P.T. had been in the hospital with inflammation, but did not recall what diagnoses were made. He had a vague recollection of P.T.'s Sutter discharge papers. When D.T. asked him to review her sister's discharge papers, respondent explained he was only authorized to do the EMG test, and no further evaluation. Still, respondent asserted that he "offered on more than one occasion to review the MRI [films] and to provide a second opinion."

He claimed that he had experience in reviewing MRI films, stating, "since the first machine was invented I've been reading these."

46. Respondent re-evaluated P.T., who was accompanied by D.T., on March 5, 2018, and on April 2, 2018. His memorialization of the March appointment consisted of three short sentences stating he evaluated P.T. for a neuropathy, that a follow up was needed, and requested authorization. He memorialized the April appointment, noting that he found "no indications of a negative change in her clinical status." He documented "her past transverse myelitis" and asked D.T. to provide the actual MRI films for a "second reading." D.T. asked him to review P.T.'s medical records for her transverse myelitis symptoms. However, respondent informed her that was beyond the scope of Dr. Hoang's referral.

At hearing, respondent conceded it is possible to review MRI films on a CD. However, he wanted the actual films because "the CD is not compatible on my computer and electronic records don't always [sync] with the next doctor's computer."

47. In response to D.T.'s grievance filed with P.T.'s insurance company seeking another neurologist, respondent wrote the insurer, in part:

> The patient has no signs, symptoms or laboratory studies suggestive of MS, and her normal MRI scan was discussed with her. This study was ordered by another physician.
>
> The patient has a simple neurologic problem in her carpal tunnel syndrome and not much time was involved.
>
> The patient is being followed again in June for her history of transverse myelitis. At this point, the films of the thoracic

MRI will be reviewed and further discussion will follow concerning any possibility of a demyelinating disease.

48. In November 2018, after D.T. had filed her complaint with the Board, respondent attempted to contact P.T. to ask she withdraw the complaint. When D.T. answered the phone, respondent stated he was calling "to follow up on P.T. because she had missed an appointment." D.T. told him that P.T. had died. Respondent never threatened D.T. or offered her money to withdraw the complaint. Rather, he asked her to withdraw it because she was "confused" about the referral to his office, and "did not know that Dr. Hoang only wanted him to do a peripheral nerve study." He admitted telling D.T., "it's a big hassle when there's a complaint."

PRACTICING MEDICINE WITH A SUSPENDED LICENSE

49. Respondent acknowledged he was required to complete the PACE Program before resuming practice, and claimed that he last practiced medicine on October 3, 2019. After that date, he had Dr. Chun assist him with covering his patients and the office, and assisting patients with their transition to another neurologist.

50. Respondent denied that he treated any patients during the Board's inspection on October 10, 2019. However, he conceded that his office called in prescriptions after his suspension.

LETTERS OF SUPPORT

51. Respondent introduced several letters of support, the majority of which were dated in January 2019. Many expressed respondent as a caring and competent physician. None of the letter writers expressed knowledge of respondent's probation, suspension or the present Second Amended Accusation and Petition to Revoke

Probation. They provided no insight into respondent's efforts at rehabilitation despite the present charges. (*Seide v. Committee of Bar Examiners of the State Bar of California* (1989) 49 Cal.3d 933, 940 ["If the character witnesses were not aware of the extent and seriousness of the petitioner's criminal activities, their evaluations of his character carry less weight."].) There are no criminal activities at issue in this case. However, neither respondent's failure to provide adequate medical treatment to P.T., nor his practice of medicine on a suspended license were addressed by any of the letters' authors. Thus, the letters are of limited value in assessing rehabilitation.

PROOF OF PACE PROGRAM COMPLETION

52. Respondent submitted a Certificate of Completion of the UC San Diego PACE Program certifying that he successfully completed the PACE Program from November 19 to 22, 2019.

Expert Testimony

BOARD'S MEDICAL EXPERT – LORNE LABEL, M.D.

53. Lorne Label, M.D., is board-certified in Psychiatry and Neurology, and is a Fellow of the American Academy of Neurology. He has been licensed by the Board since 1982. Dr. Label received his medical degree in 1978 from the University of Texas Medical Branch in Galveston Texas, and that same year, completed a Clinical Psychopharmacology program at the National Institutes of Health, Bethesda, Maryland. In 1979, he completed an internship in Internal Medicine at St. Joseph Mercy Hospital, an affiliate of the University of Michigan. In 1982, Dr. Label completed his residency in Neurology at the University of Michigan Medical School. In 1983, he completed a fellowship in Clinical Neuromuscular Diseases at the University of Southern California Neuromuscular Center.

54. Dr. Label currently works in private practice at UCLA,[6] Health Neurology. He also serves as a Clinical Professor of Neurology at the David Geffen School of Medicine at UCLA, and as Adjunct Faculty at Loyola Marymount University.

55. Complainant retained Dr. Label to review respondent's care and treatment of P.T. and render an opinion regarding whether respondent acted within the standard of care. Dr. Label reviewed several materials including: D.T.'s consumer complaint; P.T.'s medical records from respondent, Dr. Hoang, and Sutter; insurance company correspondence; P.T.'s death certificate; and, digital recordings and transcript of the Board's investigatory interview with respondent. Dr. Label memorialized his findings and opinions in a written report, dated July 6, 2019, and testified at hearing consistent with his report.

DEMYELINATION DISEASE

56. Dr. Label explained that demyelination occurs when the protective insulation of nerve fibers, much like insulation around a cable, becomes damaged. The protective insulation is called myelin. Loss of myelin damages nerve signals from point A to point B, and symptoms can occur in the brain, spinal cord, and nerves. In the case of MS, where one has myelin damage in the cable properties, a patient can suffer loss of power, balance, and visual loss, depending on how much demyelination has occurred. There are many types of demyelination disease, including MS and NMO. Transverse myelitis is an inflammatory condition that causes damage across an area of the spinal cord, anywhere from the neck to the lumbar area. This condition could lead to demyelination disease.

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[6] University of California, Los Angeles.

57. Dr. Label further explained that NMO involves a larger area of myelitis in the cervical (neck) area:

> With myelitis episodes, you have a fairly small area of spinal cord that is damaged. In NMO, you have a cervical area that is injured. It is a wider area of damage. It could affect visual [function]. Transverse myelitis is a thinner sliver of damage in the spinal cord area, and NMO [shows] longer regions of damage, typically in the cervical area. This can be seen on an MRI.

The features of NMO and transverse myelitis and/or MS on an MRI can look the same. The difference is the size and shape of the damaged area which require further testing to detect. Dr. Label also noted that, in the past, NMO was considered a subcategory of MS. Physicians have since determined that NMO is a separate disease with different treatment. Still, many PCPs and internal medicine specialists continue to refer to NMO as MS. Dr. Label explained that NMO is "by far the most serious condition, and can be a devastating disease," usually marked by "a continuing progressive loss of function." Patients become bedridden and get pneumonia, most of the time due to a respiratory and cardiopulmonary problem.

MEDICAL OPINION REGARDING TREATMENT OF P.T.

58. Dr. Label defined the standard of care as that which:

> [I]mplies the level of skill, knowledge and care of diagnosing and treating patients that a prudent practitioner would [use] under the same circumstances. If [the practitioner] is a neurologist, the standard of care should be

> the same for any neurologist that possesses the knowledge, care and treatment. There's simple departure and extreme departure, or no departure. Extreme [departure] means complete lack of even scant care.

59. Dr. Label noted that when P.T. initially saw respondent on February 14, 2018, she had already been diagnosed by Dr. Hoang with transverse myelitis at the cervical region, based on the November 2017 MRI. P.T. exhibited symptoms of neurological impairment, such as lower extremity weakness and upper extremity complaints due to her demyelinating cervical lesion. Respondent jumped to the conclusion that the cervical lesion was compression of the nerve in P.T.'s wrist. However, Dr. Label opined this conclusion was nonsensical, particularly if one was aware of damage in the cervical spine.

60. Dr. Label concluded that respondent did not attempt to obtain prior records to clarify the diagnosis and workup of P.T., nor did he obtain a full history or perform a neurological examination at the initial visit. Had respondent done so, he would have discovered the neurologic abnormalities. At the hospital, P.T. displayed a positive L'Hermitte's sign, which occurs when a patient flexes her neck forward and feels an electrical shock down the back. Dr. Label explained this is a "classical, textbook standard of MS," and does not result in a false positive. Dr. Label opined respondent violated the standard of care by failing to conduct a physical examination and obtain P.T.'s history. Respondent claimed fluctuating symptoms of P.T.'s transverse myelitis as the difference between his examination and Dr. Hoang's. Dr. Label opined, "this of course is impossible," because "at most, subtle changes can be seen in certain situations, but never a normal examination fluctuating with severe abnormalities in the same individual."

61. In addition, Dr. Label opined that the cervical lesion on the MRI "should have triggered [respondent] to be thinking that [this] was the cause of her upper extremity numbness." He further opined:

> The appearance of that lesion encompassing the entire cervical spine from the medullary junction down to T1 should have raised the question of [NMO] in a neurologist, who is the specialist who typically diagnoses this entity. In addition[,] the MRI report by Matthew Samuel Chan, M.D. dictated in the differential: [NMO]. Reportedly, the patient had a positive blood test for NMO, which should have triggered [respondent] to begin treatment for this entity with rituximab or mycophenolate mofetil. NMO is a devastating disease when not treated, as occurred in this individual.

62. Dr. Label questioned respondent's assertion he could not obtain the MRI images from Sutter in a readable format. He explained, "films are no longer used in this technologic age. CDs are typically available and can be run on any computer." Further, a review of the MRI films was "immaterial if you have the answer" from a board-certified radiologist that has already read the MRI, noting respondent was not trained as a radiologist to review the films.

63. Dr. Label questioned the validity of respondent's bilateral carpal tunnel syndrome diagnosis because he did not document the temperature of the extremity. He explained, "if the extremity is colder than 30°C, certain values can appear abnormal. In addition, he did not document his normal values." He continued:

> In most electromyography labs[,] median motor distal latency is abnormal if >4.4 ms [millisecond] and median sensory distal latency is abnormal if >3.5 ms. [P.T.'s] right median motor distal latency was 3.6 ms, left median motor distal latency was 3.7 ms, right median sensory distal latency was 3.6 ms, left median sensory distal latency was 3.5 ms. So in my EMG lab, the diagnosis would have only been "mild right carpal tunnel syndrome."

64. In addition to ignoring the medical records diagnosing MS and suggesting NMO, Dr. Label concluded that respondent did not listen to P.T. or her family. If he had, respondent would have clearly understood P.T.'s diagnoses, the progressive worsening of her conditions, and that no one else was treating these neurologic conditions.

65. Dr. Label rejected respondent's assertion that Dr. Hoang's referral restricted him to treating P.T. for her wrist numbness only, noting the authorization was for a full neurological evaluation. He further explained, "what's written on the insurance authorization is meaningless, it's up to the neurologist to figure out if it's right or wrong."

66. In summary, Dr. Label opined that respondent's care and treatment of P.T. was an extreme departure from the standard of care based on the following: (1) respondent's claim that he was only seeing P.T. for hand numbness; (2) his questionable diagnosis of bilateral carpal tunnel syndrome; (3) his disregard of the family's information regarding P.T.'s NMO diagnosis and the cervical MRI study; and (4) respondent's lack of further workup or treatment for what was ultimately concluded to be NMO. Additionally, respondent's failure to perform a complete

neurologic examination on a patient with known transverse myelitis, and failure to obtain a full history of P.T.'s neurologic disorder, were extreme departures from the standard of care.

MEDICAL RECORDKEEPING

67. Dr. Label opined the standard of care for recordkeeping is as follows:

> The physician should keep accurate and complete records of the medical history and physical examination and other evaluations, as well as treatment plans, medications, and rationale for changes in the treatment plan or medications.

Dr. Label opined that respondent "poorly documented or did not adequately document each visit" with P.T. Respondent's initial consultation "only consisted of four short paragraphs, without a history or actual examination, except for the following: "Examination reveals no significant weakness in the question of sensory loss in the median distribution of both hands." Respondent did not document any treatment plan other than splints for P.T.'s hands. There was no documentation of an examination, treatment, diagnosis, or mention that P.T. had been seen by several neurologists. "Because of that, P.T. did not get the appropriate care and died." Dr. Label opined that respondent's poor recordkeeping was an extreme departure from the standard of care. When all the evidence is considered, petitioner produced clear and convincing evidence justifying termination of probation.

RESPONDENT'S MEDICAL EXPERT TESTIMONY

68. Respondent introduced his own written report and medical expert testimony to rebut Dr. Label's findings and conclusions. He defined the standards of care at issue as follows:

> The standard of care upon referral for a neurological evaluation for a specific condition or complaint is for the [n]eurologist to obtain a history of the specified condition or complaint . . . [and] to conduct a focused physical examination relating to the specified condition or complaint.
>
> The standard of care requires a physician to maintain accurate and adequate records.

69. Respondent explained his understanding of departures from the standard of care as:

> There is a normal, simple, [or] extreme departure. A departure can be questioning use of [Food and Drug Administration]-approved seizure medicine. A standard means a safe, acceptable, off-label, approved therapy, acceptable recordkeeping, acceptable ethical conduct. Extreme departure is something unusual, probably off-label, a good example is if someone treated an individual with an NMO condition with rituximab which has severe side effects, that would be an extreme departure.

70. Respondent opined that his evaluation and treatment of P.T. was within the standard of care. He further opined that his records accurately and adequately provided:

> [I]nformation concerning the nature and scope of the referral; the patient's presenting complaints; her history and physical examination; my initial impression; the diagnostic testing that was performed; my ultimate diagnosis; and the reasons supporting that diagnosis; and my awareness of the patient's past spinal cord lesion. The documentation of the patient's history and physician examination was within the standard of care in the community for focused [n]eurologic evaluations.

71. Ultimately, respondent concluded he did not depart from the standard of care in his care and treatment of P.T., asserting:

> It was known that the patient had a past significant spinal cord lesion which was improving at the time the patient was first seen by me. Based on the Sutter Health MRI Cervical Spine Final Report of November 19, 2017, it was thought that no further care of that lesion was required at the time, at least not by me, based on the circumscribed scope of the referral and the patient's own presenting complaints.

72. Respondent agreed with Dr. Label's explanation of the difference between MS and NMO. However, although he did not review all of Sutter's medical records, respondent found no definitive diagnosis of NMO in the records, as claimed

by Dr. Label. Moreover, NMO was not listed as a cause of death on P.T.'s death certificate.

73. Respondent disagreed with Dr. Label about the relationship between a private neurologist and the PCP, noting Dr. Label "seemed very confused" and "did not realize we don't have a university that does specialized testing." Respondent claimed that Dr. Label "was not aware" of the request by Dr. Hoang, nor was he aware of the long-standing relationship between respondent and Dr. Hoang. In addition, Dr. Label was not aware "that a certain authorization number tells my office what to do, and what the scope of the evaluation is."

Analysis

CARE AND TREATMENT OF P.T.

74. Dr. Label properly articulated the standard of care as the level of skill, knowledge and care of diagnosing and treating patients that a prudent neurologist would use under the same circumstances. On the other hand, respondent's understanding of the standard of care was "a safe, acceptable, off-label, approved therapy, acceptable recordkeeping, acceptable ethical conduct." This understanding of the standard of care was incorrect, as it did not consider the exercise of due care by a prudent neurologist in similar circumstances.

75. Dr. Label's testimony that respondent should have conducted a physical examination of P.T. during her initial visit was clear, unequivocal, persuasive, and supported by competent medical evidence. This is especially true because NMO is a more serious disease with a continuing, progressive loss of function that can result in death, Dr. Label explained that the signs and symptoms P.T. showed during her hospitalization were ongoing symptoms of NMO, which would have been obvious to

respondent had he conducted a proper examination. Dr. Label's opinion was also consistent with that of other neurologists at Sutter, who had concluded that P.T. had a serious condition requiring close outpatient neurological treatment and follow-up. In contrast, the testimony and report by respondent, who served as his own expert, was incredible, self-serving, and unsupported by competent medical evidence.

76. Respondent's contention that P.T.'s Sutter diagnosis did not officially state NMO, or that her death certificate did not reflect NMO, is likewise unpersuasive. Dr. Label convincingly opined that MS and NMO are demyelinating diseases, that it is the neurologist's job to distinguish between these similarly presenting conditions and to determine the appropriate treatment. Here, respondent failed to acknowledge and treat P.T. for any demyelinating condition, despite multiple requests from other medical providers and P.T.'s family that he do so.

77. Respondent had the responsibility to take and document an adequate medical history and obtain P.T.'s prior treatment records. However, he failed to note P.T.'s multiple, serious hospitalizations and abnormal imaging reports, and actively contradicted the one report he had in his records, which clearly listed NMO as a differential diagnosis. Moreover, there was a lack of any documented treatment plan other than wrist splints.

78. Respondent's contention that he was neither required nor authorized to treat P.T.'s demyelinating condition because Dr. Hoang's referral restricted his evaluation to P.T.'s wrist tingling, is extremely reckless, and is rejected. Dr. Label persuasively opined that the authorization was for a full neurological evaluation, Dr. Hoang's working diagnosis on the authorization was meaningless, and that it was up to the neurologist to confirm or refute it.

79. Lastly, respondent's testimony was overwhelmingly contradicted by the whole of the evidence, including respondent's own actions. Dr. Hoang clearly referred P.T. to respondent for neurological treatment, not just for her wrist tingling. Respondent's failure to do so was reflected in Dr. Hoang's records. Respondent falsely wrote in an April 2, 2018 note that P.T. did not complain of a change in her symptoms or clinical status, and that there was no history or laboratory findings of further demyelinating disease. Respondent told the Board's investigators in May 2019 that he performed a "complete neurological examination" during P.T.'s first visit. However, none of this would make sense if respondent was only authorized to treat P.T. for wrist tingling. Respondent's representations were false and dishonest.

PRACTICING MEDICINE ON A SUSPENDED LICENSE

80. Likewise, respondent was dishonest to the Board's investigators on October 3, 2019, when he represented that he ceased practice and closed his office. The overwhelming evidence established that respondent continued to practice medicine on a regular basis after his certificate was suspended by the Board on October 3, 2019, and again by the ISO.

APPROPRIATE DISCIPLINE

81. Complainant established by clear and convincing evidence the allegations contained in the Second Amended Accusation. In addition, complainant established by a preponderance of the evidence the grounds set forth in the Petition to Terminate Probation.

82. Here, respondent did not simply fail to provide adequate care, he actively prevented P.T. from getting competent care by another specialist through his false

statements to the insurance company. In doing so, he showed disdain and neglect to her and her family before and after her death.

83. Respondent violated probation in numerous ways. He ignored the probationary requirement to have a practice partner, in order to protect the public from further patient harm. With a practice partner, respondent would have had the advantage of a second set of eyes and another neurologist's judgment. Respondent ignored the probation requirement that he cease practice until after he completed the PACE Program. As a result of his actions, respondent did not obey all laws.

84. The type of violations respondent committed are similar to the departures of care he committed in previous cases. In all three cases, he failed to listen to patients, take vital signs, perform adequate examinations and histories, effectively communicate, and accurately and adequately document patient interactions. Respondent spent very little time with them, and performed any type of care in a rushed, distracted manner. Sadly, in this most recent case, the patient died of cardiopulmonary arrest due to exacerbation of her MS. Despite being given multiple chances to improve his practice, respondent has demonstrated he is not amenable and open to change or improvement in his medical practice. Such obstinacy makes him a danger to the public.

85. The Board's Disciplinary Guidelines provide the recommended minimum and maximum penalties for Business and Professions Code violations. For violations of Business and Professions Code sections 2234 (general unprofessional conduct), 2234 subdivision (b) (gross negligence), 2234 subdivision (c) (repeated acts of negligence), 2266 (failure to maintain adequate and accurate records), 2261 (false medical records), 2234, subdivision (e), (dishonest and corrupt acts), the minimum penalty is stayed revocation and five to seven years of probation with conditions designed to protect

the public. The maximum penalty is revocation. The recommended penalty for violation of Business and Professions Code section 2306 (practice during suspension) is revocation.

86. Respondent has demonstrated a pattern of gross negligence and repeated acts of negligence in his treatment of patients. He has also demonstrated a repeated unwillingness to comply with the Board's probation terms and conditions, as well as the Board's ISO. Based on the totality of the evidence, the public protection is only ensured by the revocation of his certificate, and revocation of his probation.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea v. Bd. of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.)

Burden and Standard of Proof

2. Complainant bears the burden of proving each of the grounds for discipline alleged in the Accusation, and must do so by clear and convincing evidence. (*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. (*In re Marriage of Weaver* (1990) 224 Cal.App.3d 478, 487.) Comparatively, the standard of proof to revoke the probation of a professional license is preponderance of the evidence. (*Sandarg v. Dental Bd. of California* (2010) 184 Cal.App.4th 1434, 1435.)

