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

In the Matter of the Accusation/Petition to Revoke Probation Against **Nadine Helmy Yassa, M.D.** **Physician's and Surgeon's Certificate No. A 48720** **Respondent.**	**Case No. 800-2019-062809**

DECISION

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

This Decision shall become effective at 5:00 p.m. on: March 12, 2021.

IT IS SO ORDERED: February 10, 2021.

MEDICAL BOARD OF CALIFORNIA

By: Richard E. Thorp MD

Dr. Richard E. Thorp, Chair
Panel B

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
JANNSEN TAN
Deputy Attorney General
State Bar No. 237826
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7549
Facsimile: (916) 327-2247
Attorneys for Complainant

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

In the Matter of the Accusation/Petition to Revoke Probation Against: **NADINE HELMY YASSA, M.D.** **9980 Los Lagos Circle N.** **Granite Bay, CA 95746** **Physician's and Surgeon's Certificate No. A 48720** Respondent.	Case No. 800-2019-062809 OAH No. 2020070831 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Jannsen Tan, Deputy Attorney General.

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2. Respondent Nadine Helmy Yassa, M.D. (Respondent) is represented in this proceeding by her attorney Marvin Firestone, M.D., J.D., at 1700 S. El Camino Real, Ste 408 San Mateo, CA 94402.

3. On or about October 9, 1990, the Board issued Physician's and Surgeon's Certificate No. A 48720 to Nadine Helmy Yassa, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation/Petition to Revoke Probation No. 800-2019-062809, and will expire on July 31, 2022, unless renewed.

JURISDICTION

4. Accusation/Petition to Revoke Probation No. 800-2019-062809 was filed before the Board, and is currently pending against Respondent. The Accusation/Petition to Revoke Probation and all other statutorily required documents were properly served on Respondent on February 21, 2020. Respondent timely filed her Notice of Defense contesting the Accusation/Petition to Revoke Probation.

5. A copy of Accusation/Petition to Revoke Probation No. 800-2019-062809 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation/Petition to Revoke Probation No. 800-2019-062809. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation/Petition to Revoke Probation; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation/Petition to Revoke Probation No. 800-2019-062809, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

10. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in Accusation/Petition to Revoke Probation No. 800-2019-062809, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected her Physician's and Surgeon's Certificate, No. A 48720 to disciplinary action.

11. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

RESERVATION

12. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal

action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 48720 issued to Respondent Nadine Helmy Yassa, M.D. shall be and is hereby publicly reprimanded pursuant to California Business and Professions Code Section 2227, subdivision (a) (4). This public reprimand, which is issued in connection with Respondent's documentation of the treatment of Patient A, B and C as set forth in Accusation/Petition to Revoke Probation No. 800-2019-062809, is as follows:

"You failed to adequately and accurately document Patient A, Patient B and Patient C's history, treatment plan, tests, and rationale for treatment."

ACCEPTANCE

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

NADINE HELMY YASSA, M.D.
Respondent

I have read and fully discussed with Respondent Nadine Helmy Yassa, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 1/15/21

MARVIN FIRESTONE M.D., J.D.
Attorney for Respondent

ENDORSEMENT

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

DATED: _____

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

JANNSEN TAN
Deputy Attorney General
Attorneys for Complainant

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I have read and fully discussed with Respondent Nadine Helmy Yassa, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: _____ _____

MARVIN FIRESTONE M.D., J.D.
Attorney for Respondent

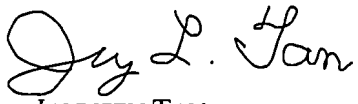
ENDORSEMENT

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

DATED: 1/20/2021

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General



JANNSEN TAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation/Petition to Revoke Probation No. 800-2019-062809

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Feb 21 20 20
BY [illegible] ANALYST

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
JANNSEN TAN
Deputy Attorney General
State Bar No. 237826
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7549
Facsimile: (916) 327-2247
Attorneys for Complainant

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

In the Matter of the Accusation/Petition to Revoke Probation Against: **Nadine Helmy Yassa, M.D.** **9980 Los Lagos Circle N.** **Granite Bay, CA 95746-5830** **Physician's and Surgeon's Certificate No. A 48720,** Respondent.	Case No. 800-2019-062809 **ACCUSATION AND PETITION TO REVOKE PROBATION**

PARTIES

1. Christine J. Lally (Complainant) brings this Accusation 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 October 9, 1990, the Medical Board issued Physician's and Surgeon's Certificate No. A 48720 to Nadine Helmy Yassa, 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 July 31, 2020, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

STATUTORY PROVISIONS

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.