Applicable Law

PRACTICING WITHOUT A CERTIFICATE

3. Business and Professions Code section 2052 states, in pertinent part:

> (a) Notwithstanding Section 146, any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter [Chapter 5, the Medical Practice Act], or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law, is guilty of a public offense, punishable by a fine no exceeding ten thousand dollars ($10,000), by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment.

VIOLATIONS OF MEDICAL PRACTICE ACT

4. Business and Professions Code section 2227 provides in pertinent part that a licensee that has been found "guilty" of violations of the Medical Practices Act, shall:

(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.

UNPROFESSIONAL CONDUCT

5. 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:

(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 constituted 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 . . .

6. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Bd. of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

GROSS NEGLIGENCE

7. 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 to 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.

FALSE DOCUMENTS

8. Business and Professions Code section 2261 states:

> Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

RECORD MAINTENANCE

9. Business and Professions Code section 2266 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.

SUSPENSION OF LICENSE AND PROHIBITION OF RIGHT TO PRACTICE

10. Business and Professions Code section 2306 states:

> If a licensee's right to practice medicine is suspended, he or she shall not engage in the practice of medicine during the term of such suspension. Upon the expiration of the term of suspension, the certificate shall be reinstated by [the Medical Board], unless the licensee during the term of suspension is found to have engaged in the practice of medicine in this state. In that event, the [Board] shall revoke the licensee's certificate to engage in the practice of medicine.

Causes for Discipline

11. Complainant established by clear and convincing evidence that respondent's treatment of P.T. constituted gross negligence, as set forth in Factual Findings 6 through 27, 53 through 67, 74 through 79, and 81 through 86. Therefore, cause was established to impose discipline on respondent's certificate pursuant to Business and Professions Code section 2234, subdivision (b).

12. Complainant established by clear and convincing evidence that respondent engaged in repeated acts of negligence, as set as set forth in Factual Findings 6 through 27, 53 through 67, 74 through 79, and 81 through 86. Therefore, cause was established to impose discipline on respondent's certificate pursuant to Business and Professions Code section 2234, subdivision (c).

13. Complainant established by clear and convincing evidence that respondent failed to maintain adequate and accurate records, as set as set forth in Factual Findings 6 through 27, 53 through 67, 74 through 79, and 81 through 86. Therefore, cause was established to impose discipline on respondent's certificate pursuant to Business and Professions Code section 2266.

14. Complainant established by clear and convincing evidence that respondent falsely represented facts in his medical records for P.T., as set as set forth in Factual Findings 8, 13, 17, 79, 84, and 86. Therefore, cause was established to impose discipline on respondent's certificate pursuant to Business and Professions Code section 2261.

15. Complainant established by clear and convincing evidence that respondent committed dishonest and corrupt acts substantially related to the qualifications, functions and duties of a physician and surgeon, as set as set forth in Factual Findings 6 through 27, 53 through 67, 74 through 79, and 81 through 86. Therefore, cause was established to impose discipline on respondent's certificate pursuant to Business and Professions Code section 2234, subdivision (e).

16. Complainant established by clear and convincing evidence that respondent engaged in the unlicensed practice of medicine, as set as set forth in Factual Findings 28 through 41, 49, 50, 80, and 81 through 86. Therefore, cause was established to impose discipline on respondent's certificate pursuant to Business and Professions Code sections 2052 and 2306.

17. Complainant established by clear and convincing evidence that respondent engaged in general unprofessional conduct, as set as set forth in Factual Findings 6 through 27, 53 through 67, 74 through 79, and 81 through 86. Therefore,

cause was established to impose discipline on respondent's certificate pursuant to Business and Professions Code section 2234.

Cause for Revocation of Probation

18. Complainant established by a preponderance of the evidence that respondent failed to comply with Probation Condition 17, as set forth in Factual Findings 28, 31 through 41, and 80 through 86, in that respondent practiced medicine in violation of his probation. Therefore, cause was established to revoke respondent's probation pursuant to Case No. 800-2017-030024.

19. Complainant established by a preponderance of the evidence that respondent failed to comply with Probation Condition 5, as set forth in Factual Findings 29, 31 through 41, and 80 through 86, in that respondent engaged in the solo practice of medicine in violation of his probation. Therefore, cause was established to revoke respondent's probation pursuant to Case No. 800-2017-030024.

20. Complainant established by a preponderance of the evidence that respondent failed to comply with Probation Condition 8, as set forth in Factual Findings 29, 31 through 41, and 80 through 86, in that respondent failed to obey all laws governing the practice of medicine by practicing without a valid, unsuspended certificate, in violation of his probation. Therefore, cause was established to revoke respondent's probation pursuant to Case No. 800-2017-030024.

Conclusion

21. The objective of an administrative proceeding relating to licensing is to protect the public. Such proceedings are not for the primary purpose of punishment. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) When all of the

evidence is considered, public safety demands revocation of respondent's certificate and probation.

ORDER

1. Physician's and Surgeon's Certificate No. A 29403, issued to respondent Richard Neill Sauer, M.D., is REVOKED.

2. The approval of respondent Richard Neill Sauer's authority to supervise physician assistants and advanced practice nurses is REVOKED.

3. Respondent's probation in the Matter of the First Amended Accusation Against Richard Neill Sauer, M.D., Case No. 800-2017-030024, is REVOKED.

DATE: December 16, 2020

Danette C. Brown
Danette C. Brown (Dec 16, 2020 16:27 PST)

DANETTE C. BROWN
Administrative Law Judge
Office of Administrative Hearings

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

In the Matter of the Second Amended Accusation and Petition to Revoke Probation Against: **Richard Neill Sauer, M.D.** **729 Sunrise Ave., #616** **Roseville, CA 95661** **Physician's and Surgeon's Certificate No. A 29403,** Respondent.	Case No. 800-2018-047592 OAH No. 2020020171 **SECOND AMENDED ACCUSATION AND PETITION TO REVOKE PROBATION**

PARTIES

1. Christine J. Lally (Complainant) brings this Second Amended Accusation and Petition to Revoke Probation solely in her official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 28, 1975, the Medical Board issued Physician's and Surgeon's Certificate Number A 29403 to Richard Neill Sauer, 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 October 31, 2020, unless renewed.

3. In a matter entitled "In the Matter of the First Amended Accusation Against Richard Neill Sauer, M.D.," Case Number 800-2014-002745, the Board issued a decision, effective May 18, 2018, which revoked Respondent's license. That revocation was stayed and Respondent was placed on probation for a period of 5 years on certain terms and conditions. A copy of that Decision is attached as Exhibit A and is incorporated herein by this reference.

4. In a matter entitled "In the Matter of the First Amended Accusation Against Richard Neill Sauer, M.D.," Case Number 800-2017-030024, the Board issued a decision, effective October 3, 2019, which revoked Respondent's license. That revocation was stayed and Respondent was placed on probation for a period of 5 years, to run concurrently to the probation in Case Number 800-2014-002745, on the same and additional terms and conditions. A copy of that Decision is attached as Exhibit B and is incorporated herein by this reference.

5. On or about October 18, 2019, the Office of Administrative Hearings issued an Ex Parte Order of Interim Suspension on Physician's and Surgeon's License No. A 29403, suspending Respondent Richard Neill Sauer, M.D. from practicing medicine until the matter could be heard on notice. On or about November 8, 2019, the matter came on for a regularly noticed hearing on the petition for interim suspension. On or about November 15, 2019, the Office of Administrative Hearings issued an order after the noticed hearing suspending Respondent from practicing medicine until this Accusation is filed and heard, and a decision is entered on it, in compliance with the time limits of Government Code section 11529, subdivision (f). The Board's Case number for the Petition seeking interim suspension is Case Number 800-2019-060521, and the Office of Administrative Hearings Case Number is 2019100659.[1]

JURISDICTION

6. This First Amended Accusation and Petition to Revoke Probation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

[1] At the time the Board filed the Petition for Interim Suspension, there was already an Accusation pending before the Board containing the First through Fifth Causes for Discipline. Following the issuance of the suspension order, the Board amended the Accusation to include the additional grounds for discipline relating to the unlicensed practice of medicine and probation violations, which formed the basis for the petition for suspension.

7. Section 118 of the Code states:

(a) The withdrawal of an application for a license after it has been filed with a board in the department shall not, unless the board has consented in writing to such withdrawal, deprive the board of its authority to institute or continue a proceeding against the applicant for the denial of the license upon any ground provided by law or to enter an order denying the license upon any such ground.

(b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.

(c) As used in this section, "board" includes an individual who is authorized by any provision of this code to issue, suspend, or revoke a license, and "license" includes "certificate," "registration," and "permit."

8. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

9. Section 2004 of the Code states:

The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

10. 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.

11. 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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12. Section 2261 of the Code states: Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

13. Section 2052 of the Code states:

> (a) Notwithstanding Section 146, any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter [Chapter 5, the Medical Practice Act], or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law, is guilty of a public offense, punishable by a fine not exceeding ten thousand dollars ($10,000), by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment.
>
> (b) Any person who conspires with or aids or abets another to commit any act described in subdivision (a) is guilty of a public offense, subject to the punishment described in that subdivision.
>
> (c) The remedy provided in this section shall not preclude any other remedy provided by law.

14. Section 2306 of the Code states:

> If a licensee's right to practice medicine is suspended, he or she shall not engage in the practice of medicine during the term of such suspension. Upon the expiration of the term of suspension, the certificate shall be reinstated by Medical Board, unless the licensee during the term of suspension is found to have engaged in the practice of medicine in this state. In that event, the division shall revoke the licensee's certificate to engage in the practice of medicine.

15. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Bd. of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

16. Respondent is subject to disciplinary action under section 2234, subdivision (b) in that he was grossly negligent in his care and treatment of a confidential patient, (C.P.). The circumstances are as follows:

17. Respondent is a Board-certified neurologist, practicing in Sacramento, California. C.P. was a 60-year-old woman who began experiencing pain and weakness in her extremities in October of 2017. MRI studies she had done in November of 2017, showed a lesion on her cervical spinal cord region and white matter signal changes of the brain. The cervical spine report stated that overall the finding was of sequela from prior transverse myelitis with a differential diagnosis of neuromyelitis optica (NMO).

18. C.P.'s primary care physician referred her to Respondent for neurological care. The referral to Respondent specifically stated that C.P. had been diagnosed with idiopathic transverse myelitis. The referral to Respondent contained the final reports of the MRI studies taken in November of 2017. During his interview with Board investigators, Respondent stated that C.P. had been referred to him with a primary complaint of tingling in her hands, with greater tingling in the right hand than the left. He stated at the first appointment with C.P., he did a "focused examination." He admitted that he did not review any hospital or primary care records of C.P. before the first appointment.

19. Respondent prepared a document, on his letterhead, memorializing an appointment with C.P. on February 14, 2018. Although this was C.P.'s first appointment with Respondent for a referral following diagnosis with transverse myelitis, he did not document any examination or neurological history. The note in its entirety is as follows:

> The patient comes in complaining of right greater than left hand tingling. This is in the median distribution. No weakness is reported.
>
> The patient reports that his [sic] blood pressure at his primary physician's [sic] have all been in the normal range and of no concern. Examination reveals no significant weakness and a question of sensory loss in the median distribution of both hands.
>
> At this point, the patient is on gabapentin for this and is doing reasonably well.
>
> It appears this patient has a compressive neuropathy in both wrists. To confirm this the patient will have a both upper extremities EMG and conduction velocity examination and further therapy will follow.

20. Respondent also prepared a letter to C.P.'s primary care provider, stating that she was evaluated for probable neuropathy versus radiculopathy, and asking the primary care provider to authorize an EMG and conduction velocity examination.

21. On or about February 23, 2018, C.P. presented to Sutter Roseville Emergency Room with bilateral lower extremity weakness and pain. She was admitted to Sutter Roseville Hospital, and was diagnosed with multiple sclerosis with a differential diagnosis of neuromyelitis optica (NMO). An MRI of her spine showed a new lesion. The radiologist noted that "this suggests an active demyelinating process/myelitis." C.P. was treated with high-dose steroids, and her condition resolved. The Sutter physicians observed that C.P. had "claw hand," a condition that can occur with multiple sclerosis where the fingers curl up. C.P. was discharged on or about March 1, 2018. The discharge paperwork from the hospital stay noted that "Pt does needs CLOSE neurologic follow-up as NMO and Multiple Sclerosis are treated differently." The discharge summary noted that the Sutter neurologist recommended C.P. should be followed by the UCSF neurology department and receive physical therapy.

22. C.P. presented for a scheduled appointment with Respondent on or about March 5, 2018. C.P.'s sister accompanied her to the appointment because C.P. was no longer able to drive due to the pain and weakness in her limbs. They brought the discharge paperwork from Sutter with them, showing that C.P. had been discharged from the hospital with a diagnosis of multiple sclerosis and/or NMO just days earlier. C.P.'s sister reported that after checking in, Respondent called C.P. back to the examination room. No one took C.P.'s vital signs either before or during the appointment. Respondent did not discuss the reason for the appointment or inquire about C.P.'s history. Respondent told C.P. to lay on the examination table and he performed an electromyography (EMG) test. Respondent did not document the temperature of C.P.'s extremities when performing the EMG, and the results showed values that were consistent with mild carpal tunnel syndrome in the right extremity. After the EMG, Respondent told C.P. that her symptoms were due to carpal tunnel syndrome. C.P. and her sister attempted to show Respondent the discharge summary from Sutter, and to explain that the MRI studies showed a new lesion, but Respondent refused to look at it. Instead, he instructed C.P. to bring him the MRI films from Sutter Medical Hospital so he could review them.

23. At the March 5, 2018 appointment, Respondent wrote C.P. a prescription for a splint, and told her to wear it as often as possible. Respondent quickly left the room without giving C.P.

or her sister a chance to ask any questions or provide any further information about her recent discharge and diagnosis. C.P. and her sister attempted to obtain the MRI films from Sutter Medical Hospital, but the Hospital would only provide them with a copy of a C.D. containing the images, not the actual films.

24. C.P. returned for a follow-up appointment on or about April 2, 2018. Respondent refused to look at the C.D. of the MRI C.P. and her sister brought, and insisted he was only able to look at the actual films.[2] Respondent documented that "the patient complains of no change in his [sic] symptoms or clinical status. Examination shows no abnormality at this time." Once again, no vital signs or physical examination was documented. C.P.'s sister reported that at this visit she and C.P. were directed to Respondent's office, instead of a medical examination room. Respondent asked how C.P. was doing, and C.P. explained that she continued to have difficulty walking, had weakness in her legs, and numbness in her arms and legs. C.P. and her sister also reminded Respondent that she had been diagnosed with multiple sclerosis and transverse myelitis, but Respondent did not appear to be paying attention to their statements. Respondent instructed C.P. to continue wearing the splint and to return for another appointment in June. Before C.P. or her sister could continue the conversation, Respondent stood up from his desk and left the office. C.P.'s sister estimated the entire time with Respondent was approximately five minutes.

25. On or about April 25, 2018, C.P. presented to the Sutter emergency room for another exacerbation of her symptoms of multiple sclerosis/NMO. She was again treated with steroids, and had improvement. Her gabapentin dose was increased. Sutter advised her to follow up with her outpatient neurologist and primary care physician.

26. On or about May 3, 2018, C.P. followed up with her primary care physician. He noted that C.P. required a walking stick to assist her to walk. The provider noted that C.P. had many imaging studies from previous emergency room visits suggesting multiple sclerosis, but that the neurologist she was referred to diagnosed her with carpal tunnel syndrome and did not

[2] At his interview with Board investigators, Respondent admitted C.P. brought him a C.D. of the MRI studies, but claimed he lacked the equipment to view C.D.s at his office.

want to pursue any other diagnoses. He noted that he would refer C.P. to the multiple sclerosis clinic at U.C. Davis.

27. Following C.P.'s April appointment with Respondent, she decided it was useless to continue seeing Respondent because he would not consider or act on her diagnosis of multiple sclerosis. Instead, she sought a referral to a different neurologist for treatment. In order to obtain a referral to a different neurologist, she had to file a grievance with her insurance program. C.P. filed a grievance on or about May 4, 2018, complaining that Respondent would not treat her for multiple sclerosis. The grievance analyst contacted Respondent, asking him to explain why he was not treating C.P. for multiple sclerosis. Respondent wrote a letter to the analyst, dated May 9, 2018, stating that he was treating C.P. for carpal tunnel syndrome, and had prescribed a splint for her to wear. He continued, "the patient has no signs, symptoms or laboratory studies suggestive of M.S., and her normal MRI scan was discussed with her." He further wrote, "the patient has a simple neurologic problem in her carpal tunnel syndrome and not much time was involved."

28. On or about May 15, 2018, C.P. returned to her primary care provider with worsening symptoms. At this point, C.P. was no longer able to walk, even with a cane, and was wheelchair bound. The physician documented that "she was suspected of having M.S. and she was initially referred to a neurologist who insisted that she has carpal tunnel synd. We have tried to refer her to a MS clinic at UCD-MC for further evaluation, however it was denied." The physician further noted "she needs urgent neurological referral" due to the rapid progression of her symptoms, and that "she requests to be referred to another neurologist different than the first one."

29. On or about May 25, 2018, C.P. received a letter from the grievance analyst informing her that she had researched the grievance and obtained a letter from Respondent about her care. The analyst determined that C.P. was receiving appropriate care from Respondent. The analyst reported that Respondent told the insurance provider that he had discussed her normal MRI with her, which C.P. and her sister knew was not true. The letter further stated that Respondent indicated that he would discuss the "films" of her thoracic MRI with her at her next

scheduled appointment in June. C.P. and her sister knew that they would not be able to bring the actual films to Respondent, and canceled the appointment.

30. On or about June 19, 2018, C.P. presented to her primary care physician with even further deterioration of her neurological symptoms. She had begun having a sharp headache in addition to worsening of her previous symptoms of weakness and balance disturbances. She was now having difficulty remaining sitting upright in the wheelchair. The physician noted that she has been referred to a different neurologist, but the referral was still pending.

31. On or about July 14, 2018 C.P. presented to the Sutter Emergency Room with extreme weakness. She could not move parts of her body, was having trouble breathing, and difficulty swallowing. Under "History of Present Illness," the emergency room physician documented that C.P. had initially presented to the emergency department in September of 2017 and had subsequent visits and admissions in 2018, during which the neurology department diagnosed her with atypical multiple sclerosis. The emergency room physician further noted that C.P. followed up from her hospital discharges with an outpatient neurologist who did not treat her for the multiple sclerosis. She was diagnosed with having an acute exacerbation of her untreated multiple sclerosis. The MRI studies showed further demyelinating disease. The neurologist concluded that her laboratory results and symptoms were consistent with NMO.

32. C.P. was given steroids, but this time the therapy did not work. When she did not respond to steroid treatment, the hospital team attempted to treat her with plasmapheresis (exchanging blood products to reduce the inflammatory antigens in her blood). This treatment also failed. By July 27, 2018, C.P. was not improving and was in extreme pain despite the ever increasing amounts of morphine. She and her family met with her treatment team and decided to change to hospice care. She died approximately two days later. Her official cause of death was cardiopulmonary arrest due to multiple sclerosis exacerbation.

33. C.P.'s sister filed a complaint with the Board about Respondent's lack of care to her sister. Board investigators requested C.P.'s records from Respondent on or about November 13, 2018. On or about November 27, 2018, Respondent telephoned the number he had on file for C.P. and asked to speak with her. C.P.'s sister spoke to Respondent and told him that C.P. had

passed away. Respondent then inquired about the complaint to the Medical Board and C.P.'s sister confirmed that she had filed the complaint. Respondent asked C.P.'s sister to withdraw her complaint to the Board. C.P.'s sister refused to do so and immediately wrote a letter to the Board documenting the telephone call. She wrote that Respondent called her and argued with her on the telephone for approximately 18 minutes asking her to cancel her complaint to the Board. She wrote that she was very distressed by having to discuss her sister's care with Respondent.

34. During his interview with Board investigators on or about May 3, 2019, Respondent was asked whether C.P. ever attempted to inform him of her multiple sclerosis diagnosis. Respondent stated:

> I remember vaguely that the caregiver -- um -- had brought up the idea of the MS, but -- and I reviewed the record and saw no evidence that someone had diagnosed the patient with that.

35. Also during the May 3, 2019 interview, Respondent acknowledged that he called and spoke with C.P.'s sister shortly after receiving the request for C.P.'s medical records from the Board. He claimed that the purpose of his call was to inquire how C.P. was doing, since she had canceled her last appointment with him in June. When asked whether he requested C.P.'s sister to withdraw her complaint to the Board, he responded:

> I -- I may have talked to one of the family members that if they complain about anything, it's a huge hassle, and -- uh -- yeah, if she remembers that, that is probably what I called about.

36. Respondent was grossly negligent in his care and treatment of C.P., for his acts and omissions, including but not limited to, the following:

(a) proceeding as if he was only treating C.P.'s hand numbness despite the MRI study showing C.P. had had a large demyelinating lesion and despite information provided to him by C.P. and her sister;

(b) failing to conduct a thorough neurological history and examination of C.P.;

(c) failing to diagnose and treat NMO in C.P.; and

(d) failing to maintain accurate and complete records for C.P.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

37. Respondent is subject to disciplinary action under section 2234, subdivision (c) in that he was repeatedly negligent in his care and treatment of C.P. The circumstances are set forth in paragraphs 16 through 36, above, which are incorporated here by reference as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

38. Respondent is subject to disciplinary action under section 2266 by failing to maintain adequate and accurate records relating to the provision of medical care to C.P. The circumstances are set forth in paragraphs 16 through 36, above, which are incorporated here by reference as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(False Medical Record)

39. Respondent is subject to disciplinary action under section 2261 in that he falsely represented facts in C.P.'s medical records. The circumstances are set forth in paragraphs 16 through 36, above, which are incorporated here by reference as if fully set forth herein. Additional circumstances are as follows:

40. Respondent is subject to disciplinary action in that he falsely documented that C.P. complained of no changes in her clinical status at the April 2, 2018 appointment and that he performed an examination on her that showed no abnormalities.

FIFTH CAUSE FOR DISCIPLINE

(Dishonest/Corrupt Act)

41. Respondent is subject to disciplinary action under section 2234, subdivision (e), in that he committed dishonest and corrupt acts substantially related to the qualifications, functions, or duties of a physician and surgeon. The circumstances are set forth in paragraphs 16 through 36, above, which are incorporated here by reference as if fully set forth herein.

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SIXTH CAUSE FOR DISCIPLINE

(Unlicensed Practice of Medicine)

42. Respondent is subject to disciplinary action under section 2052 and 2306 in that he practiced medicine without a valid license to do so. The circumstances are as follows:

43. On or about March 5, 2018, the Board filed an Accusation against Respondent's medical license, in Board Case No. 800-2017-030024, and OAH Case No. 2018040456. The issues giving rise to that Accusation came to the Board's attention when the disabled patient's nurse-caregiver filed a complaint reporting that Respondent was dismissive and indifferent to the patient during her appointments with him during 2016 and 2017. A hearing on the Accusation took place in January of 2019. Following hearing, the Board concluded that Respondent had violated the standard of care in each of the five areas charged in the Accusation and issued a Decision, which became effective on October 3, 2019.

44. The October 3, 2019 Decision imposed a condition on Respondent's license that he must take and pass a clinical training program as a condition precedent to practicing medicine. The Decision explicitly states that, "Respondent shall not practice medicine until respondent has successfully completed the program and has been so notified by the Board or its designee in writing."

45. On or about September 25, 2019, Respondent filed a writ of mandamus in San Francisco Superior Court challenging the Board's Decision. On or about September 30, 2019, Respondent filed an ex-parte application for a stay of the Board's Decision pending resolution of the writ. The San Francisco Superior Court denied the request for a stay following briefing and a hearing on October 2, 2019, finding that the stay was not in the public interest due to the potential risk to public safety.

46. In preparation for ensuring Respondent's compliance with the Board's order, the Board's probation staff contacted Respondent before October 3, 2019 to set up a probationary intake interview. Respondent initially declined to come in for his interview, telling probation staff that he anticipated obtaining a stay of the Decision, which would make the interview unnecessary. A supervisory employee from the Board's probation department called Respondent

and explained to him that unless he provided her with court documents showing that the Decision had been stayed, he was required to comply with the terms of his probation. The probation supervisor further explained that the terms required that he stop practicing as of October 3, 2019 at 5:00 p.m. and that he come in for an intake interview in advance of the effective date of the Decision. Respondent agreed to come in for an interview on October 3, 2019 at 3:30 p.m.

47. Respondent appeared for his intake interview with the probation department staff on October 3, 2019 at approximately 3:30 p.m. During this interview, probation staff went over the Decision and discussed each and every term and condition of the probation with Respondent. Respondent frequently attempted to change the topic and speak of tangential issues, but the probation department supervisor redirected him back to the topic at hand. The probation department staff reinforced with Respondent that he must stop practicing medicine, and must not resume practicing medicine until he has successfully completed a clinical assessment program and been informed by the Board that he may resume practicing medicine. Respondent responded that he had already shut his medical practice and closed his office.

48. On or about Thursday, October 10, 2018, at approximately 11:50 a.m., the Board's probation department staff went to Respondent's practice location at 729 North Sunrise Boulevard, Suite 616, in Roseville, California. Before they entered the medical office, a probation inspector was able to see through the window into the waiting room of the practice. Through the window, the inspector observed Respondent enter the waiting room from a door leading back to the rest of the practice area. Respondent was wearing a white laboratory coat. He called back two individuals who were waiting in the waiting room and brought them back with him into the back portion of the practice area.

49. The two probation employees entered into the waiting room and approached the front desk. They spoke with a woman at the front desk, who identified herself as Ms. L.A. They asked Ms. L.A. if Respondent was in. She said that he was, and they asked to speak with him. The probation inspector also asked Ms. L.A. if she would provide them with sign-in sheets tracking the patients that came into and out of the office for the last several days. Ms. L.A. responded that she was unable to do so because the office throws away the sign-in sheets at the end of each day.

The probation supervisor and the probation inspector waited approximately ten minutes or so, and another woman, Ms. K.K., came and escorted them from the waiting room and brought them back to speak with Respondent. Before Ms. K.K. brought the two back to speak with Respondent, while they were waiting, the probation inspector was able to observe Respondent removing his white laboratory coat.

50. Ms. K.K. brought the probation supervisor and the probation inspector to Respondent's office. The probation supervisor and the probation inspector asked Respondent why he was at the office when he knew he was not permitted to practice medicine and he had told them both last week at the probation office that he had already closed his practice. Respondent stated that he was only present at the office acting as a "technician." He said that he was using neurological machines, and that running these machines did not require even a college degree, so there was no problem with him running these machines as a technician.

51. The probation supervisor confronted Respondent with the fact that she and the probation inspector had observed patients in his office and had seen him with the patients. Respondent responded that the patients were there to be seen by his practice partner, Dr. C. The probation supervisor and the probation inspector asked Respondent where Dr. C. was at this moment. Respondent said that Dr. C. was at lunch. They asked when Dr. C. would return. Respondent stated that he did not know. The probation supervisor then commented that she had seen Respondent walking with the patients, and Respondent stated that he was only doing "emergency refills" of medication for patients. Respondent stated that he had to refill patient prescriptions because he could not just stop seeing patients suddenly and leave them without care. He stated that he was required to complete neurological consultations or patients would be harmed. The probation supervisor pointed out to him that writing prescriptions and doing consultations constituted the practice of medicine. In response to this Respondent stated that "he was saving lives." The probation supervisor and the probation inspector asked Respondent if he could provide the sign-in sheets for the patients at his office between October 4, 2019 and the present. Respondent stated that he would fax the sign-in sheets to the probation office during the lunch hour.

52. As the probation supervisor and the probation inspector were leaving the office the inspector observed Ms. K.K. and asked her if she would come speak with them in the hallway. Ms. K.K. came out into the hallway. The inspector asked her if Dr. C. had been in the office at all that day. Ms. K.K. said that he had not. She stated that she had not seen Dr. C. at the office for some time.

53. The inspector remained at Respondent's practice location on or about October 10, 2019, until an investigator from the Division of Investigation, Health Quality Enforcement Unit joined him in the parking lot at approximately 1:35 p.m. The investigator and the inspector returned to the office. At this time there were still people in the waiting room. They were different people than the inspector had seen the first time he was in the waiting room. The investigator and the inspector met with Respondent again. At this meeting the inspector asked Respondent approximately how many prescriptions he had filled since October 4, 2019. Respondent stated that he had filled approximately three or four per day. The inspector asked Respondent what medications he had prescribed during this time. Respondent stated that he had prescribed Mavenclad and Aubagio. Respondent further stated he had completed a couple of consultations each day since October 4, 2019. He specified that he was acting as a neurologist in those consultations, not as a doctor.

54. Before the second interview with Respondent, the inspector had called back to the probation office to inquire whether the office had received any faxed sign-in sheets from Respondent. The inspector was informed that no sign-in sheets had been received. During this second interview with Respondent, the inspector told Respondent that he had not received the sign-in sheets and asked Respondent if he would provide them. Respondent stated that he was too busy to provide the sign-in sheets because he was gathering information he needed to provide the U.C. San Diego PACE program to complete his clinical assessment program requirement.

55. On October 17, 2019, the Board filed an Ex Parte Petition for an Interim Order of Suspension against Respondent's license based on his presence at his office on October 10, 2019, and his statements that he was still seeing patients and refilling medications. The Petition was heard at the Office of Administrative Hearings (OAH), in Sacramento, California, OAH Case

Number 2019100659. In opposition to the Petition, Respondent executed a Declaration, under penalty of perjury, dated October 18, 2019, stating that he was unable to shutter his office because his practice partner, Dr. C. sees patients at that location. He further attested that he was at his office to see patients to refer them to other providers, to perform "technician functions that do not require medical licensure," such as performing EEGs, and to write out prescription refills for Dr. C. to sign.

56. On October 18, 2019, the OAH issued an ex parte order suspending Respondent's medical license pending a Noticed Hearing on the petition. The Order prohibited Respondent from practicing any aspect of medicine in the state of California, or holding himself out as practicing or being available to practice medicine. It further prohibited Respondent from being present in any location or office which is maintained for the practice of medicine, or where medicine is practiced, except as a patient or visitor of family or friends. A true and correct copy of the ex parte order, issued on October 18, 2019, is attached to this Second Amended Accusation and Petition to Revoke Probation as Exhibit C. The Noticed Hearing on the Petition was scheduled for November 8, 2019.

57. In preparation for the Noticed Hearing on the Petition, Respondent filed a second Declaration, executed under penalty of perjury, dated November 5, 2019, stating that when the Investigators and Probation staff observed him at his office on October 10, 2019, he was only preparing paperwork for Dr. C. and that the investigators mistook his presence there to mean he was actually practicing medicine. He attested that although he had been present at his office since October 3, 2019, he had not seen or treated any patients, or written any prescriptions. Respondent again attested that he was unable to shutter his practice because Dr. C. also sees his own patients at the practice. Respondent argued that the ex-parte order should be modified to at least permit him to be present at his office for business purposes.

58. On or about November 15, 2019, the OAH issued an order granting the Interim Order of Suspension pending a full hearing on the Accusation, and requiring Respondent to not be present at his medical office. The Administrative Law Judge (ALJ), ruled that Respondent's assertion that he was present at his office, but not practicing medicine, was not credible. She

noted that his excuses for why he was present at the office, (that he needed to be present to transfer his patients to Dr. C. and that he was gathering up his papers), were invalid as he had been placed on notice of the impending closure a month earlier during which time he could have completed these functions. She further pointed out the complete absence of any corroborating declarations from Dr. C. that he was present at the office with Respondent, or taking over patients and prescriptions. Finally, the ALJ concluded that Respondent could not be trusted to be in a medical office and not treat patients, as he has shown that he does not respect the Board's authority, and offered no assurances that he will comply with the Board's suspension order.

59. Unknown to Complainant at the time of the hearings on the Petition for Interim Order of Suspension, Respondent had been continuing to go to his medical offices at 729 Sunrise Avenue throughout the proceedings on the ex parte and noticed hearings on the suspension. Respondent was present at his office on or about October 21, 2019, only three days after the ALJ issued the ex parte order prohibiting him from being present at any medical practice unless as a patient or personal visitor of patients. Respondent was present at his medical offices on or about February 11, 2020. Respondent has been going into his office approximately once per week, through at least February of 2020.

60. Between October 4, 2019 and February of 2020, Respondent was in frequent contact with his office staff by telephone to provide directions on patient care and provide instructions for Dr. C. to provide care to his patients between October 4, 2019 and the present. Respondent has been allowing his staff to authorize refills of controlled prescriptions under his name and D.E.A. number. Patient 2 was a female patient to whom Respondent has been prescribing clonazepam on an ongoing basis before October 4, 2019. On or about October 16, 2019, Bel Air Pharmacy in Antelope, California received a telephone request from Respondent's office to authorize a refill of clonazepam for Patient 2. The prescription shows that Bel Air Pharmacy filled the prescription, under Respondent's D.E.A. number with a notation that the telephone authorization was relayed by L.A. at Respondent's office. The medication was dispensed on October 16, 2019. Patient 3 was another female patient to whom Respondent has been prescribing phenobarbital on an ongoing basis before October 4, 2019. On or about October 21, 2019, Anderson Bros. Pharmacy

in Sacramento, received a telephone prescription for phenobarbital for Patient 3 under Respondent's D.E.A. number. The prescription notes that the prescription was authorized by Respondent, "per [L.A.]." The medication was dispensed on October 22, 2019.

61. During February of 2020, a Board Investigator interviewed Ms. K.K., Ms. L.A., and Dr. C. at Respondent's medical offices. During various occasions during these interviews, Ms. K.K. and L.A. acknowledged that it has been the custom and practice in Respondent's office for a long time that each of them would call and authorize refills of medications for patients in Respondent's name, and that Respondent was aware of this process. At some point after his suspension, Respondent directed Ms. K.K. and L.A. to obtain authorizations for refills by Dr. C., but Dr. C. will only prescribe to patients he sees himself, and will not authorize prescriptions or refills over the telephone as Respondent did. Ms. K.K. initially denied that Respondent has been present at the office recently, but later admitted that he does come to the office about one time per week to check his mail.

62. On or about February 25, 2020, a Board Investigator interviewed Dr. C. at Respondent's Office. Dr. C. stated that when Respondent was suspended from the practice of medicine, he approached Dr. C. and asked him to assist by seeing a limited number of Respondent's patients for the purpose of continuing their medications. Dr. C. goes to Respondent's practice once per week on Tuesdays for about a half an hour and sees approximately two to four patients. He confirmed that he observed Respondent present at the office approximately two weeks earlier. Dr. C. is not a neurologist, and has his own, separate practice at a different location where he sees his own patients.

SEVENTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

63. Respondent is subject to disciplinary action under section 2234 in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. The circumstances are set forth in paragraphs 16 through 62, above, which are incorporated here by reference as if fully set forth herein.

FIRST CAUSE TO REVOKE PROBATION

(Failure to Comply: Condition 17, Clinical Competence Assessment Program Condition Precedent)

64. At all times after the effective date of Respondent's probation in *In the Matter of the Amended Accusation Against Richard Neill Sauer, M.D.*, Case No. 800-2017-030024, Probation Condition 17 stated, in pertinent part:

"Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment...Respondent shall not practice medicine until Respondent has successfully completed the program and has been so notified by the Board or its designee in writing."

65. Respondent's probation is subject to revocation because Respondent failed to comply with Probation Condition 17, in that he practiced medicine in violation of this condition before successfully completing the program. Paragraphs 42 through 62, above, are incorporated by reference as if fully set forth herein. Respondent is, therefore, in violation of the probation imposed on his medical license, and is subject to revocation of the probation.

SECOND CAUSE TO REVOKE PROBATION

(Failure to Comply: No Solo Practice)

66. At all times after the effective date of Respondent's probation in *In the Matter of the Amended Accusation Against Richard Neill Sauer, M.D.*, Case No. 800-2017-030024, Probation Condition 5 stated, in pertinent part:

"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."

67. Respondent's probation is subject to revocation because Respondent failed to comply with Probation Condition 5 in that he engaged in the solo practice of medicine. Dr. C was rarely

present before the suspension, and did not share Respondent's practice specialty or coordinate care for mutual patients. After the suspension, he was only present one day per week to treat Respondent's patients by refilling prescriptions Respondent began. Dr. C. has his own, separate internal medicine practice at a different location. Paragraphs 42 through 62, above, are incorporated by reference as if fully set forth herein. Respondent is, therefore, in violation of the probation imposed on his medical license, and is subject to revocation of the probation.

THIRD CAUSE TO REVOKE PROBATION

(Failure to Comply: Obey all Laws/Unlicensed Practice of Medicine)

68. At all times after the effective date of Respondent's probation in *In the Matter of the Amended Accusation Against Richard Neill Sauer, M.D.*, Case No. 800-2017-030024, Probation Condition 8 stated, in pertinent part:

"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, payment, and other orders."

69. Respondent's probation is subject to revocation because Respondent failed to comply with Probation Condition 8, in that he practiced medicine without a valid, unsuspended license to do so, in violation of sections 2052 and 2306. Paragraphs 42 through 62, above, are incorporated by reference as if fully set forth herein. Respondent is, therefore, in violation of the probation imposed on his medical license, and is subject to revocation of the probation.

DISCIPLINARY CONSIDERATIONS

70. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about September 3, 2019, in a prior disciplinary action entitled, "In the Matter of the Accusation Against Richard Neill Sauer, M.D." before the Medical Board of California, in Case No. 800-2017-030024, Respondent's license was revoked. However, the revocation was stayed and Respondent's Physician's and Surgeon's Certificate was placed on probation for a period of five years with certain terms and conditions. That decision is now final and is attached as Exhibit B. It is incorporated by reference as if fully set forth herein.

71. Complainant further alleges that on or about May 25, 2018, in a prior disciplinary action entitled "*In the Matter of the First Amended Accusation Against Richard Neill Sauer, M.D.*" before the Medical Board of California, in Case No. 800-2014-002745, Respondent's license was revoked. However, the revocation was stayed and Respondent's Physician's and Surgeon's Certificate was placed on probation for a period of five years with certain terms and conditions. That decision is now final and is attached as Exhibit A. It is incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 29403, issued to Richard Neill Sauer, M.D.;

2. Revoking, suspending or denying approval of Richard Neill Sauer, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Richard Neill Sauer, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: JUN 10 2020

Christine J. Lally
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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EXHIBIT A

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

In the Matter of the Accusation Against:	)	
Richard Neill Sauer, M.D.	)	Case No. 800-2014-002745
Physician's and Surgeon's Certificate No. A 29403	)	
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on May 18, 2018.

IT IS SO ORDERED: April 18, 2018.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Accusation Against: RICHARD NEILL SAUER, M.D. Physician and Surgeon's Certificate No. A 29403 Respondent.	Case No. 800-2014-002745 OAH No. 2017040877

PROPOSED DECISION

This matter was heard before Administrative Law Judge Marcie Larson, Office of Administrative Hearings, State of California, on October 23, 25, 26 and 31, 2017, in Sacramento, California.

Megan O'Carroll, Deputy Attorney General, represented complainant Kim Kirchmeyer, Executive Director of the Medical Board of California (Board).

Albert Garcia, Attorney at Law, represented respondent Richard Neill Sauer, M.D., who was present at the hearing.

Evidence was received, the record was held open for submission of written closing briefs. On February 14, 2018, the parties filed closing briefs. On March 7, 2018, the parties filed reply briefs.[1] The record closed and the matter was submitted for decision March 7, 2018.

FACTUAL FINDINGS

1. On July 28, 1975, the Board issued respondent Physician and Surgeon's Certificate No. A 29403 (certificate). The certificate was current at all times relevant to this matter. It will expire on October 31, 2018, unless renewed or revoked.

[1] Complainant's closing brief was marked as Exhibit 30 and respondent's closing brief was marked as Exhibit G. Complainant's reply brief was marked as Exhibit 31 and respondent's reply brief was marked as Exhibit H.

2. On March 15, 2017, complainant, acting in her official capacity, signed and thereafter filed the Accusation against respondent.[2] Complainant seeks to impose discipline on respondent's certificate, based on his alleged unprofessional conduct in connection with his treatment of patients M.Z. and C.P.,[3] who sought treatment from respondent for migraine headaches. During the course of treatment, respondent utilized Botox to treat both patients. Generally, complainant alleged that respondent failed to properly dose and administer Botox injections, failed to adequately and accurately maintain medical records documenting the administration of Botox, and failed to conduct thorough examinations of the patients, including failing to take vital signs. Complainant alleged that respondent's unprofessional conduct constituted gross negligence and repeated acts of negligence. Complainant also alleged that respondent failed to keep adequate and accurate medical records for the treatment he rendered to the patients.

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. In 1974, respondent completed his medical degree at the University of Iowa, College of Medicine. Thereafter he completed an internship at United Hospitals in St. Paul Minnesota. In 1975, he was licensed by the Board. In 1978, respondent completed a three year residency in neurology at the University of California, Davis (UC Davis). In 1981, he obtained his board certification by the American Academy of Neurology and Psychiatry.

5. Since approximately 1978, respondent has been operating a sole practice in general neurology in Roseville, California. He also treats patients in Truckee, California approximately one time per month, and maintains a part-time office in Auburn, California. Respondent employees an office manager and two part-time testing technicians. His practice does not include any additional medical staff.