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

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

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

(d) Incompetence.

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

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

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

6. Section 725 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

7. 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.

8. 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.

FACTUAL ALLEGATIONS

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence and Excessive Treatment- Patient A)

9. Respondent is subject to disciplinary action under sections 2227 and Section 2234 (b) of the Code in that she committed grossly negligent acts in the care and treatment of Patient A[1]. The circumstances are as follows:

10. Respondent is a physician and surgeon who practices neurology under the business name of Nadine H. Yassa M.D., in Roseville, CA.

11. Patient A was at the time a 62-year-old female who was evaluated by her primary care practitioner for "severe headaches and vertigo for past 7 years." Patient A also reported having "jerking motions to her arms and legs; weird sensations to her head in waves, possibly related to migraines or to DDD or to her prior history of concussions." Patient A was referred to a neurologist.

12. On or about November 2, 2016, Respondent saw Patient A for an office visit. Respondent documented the reason for the referral was headaches and dizziness that started 10 years ago. Patient A reported that she suspected the cause for her headaches and vertigo was a vehicular accident that occurred when she was 23 years old. A brain MRI dated December 4, 2013 revealed nonspecific white matter signal changes consistent with chronic small vessel ischemia. Patient A's neurological examination was normal. Respondent diagnosed abnormal brain MRI study, and bilateral occipital neuralgia even though Respondent did not document palpation or pain in the occipital region. Respondent ordered an EEG[2], ambulatory EEG,

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[1] Patient and provider names are abbreviated to protect patient confidentiality. Full patient names will be provided upon receipt of a Request for Discovery.

[2] Electroencephalogram is a measure of brain waves. It is used in the evaluation of brain disorders, most commonly used to show the type and location of the activity in the brain during a seizure.

EMG/NCV[3] lower extremities, MRI brain with and without contrast, vestibular rehabilitation training, and brain stem auditory evoked responses. The brain MRI dated December 16, 2016 revealed no changes. The 48-hour ambulatory EEG dated December 22, 2016, and the brain stem auditory evoked response test dated December 27, 2016 were normal.

13. On or about December 27, 2016, Respondent saw Patient A for a follow up visit. Respondent documented that the December 27, 2016 awake and sleep EEG revealed "abrupt onset of polyspike and wave, spike and slow wave, spike and sharp wave of high amplitude" Respondent's impression was "random samples of interictal EEG in the wakefulness and drowsiness, including computerized spike and seizure activity did not detect epileptiform discharges during the video monitor EEG session." Respondent diagnosed "complex partial seizures evolving to generalized seizure." Respondent added that Patient A's "seizures are very little never the big ones... She denies new associated symptoms from previous stroke." Respondent diagnosed epilepsia partialis continua with intractable epilepsy, bilateral sensory hearing loss, bilateral hearing loss, vertigo, and adverse effect of medications. Respondent ordered the anticonvulsant Levetiracetam 750 mg twice daily, which Patient A did not fill. Respondent documented, "over 50% of the 50 min. office visit was in counseling about stroke and its management."

14. Patient A was subsequently evaluated by a neurologist who performed a completely normal EEG.

15. Respondent committed gross negligence in her care and treatment of Patient A which included, but was not limited to the following:

A. Respondent failed to perform an accurate consultation history for Patient A. Respondent's examination is from a template that did not accurately document whether all neurologic testing were actually performed. Respondent documented several incorrect and baseless diagnoses including intractable epilepsy, hearing loss and adverse medication effects.

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[3] Electromyography test records the electrical signals moving through the muscles. Nerve Conduction Velocity Test is an electrical test used to detect nerve conditions. Both tests are often performed alongside each other.

B. Respondent made an incorrect diagnoses of imbalance based on a note by a nurse practitioner and not based on her own complete examination and testing.

C. Respondent ordered and performed several unnecessary tests including nerve study/EMG of the lower extremities, brain stem auditory evoked response testing[4] (BAER), EEG, ambulatory EEG .

D. Respondent lacked knowledge and failed to understand what is a BAER test and its indications and interpretations.

E. Respondent documented a template EEG report which she incorrectly interpreted and failed to review. Respondent failed to take into consideration that Patient A had no history of seizures, and the type of seizures reported in the incorrect EEG report would have clearly manifested by dramatic, tonic-clonic generalized seizures with loss of consciousness. Based on the incorrect report, Respondent reported Patient A to the Department of Motor Vehicles, resulting in the erroneous revocation of Patient A's driver's license.

F. Respondent ordered ambulatory EEGs without medical indication. Respondent ordered an ambulatory EEG based on "history of sometimes walking up and being completely wiped out".

G. Respondent reported Patient A to the Department of Motor Vehicles based on "possible seizures."

H. Respondent failed to adequately document Patient A's treatment plans and rationale for treatment. Respondent documented inaccurate diagnoses.

SECOND CAUSE FOR DISCIPLINE
(Gross Negligence - Patient B)

16. Respondent is subject to disciplinary action under sections 2227 and Section 2234 (b) of the Code, in that she committed grossly negligent acts in the care and treatment of Patient B. The circumstances are as follows:

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[4] Brainstem Auditory Evoked Response is a test to measure brain wave activity in response to clicks or certain tones.

17. On or about October 2, 2015, Respondent saw Patient B for an office visit. Patient B was at the time a 63-year-old male who was referred by his primary physician to Respondent for obstructive sleep apnea. Respondent documented the chief complaint was sleep apnea fatigue. The Apneatrak report dated October 13, 2015, revealed a normal study with no suggestion of obstructive sleep apnea.

18. On or about November 3, 2015, Respondent saw Patient B for a follow up visit. Respondent documented a normal neurological examination. Respondent diagnosed Patient B with obstructive apnea, central apnea, vertiginous migraine and migraine without aura. There was no plan written for this encounter.

19. On or about May 3, 2016, Respondent saw Patient B for a follow up visit. Respondent documented under "history of present illness", that Patient B was being referred for "evaluation of episodes of changes in [mental status] and bad(sic) being forgetful." Respondent documented a normal neurological examination. Patient B reported flipping 5 times in a car when he was a teenager. Patient B's wife assumed that his problems were due to a traumatic brain injury. Respondent documented that Patient B was having these episodes continuously and daily for years. Respondent believed "the history seems most consistent with ETOH". Respondent ordered numerous tests.

20. On or about June 20, 2016, Respondent saw Patient B for a follow up visit. Respondent documented a normal 2-day ambulatory/overnight EEG with a reported abnormal ENG[5] and BAEP[6]. However, the stated brain auditory evoked potential report findings were "baseline needle potentials", which is meaningless. On or about August 17, 2016, Respondent recommended vestibular rehabilitation. A vestibular nystagmogram on September 7, 2016 revealed unilateral weakness on the right.

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[5] Electronystagmography is a diagnostic test to record involuntary movements of the eye caused by nystagmus. It can also be used to diagnose the cause of vertigo, dizziness or balance dysfunction by testing the vestibular system.

[6] Brainstem Auditor Evoked Potential is an evoked potential caused by an aural stimulus, usually a series of clicks. Electrodes positioned on the scalp record responses to sound; these are then observed as a reading on an electroencephalogram.

21. On or about October 19, 2016, Respondent saw Patient B for a follow up visit. Respondent documented that Patient B's headaches have improved by as much as 90%. Respondent documented that Patient B had an abnormal brainstem auditory evoked response tests (due to poor hearing) and a normal EEG. Patient B was diagnosed with traumatic brain injury and alcohol abuse. Full neurological examination was normal. Patient B was also diagnosed with benign positional vertigo, tinnitus, adverse effects of medication, hearing loss, obstructive sleep apnea, central apnea, vertiginous migraine and migraine without aura with status migrainosus, not intractable.