6. In approximately 2000, respondent began using Botox to treat patients with neurological conditions. Botox is a purified neurotoxin that is derived from bacteria that is used to treat various medical conditions. Botox prevents injected muscles from contracting. Botox helps to treat neurological conditions including migraine and cervical dystonia, a condition that can be caused by muscle spasms near the neck. Respondent treats approximately one-third of his patients with Botox.

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[2] At hearing, complainant amended the Accusation to remove the allegations on page 7 lines 26 and 27, and page 8, lines 10 and 11.

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

Investigation Conducted by Investigator Adam Brearley

7. On or about January 31, 2014, the Board received an online written complaint from K.S., a patient treated by respondent.[4] The complaint related to respondent's administration of Botox for treatment of her migraine headaches.

8. On September 3, 2014, Adam Brearley, an Investigator for the Department of Consumer Affairs, was assigned to investigate the complaint. Mr. Brearley issued an Investigation Report regarding his investigation of respondent. Mr. Brearley testified at hearing. During the course of Mr. Brearley's investigation, he learned M.Z. and C.P. had concerns about the Botox injections they received from respondent for treatment of migraine headaches. Mr. Brearly interviewed M.Z. and C.P. He interviewed respondent and obtained his patient records for M.Z. and C.P. Mr. Brearley also obtained records from the patients' pharmacies and insurance providers.

9. On September 19, 2016, Mr. Brearley sent a letter, draft report, a transcript of respondent's interview and the patients' medical records to Board expert reviewer Jeremy Hogan, M.D., who is board-certified in Neurology. On November 9, 2016, Dr. Hogan issued a report in which he opined that respondent's treatment of patients M.Z. and C.P. departed from the standard of care.

Respondent's Treatment of Patient M.Z.

10. M.Z. is 31 years old. Since 2011, M.Z. has worked as a Medical Assistant at Tahoe Forest Hospital in Truckee. M.Z. has suffered from migraine headaches for approximately ten years. Initially, she was prescribed Amitriptyline for her headaches. In 2011, her neurologist retired, and M.Z.'s primary care physician prescribed her medication to treat her migraines for a period of time. In 2012, M.Z. learned from a co-worker that respondent travelled to Truckee to see patients and that he treated patients with migraine headaches. M.Z. scheduled an appointment with respondent.

11. On January 11, 2013, M.Z. had her initial consultation with respondent. M.Z. informed respondent of her history of migraine headaches and that she was seeking treatment. M.Z. explained that she tracked her migraines on a calendar. M.Z. did not provide respondent copies of her medical records concerning her past treatment and respondent did not provide her a medical release to obtain her medical records.

During the initial visit, respondent did not take M.Z.'s vital signs, listen to her heart, or take or ask her about her blood pressure. Respondent felt M.Z.'s neck and found spasm on the left and right side. He explained to M.Z. that her neck was tense. Respondent did not

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[4] Dr. Hogan's report references allegations by K.S. The allegations were not included as a cause for discipline in the Accusation and were not considered or referenced in this decision.

observe that M.Z. had any issues moving or turning her head or neck. M.Z. had no history of neck issues, other than normal tenderness and soreness from working at a computer.

Respondent informed M.Z. that he used Botox to treat migraine headaches. M.Z. had never been treated with Botox for her headaches. Respondent explained that he would write a letter to her insurance company to obtain approval for the Botox. Respondent told M.Z. that there were no side effects from the Botox and there was "nothing to worry about." He did not obtain written consent from M.Z. to treat her with Botox. He did not inform M.Z. of the potential risks or side effects of Botox. Nor did he discuss any alternative treatment for her migraines. Respondent prescribed M.Z. medication for her headaches to take while she waited for approval for the Botox. Respondent also ordered an Electroencephalogram (EEG) to rule-out any brain or artery abnormalities.

Respondent prepared an illegible handwritten entry for his initial consultation of M.Z. At hearing, respondent interpreted the entry to state that he conducted a neurological examination, evaluated her cranial nerves and tested her reflexes. His practice when treating patients for Botox therapy was to conduct a neurological evaluation by "observation." He documented her blood pressure as "110/60."

12. Respondent wrote a letter to M.Z.'s insurance company dated January 15, 2013, concerning his evaluation of M.Z., to obtain approval for the use of Botox. He wrote that M.Z. had "chronic cervical dystonia" and that the examination showed "moderate cervical paraspinal muscle spasm and some anterocollis," which is an anterior flexion of the neck seen in patients with cervical dystonia. Respondent also wrote that M.Z. had "failed on physical therapy measures, anti-inflammatory medications, anti-convulsive medications and multiple other medication programs." Respondent requested approval for a total of 300 units of Botox for treatment of the "cervical dystonia."

At hearing, respondent admitted the information in the letter was not correct. M.Z. did not report a history of chronic cervical dystonia. Nor had she participated in physical therapy measures, or taken anti-inflammatory medications, anti-convulsive medications and other medications for the treatment of chronic cervical dystonia. She also did not have anterior flexion of the neck.

13. Respondent wrote a second letter to M.Z.'s insurance company dated January 24, 2013, concerning his evaluation of M.Z., to obtain approval for the use of Botox. Respondent wrote that M.Z. had a "chronic history of pain in the neck and shoulder regions, head-turning, spasm found on physical examination and disability related to the symptoms." Respondent again wrote that respondent had "failed on physical therapy" and failed on "anti-spasticity medications, including Baclofen and Zanaflex; and failed on injection with anti-inflammatory medications." Respondent also wrote that M.Z. had "visited Emergency Rooms, on a number of occasions, for symptoms related to the cervical dystonia." Respondent stated that "200 to 300 units" of Botox were needed to treat M.Z.'s cervical dystonia condition. Respondent recommended and used higher doses of Botox to treat cervical muscle problems and bilateral headaches.

At hearing, respondent admitted the information in the letter was not correct. Respondent testified that the letter was a "form letter" sent by his office. Respondent admitted that M.Z. had not reported that she had participated in physical therapy, or taken medication for the treatment of cervical dystonia. M.Z. had never visited the emergency room due to a migraine headache or cervical dystonia. She also did not have a chronic history of pain in the neck and shoulder regions or head-turning. Respondent admitted that he told M.Z.'s insurance company that she had taken medication for treatment of cervical dystonia, to obtain authorization for Botox therapy.

14. Based upon the letter sent by respondent to M.Z.'s insurance company, she was approved for 300 units of Botox. On February 8, 2013, M.Z. had her second appointment with respondent. Respondent did not take M.Z.'s vital signs or blood pressure. M.Z. observed one Botox vial sitting on the sink counter when she entered the examination room. Respondent withdrew the contents of the liquid in the vial into a one milliliter (ml) syringe. Respondent injected M.Z. six times, which included two injections, left and right, into the corrugator muscles in between the eyebrows, two injections, left and right, into the temporal muscles near the temples, and two injections, left and right, into the top of her neck.

Respondent did not inform M.Z. how much Botox he injected. The visit lasted approximately five minutes. Respondent did not document a description of locations and amount of Botox administered in M.Z.'s patient record. Instead, he drew a rough picture of what appeared to be eyes, and placed two dots between the eyes, which represented injections into the corrugator muscles. He noted on a billing form that he injected a total of 220 units of Botox and wasted 80 units.

15. Respondent completed an undated pre-printed document titled "Botox Therapy" which lists three columns titled: "Muscle, Right Units, [and] Left Units." The document represented M.Z.'s treatment plan. Respondent handwrote that the plan was to inject 55 units of Botox into the right and left trapezius muscles which extend along the neck and shoulders, for a total of 110 units; 50 units of Botox into the right and left splenius capitis which are the lateral muscles that run on the back of the neck into the hairline, for a total of 100 units; and 10 units of Botox on the right and left semispinalis capitis, which is also a muscle on the upper and back part of the neck, for a total of 20 units. Respondent testified that he also injected 5 units of Botox into the corrugator muscles, left and right, which are the muscles in between the eyebrows, for a total of 10 units. The corrugator and temporal muscles are not listed on the Botox Therapy form. Respondent intended to follow the plan listed on the Botox Therapy form for each Botox therapy visit, unless he noted a change to the plan.

16. Respondent wrote a letter dated February 12, 2013, to M.Z.'s insurance company. He explained that M.Z. was evaluated on February 8, 2013, for "her cervical dystonia." He requested approval for 300 units of Botox to be administered in three months to treat M.Z.'s condition.

17. On or about February 27, 2013, M.Z. travelled to respondent's office in Roseville to have an EEG performed. The results were normal.

18. On March 15, 2013, M.Z. saw respondent for a follow-up appointment. No Botox was administered during the visit. Respondent wrote a letter dated March 19, 2013, to M.Z.'s insurance company. He explained that M.Z. was evaluated on March 15, 2013 and that she had a "greater than 80% resolution of the cervical dystonia with the Botox." He requested authorization for 300 units of Botox to be administered in five weeks.

19. On April 26, 2013, M.Z. saw respondent for a second course of Botox injections. M.Z. reported that the Botox did not help her migraines. Respondent told M.Z. that continued Botox therapy would give her better results. Respondent injected Botox into the same locations as her first visit. The visit lasted approximately five minutes. Respondent did not document in M.Z.'s patient record a description of the locations or amount of Botox injected. He drew a picture of eyes, with two dots between the eyes and one dot on each side of the eyes, which represented two injections into the left and right corrugator muscles, and two injections, left and right, into the temporal muscles. There is no indication on the drawing where the two additional injections were administered. There is no record of the amount of Botox injected to each site. Respondent noted on a billing form that he injected a total of 220 units of Botox and wasted 80 units.

20. Respondent wrote a letter dated June 11, 2013, to M.Z.'s insurance company. He explained that M.Z. had a "resolution of symptoms and examination shows no significant spasm." Respondent requested 300 units of Botox to be administered in five weeks.

21. In June 2013, M.Z. learned that she was pregnant and decided to stop Botox therapy for her migraines. In December 2014, M.Z. began seeing a new neurologist. He obtained M.Z.'s medical record from respondent. M.Z. learned for the first time from her new neurologist that respondent had diagnosed her with cervical dystonia. M.Z.'s current neurologist has not diagnosed her with cervical dystonia. M.Z. currently receives Botox injections for her migraines from her new neurologist. Her new neurologist injects Botox into approximately 30 locations.

Respondent's Treatment of Patient C.P.

22. C.P. is 51 years old. She has suffered from chronic migraines since she was a child. Her migraine pain is typically behind her left eye. In approximately 2011, she began receiving Botox injections to treat her migraines at Kaiser. Each visit, she received approximately 30 injections of Botox in her head, neck and shoulders.

23. C.P. lives in Truckee and works at Tahoe Forest Hospital. In 2012, when she changed insurance to Aetna, she was referred to respondent for treatment of her migraines by Robert Chase, M.D., her primary care physician. C.P.'s first appointment with respondent was on May 18, 2012. C.P. explained her history of migraines to respondent, and that she had been treated with Botox. Respondent palpated C.P.'s neck and conducted a "brief"

neurological examination of C.P. by observing her facial expressions, motor functions, and functional movement of her head and neck. He did not take her vital signs. C.P. did not provide respondent copies of her medical records concerning her past treatment and respondent did not provide her a medical release to obtain her medical records.

Respondent diagnosed C.P. with "classic chronic migraines." Respondent recommended C.P. continue with Botox therapy for her migraines. No Botox was administered during the first visit, because respondent was required to obtain authorization from C.P.'s insurance company for the treatment. Respondent did not obtain written consent from C.P. to treat her with Botox. He did not inform C.P. of the potential risks or side effects of Botox. Nor did he discuss any alternative treatment for her migraines.

Respondent prepared written treatment notes for the visit which are mostly illegible. He did not document any history of past medications C.P. had used to treat her migraine headaches. He noted that C.P.'s blood pressure was "120/70."

24. Respondent prepared a letter dated May 21, 2012, to Dr. Chase concerning his evaluation of C.P. He wrote that C.P. had used Botox therapy in the past for treatment of her migraines with success. He explained that her physical examination was normal, her blood pressure was "120/70," her cardiovascular examination revealed "a regular rhythm," her "cranial nerves 11-XII intact," and her "motor exam shows symmetrical strength and bulk." Respondent recommended that C.P. continue with Botox therapy for her migraines.

25. On May 24, 2012, respondent's office staff completed an Aetna "Botulinum Toxins Injectable Medication Precertification Request" form (Aetna Form). The information on the form noted that C.P. had tried Amitriptyline, Topiramate and Propranolol, medications to treat her migraine headaches in the past, with no success. Aetna authorized the use of 300 units of Botox every three months for the treatment of C.P.'s migraines.

26. On June 22, 2012, C.P. received her first Botox injections from respondent. No examination was performed and vital signs were not taken. Respondent prepared illegible handwritten notes for the visit. Respondent drew a picture of eyes, with two dots between the eyes, which represented injections in the corrugator muscles. Respondent did not document how much Botox he injected into each site. He noted on a billing form that he injected a total of 220 units of Botox and wasted 80 units.

27. On September 21, 2012, C.P. saw respondent for Botox injections. Respondent prepared a note for the visit that stated "BOTOX," with no other information. No examination was performed and vital signs were not taken. Respondent did not document the amount or location of Botox injected. He noted on a billing form that he injected a total of 220 units of Botox and wasted 80 units.

28. Respondent wrote a letter dated December 10, 2012, which was sent to C.P.'s insurance company, requesting authorization for 300 units of Botox to be administered in

January 2013. He wrote that C.P. had "very good response to the Botox injections for chronic migraine" and an "80% resolution of the headaches."

29. On March 29, 2013, C.P. saw respondent for Botox injections. No examination was performed and vital signs were not taken. Respondent prepared illegible medical notes for the visit, which included a picture of eyes, with three dots between the eyes and one dot on each side of the eyes, which represented three into injections into corrugator muscles, and two injections, left and right, into the temporal muscles. Respondent did not document the amount of Botox injected into each site. He noted on a billing form that he injected a total of 220 units of Botox and wasted 80 units.

30. On June 28, 2013, C.P. saw respondent for Botox injections. No examination was performed and vital signs were not taken. Respondent prepared an illegible medical note for the visit, which included a picture of eyes, with two dots between the eyes and one dot on each side of the eyes, which represented two injections, left and right, into corrugator muscles, and two injections, left and right, into the temporal muscles. Respondent did not document the amount of Botox injected into each site. He noted on a billing form that he injected a total of 220 units of Botox and wasted 80 units.

31. Respondent wrote a letter dated July 22, 2013, which was sent to C.P.'s insurance company, requesting authorization for 300 units of Botox to be administered in September 2013. He wrote that the Botox "has always worked very well with resolution of all of her symptoms."

32. On September 27, 2013, C.P. saw respondent for her last Botox injection appointment. No examination was performed and vital signs were not taken. Respondent prepared an illegible medical note for the visit, which included a picture of eyes, with two dots between the eyes and one dot on each side of the eyes, which represented two injections, left and right, into the corrugator muscles, and two injections, left and right, into the temporal muscles. He did not document the amount of Botox injected into each site. He noted on a billing form that he injected a total of 220 units of Botox and wasted 80 units.

33. All of C.P.'s appointments with respondent lasted approximately five minutes. For the visits she received Botox, C.P. observed one vial of Botox sitting on the counter. Respondent filled one syringe, one time. During one visit, C.P. told respondent that she had received approximately 30 Botox injections when treated at Kaiser. He replied that was the "old way" of treating migraines with Botox.

C.P. explained that during her first couple of visits, respondent injected Botox into two locations in the middle of her eyebrow, one on each side of her temple, one on each side of her head, and a couple of injections on her lower neck. Towards the middle and end of treatment, he was only administering four injections, two in the middle of her eyebrows and one on each side of the temple. He never told C.P. how much Botox he was injecting. C.P. received some benefit from the Botox injections. Respondent talked to C.P. several times about requesting her insurance company approve Botox treatments one-and-a half to two

months apart. He told C.P. that she would receive better relief from her migraines with more frequent injections. Her insurance company never authorized more frequent injections.

34. After the September 27, 2013, appointment, C.P. began seeing a new neurologist. He also treats C.P. with Botox injections, every three months. She receives approximately 30 injections during each visit.

Respondent's Testimony Regarding His Treatment of M.Z. and C.P.

35. Over the course of respondent's career, he has treated approximately 2,000 patients with Botox. In his practice, he does not follow a uniform regimen for dosing and administering Botox. He individualizes treatment based on his experience, the patient's complaints and the success of the treatment.

36. Respondent explained that he is aware that some neurologists follow a regimen recommended by the Food and Drug Administration (FDA) and Allergan, the manufacturer of Botox. As a result of studies funded by Allergan referred to as PREEMPT-1 and PREEMPT-2, a regimen of injecting a total 155 units of Botox in 31 injections sites is recommended for the treatment of migraine headache. Respondent contended that the recommendation is a "marketing gimmick." Based on respondent's experience, he has determined that some of his patients require higher doses of Botox to treat cervical muscles which can contribute to migraine headaches. He also contended that there is no fixed dose of Botox that is required to treat migraine headache.

37. Respondent repeatedly testified that M.Z. and C.P. were not referred to him for diagnosis. His role was to only provide Botox treatments. He contended that both patients asked to be treated with Botox. As a result, he did not obtain detailed histories from the patients, or conduct complete physical and neurological evaluations. Respondent also explained that he did not take the patients' vital signs because they were not "relevant" to his treatment. He testified that his practice was to document the patient's blood pressure based on self-report. Respondent also testified that he obtained verbal consent to treat by patients, but did not document the consent.

38. Respondent's treatment of C.P. was focused on treatment of her migraine headaches. He contended that C.P. had already been "cleared" for Botox therapy by Dr. Chase. Respondent explained that although he did not document in C.P.'s patient records the specific locations and amount of Botox he injected into each site for each visit, he recalled at hearing that he injected the right and left trapezius muscles, the right and left splenius capitis, right and left semispinalis capitis, and the right and left corrugator muscles. His practice was to inject a total of 210 units into the various necks muscles and 10 units in the face divided among the corrugator and temporal muscles.

39. Concerning M.Z., respondent determined that 220 units of Botox were needed to treat her migraines and cervical dystonia. Higher doses of Botox were needed to treat the larger muscles in the neck. He sought approval for higher doses of Botox from M.Z.'s

insurance company. Respondent admitted that the two letters sent to M.Z.'s insurance company contained incorrect information about her history of cervical dystonia, but "the job got done."

40. Respondent also explained his practice for reconstituting Botox for both patients. He explained that the Botox vial contains a powder which must be reconstituted with saline in order to inject the substance. Respondent reconstituted three 100 unit vials of Botox with .33 cubic centimeters (cc) of saline in each vial. Respondent placed the liquid from two of the vials into the third vial, which he contended was more efficient. He placed one vial containing all of the liquid in the treatment room. In the patient's presence, he drew up all of the liquid from the vial containing all of the liquid, into a one cc syringe. The syringe contained 300 units of Botox. The syringe had 10 gradient lines that he used to determine how much Botox he was injecting into each site. He then injected 220 units from the syringe. He wasted the remaining 80 units. Respondent did not document how he reconstituted the Botox.

Complainant's Expert

41. Jeremy Hogan, M.D. is board-certified in adult neurology, clinical neurophysiology and headache medicine. Dr. Hogan graduated from University of Rochester School of Medicine and Dentistry in 2000, the same year he was licensed by the Board. He completed a medical residency in Adult Neurology at the David Geffen School of Medicine, University of California, Los Angeles in 2004. Thereafter, Dr. Hogan completed a one-year fellowship in Clinical Neurophysiology and Electromyography (EMG) at the University of California, San Diego.

After Dr. Hogan completed his fellowship, he began working as a staff neurologist at Sharp-Rees Stealy Medical Group (Sharp-Rees) in San Diego, where he is still employed. Dr. Hogan is currently the chief neurologist at Sharp-Rees. He manages a staff of 12 neurologists. Since 2008, Dr. Hogan has served as an expert reviewer for the Board. He has also served as an expert in numerous civil matters. For the past eight years, Dr. Hogan has worked as a consultant for Allergen, the manufacturer of Botox. Dr. Hogan trains neurologist how to administer Botox for neurological conditions, including migraine headache.

42. Following a September 19, 2016 referral from Mr. Brearley, Dr. Hogan authored a report dated November 9, 2016, concerning his evaluation of respondent's conduct related to the treatment of patients M.Z. and C.P. In the report, Dr. Hogan listed the documents he reviewed to reach his opinions and conclusions. Dr. Hogan reviewed the certified medical records of M.Z. and C.P., respondent's curriculum vitae, and a transcript of respondent's interview with the Board's investigator. Dr. Hogan testified at hearing. Dr. Hogan opined that respondent's treatment of M.Z. and C.P. departed from the standard of care, which he defined as what a reasonable neurologist would do in a similar circumstance.

ADEQUATE DOSING AND ADMINISTRATION OF BOTOX

43. Dr. Hogan opined that the standard of care for administering Botox for the prevention of chronic migraine for the initial rounds of injections is for the physician to inject "155 units of Botox in 31 injections sites (5 units per site)." The areas include the face and head. Dr. Hogan's opinion is based on the findings of PREEMPT-1 and PREEMPT-2 which he described as "two large, placebo-controlled, published studies on chronic migraine." He explained that other studies performed have demonstrated that lower doses and other injection patterns of Botox "failed to demonstrate an effect." As a result, the FDA and Allergan the manufacturer of Botox, recommend the 31-injection site regimen for treatment of migraine.

However, Dr. Hogan acknowledged that "in the community, there is significant variability in the way neurologists perform this procedure (in terms of dosing and muscle selection." Dr. Hogan opined that departing for the 31-injection site regimen does not depart from the standard of care. He explained that it was "quite controversial" when the FDA gave the recommendation about dosing and muscle sites because many neurologist were treating migraine with Botox successfully without following the 31-injection site regimen, before the FDA approved it with different doses. He also explained that some physicians use dosages of up to 200 units of Botox to treat chronic migraines, but an "initial dosing higher than 200 units" would be outside the standard of care.

44. Dr. Hogan opined that respondent departed from the standard of care by injecting C.P. and M.Z. with 220 units of Botox in four to eight injection sites. He explained that injecting high doses of Botox in a few areas, increases the risk of side effects and harm to the patient. Also, large doses of Botox in the neck area can cause neck weakness. He further opined that the standard of care is to inject small muscles with five units of Botox, when treating migraines. Additionally, if respondent was injecting up to 50 units in the patients' facial muscles, the risks would include side effects, such as droopy eyelids. He opined that injecting 50 units of Botox into facial muscles is an extreme departure from the standard of care, because of the risk of harm to the patient.

FAILURE TO MAINTAIN MEDICAL RECORDS AND OBTAIN INFORMED CONSENT

45. Dr. Hogan opined that the standard of care requires physicians to maintain accurate and truthful medical records for patients, so that there is a clear record of the treatment rendered. He opined that for both patients, respondent failed to maintain medical records that adequately and accurately explained the locations and amount of Botox he injected during each visit. He opined that the information is important if the patient suffers from side effects or problem that occurs as a result of a treatment a physician has given. If the records are not accurate or complete, it is more difficult to know what happened. Additionally, the information is important for future medical providers treating the patients.

46. Dr. Hogan also opined that the standard of care requires a physician to discuss with a patient the risks, benefits, and alternatives to a medical procedure. The physician

must also obtain a signed written consent to treat the patient. Dr. Hogan explained that Botox contains a "black box warning" which is the FDA's most serious warning for a medical treatment. The purpose of the warning is to alert physicians and patients who are given Botox that symptoms and side effects can occur as a result of use.

Dr. Hogan explained that there have been reports of patients having trouble swallowing and breathing. There have also been reports of death. There are also benign side effects that a patient needs to be made aware of, such as pain at the site of the injection, bruising, bleeding, and drooping eye lids. People can also have trouble with neck weakness or neck pain after the injections. Some patients who get migraine injections can have an increase in their headaches for a few weeks after the initial treatment. Additionally, the higher the dose of Botox, the greater risk of spread and the greater the risk of side effects.

47. Dr. Hogan opined that respondent failed to obtain written or verbal informed consent from the patients. He did not discuss with the patients the risks, benefits, or alternatives. He opined that respondent's "poor medical record keeping, lack of documented informed consent for Botox procedures and failure to discuss risks/benefits/alternatives of Botox procedures" with M.Z. and C.P. collectively constituted an extreme departure from the standard of care.

FAILURE TO DOCUMENT AND MEASURE VITAL SIGNS

48. Dr. Hogan opined that the standard of care requires that vital signs and a physical examination be performed by the treating neurologist or medical staff. The purpose of the examination and obtaining vital signs to "help establish an appropriate diagnosis and treatment plan." Dr. Hogan opined that it is a simple departure from the standard of care to not check or document a patient's vital signs. Failure to check and document vital signs is not a practice that most reasonable neurologist would do, but the risk of harm to the patient is less than an extreme departure.

Dr. Hogan further opined that respondent's practice of basing M.Z. and C.P.'s blood pressure on self-report and recording the information is a simple departure from the standard of care. Respondent should have noted in the medical records that the blood pressure was based on the patient's self-report. However, he opined that falsification of blood pressure is an extreme departure from the standard of care.

IMPROPER EXAMINATION, DIAGNOSIS AND TREATMENT OF CERVICAL DYSTONIA

49. Dr. Hogan opined that the standard of care requires a neurologist who is treating a patient with migraine or cervical dystonia, to conduct a "thorough interview and examination, as well as review prior records, in determining the diagnosis and course of treatment." Dr. Hogan opined that the medical records respondent maintained for M.Z. "indicate an apparent lack of knowledge, or at least significant carelessness, in differentiating chronic migraine from cervical dystonia." He further opined that "not all patients with cervical pain or muscle spasms have cervical dystonia."

Dr. Hogan explained that cervical dystonia is a neurological movement condition that causes abnormal postures of the neck. Most patients with cervical dystonia report neck pain. Upon examination, a physician will observe enlargement of muscles in patient's neck. The patient may also have twisting or tilting of the head to one side. Dr. Hogan explained that it is "fairly obvious" when a patient is suffering from cervical dystonia, because of the abnormal posture of the head and neck. Dr. Hogan opined that cervical dystonia is an unusual condition and is "much more rare" than migraine headaches.

He also explained that Botox can be used to treat cervical dystonia. However, the injection sites are typically different and the dosages of Botox are "radically different" than for migraines. Dr. Hogan explained that much higher dosages of Botox are used to treat cervical dystonia, compared to migraine. He further opined that generally most insurance companies will only authorize 100 or 155 units of Botox to treat migraines. When treating cervical dystonia, there is a higher range, so the decision regarding the amount of units of Botox that is needed is based on the physician's recommendation.

Dr. Hogan opined that respondent failed to document any history or examination findings that supported a diagnosis of cervical dystonia. Respondent failed to review any past treatment records for M.Z. Additionally, the "very limited examination" respondent conducted of M.Z. "was not thorough enough to allow for a proper diagnosis and treatment plan." He also failed to document an enlargement of neck muscles, or abnormal posture of M.Z.'s neck. He opined that respondent's examination and diagnoses of M.Z. with cervical dystonia constituted a simple departure from the standard of care, because it is possible for a patient to have cervical dystonia and not have obvious signs of the condition.

50. Dr. Hogan also opined that respondent departed from the standard of care by informing M.Z. that he was treating her for migraine, but documenting in her medical records the administration of Botox for cervical dystonia. He opined that if respondent injected M.Z. with 55 units of Botox on the right and left trapezius muscle and 50 units on the right and left splenius capitis, for a total of 210 units, as documented on the undated Botox Therapy form, then his conduct would be an extreme departure from the standard of care for the treatment of migraine. However, it would not be if he was treating cervical dystonia. Dr. Hogan opined that injecting neck muscles is not a typical pattern for treating migraine. Additionally, high doses of Botox in neck muscles can cause muscle weakness.

IMPROPER RECONSTITUTION OF BOTOX

51. Dr. Hogan opined in his report that the standard of care for reconstituting Botox is to use one to two cc of saline for one 100 unit vial of Botox. He explained that Allergan recommends physicians use two cc of saline for every 100 units of Botox. In his report, Dr. Hogan opined that respondent's practice of using one-third cc of saline in each of three 100 unit vials of Botox was a simple departure from the standard of care. At hearing, he opined that respondent's practice was "unconventional and unlikely." He also opined that it would be difficult to accurately inject Botox at a higher concentration.

52. However, Dr. Hogan admitted that the practice of reconstituting Botox "varies from practice to practice." There is no standard of care for the concentration of Botox. He explained that some physicians use more concentrated reconstitutes of Botox, which is within the standard of care.

IMPROPER RECOMMENDATION FOR INTERVALS OF TREATMENT

53. Dr. Hogan opined that the standard of care for intervals of Botox injections is every 12 weeks to three months, when treating migraine or cervical dystonia. As a physician treats a patient over time, then shorter or longer intervals may be appropriate and within the standard of care.

54. Dr. Hogan opined that the intervals of Botox treatment respondent administered to C.P. were within the standard of care. However, respondent's advice to C.P. to return for Botox injections every two months was a simple departure from the standard of care, because it was not based on a careful tracking of C.P.'s headache frequency and symptoms, over a long period of time to determine the appropriate intervals.

UNNECESSARY EEG STUDY

55. Dr. Hogan opined that the standard of care requires the use of an EEG to "identify abnormalities suggestive of epilepsy/seizure disorders." An EEG is not typically useful in evaluating headache disorders or cervical dystonia. Dr. Hogan opined that respondent's decision to order an EEG for M.Z. constituted a simple departure from the standard of care, based on his treatment of her for migraines and cervical dystonia.

Respondent's Experts

56. Dr. Christopher O'Carroll and Dr. Lin Zhang testified as experts on behalf of respondent. Both experts are practicing neurologists and are licensed by the Board. Dr. O'Carroll is a Diplomate of the American Board of Neurology and Psychiatry. He graduated from University College Dublin Medical School in 1975. He completed a residency in internal medicine at the University Alberta Hospital, Edmonton, Canada in 1978. Thereafter, Dr. O'Carroll completed a three-year residency in neurology at the Massachusetts General Hospital in Boston, Massachusetts. He then completed a fellowship in clinical electrophysiology at the Mayo Clinic in Rochester, Minnesota. Since 1982, Dr. O'Carroll has worked in a private practice in Newport Beach, California. His practice if focused on the management of intractable pain disorders, including headaches. Dr. O'Carroll uses Botox to treat his patients with migraine headache and cervical dystonia.

57. Dr. Lin Zhang is a clinical professor and practicing neurologist. He is licensed by the Board and is board-certified by the American Board of Neurology and Psychiatry. He obtained his medical degree from the Beijing Medical College in 1983. Thereafter, he attended Tulane University and obtained his Ph.D. in neuroscience. In 1998, he began a residency in neurology at the Cleveland Clinic. Upon completion, he participated in a three-

year fellowship program at the Department of Neurology, University of Rochester, in Rochester, New York. The program was designed to train fellows in movement disorders and experimental therapeutics.

In 2001, Dr. Zhang was hired by the Department of Neurology, at UC Davis, where he is currently a full clinical professor. He operates a clinical practice three and a half days per week. The remaining time he advises residents, teaches fellows and conducts research. He is the Director of the Department's neuro-classroom clinic. As the director, he and his staff use Botox therapy on a daily basis to treat patients with neurological conditions including migraines and cervical dystonia. He has employed Botox therapy since 2001.

58. Both experts were asked to render opinions as to whether respondent's treatment of M.Z. and C.P. departed from the standard of care. Dr. O'Carroll defined that standard of care as the standard established by organizations such as the American Academy of Neurology. Dr. Zhang defined the standard of care as a uniform and basic level of care to preserve the efficacy and safety for patients. Both experts reviewed the Accusation, respondent's medical records for the patients, and Dr. Hogan's report. Dr. O'Carroll opined that, with the exception of respondent's medical record documentation, his treatment of the two patients was "well within" the standard of care. Dr. Zhang opined that respondent's treatment of the patients was within the standard of care.

ADEQUATE DOSING AND ADMINISTRATION OF BOTOX

59. Both experts opined that there is no standard of care for the administration and dosing of Botox for migraine headaches. Dr. O'Carroll explained that there is "significant variability" in the way neurologists perform Botox injections for migraines in terms of both dosing and muscle selection. Physicians are allowed to use experience and discretion in determining the best course.

60. Both experts were familiar with the PREEMPT studies. Dr. Zhang explained that the goal of the studies was to determine the safety, efficacy and recommended dose for treating migraine headaches. The result was that Botox therapy was found to be a scientifically effective treatment for chronic migraine.

Dr. O'Carroll's practice participated in the PREEMPT-1 and PREEMPT-2 studies. He contended that the recommendations that resulted from the study that physicians utilize a 31-injection site regimen did not have a "shred of scientific validity." He further opined that there is no "true scientific validity or evidence" to show that putting Botox anywhere other than the glabellar lines, which are the forehead frown lines, is of any value for chronic migraine.

61. Both experts opined that respondent's administration and dosage of 220 units of Botox in M.Z. and C.P. was within the standard of care. Dr. O'Carroll opined that when treating areas such as the large neck muscles, higher doses of Botox of up to 400 units in the neck muscles is "virtually mandatory" if a physician wants to affect the muscles. For smaller

facial areas, two to five units is typically sufficient. He opined that based on the documentation he reviewed, the areas and amounts of Botox respondent injected was within the standard of care.

62. Dr. Zhang opined that concerning the pattern of injections for M.Z. that respondent documented in the medical records, respondent appropriately treated migraines and cervical dystonia. In addition, he treated other symptoms in the shoulders and neck that are concurrent with migraines.

FAILURE TO MAINTAIN MEDICAL RECORDS AND OBTAIN INFORMED CONSENT

63. Dr. Zhang did not opine as to the standard of care for maintaining medical records. However, Dr. O'Carroll opined that the standard of care requires a physician to maintain accurate and honest medical records. He explained that respondent's notes for the treatment he rendered to M.Z. and C.P. were difficult to read, which he opined was a simple departure from the standard of care. He also opined that it would be a departure from the standard of care if respondent recorded vital signs in the patients' records, but had not taken or obtained the vital signs.

64. Both experts testified that the standard of care requires a physician to record the amount of Botox injected per site. Both opined that respondent's documentation that he administered 220 units of Botox is within the standard of care, and that the locations of the injections are sufficiently identified in the records.

65. Dr. O'Carroll opined that the false information respondent wrote in the letters sent to M.Z.'s insurance company, in order to obtain approval for Botox therapy, did not depart from the standard of care, because "any practicing doctor knows the way the game is played and knows we have to take shortcuts through this maze, this thicket of bureaucracy so we can get treatment for our patients."

66. Both experts opined the standard of care requires that the physician communicate to the patient the treatment that is being provided, including Botox therapy. Both experts also opined that written informed consent is not required. However, Dr. O'Carroll opined that the patient and physician should engage in a dialogue regarding the treatment, the benefits and risks. Dr. O'Carroll explained that the risks of Botox therapy can include difficulty swallowing, drooping eyes, bruising and asymmetry of facial lines. He further opined that the discussion is "mandatory. He explained that if respondent had a discussion with the patient, but failed to document the conversations in the medical records, then he committed a simple departure from the standard of care. If he failed to have the discussion, then he committed an extreme departure from the standard of care. Dr. O'Carroll did not provide definitions for simple and extreme departures from the standard of care.

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FAILURE TO DOCUMENT AND MEASURE VITAL SIGNS

67. Dr. Zhang did not offer any opinions concerning respondent's failure to document and measure vital signs. Dr. O'Carroll opined that the standard of care does not require a neurologist treating a patient with Botox therapy for migraine headaches, to take the patient's vital signs. He opined that the patient's primary physician is required to take vital signs.

68. Initially, Dr. O'Carroll testified that he had "no idea" what the standard of care required for a neurologist to document blood pressure reported by a patient. He contended that a patient's blood pressure was "irrelevant." Later, he changed his testimony and opined that the standard of care does not require a neurologist to document when the patient self-reports blood pressure.

IMPROPER EXAMINATION, DIAGNOSIS AND TREATMENT OF CERVICAL DYSTONIA

69. Both experts treat patients with cervical dystonia. Dr. Zhang explained that cervical dystonia is a condition that causes abnormal posturing of the head and the neck. The condition causes pain, spasms of the neck muscles, and motion restriction which leads to impairment of daily function.

Dr. O'Carroll treats patients with cervical dystonia, which he described as a painful neurological condition that causes the head to be in a forced deviated position, either laterally forward or backwards. He opined that in recent years, there has been "diagnostic creep around the pure culture of the disorder." He explained that neurologists will diagnose a patient with cervical dystonia based on severe neck spasm, which he opined is "a modified form of cervical dystonia."

70. Dr. Zhang did not opine as to the standard of care for conducting a neurological examination or the diagnosis and treatment of cervical dystonia. However, he opined that a physician can conduct a neurological evaluation based on observation, as respondent performed with the M.Z. and C.P. The physician can observe a patient's facial symmetry, check to see if the patient's tongue is mid-line and examine pupil size.

71. Both experts opined that respondent appropriately diagnosed M.Z. with cervical dystonia based on an examination finding of moderate cervical paraspinal muscle spasm, which is consistent with a diagnosis of cervical dystonia.

IMPROPER RECONSTITUTION OF BOTOX

72. Dr. O'Carroll prepared a letter dated September 12, 2017, in which he opined that the issue of how Botox is reconstituted is of "little importance." He opined that the total units of Botox and where it is injected is the "determining factor." He further opined that respondent's practice of reconstituting 300 unit of Botox with one cc of saline is not unusual.

73. Dr. Zhang also prepared a letter, in which he opined that there is no standard for the concentration of Botox to be used to treat "dystonias and headache disorders." He opined that the decision concerning concentration is determined by the physician based on the patient's "clinical presentation, medical history and previous exposures to the neurotoxins."

IMPROPER RECOMMENDATION FOR INTERVALS OF TREATMENT

74. Both experts opined that respondent complied with the standard of care by recommending that C.P. shorten the duration between the Botox injections. Dr. O'Carroll explained that there is no set standard for how often Botox should be administered. He further opined that the FDA has approved three-month regimens and insurance companies will pay for that period of time, but that does not define the standard of care.

75. Dr. Zhang opined that typically the effects of the Botox last approximately three months. However, the interval of Botox therapy depends on the needs of the patient and how the patient responds to the treatment.

UNNECESSARY EEG STUDY

76. Both experts opined that respondent complied with the standard of care by ordering an EEG for M.Z. Dr. Zhang opined that an EEG can provide a physician with valuable information about brain function. Dr. Zhang speculated that respondent ordered the EEG to determine if M.Z.'s headaches were caused by a vascular malformation, tumors, or infection. He opined that the EEG result would help to provide a differential diagnosis.

77. Dr. O'Carroll explained that the EEG is a routine procedure that gives some information about the brain. He did not explain how the EEG could have provided respondent information about the diagnosis of migraines and cervical dystonia. Nor did he explain how any of the information respondent obtained from M.Z. about her history of migraines or symptoms justified the ordering of the EEG.

Discussion of Accusation Allegations

ADEQUATE DOSING AND ADMINISTRATION OF BOTOX

78. Complainant alleged that respondent failed to adequately dose and administer Botox injections for M.Z. and C.P., which constituted an extreme departure from the standard of care and general unprofessional conduct.

79. The evidence established that respondent treated both patients with approximately 220 units of Botox, injected into several locations on the face and neck area. In both patients, he observed neck tension. In M.Z., he observed neck spasms. Respondent has treated over 2000 patients with Botox. He determines the amount and locations of Botox to inject based on his experience, the patient's complaints and the success of the treatment.

80. The experts agreed that there is a significant variability in how neurologists dose and administer Botox for the treatment of migraines and cervical dystonia. Dr. Hogan explained that the PREEMPT studies recommend that physician's utilize 155 units of Botox in 31 injections sites (5 units per site). However, he conceded that deviating from the recommendation does not violate the standard of care.

81. Additionally, Dr. Hogan's opinion that the use of an initial dose of higher than 200 units of Botox to treat migraine headaches would be outside the standard of care was not persuasive, due to the variability of dosing based on the symptoms that are treated. Dr. Zhang persuasively opined that patients with migraine headache are suffering from a very complex neurological condition that can cause symptoms other than headaches. Additionally, Dr. O'Carroll explained that higher doses of Botox are often needed in the neck muscles to address areas of tension. As a result, the treating physician has discretion in determining the administration and dose of Botox that is required to treat a particular patient.

82. Complainant failed to establish by clear and convincing evidence that respondent's dosing and administration of Botox injections for M.Z. and C.P. constituted an extreme departure from the standard of care and general unprofessional conduct. Respondent appropriately used his discretion in determining the dose and administration of Botox in both patients.

FAILURE TO MAINTAIN MEDICAL RECORDS AND OBTAIN INFORMED CONSENT

83. Complainant alleged that respondent failed to adequately and accurately maintain medical records for both patients, including failing to document the amount of Botox that was actually injected, obtaining informed written consent, having discussions regarding the risks, benefits, and alternatives of Botox injections and having legible records. Complainant alleged that collectively, respondent's conduct constituted an extreme departure from the standard of care, failure to maintain adequate and accurate records and general unprofessional conduct.

84. Dr. Hogan and Dr. O'Carroll agreed that the standard of care requires a physician to maintain accurate and adequate records. The experts agreed that the standard of care when rendering Botox requires the physician to document the locations and amount of Botox he injected during each visit. This information is important if the patient suffers from side effects or problems that occur as a result of a treatment a physician has given. If the records are not accurate or complete, it is more difficult to know what happened. Additionally, the information is important for future medical providers treating the patients.