22. On or about March 14, 2017, Respondent saw Patient B for a follow up visit. Respondent documented that Patient B was doing better using a CPAP. Respondent diagnosed traumatic brain injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, and alcohol use. Respondent recommended that Patient B continue with the CPAP and was to see him again in 5 months. A brain MRI on December 16, 2016, revealed mild chronic microvascular ischemic changes.

23. Respondent committed gross negligence in her care and treatment of Patient B which included, but was not limited to the following:

A. Respondent failed to adequately document Patient B's consultation history. The consultation history was limited and not fully developed for any of Patient B's symptoms.

B. Respondent ordered excessive testing. Respondent ordered a BAER to diagnose hearing loss. A hearing test would have been the appropriate test for hearing loss. Respondent ordered an ambulatory EEG without indication since Patient B had no history of seizures.

C. Respondent diagnosed a series of neurological impairments without meeting diagnostic criteria. Respondent diagnosed obstructive sleep apnea and, central apnea despite a normal sleep study. Respondent also diagnosed seizures and vertiginous migraines, without any diagnostic basis. Despite not doing various balance tests such as the Epley maneuver or diagnosing Benign Paroxysmal Positional Vertigo, Respondent referred Patient B for vestibular rehabilitation to her office.

D. Respondent failed to adequately document his treatment plans and rationale.

THIRD CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

24. Respondent is further subject to disciplinary action under section under sections 2227 and 2234 (c), of the Code, in that she committed repeated negligent acts in her care and treatment of Patients A, B, and C collectively and individually as more particularly alleged hereinafter: Paragraphs 9 through 23, above, are hereby incorporated by reference and realleged as if fully set forth herein.

25. Patient C was at the time, a 55-year-old female who was referred to Respondent for a neurological examination by her primary care physician. The chief complaint was for burning pain and numbness on the right side of her trunk for a 6-week period. MRI lumbar spine dated August 18, 2016 revealed a grade 1 anterior listhesis at L4-5 and L5-S1. Patient C had previously had a lumbar disc compression and fusion on November 16, 2016, and had a fall on January 23, 2017, where the pain and numbness began.

26. On or about January 4, 2017, Patient C went to another medical provider since Patient C abandoned her appointment with Respondent due to a long office wait. Patient C was evaluated for numbness in her right shoulder and arm, and had restless leg syndrome and left carpal tunnel syndrome. An MRI study on April 4, 2017, revealed increased T2 signal in the right lateral aspect of the cervical cord at C2-3, raising the question of demyelinating plaque. A referral to neurology was placed and a brain MRI was ordered for continuing numbness and tingling on the right side despite being on pain medications.

27. On or about October 5, 2017, Respondent saw Patient C for an office visit. Respondent documented a primary diagnosis of "abnormal brain MRI." Patient C presented with complaints of balance problems; chronic pain and restless leg syndrome. Respondent's history was brief and inadequate and was not historically developed for Patient C's complaint. Respondent ordered laboratory studies, EEG, EMG, and a request to obtain Patient C's MRI brain report. Later in the day, Respondent subsequently reviewed Patient C's MRI brain report dated August 24, 2017. The MRI brain report revealed several white matter lesions adjacent to right and left lateral ventricles, pons, medulla, and middle cerebellar peduncle, suggestive of multiple

sclerosis. Respondent failed to communicate and discuss the MRI report with Patient C, and failed to order the appropriate workup for suspected multiple sclerosis. Respondent documented an 80-minute encounter.

28. Respondent committed repeated negligent acts in her care and treatment of Patient C, which included, but was not limited to the following:

A. Respondent failed to perform and/or document an adequate patient history that was historically developed for Patient C's complaint.

B. Respondent ordered inappropriate tests that had nothing to do with Patient C's diagnosis of multiple sclerosis.

C. Respondent failed to follow through with Patient C after she received the abnormal MRI study.

FOURTH CAUSE FOR DISCIPLINE
(Excessive Treatment)

29. Respondent is further subject to discipline under sections 2227 and 725, in that she excessively ordered tests including but not limited to EEGs and BAER for her patients. Paragraphs 9 through 28, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Medical Records)

30. Respondent is further subject to discipline under sections 2227 and 2234, as defined by section 2266, of the Code, in that she failed to maintain adequate and accurate medical records in the care and treatment of her patients. Paragraphs 9 through 28, above, are hereby incorporated by reference and realleged as if fully set forth herein.