85. The evidence established that for both patients respondent failed to adequately or accurately document the amount and location of Botox he injected during each visit. First, respondent's handwritten medical notes for the patients are illegible. The only information that indicates the location of injections are depictions of the patient's eyes with dots that represent injection sites. However, not all injects locations are identified on the drawings. Additionally, for M.Z., the undated Botox Therapy form respondent completed, which lists

the amount and location of Botox to be injected, was not consistent with the locations respondent injected. The form listed injections of 55 units of Botox on the right and left trapezius muscles, for a total of 110 units; 50 units of Botox on the right and left splenius capitis, for a total of 100 units, and 10 units of Botox on the right and left semispinalis capitis, for a total of 20 units. Respondent also injected Botox into the corrugator and temporal muscles, which is not documented.

Additionally, respondent failed to prepare any documentation in C.P.'s medical records concerning the amount and location of Botox he injected. Respondent's contention at hearing that he could recall the locations and amounts of Botox he injected based on his past practice, was not persuasive. Over four years had passed since respondent treated C.P.

86. The evidence also established that respondent failed to obtain informed consent from the patients. The experts agreed that the standard of care requires a physician to discuss with a patient the risks, benefits, and alternatives to a medical procedure. Dr. Hogan persuasively opined that a physician must also obtain a signed written consent to treat the patient, which provides written documentation of the information communicated.

87. The evidence established the respondent failed to discuss with the patients the risks, benefits, and alternatives to Botox therapy. He told M.Z. that there were no side effects from Botox and there was "nothing to worry about." This information was false. Botox contains a Black Box warning. Side effects from Botox can include difficulty swallowing and breathing, pain at injections sites, bruising, bleeding and drooping eye lids. Respondent's contention that he obtained verbal consent from both patients, but failed to document the conversation was not credible.

88. The evidence established that respondent failed to obtain either written or verbal informed consent from the patients. Complainant established by clear and convincing evidence that respondent failed to adequately and accurately maintain legible medical records for both patients. He failed to document the amount of Botox that was actually injected into each site and failed to obtain informed consent. As a result, complainant established that respondent's conduct constituted an extreme departure from the standard of care, failure to maintain adequate and accurate records and general unprofessional conduct.

FAILURE TO DOCUMENT AND MEASURE VITAL SIGNS

89. Complainant alleged that respondent failed to accurately document or measure the vital signs for both patients. Complainant alleged that respondent's conduct constituted an extreme departure from the standard of care, failure to maintain adequate and accurate records and general unprofessional conduct.

90. Dr. Hogan persuasively opined that the standard of care requires that the treating neurologist or medical staff obtain a patient's vital signs. The purpose is to help establish an appropriate diagnosis and treatment plan." Dr. Hogan opined that it is a simple departure from the standard of care to not check or document a patient's vital signs or record

a patient's blood pressure on self-report. However, falsifying a patient's blood pressure is an extreme departure from the standard of care.

91. The evidence established that respondent failed to take the patient's vital signs. Respondent's office visits with the patients lasted no more than five minutes. During that time, he did not listen to the patient's heart, obtain a pulse, or check blood pressure. Respondent admitted that he did not take the patients vital signs because they were "not relevant" to his treatment. Additionally, respondent's contention that the blood pressure he wrote in the patient's medical records was based on their self-report is not plausible. Both patients stated that respondent neither took nor asked them about their blood pressure. Which demonstrates that the information respondent included in the medical records about their blood pressure is false.

92. Complainant established by clear and convincing evidence that respondent failed to accurately document or measure the vital signs for both patients. His conduct constituted an extreme departure from the standard of care, failure to maintain adequate and accurate records and general unprofessional conduct.

IMPROPER EXAMINATION, DIAGNOSIS AND TREATMENT OF CERVICAL DYSTONIA

93. Complainant alleged that respondent failed to conduct a thorough interview, physical examination, and review of M.Z.'s medical records prior to diagnosing her with cervical dystonia. Additionally, complainant alleged that respondent failed to document any history or examination finding that would support his diagnosis of cervical dystonia. Complainant alleged that respondent's conduct constituted repeated acts of negligence, failure to maintain adequate and accurate records, and general unprofessional conduct.

94. Dr. Hogan persuasively opined that the standard of care requires a neurologist who is treating a patient with migraines or cervical dystonia, to conduct a "thorough interview and examination, as well as review prior records, in determining the diagnosis and course of treatment." All of the experts described cervical dystonia as a painful neurological condition that causes abnormal posture of the neck.

95. The evidence established that respondent failed to do a thorough interview, physical examination and review of M.Z.'s medical records prior to diagnosing her with cervical dystonia. Respondent's initial examination of M.Z. lasted no more than five minutes. The physical examination consisted of respondent touching her neck. Other than obtaining information regarding M.Z.'s history of migraine headaches, respondent failed to obtain any additional medical history from M.Z. Respondent failed to request any of M.Z.'s past treatment records. Additionally, M.Z. did not report any issues with her neck, other than normal tenderness and soreness. She did not display any issues moving or turning her head or neck, or abnormal posture of her neck, which would have been consistent with a diagnosis of cervical dystonia.

96. Respondent's contention that he appropriately diagnosed cervical dystonia based on a finding of spasm on the left and right sides of her neck was not persuasive. While all the experts agreed that neck spasms can be a finding that is consistent with cervical dystonia, the standard of care required respondent to obtain and document more information through obtaining a history, conducting an examination and reviewing past medical records before diagnosing M.Z. with cervical dystonia. Additionally, respondent admitted that the information he included in the letters to M.Z.'s insurance provider regarding her treatment and symptoms of cervical dystonia was incorrect. M.Z. never reported any history of suffering from cervical dystonia or seeking treatment for the condition.

97. Complainant established by clear and convincing evidence that respondent failed to conduct a thorough interview, physical examination, and review of M.Z.'s medical records prior to diagnosing her with cervical dystonia. Complainant also established by clear and convincing evidence that respondent failed to document any history or examination findings that supported his diagnosis of cervical dystonia. His conduct constituted simple departures from the standard of care, failure to maintain adequate and accurate records and general unprofessional conduct.

IMPROPER RECONSTITUTION OF BOTOX

98. Complainant alleged that for both patients, respondent failed to properly reconstitute the Botox he injected in the proper "1-2 cc/100 units ratio." Complainant alleged that respondent's failure constituted a repeated act of negligence, failure to maintain adequate and accurate medical records, and general unprofessional conduct.

99. All of the experts agreed that the standard of practice allows for variability in how a physician reconstitutes Botox before it is injected into a patient. Dr. Hogan opined that the standard of care requires one to two cc of saline for one 100 unit vial of Botox. But also admitted that there is no standard of care for the concentration of Botox. None of the experts opined that the standard of care required respondent to document how he reconstituted the Botox.

100. The evidence established that respondent used .33 cc of saline per 100 unit vial of Botox. He combined the contents of three 100 unit vials and injected the contents from the one vial. While Dr. Hogan opined that this method is unconventional and unlikely, complainant failed to establish by clear and convincing evidence that respondent's conduct constituted a departure from the standard of care or unprofessional conduct.

IMPROPER RECOMMENDATION FOR INTERVALS OF TREATMENT

101. Complainant alleged that respondent advised C.P. to return for more frequent Botox injections without determining that it was appropriate to do by tracking her headache frequency and symptoms. Complainant alleged that respondent's conducted constituted a simple departure from the standard of care, failure to maintain adequate and accurate medical records and general unprofessional conduct.

102. Dr. Hogan persuasively opined that the standard of care for intervals of Botox injections is every 12 weeks to three months, when treating migraines or cervical dystonia. All the experts agreed that as a physician treats a patient over time, then shorter or longer intervals may be appropriate and within the standard of care.

103. The evidence established that respondent recommended to C.P. on several occasions that she ask her insurance company to approve more frequent Botox injections, approximately two months apart. However, his recommendation was not based on documenting over time the effectiveness of the injections he had provided C.P. In fact, based on the documentation prepared by respondent regarding his treatment of C.P., the injections he was providing were resulting in significant improvement in her migraines. C.P. received Botox injections on June 22 and September 21, 2012. Respondent wrote a letter dated December 10, 2012, to C.P.'s insurance company, claiming that she had a "very good response to the Botox injections for chronic migraine" and an "80% resolution of the headaches." C.P. received additional injections on March 29 and June 28, 2013. Respondent wrote a letter dated July 22, 2013, to C.P.'s insurance company, claiming that the Botox therapy "has always worked very well with resolution of all of her symptoms."

104. Complainant established by clear and convincing evidence that respondent's recommendation to C.P. that she return for more frequent Botox injections departed from the standard of care. His conduct constituted a simple departure from the standard of care, failure to maintain adequate and accurate medical records and general unprofessional conduct.

UNNECESSARY EEG STUDY

105. Complainant alleged that respondent "unnecessarily ordered" an EEG study for M.Z. Complainant alleged that respondent's conduct constituted a simple departure from the standard of care, failure to maintain adequate and accurate medical records and general unprofessional conduct.

106. The experts agreed that an EEG is a routine study that can provide a neurologist important information concerning the function of a patient's brain and other information that may help assist with a diagnosis. Dr. Hogan persuasively opined that an EEG is used to identify abnormalities suggestive of epilepsy/seizure disorders.

107. Based on M.Z. medical records and respondent's testimony, it is not clear why he ordered an EEG study. M.Z. reported a history of migraine headaches. Respondent diagnosed M.Z. with cervical dystonia and sought authorization for Botox therapy based on that diagnosis. Respondent contended that he ordered the EEG to rule-out any brain or artery abnormalities. However, there is no information or differential diagnosis in the medical records respondent prepared to establish the medical necessity for an EEG. He did not document any findings based on an examination, history or complaints from M.Z. to establish the need for an EEG. While an EEG may be a routine procedure, the standard of care requires that there be a medical necessity for the test.

108. Complainant established by clear and convincing evidence that respondent's decision to order an EEG test for M.Z. was a simple departure from the standard of care, failure to maintain adequate and accurate medical records and general unprofessional conduct.

Rehabilitation Evidence

109. Respondent has been active in the neurologist community for many years. He is a member of the Board of Directors for the Sacramento Epilepsy Foundation. He is also a member and founder of the North Area Neuroscience Society and a member of the Global Multiple Sclerosis Advisory Board. Respondent is also the inventor and developer of a medical device used for the delivery of oral medication.

110. Respondent acknowledged that the medical records he prepared for M.Z. and C.P. were difficult to read. He explained that in the future he intends to print rather than use cursive. He also stated that "one could always be more complete" when referring to the lack of information contained in the records. Respondent attributed the false information in the form letters sent to M.Z.'s insurance company, to his staff. Respondent explained that he would "crack the whip" and ensure that his staff sends accurate correspondence.

CHARACTER WITNESS AND LETTERS

111. Raymond Mikelionis, M.D., testified on behalf of respondent and prepared a letter of support. Dr. Mikelionis practices family medicine. He has known respondent for approximately 40 years. Over the years, he has consulted with respondent concerning multiple patients. He described respondent as a "very professional, honest, caring and competent physician." Dr. Mikelionis is aware of the Accusation filed against respondent. The allegations do not change his opinion of respondent.

112. Respondent also submitted a letter of support from Jose Abad, M.D., the president of River City Medical Group. Dr. Abad wrote that his organization "deals with the Medi-Cal population" and that it is difficult to find physicians who will serve this population. He explained that respondent serves Medi-Cal patients in need of neurological care. He explained that respondent is "a very caring and motivated physician."

Appropriate Discipline

113. Complainant established by clear and convincing evidence, the majority of the allegations contained in the Accusation. While complainant failed to establish that respondent's dosing, administration and reconstitution of Botox departed from the standard of care, complainant did establish that respondent's failure to maintain adequate and accurate medical records, failure to obtain informed consent and failure to take and document vital signs constituted extreme departures from the standard of care. Additionally, complainant established that respondent engaged in multiple simple departures from the standard of care,

including improperly diagnosing M.Z. with cervical dystonia, recommending to C.P. improper intervals of Botox treatment, and ordering an unnecessary EEG for M.Z.

114. Most concerning is respondent's failure to acknowledge the serious nature of his multiple failures in treating M.Z. and C.P. For both patients, he failed to maintain adequate and accurate records. All of his handwritten notes were illegible. He failed to document the amount and locations of Botox injected for each visit. Although respondent prepared a Botox treatment plan for M.Z, he injected locations not listed on the plan or adequately documented in her patient record. Respondent also failed to complete accurate documentation for C.P. concerning the amount and locations of the Botox injections. He also falsified the patients' blood pressure and admitted that the information he submitted to M.Z.'s insurance company regarding her diagnosis and treatment history was false. He justified his conduct by asserting that "the job got done."

Respondent repeatedly attempted to justify his failure to perform thorough examinations and obtain vital signs based on his contention that his role in treating the patients was to only provide Botox treatment. However, the contention was not supported by the evidence. In both cases, respondent took over care as the patients' treating neurologist. Respondent diagnosed both patients and rendered treatment based on his diagnosis. The standard of care required respondent to obtain a thorough history, and conduct physical and neurological evaluations, before rendering treatment. He failed to do so. Respondent's conduct raised serious questions regarding the treatment he rendered to M.Z. and C.P. He repeatedly failed to exercise the care that was expected during the course of the treatment he provided to the patients.

115. Respondent has been licensed to practice medicine in California since 1975. He has no record of discipline with the Board. Respondent is active in the medical community. However, due to the severity of respondent's conduct and violations, the Board must be assured that respondent is safe to practice. The protection of the public is the Board's highest priority. In determining appropriate disciplinary action and in exercising disciplinary authority the Board shall, whenever possible, "take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence." (Bus. & Prof. Code, § 2229, subd. (b).) The Board's Disciplinary Guidelines provide that the minimum discipline that should be imposed, for an extreme departure from the standard of care, repeated acts of negligence, and failure to keep complete and accurate records is stayed revocation, with five years of probation which includes conditions designed to protect the public. There is no basis to deviate from the Disciplinary Guidelines.

116. Based on the totality of the evidence, the public protection would be served by imposing a five-year term of probation, with terms and conditions designed to protect the public. Respondent is prohibited from engaging in a solo practice and is required to obtain a practice monitor who will ensure that his practices are within the standards of practice of medicine. Additionally, respondent is directed to complete a professionalism program and

medical record keeping course to ensure that he understands his ethical obligations and his duty to maintain accurate and adequate records.

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.)

Applicable Law

2. Business and Professions Code section 2227 provides in pertinent part that a licensee that has been found "guilty" of violations of the Medical Practices Act, shall:

> (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.

3. 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.

4. 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.

5. 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.

Causes for Discipline

6. Complainant established by clear and convincing evidence that respondent's treatment of M.Z. and C.P. constituted unprofessional conduct. Specifically, an extreme departure from the standard of care, as set forth in Findings 10 through 34, 45 through 49, 63, 66, and 83 through 92. Therefore, cause was established to impose discipline on respondent's certificate pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b).

7. Complainant did not establish by clear and convincing evidence that respondent failed to adequately dose and administer Botox injections, as set forth in Findings 34 through 36, 43, 59 through 62, and 78 through 82. Therefore, no cause for discipline was

established pursuant to Business and Professions Code section 2234, subdivision (b) as to these allegations.

8. Complainant established by clear and convincing evidence that respondent's treatment of patients M.Z. and C.P. constituted repeated acts of negligence, as set forth in Findings 10 through 34, 49, 50, 53 through 55, 74, 75, 93 through 97, and 101 through 108. Therefore, cause was established to impose discipline on respondent's certificate pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c).

9. Complainant did not establish by clear and convincing evidence that respondent failed to properly reconstitute Botox, as set forth in Findings 40, 51, 52, 72, and 73. Therefore, no cause was established to impose discipline on respondent's certificate pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c) as to these allegations.

10. Complainant established by clear and convincing evidence that respondent failed to maintain adequate and accurate records related to his treatment of M.Z. and C.P. as set forth in Findings 10 through 34, 45 through 49, 50, 53 through 55, 63, 66, 74, 75, 83 through 97, and 101 through 108. Therefore, cause exists to impose discipline on respondent's certificate pursuant to Business and Professions Code sections 2227 and 2234, as defined by section 2266.

11. Complainant established by clear and convincing evidence that respondent engaged in conduct which breaches the rules or ethical code of the medical profession, as set forth in Findings 10 through 34, 45 through 49, 50, 53 through 55, 63, 66, 74, 75, 83 through 97, and 101 through 108. Therefore, cause exists to impose discipline on respondent's certificate pursuant to Business and Professions Code sections 2227 and 2234.

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 five years, with appropriate terms and conditions set forth below, to protect the public.

ORDER

Physician's and Surgeon's Certificate A 29403 issued to respondent Richard Neill Sauer M.D. is REVOKED, pursuant to Legal Conclusions 2 through 12, but the revocation is STAYED, and respondent is placed on probation for five 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 of 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 are in satisfaction of this condition.

2. Medical Record Keeping Course

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

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

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

3. Professionalism Program (Ethics Course)

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

professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

4. **Monitoring – Practice**

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

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

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

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

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

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

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 and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

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. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

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

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

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

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

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; and Quarterly Declarations.

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 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.

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

In the Matter of the Accusation Against:	)	
	)	
Richard Neill Sauer, M.D.	)	Case No. 800-2014-002745
Physician's and Surgeon's	)	
Certificate No. A 29403	)	
	)	
Petitioner	)	
	)	
	)	

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Albert J. Garcia, Esq., attorney for Richard Neill Sauer, M.D. for the reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on May 25, 2018.

IT IS SO ORDERED: May 25, 2018

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

EXHIBIT B

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

In the Matter of the First Amended Accusation Against: RICHARD NEILL SAUER, M.D. Physician and Surgeon's Certificate No. A 29403 Respondent.	Case No. 800-2017-030024 OAH No. 2018040456

DECISION AFTER NON-ADOPTION

This matter was heard before Administrative Law Judge ("ALJ") Danette C. Brown, Office of Administrative Hearings (OAH), State of California, on January 28 to 30, 2019, in Sacramento, California.

Megan O'Carroll, Deputy Attorney General, represented complainant Kim Kirchmeyer, Executive Director of the Medical Board of California (Board).

Albert Garcia, Attorney at Law, represented respondent Richard Neill Sauer, M.D., who was periodically present at the hearing.

Evidence was received, the record was held open for submission of written closing briefs. On February 1, 2019, OAH received and marked complainant's closing brief as Exhibit 17. On February 19, 2019, OAH received and marked respondent's closing brief as Exhibit D. On February 22, 2019, OAH received and marked complainant's reply brief as Exhibit 18. The record closed and the matter was submitted for decision February 22, 2019.

On March 19, 2019 ALJ Brown issued her Proposed Decision. Panel B of the Medical Board of California ("Board") declined to adopt the Proposed Decision and on May 14, 2019 issued its Order of Non-Adoption of Proposed Decision and afforded the parties the opportunity for written argument. The Board having read and considered the administrative record and the written arguments submitted by the parties, and having heard oral argument, hereby renders its decision in this matter.

FACTUAL FINDINGS

1. On July 28, 1975, the Board issued respondent Physician and Surgeon's Certificate No. A 29403 (certificate). The certificate was current at all times relevant to this matter. It will expire on October 31, 2020, unless renewed or revoked.

2. On January 23, 2019, complainant, acting in her official capacity, signed and thereafter filed the First Amended Accusation against respondent. Complainant seeks to impose discipline on respondent's certificate, based on his alleged repeated acts of negligence in connection with his treatment of patient D.D.,[1] who sought treatment from respondent for tremors. Generally, complainant alleged that respondent departed from the standard of care by: (1) failing to perform an adequate initial neurological consultation; (2) failing to document the medical records with legible entries of vital signs, examination and significant changes or response to treatments; (3) failing to order appropriate tests and medical investigation of symptoms; (4) failing to appropriately prescribe medications; and (5) failing to effectively communicate with D.D. about D.D.'s condition, treatment plan, and prescriptions. Complainant also alleged that respondent failed to keep adequate and accurate medical records for services rendered to D.D.

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. In 1974, respondent completed his medical degree at the University of Iowa, College of Medicine. Thereafter he completed an internship at United Hospitals in St. Paul Minnesota. In 1975, he was licensed by the Board. In 1978, respondent completed a three-year residency in neurology at the University of California, Davis (UC Davis). In 1981, he obtained his board certification by the American Academy of Neurology and Psychiatry.

5. In a prior disciplinary action entitled, "In the Matter of the Accusation against Richard Neill Sauer, M.D." before the Medical Board of California, OAH No. 2017040877, respondent's certificate was revoked, the revocation stayed, and respondent was placed on Board probation for five years, subject to terms and conditions. The Board adopted the administrative law judge's proposed decision, which became effective on May 18, 2018. The allegations in the case included respondent's repeated acts of negligence in his treatment of two patients for migraines, failing to document and take vital signs, and ordering an unnecessary EEG study.

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[1] The patient is identified by initials to protect the patient's privacy.

Board Investigation

6. On or about February 8, 2017, the Board received an online written complaint from D.D.'s caregiver, Meghan Maloney, who, at the time, was a recent registered nursing graduate. The complaint related to respondent's diagnosis and treatment of D.D.'s loss of motor skills, difficulty swallowing, difficulty speaking, and tremors. The complaint stated, in part:

> I went with [D.D] to see [respondent] and was absolutely sickened by his demeanor and lack of empathy or concern for [D.D.]. He had a pleasant smile but never asked [D.D.] any questions or bothered to look at [D.D.] when [D.D.] was speaking.
>
> [D.D.'s] primary doctor told [D.D.] that she suspects MS[2] . . . Sadly, [respondent] laughed at [D.D.] saying no you don't have MS. But he didn't even ask her if things had changed or how she was since last visit!
>
> [¶] . . . [¶]
>
> He told [D.D.] the reason for [D.D.'s] new tremors was likely due to being in so much pain it was being expressed as a tremor. When I questioned his logic, asking for an explanation, he wasn't able to give me an answer that made sense and wrote a prescription for another medication without any info or explanation of how it would work or why he chose it.

7. On March 17, 2017, Michel Torres, a Special Investigator for the Department of Investigation, Health Quality Investigation Unit, was assigned to investigate the complaint. Investigator Torres issued an Investigation Report regarding his investigation of respondent. Investigator Torres testified at hearing. During the course of his investigation, Investigator Torres learned that Ms. Maloney had concerns about the care D.D. received from respondent on February 8, 2017, in that he did not address D.D.'s symptoms and prescribed D.D. medication that D.D. did not need. Ms. Maloney made attempts to contact respondent but did not receive a phone call back. Investigator Torres interviewed Ms. Maloney and D.D. He interviewed respondent and obtained his patient records for D.D.

8. On December 12, 2017, Investigator Torres sent a letter, draft report, a transcript of respondent's interview and the D.D.'s medical records to Board expert reviewer For Shing Lui, M.D., who is board-certified in Neurology. On December 18, 2017, Dr. Lui issued a report in which he opined that respondent's treatment of patient D.D. departed from the standard of care.

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[2] Multiple sclerosis.

Respondent's Treatment of Patient D.D.

9. D.D. is 48 years old. At the time D.D. was seen by respondent, D.D. was 46 years old. Prior to seeing respondent, D.D. had been treated regularly by Marina Kamyshin, Physician Assistant (PA), at the Sacramento Family Medical Clinic. D.D. had a complicated medical history of hypertension, chronic pain, fibromyalgia, depression, obesity, cholelithiasis[3], and hepatosplenomegaly[4]. D.D. had a history of seizures during childhood and was treated with phenobarbital until age 13. D.D.'s seizures reoccurred in 2007. The seizures were described in the medical records as "inconsistent" and "not stereotyped." D.D. had an inconsistent history of any impairment of consciousness. D.D. experienced intermittent body spasms with full awareness. D.D. was sent to the emergency department at Mercy San Juan Medical Center with one of these spells.

10. D.D. is a chronic cigarette smoker and used methamphetamine. In 2012, D.D. attempted suicide by taking Ativan and methamphetamine. D.D. is unemployed, and has a caregiver 30 hours per week. Prior to being seen by respondent, D.D.'s medications included Atenolol, Losartan, Oxybutynin, Gabapentin, Cymbalta, Ibuprofen, Norco (as needed), Comapazine (as needed), and Zofran (as needed).

11. D.D.'s primary care provider, PA Kamyshin, referred D.D. to respondent. Respondent first saw D.D. on November 17, 2016[5], with follow-up appointments on December 15, 2016, February 7, 2017, and March 6, 2017. Respondent provided a typewritten report to PA Kamyshin concerning his initial evaluation of D.D., describing that D.D. presented with bothersome head and upper extremity tremor starting in 2011. D.D. also had a spell of tonic-clonic[6] activity in October 2016, with probable loss of consciousness during the spell. Examination was normal except mild intention of tremor of D.D.'s upper extremities. Respondent's impression was the following:

a. This patient's tremor appears to be a benign essential tremor. The patient is moderately bothered with this now.

b. The patient's tonic-clonic spell may be a seizure or have another etiology.

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[3] Gallstones.

[4] Enlarged liver and spleen.

[5] The First Amended Accusation identified the first visit date as November 7, 2016. However, respondent's typewritten report indicates that the first visit took place on November 17, 2016, which was confirmed by respondent and complainant's expert at hearing.

[6] Grand-mal seizure.

Respondent recommended further evaluation with an electroencephalogram (EEG) and ultrasonography, also referred to as transcranial ultrasound. Respondent also prescribed Keppra 500 milligrams (mg) and Mysoline 50 mg twice a day.

12. On December 7, 2016, respondent performed the transcranial Doppler ultrasound and EEG tests on D.D. Respondent reported the results of both tests as normal.

13. On December 15, 2016[7], respondent saw D.D. for a follow-up appointment. Respondent's handwritten notes of this visit were illegible. Respondent provided a transcription of his notes to Investigator Torres, wherein D.D. complainted of "twitching." Respondent noted a history of childhood seizures, and noted a normal examination. Respondent's impression was that some of the reported symptoms were "pseudoseizures." He continued D.D. on Keppra 500 mg twice a day. The record is unclear whether respondent also continued D.D. on Mysoline at the same dose, however, in D.D.'s follow-up appointments, respondent continued D.D. on Keppra and Mysoline at the same doses.

14. D.D. returned to respondent for a follow-up appointment on February 7, 2017. Respondent's handwritten clinical notes were illegible. Respondent told Investigator Torres during his interview that D.D. complained of the same symptoms as in previous visits, and that the D.D. spoke in whispers with intermittent normal voice. D.D.'s speech pattern had been abnormal since 2007. D.D.'s examination was unremarkable. Respondent continued D.D. on Keppra and Mysoline at the same doses.

15. D.D. returned to respondent for a follow-up appointment on March 6, 2017. Respondent's handwritten clinical notes were illegible. Based on respondent's transcription of his notes and his interview with Investigator Torres, D.D. complained of seizures, with one that occurred the previous day. D.D. spoke with a lisp, which respondent noted had been present since age five. Respondent increased the Keppra dosage to 500 mg, two tablets, twice a day. Mysoline was continued at the same dose. Respondent scheduled a repeat EEG and a return visit in six weeks. The EEG was performed on March 13, 2017, and reported by respondent as normal. D.D. also had magnetic resonance imaging (MRI) performed on April 1, 2017, which was reported as "artefactual."[8] D.D. failed to show up to her appointments with respondent on April 17, 2017, and May 2, 2017. Ms. Maloney, who was with D.D. during her appointments with respondent, filed her complaint with the Board on February 8, 2018.

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[7] The First Amended Accusation indicates the follow-up visit took place on December 1, 2016. However, respondent's notes and complainant's expert confirmed that the follow-up visit occurred on December 15, 2016.

[8] "Artefactual" means referring to an inaccurate finding, deviation, or alteration of electronic readout or morphology due to some form of systemic error. (https://medical-dictionary.thefreedictionary.com/artefactual.)

Complainant's Expert

16. For Shing Lui, M.D., is Board-certified in neurology and the subspecialty of vascular neurology. Dr. Lui has been a Fellow of the American Academy of Neurology since 2017. In 1978, Dr. Lui graduated from the University of Hong Kong Medical School as the top graduate in his class. Following his residency in internal medicine, Dr. Lui went to England to become a Fellow in Clinical Neurology at the Regional Neurological Center. He returned to Hong Kong in 1984, as the medical officer at Queen Elizabeth Hospital, then worked in private practice as a neurologist and internist. Dr. Lui came to the United States, and in 1995, he became a resident in Neurology at UC Davis. He was Chief Resident at UC Davis in 1998. He thereafter served as a clinical professor at UC Davis from 1999 to 2014. He was Chief of Neurology Services at the Kaiser Permanente Medical Group in Sacramento and Roseville from 2004 to 2007.

Dr. Lui has served as a medical expert for the Board since September 2016. He currently serves as the Vice Chair of Clinical Sciences at California Northstate University College of Medicine.

17. Following a December 12, 2017 referral from Investigator Torres, Dr. Lui authored a report dated December 18, 2017, concerning his evaluation of respondent's conduct related to the treatment of D.D. In the report, Dr. Lui listed the documents he reviewed to reach his opinions and conclusions. Dr. Lui reviewed Investigator Torres's report, Ms. Maloney's complaint to the Board, the certified medical records of D.D., and a transcript and voice recording of respondent's interview with Investigator Torres. Dr. Lui testified at hearing consistent with the contents of his report. Dr. Lui opined that respondent's treatment of D.D. departed from the standard of care, which he defined as what a reasonable neurologist would do in a similar circumstance. Dr. Lui further explained that a simple departure from the standard of care means "any deviation," and an extreme departure from the standard of care means "reckless disregard or gross negligence."

INITIAL NEUROLOGY CONSULTATION

18. Dr. Lui opined that the standard of care for a neurologist's first consultation requires a detailed and comprehensive history of present illness, including relevant positives and negatives to help define the diagnosis and differential diagnoses. The elements of a complete history include: past medical history; medications; allergies; family history; social history; and review of systems. There should be at least a focused physical examination with vital signs documented. The assessment and plan should include a list of diagnoses or differential diagnoses with discussions about the more likely diagnoses followed by tests to help differentiate the diagnoses and recommend a treatment plan.

19. Dr. Lui reviewed respondent's typewritten report dated November 17, 2016, addressed to PA Kamyshin. Respondent's report stated that the initial consultation with D.D. occurred on November 17, 2016. Respondent listed two symptoms that D.D. complained of without providing details. Dr. Lui found no past medical history, history of allergies, an

inadequate social history lacking alcohol and drug use, and no review of systems. There were no vital signs noted in D.D.'s examination except a blood pressure reading. Dr. Lui opined that respondent's description of D.D.'s history, and respondent's physical examination were "grossly inadequate." Moreover, respondent did not obtain any details about D.D.'s childhood seizures and treatment, yet diagnosed D.D with possible seizures and benign essential tremor. Dr. Lui concluded that respondent's first visit with D.D. was a simple departure from the standard of care.

FAILURE TO DOCUMENT MEDICAL RECORD WITH LEGIBLE ENTRIES OF VITAL SIGNS, EXAMINATION, AND SIGNIFICANT CHANGES

20. Dr. Lui opined that the standard of care for any physician is to take a complete or focused history and physical examination with truthful, accurate, and legible documentation in the patient's chart. Vital signs are an important part of the physical examination.

21. Dr. Lui reviewed respondent's notes in D.D.'s chart. The notes were handwritten, extremely brief, and illegible. Dr. Lui opined that respondent's documentation lacked any description of significant changes in D.D.'s existing problems and response to treatment. No vital signs were documented in any return visit after the initial consultation. Neither Dr. Lui nor any other physician would be able to rely on respondent's handwritten notes because they were illegible. Dr. Lui concluded that respondent's chart documentation in D.D.'s medical record was a simple departure from the standard of care.

FAILURE TO ORDER APPROPRIATE TESTS AND MEDICAL INVESTIGATION OF SYMPTOMS

22. Dr. Lui opined that the standard of care in clinical practice by any physician for requesting or ordering tests or investigations is to define the indication of the test as well as cost consideration under the circumstances.

23. Dr. Lui further opined that D.D. presented with "clinical seizures or pseudoseizures" and tremor, and that it would be important for respondent to obtain a history from D.D. to get details of the "spells" and the factors that may aggravate or alleviate D.D.'s symptoms of tremor. Logical lab studies would include a complete metabolic panel, thyroid function, EEG, and MRI. A metabolic panel would be informative due to D.D.'s enlarged liver and spleen. Thyroid function studies would also be important because the thyroid could be the cause of D.D.'s tremor. Respondent ordered an EEG, and he determined that the results were normal. Respondent did not order or obtain recent results of the thyroid or metabolic panel tests.

24. Dr. Lui testified that a transcranial Doppler test is indicated for the following reasons: (1) sickle cell disease where a follow-up is needed to determine the patient's need

for a blood transfusion; (2) subarachnoid hemorrhage vasospasm[9]; and (3) determining velocity of blood flow in the intracranial vessels. There was nothing in D.D.'s history to indicate a stroke. There was "absolutely NO indication for the transcranial Doppler testing" for D.D. (Capital letters in original.) Dr. Lui concluded that the transcranial Doppler test requested by respondent was a simple departure from the standard of care.

FAILURE TO APPROPRIATELY PRESCRIBE MEDICATIONS

25. Dr. Lui opined that the standard of care in prescribing any medication by a physician requires the physician to know the patient's past medical history, including renal and liver functions. Those functions provide information on whether any dose adjustment is necessary. In addition, allergy and social history, especially use of alcohol and street drugs, may affect the choice of medications prescribed to the patient. Obtaining a detailed history of the patient's medications is especially important because of drug interactions. It is only after obtaining the patient's histories that the best medication specific to the patient may then be prescribed.

26. Dr. Lui determined that respondent obtained very limited medical history of D.D. Respondent also needed to obtain vital signs. D.D. used methamphetamine, which could have increased her blood pressure and heart rate. D.D. was taking Gabapentin for seizures and tremors. Gabapentin may increase body weight. Given that D.D. was morbidly obese, considered as having a body max index (BMI) over 40, respondent would have needed to continue discussing with D.D. whether to discontinue Gabapentin. In a morbidly obese individual such as D.D., continued use of Gabapentin would have affected D.D.'s everyday activities, and contributed to sleep apnea, right side heart failure, metabolic syndrome, and liver and spleen enlargement.

27. D.D. was also taking Mysoline, known as a "beta-blocker," which may have helped her tremors. Instead of adding a new medication with different side effects, Dr. Lui opined that respondent should have considered adjusting the dose of her existing medications before switching to a new medication. He stated, "when we start a patient on a new medication, we need to explain very clearly the reason for the use, side effects, and it relevance on the effects of daily living."

Respondent knew that D.D. was taking Cymbalta[10] for fibromyalgia. Despite being contraindicated for depression, respondent prescribed Keppra for D.D.'s seizures, which was troubling for Dr. Lui, and "would not have been a good choice in the presence of depression." Dr. Lui opined that 15 percent of patients taking Keppra will experience the

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[9] Bleeding in the space between the brain and the tissue covering the brain. (https://emedicine.medscape.com/article/1164341-overview.)

[10] Duloxetine is the generic name for Cymbalta. It is used to treat depression and anxiety. In addition, duloxetine is used to help relieve nerve pain (peripheral neuropathy) in people with fibromyalgia and other medical conditions. (https://www.webmd.com/drugs/2/drug-91491/cymbalta-oral/details.)

side effect of depression. Dr. Lui further opined that prescribing Keppra "was especially risky" given that D.D. attempted suicide in 2012. Moreover, respondent increased the dose of Keppra when he suspected more pseudoseizures. Dr. Lui conceded that Keppra is commonly used, and he gave respondent "the benefit of the doubt" in this regard. However, given D.D.'s depression and suicidal history, Dr. Lui concluded that respondent's choice of prescription medication, Keppra, was a simple departure from the standard of care.

FAILURE TO EFFECTIVELY COMMUNICATE WITH PATIENT D.D.

28. Dr. Lui opined that the standard of care for a physician to communicate with a patient "is to always try to communicate well with the patient and show empathy." Diagnoses, treatment plans, medications prescribed and their indications, side effects, and drug interactions, must be clearly conveyed to the patient.

29. Dr. Lui found no documentation in D.D.'s chart that respondent explained to D.D. and Ms. Maloney any details about D.D.'s diagnoses, or the risks and benefits of medication prescribed to D.D. Dr. Lui opined that neither D.D. nor Ms. Maloney would have filled the Keppra prescription had they known of Keppra's side effects of depression, given D.D.'s history. Dr. Lui noted that inadequate communication and lack of empathy by respondent was also the main complaint filed by Ms. Maloney. D.D. called respondent the day after her March 13, 2017 EEG appointment, seeking clarification on how often she was to take a particular prescribed medication, demonstrating respondent's failure to effectively communicate with D.D. on how to take the medication. Dr. Lui did not see from respondent's documentation "any real communication." Dr. Lui testified that "MS was not discussed. I would expect respondent would document that MS was brought up by the provider and referring PA, and that respondent would document that [MS] was not likely." Dr. Lui concluded that respondent's failure to effectively communicate was a simple departure from the standard of care.

Respondent's Testimony

30. Respondent acknowledged that his handwritten notes regarding D.D. were difficult to read. However, he claimed that he was able read his own notes, as was his staff. Respondent later conceded, "there is always room for improvement" concerning his medical record documentation. When asked about a note written by one of his staff, which was also difficult to read, respondent snidely remarked that the Board should "go after her too" for poor penmanship. Respondent has a transcriber, and he will "type more and write less" in the future. He referred to his handwritten notes as "secret handwriting" which enables him at the end of the day to dictate a specific note to the referring doctor. Respondent described himself as the "pawn of the referring doctor," meaning that the referring doctor is less concerned with his notes than the ongoing treatment plan for the patient. He asserted that referring physicians have been happy with his typewritten reports.

31. Respondent also asserted that he performs a thorough and focused examination of his patients, which includes history taking. He relies on the primary care provider to

provide the vital signs. Respondent did not take D.D.'s temperature or weight, explaining that this information was not pertinent to the referral. He "rarely checks" the blood pressure of patients. He noted D.D.'s blood pressure during his initial consultation, but he did not know who took D.D.'s blood pressure, stating that either the patient told him, it was on another record, or his staff took D.D.'s blood pressure. He believed it a "ludicrous suggestion" to document oxygen saturation,[11] which should be done by a pulmonologist, not him. In his experience, no one has "jotted that down" as a vital sign. He asserted that every patient that comes to his practice has already had their vital signs taken, and therefore the vital signs need not be a part of his documentation. He only focuses on what is asked of him. Respondent claimed that he discussed D.D.'s vital signs with PA Kamyshin, but there is no documentation of that discussion.

32. Respondent has performed transcranial Doppler tests since the technology was invented. He performs four to six tests per month. He stated that the test is non-invasive, not painful, and is a tenth of the cost of other technologies. The transcranial Doppler is helpful in providing information about vasospasms, blood flow, and seizure activity. Respondent ordered a transcranial Doppler test for D.D. because D.D.'s "tremor history was confusing," D.D. was a smoker that potentially put her at risk for stroke, and the test would have provided information on blood vessel abnormalities, blood flow problems, stroke detection, and vascular supply to neurons, known as neurovascular coupling.

33. Respondent did not order a metabolic panel or thyroid function test for D.D., but would have done so in a "brand new patient with no testing or blood workup." If D.D. presented with a suspicious condition of a metabolic process or thyroid abnormality, or if D.D. had clinical signs of low or high thyroid hormone levels, he would have ordered the tests.

34. Respondent has prescribed Keppra to "thousands of people." It is an anti-convulsant used in the treatment of seizures. Respondent chose Keppra for D.D. for two reasons: (1) Keppra prevented D.D. from dying from a seizure; and (2) Keppra would "stop or diminish the spells [D.D.] was describing." Respondent also chose Keppra for D.D. because it would not interact with the Gabapentin D.D. was taking. In his experience, respondent believed that Keppra and Gabapentin were a good combination. He also chose Keppra because over 50 percent of people actually need more than one anti-convulsant. Respondent asserted that very few, out of the thousands of his patients, have had a side effect from Keppra, and none have experienced depression or suicidal ideation. Respondent had no documentation that he communicated the negative effects of Keppra to D.D., and admitted that he did not inquire about D.D.'s condition after he prescribed Keppra.

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[11] Oxygen saturation is typically measured using a pulse oximeter. The patient's finger is inserted into spring-loaded clip which is attached to a sensor that provides a digital readout of the patient's oxygen saturation level. (https://www.healthline.com/health/pulse-oximetry.)

35. Respondent did not address his lack of communication with D.D. about D.D.'s condition, treatment plan, and prescriptions. Respondent testified that D.D. stopped seeing him because there was a "personality conflict" between himself and Ms. Maloney.

Discussion of Allegations

INITIAL NEUROLOGY CONSULTATION

36. Complainant alleged that respondent failed to perform an adequate initial neurological consultation on D.D., including failing to obtain detailed symptoms, perform a history and a physical, obtain significant social, allergy and medical history, and history of childhood seizures to reach a proper diagnosis and treatment plan. Complainant alleged that respondent's conduct constituted a repeated act of negligence, failure to maintain adequate and accurate records and general unprofessional conduct.

37. Dr. Lui persuasively opined that the standard of care requires that the treating neurologist's first consultation requires documentation of a detailed and comprehensive patient history, along with a focused physical examination with vital signs documented. This information is necessary to establish a list of diagnoses or differential diagnoses and a treatment plan. Dr. Lui opined that it is a simple departure from the standard of care to fail to document the patient's history and physical examination. Respondent's documentation in this regard was "grossly inadequate."

38. Respondent believed that he performed a thorough and focused examination, and provided an adequate history during his initial neurological consultation with D.D. Describing himself as the "pawn of the referring doctor," respondent asserted that he relies on the primary caregiver to obtain all of the detailed information that Dr. Lui set forth as the standard of care. Respondent provided no conflicting expert opinion on the standard of care.

39. The evidence established that respondent failed to document detailed symptoms, a thorough history and physical examination with vital signs for D.D. Respondent's assertion that referring physicians are happy with his reports is irrelevant.

40. Complainant established by clear and convincing evidence that respondent failed to perform an adequate initial neurological consultation on D.D. His conduct constituted a simple departure from the standard of care, failure to maintain adequate and accurate records and general unprofessional conduct.

LEGIBLE RECORDS

41. Complainant alleged that respondent failed to document the medical record adequately with legible records of vital signs, examination, and significant changes or response to treatments. Complainant further alleged that respondent's conduct constituted repeated acts of negligence, failure to maintain adequate and accurate records, and general unprofessional conduct.

42. Dr. Lui persuasively opined that the standard of care for charting is to legibly and accurately document the relevant medical information, including the vital signs of the patient. Respondent provided no conflicting expert testimony on the standard of care.

43. Respondent acknowledged his illegible notes regarding D.D. He explained that he and his staff could understand his writing, which he intended to transcribe later. However, even when transcribed, the content of the records was lacking in vital signs, and information concerning symptoms and response to treatment.

44. Complainant established by clear and convincing evidence that respondent failed to legibly and accurately document relevant medical information, including vital signs of D.D. His conduct constituted a simple departure from the standard of care, failure to maintain adequate and accurate records and general unprofessional conduct.

ORDERING APPROPRIATE TESTS AND MEDICAL INVESTIGATION OF SYMPTOMS

45. Complainant alleged that respondent failed to order appropriate tests and medical investigation of symptoms, by ordering unnecessary tests, such as the transcranial Doppler test, and failing to obtain necessary tests such as a metabolic panel and thyroid function tests. Complainant alleged that respondent's failures constituted repeated acts of negligence, failure to maintain adequate and accurate medical records, and general unprofessional conduct.

46. Dr. Lui persuasively opined that the standard of care in ordering tests or investigations is to define the indication, and to consider the cost. Dr. Lui further persuasively opined that there was no indication for ordering the transcranial Doppler test for D.D. Respondent provided no conflicting expert opinion on the standard of care. Respondent's testimony that he ordered the transcranial Doppler test because it would have provided information on stroke detection or blood vessel abnormalities was less persuasive, because respondent did not document any differential diagnoses that would have justified the test. Dr. Lui is Board-certified in neurology and in the subspecialty of vascular neurology, which specifically addresses blood flow in the brain. His opinion with respect to respondent unnecessarily ordering the transcranial Doppler test for D.D. is given greater weight. Dr. Lui did not find any departures from the standard of care with respect to respondent failing to obtain necessary tests such as the metabolic panel and thyroid function tests.

47. The evidence did not establish that respondent violated the standard of care by failing to obtain necessary tests such as the metabolic panel and thyroid function tests. Complainant established by clear and convincing evidence that respondent's conduct in ordering the transcranial Doppler test, without medical indications, constituted a simple departure from the standard of care, failure to maintain adequate and accurate records and general unprofessional conduct.

PRESCRIBING APPROPRIATE MEDICATIONS

48. Complainant alleged that respondent failed to appropriately prescribe medications, including prescribing Keppra in the presence of psychiatric and suicide history, and adding new medications without reference to existing prescriptions. Complainant alleged that respondent's conduct constituted a repeated act of negligence, failure to maintain adequate and accurate records and general unprofessional conduct.

49. Dr. Lui persuasively opined that the standard of care in prescribing any medication requires the physician to know the patient's past medical history, including renal and liver functions, as that information may require dosage adjustments. The standard of care also requires the physician to obtain a detailed history of the patient's medications as there may be drug interactions. Respondent provided no conflicting expert testimony on the standard of care.

50. Respondent's prescribing of Keppra to D.D. is the most serious issue in this case. Despite respondent's testimony that he prescribes Keppra to "thousands," and none of his patients have experienced depression or suicidal ideation, he provided no appropriate consideration of D.D.'s past history. If he did, it was not documented. The purpose of obtaining and considering the patient's history is to limit the risk of potential drug interactions and side effects. Respondent did not inquire about D.D.'s condition after the last time he saw her, and would have no way of knowing whether D.D. experienced any negative effects while taking Keppra.

51. The evidence established that respondent prescribed Keppra to a D.D., a patient with a history of depression and suicide. Complainant established by clear and convincing evidence that respondent's choice of Keppra was a simple departure from the standard of care, failure to maintain adequate and accurate medical records and general unprofessional conduct.

EFFECTIVE COMMUNICATION WITH PATIENT D.D.

52. Complainant alleged that respondent failed to communicate with D.D. about D.D.'s condition, treatment plan, and prescriptions. Complainant alleged that respondent's conduct constituted a repeated act of negligence, failure to maintain adequate and accurate medical records and general unprofessional conduct.

53. Dr. Lui persuasively opined that the standard of care in effectively communicating with a patient is to show empathy, and to clearly convey to the patient diagnoses, treatment plans, prescribed medications and their indications, side effects and drug interactions. Respondent provided no conflicting expert testimony on the standard of care.

54. Respondent did not acknowledge that he failed to effectively communicate with D.D. regarding her treatment, or that he lacked empathy. He defended his illegible

handwriting by asserting that he and his staff could read his notes, and referred to his notes as "secret handwriting." However, any reviewing doctor or D.D. would not be able to read or understand such notes, particularly if there are no transcribed notes in the patient's medical record. He did not convey to D.D. the risks to taking Keppra. He did not follow up with D.D. to inquire as to her condition when she stopped seeing him. He appeared defensive at hearing in having to account for his medical decision-making. Respondent provided no credible or persuasive testimony to demonstrate that he met the standard of care.

55. Complainant established by clear and convincing evidence that respondent's failure to communicate with D.D. about D.D.'s condition, treatment plan, and prescriptions, was a simple departure from the standard of care, a failure to maintain adequate and accurate medical records and general unprofessional conduct.

Rehabilitation Evidence

56. Respondent submitted five character reference letters which were received in evidence and considered to the extent permitted by Government Code section 11513, subdivision (d).[12]

a. Ingeborg Henderson, Ph.D., wrote in an email sent to respondent on January 9, 2019, that she has been treated by respondent since 2007 for chronic pain. Respondent suggested a course of treatment that restored Ms. Henderson's quality of life. Ms. Henderson was "profoundly impressed" with respondent's care, as well as respondent's willingness to "always listen" to Ms. Henderson's concerns, and to answer all of her questions. Ms. Henderson described respondent as a credit to his profession.

b. Sayed Hussain, M.D., wrote in his signed letter of January 7, 2019, that he has known respondent for decades, has referred patients "back and forth" over the years, and characterized respondent as an excellent physician. Dr. Hussain is aware of the Board's allegations in this case. Dr. Hussain's opinion is that respondent is "an honest, caring and competent physician, and certainly very professional." The allegations against respondent do not alter Dr. Hussain's opinion of respondent.

c. Raymond Mikelionis, M.D., wrote in his undated, signed letter, that he has known respondent for 40 years, and has worked with respondent in hospitals and a clinic. Dr. Mikelionis described

[12] Government Code section 11513, subdivision (d), provides, in pertinent part, that "[h]earsay evidence may be used for the purpose of supplementing or explaining other evidence but over timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions."

respondent as a "mainstay" at the local hospital who has "excellent results" as a general neurologist. Dr. Mikelionis especially appreciates respondent's "expertise in treating seizures." Dr. Mikelionis aware of the Board's allegations in this case, but his opinion of respondent as "very professional, honest, caring and competent" has not changed.

d. Algerd Mostavicius wrote in his signed letter of January 7, 2019, that he was a licensed physician in California from 1967 to 2017. He voluntarily surrendered his license (no payment of fees) and was in good standing with the Board. Mr. Mostavicius's wife, Barbara, was also an M.D. who surrendered her license in 2017 due to Alzheimer's Disease. Both are being treated by respondent. Both are aware of the Board's allegations, and are of the opinion that respondent is an "honest, well-trained, caring and very competent physician."

e. David S. Gould wrote in his signed and dated letter of January 7, 2019, that he has known respondent for many years, and "his care is of the highest standard." Mr. Gould is aware of the Board's allegations, "which in part includes an argument over which seizure medicine ought to be used." Despite the Board's allegations, Mr. Gould's opinion of respondent is not altered. He described respondent as an "honest, caring and competent physician, and certainly very professional."

57. The authors of the character reference letters were either physicians or respondent's patients. Mr. Gould is a good friend. Most of the authors had knowledge of the Board's allegations, but their opinion of respondent as a competent and compassionate medical professional did not change. Despite their knowledge of the Board's allegations, none of the authors provided any insight into respondent's efforts at rehabilitation despite the charges. (See, *Seide v. Committee of Bar Examiners of the State Bar of California* (1989) 49 Cal.3d 933, 940 ["If the character witnesses were not aware of the extent and seriousness of the petitioner's criminal activities, their evaluations of his character carry less weight."].) While there are no criminal activities at issue in this case, respondent's failure to adequately document D.D.'s symptoms, treatment, medical history, medications history, social history, and his failure to effectively communicate D.D.'s condition, treatment plan and prescriptions, were not addressed by any of the authors. Because the authors do not discuss knowledge of respondent's conduct, they are of limited value in assessing rehabilitation.

Appropriate Discipline

58. Complainant established by clear and convincing evidence the allegations contained in the First Amended Accusation. Additionally, complainant established that respondent engaged in multiple simple departures from the standard of care, including failing

to conduct an adequate initial consultation, documenting D.D.'s medical record with illegible notes, ordering a transcranial Doppler test without indication, prescribing inappropriate medication for the D.D., and failing to effectively communicate with D.D.

59. Most concerning is respondent's failure to acknowledge the serious nature of his multiple failures in treating D.D. He failed to maintain adequate and accurate records. His handwritten notes were illegible. He failed to document detailed information on D.D.'s medical history in order to reach a proper diagnosis and treatment plan. He did not convey medication risks.

60. Respondent failed to understand the seriousness of his illegible handwritten notes. A member of his staff also had poor handwriting which was difficult to read, and respondent snidely remarked that the Board should "go after her too" for poor penmanship. Respondent's hubris raises serious questions about his ability to examine his own professional conduct, take ownership of his actions, improve his practices as a medical practitioner, be open to accept challenges or suggestions by other medical practitioners, and demonstrate compassion towards patients. Respondent's preference of his own medical judgment over that of others poses a danger to his patients. At hearing, he demonstrated sarcasm and lack of respect for the discipline process, and the important role that the Board holds in protecting the public.

61. Respondent has been licensed to practice medicine in California since 1975. The Board imposed discipline in a prior Medical Board Case, OAH No. 2017040877. The allegations in the prior Board case involved, in part, respondent's treatment for migraines using Botox, his failure to document and take vital signs, and ordering of an unnecessary EEG test. Due to the severity of respondent's conduct and violations in that case, the Board needed assurances that respondent is safe to practice. The Board's Disciplinary Guidelines were considered, and discipline was imposed without deviation from the guidelines. The Board imposed a five-year disciplinary term, and required practice monitoring and a medical record keeping and ethics course, and a no solo practice term.

62. Here, D.D. was being treated for tremors and seizure, and the allegations highlighted the deficiencies in respondent's overall care and treatment, not just a specific subspecialty of neurology. This case implicated a much larger question of respondent's general fitness to practice. The protection of the public is the Board's highest priority. In determining appropriate disciplinary action and in exercising disciplinary authority the Board shall, whenever possible, "take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence." (Bus. & Prof. Code, § 2229, subd. (b).)

63. The Board's Disciplinary Guidelines provide the recommended minimum and maximum penalties for Business and Professions Code violations. For violation of Business and Professions Code sections 2234 (general unprofessional conduct), 2234, subdivision (c), (repeated negligent acts), and 2266 (failure to maintain adequate records), the minimum

penalty[13] is stayed revocation and five years of probation with conditions designed to protect the public. The maximum penalty is revocation. There is no basis here to deviate from the Disciplinary Guidelines.

64. Based on the totality of the evidence, the public protection would be served by imposing a five-year term of probation, with terms and conditions designed to protect the public. The five-year term of probation shall run concurrently with respondent's five-year term of probation in OAH Case No. 2017040877. Consistent with the conditions of probation in that case, respondent is prohibited from engaging in a solo practice and is required to obtain a practice monitor who will ensure that his practices are within the standards of practice of medicine. He is directed to complete a professionalism program and medical record keeping course to ensure that he understands his ethical obligations and his duty to maintain accurate and adequate records. Lastly, an additional term of probation, not required in his previous Medical Board case, will be required: Respondent shall complete a Clinical Competence Assessment Program as a condition precedent to his continuing practice. Completion of the assessment program will give the Board adequate assurances that the issues raised in the present case have been addressed, respondent's general fitness to practice is sound, and public protection is served.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.)

Burden and Standard of Proof

2. 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.)

Applicable Law

3. Business and Professions Code section 2227 provides in pertinent part that a licensee that has been found "guilty" of violations of the Medical Practices Act, shall:

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

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[13] The Board's Guidelines note that "in cases charging repeated negligent acts with one patient, a public reprimand may, in appropriate circumstances, be ordered."

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

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

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

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

4. 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:

[¶] . . . [¶]

(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.

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. 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.

Causes for Discipline

7. Complainant established by clear and convincing evidence that respondent's treatment of D.D. constituted repeated acts of negligence, as set forth in Factual Findings 18 through 29, and 36 through 55. Therefore, cause was established to impose discipline on respondent's certificate pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c).

8. Complainant established by clear and convincing evidence that respondent failed to maintain adequate and accurate records related to his treatment of D.D. as set forth in Factual Findings 18 through 29, and 36 through 55. Therefore, cause exists to impose discipline on respondent's certificate pursuant to Business and Professions Code sections 2227 and 2234, as defined by section 2266.

Conclusion

9. 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 five years, with appropriate terms and conditions set forth below, to protect the public. Respondent's five-year probation in this case shall run concurrent with his five-year probation imposed in a prior Medical Board case, OAH No. 2017040877.

ORDER

Physician's and Surgeon's Certificate A 29403 issued to respondent Richard Neill Sauer M.D. is REVOKED, pursuant to Legal Conclusions 7 and 8, but the revocation is STAYED, and respondent is placed on probation for five years, upon the following terms and conditions listed below. The five-year probationary period shall run concurrently with the five-year probationary period currently in effect pursuant to OAH No. 2017040877.

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 of

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 are in satisfaction of this condition.

2. Medical Record Keeping Course

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

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

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

3. Professionalism Program (Ethics Course)

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

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

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

4. Monitoring – Practice

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

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

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

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine and whether respondent is

practicing medicine safely. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

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

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

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.

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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 and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

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. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

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

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

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

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

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; and Quarterly Declarations.

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 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.

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17. Clinical Competence Assessment Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusations(s), and any other information that the Board or its designee deems relevant. The program shall require respondent's on-site participation for a minimum of three and no more than five days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendations(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

Respondent shall not practice medicine until respondent has successfully completed the program and has been so notified by the Board or its designee in writing.

This Decision shall become effective at 5:00 p.m. on **October 3, 2019**.

IT IS SO ORDERED **September 3, 2019.**

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

EXHIBIT C

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

In the Matter of the Petition for an Interim Suspension Order Against: **RICHARD NEILL SAUER, M.D.** **729 Sunrise Ave., #616** **Roseville, CA 95661** **Physician's and Surgeon's Certificate No. A 29403,** Respondent	OAH No. 2019100659 MBC Case No. 800-2019-060521 **~~[PROPOSED]~~ ORDER** [Government Code Section 11529] **Date: October 18, 2019** **Time: 1:30 P.M.** **Place: Office of Administrative Hearings, 2349 Gateway Oaks Dr., Ste. 200 Sacramento, CA 95833**

[PROPOSED] ORDER FOLLOWING HEARING ON PETITION FOR INTERIM SUSPENSION ORDER

The Petition for Interim Suspension Order ("Petition") of Kimberly Kirchmeyer, ("Petitioner") serving solely in her capacity as the Executive Director of the Medical Board of California, State of California ("Board"), seeking an interim order suspending Physician's and Surgeon's License No. A 29403 issued to Richard Neill Sauer, M.D., ("Respondent") pursuant to Government Code section 11529, came on for hearing before the Honorable Heather M. Rakun

[~~Chief~~] Administrative Law Judge, at the Office of Administrative Hearings (OAH), in Sacramento, California, on October 18, 2019 at 1:30 p.m. Petitioner was represented at the hearing by Megan O'Carroll, Deputy Attorney General, Health Quality Enforcement Section, Department of Justice. Respondent Richard Neill Sauer, M.D., ("Respondent"), [~~was~~ was not] present, and [was ~~was not~~] represented by counsel Albert J. Garcia, Attorney at Law. Evidence in the form of the declarations of counsel, of Probation Inspector Christopher King, and of Staff Services Manager II Paulette Romero, as well as records of proceeding OAH and Superior Court records were received. The matter was deemed submitted.

[~~PETITION DENIED~~]

~~[This court having read and considered the Petition, as well as any documentary evidence, declarations, Memorandum of Points and Authorities submitted in support thereof, and the oral argument presented at the hearing of this matter, and it appearing to the court that Petitioner has not met the requisite showing justifying an interim suspension of Respondent's physician's and surgeon's license at this point in time,~~

~~IT IS HEREBY ORDERED that the instant Petition is denied.]~~

[PETITION GRANTED]

[This court having read and considered the Petition, as well as any documentary evidence, declarations, Memorandum of Points and Authorities submitted in support thereof, and the oral argument presented at the hearing of this matter, it has been made satisfactorily to appear that:

1. Respondent, a physician and surgeon licensed by the State of California under Physician's and Surgeon's Certificate Number A 29403 is in violation of Business and Professions Code sections 2052 and 2234;

2. Permitting Respondent to continue to engage in the practice of medicine will endanger the public health, safety and welfare;

3. There is a reasonable probability Petitioner will prevail in the underlying action;

4. The likelihood of injury to the public if the instant order is not issued outweighs

the likelihood of injury to the Respondent in issuing the order; and,

5. Serious injury will result to the public before the matter may be heard on regular notice.]

[**WHEREFORE IT IS ORDERED** that Physician's and Surgeon's Certificate Number A 29403 issued to Richard Neill Sauer, M.D., is hereby immediately suspended until a regularly noticed hearing pursuant to Government Code section 11529(d), may be held in this matter. Said hearing shall take place on November 8, 2019, at 1:30 p.m., at the Office of Administrative Hearings, located at 2439 Gateway Oaks Drive, Suite 200, Sacramento, California.]

[**WHEREFORE IT IS ORDERED** that Physician's and Surgeon's Certificate Number A 29403 issued to Richard Neill Sauer, M.D., is hereby immediately suspended. Pursuant to representations made through his counsel, Respondent has waived his right to a regularly noticed hearing pursuant to Government Code section 11529(d).]

[**IT IS FURTHER ORDERED** that Respondent Richard Neill Sauer, M.D., shall, within 15 days of service of this order, provide the Board with proof of service of a true copy of this interim suspension order on the Chief of Staff or Chief Executive Officer at every medical clinic or other institution or location where Respondent has practice privileges or is employed in the practice of medicine, and on the Chief Executive Officer of every insurance carrier where malpractice insurance coverage is extended to Respondent, if any.]

[**IT IS FURTHER ORDERED** that Respondent shall not:

1. Practice or attempt to practice any aspect of medicine in the State of California pending further adjudication of this matter;

2. Advertise, by any means, or hold herself out as practicing or available to practice medicine in any capacity; and shall not;

3. Be present in any location or office which is maintained for the practice of medicine, or at which medicine is practiced for any purpose, except as a patient or as a visitor of family or friends.]

[**IT IS FURTHER ORDERED** that Respondent shall:

Immediately deliver to the Board, or its agent, for safekeeping pending further adjudication of this matter, all indicia of ~~her~~ his licensure as a physician or surgeon.]

[**IT IS FURTHER ORDERED** that service of this order, including all declarations and all other information in support of this order, was accepted on behalf of Respondent at the hearing of this matter through his counsel _____, and the service requirements of Government Code §11529(c) are deemed as having been satisfied.]

[**IT IS FURTHER ORDERED** that this order, including all declarations, exhibits, and documentation in support thereof, shall be served on Respondent through his counsel, Albert J. Garcia, pursuant to the provisions of Government Code §11529(c).]

DATED: October 18, 2019

[~~Chief~~] Administrative Law Judge
Medical Quality Hearing Panel
Office of Administrative Hearings

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