CAUSE TO REVOKE PROBATION
(Failure to Practice Medicine Safely)

31. In a prior disciplinary action entitled, *In the Matter of the First Amended Accusation Against Nadine Helmy Yassa M.D.*, before the Board, Case Number 02-2013-231688, the Board issued a Decision and Order effective February 16, 2018, in which Respondent's Physician's and

Surgeon's license No. A 48720 was revoked. However, the revocation was stayed and Respondent Physician's and Surgeon's certificate was placed on probation for a period of five (5) years with other terms and conditions. The Decision and Order is attached as Exhibit A and is incorporated herein by reference.

32. Paragraphs 9 through 28, above, are hereby incorporated by reference and realleged as if fully set forth herein.

33. At all times after the effective date of Respondent's probation in Case No. 02-2013-231688, Condition No. 5 provided:

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

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

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

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

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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.

34. At all times after the effective date of Respondent's probation in Case No. 02-2013-231688, Condition No. 9 provided:

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.

35. At all times after the effective date of Respondent's probation in Case No. 02-2013-231688, Condition No. 15 provided:

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.

36. On or about August 22, 2018, the Board received confirmation that Respondent had enrolled in the Physician Enhancement Program (PEP) at UCSD.

37. On or about February 26, 2019, the Board received Respondent's quarterly summary report from PEP. The months included in the summary are August, October, and November 2018. Respondent was found to need improvement in several areas. The PEP monitor found that Respondent needed improvement in the area of "Assessment." The PEP monitor found that

Respondent needed to write a formulation where she discusses what she thinks the problem is and a differential diagnosis. The PEP monitor also found that Respondent should describe her reasons for ordering tests and document her plan for follow-up. The PEP monitor also found that Respondent needed to improve her documentation of examination findings and write a formal report after an EMG/NCS is performed. The PEP monitor found that Respondent was relying on a template for her neurological examinations, and that Respondent needed to do a better job of altering the template when she finds abnormalities, so that they can be better documented.

38. On or about October 24, 2019, the Board received Respondent's summary report from PEP. The months included in the summary are June, July, August 2019. The PEP monitor found that Respondent's "Physical Examination" portion of her notes was "UNSAFE." The PEP monitor found that the physical examination portion was inadequate. Respondent used a template for follow up that described what was supposedly tested but failed to provide an actual description of examination observations, thus lacking important objective information. The PEP monitor also found that Respondent's "History of Presenting Illness", "Assessment", "Plan", and "Evaluation of Patient Education Component" portions of her note also needed improvement.

39. Respondent's probation is subject to revocation because she failed to comply with Probation Condition No. 5, 9 and 15, in that her practice of medicine was found to be unsafe.

DISCIPLINARY CONSIDERATIONS

40. To determine the degree of discipline, if any, to be imposed on Respondent Nadine Helmy Yassa, M.D., Complainant alleges that on or about February 16, 2018, in a prior disciplinary action titled In the Matter of the Accusation Against Nadine Helmy Yassa, M.D. before the Medical Board of California, in Case Number 02-2013-231688, Respondent's license was revoked, revocation stayed and placed on five years probation with Education Course, Medical Record Keeping Course, Professionalism Program, Clinical Competence Assessment Program, Practice Monitoring, Solo Practice Prohibition and standard terms and conditions, for gross negligence, repeated negligent acts, excessive use of diagnostic procedures, failure to maintain adequate documents and failure to provide a complete copy of a patient record. That decision is now final and 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 No. A 48720, issued to Nadine Helmy Yassa, M.D.;

2. Revoking the probation that was granted by the Medical Board of California in Case No. 02-2013-231688, and imposing the disciplinary order that was stayed thereby revoking Physician's and Surgeon's Certificate No. A 48720 , issued to Nadine Helmy Yassa, M.D.;

3. Revoking, suspending or denying approval of Nadine Helmy Yassa, M.D.'s authority to supervise physician assistants and advanced practice nurses;

4. Ordering Nadine Helmy Yassa, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: FEB 21 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 First Amended Accusation Against: Nadine Helmy Yassa, M.D. Physician's and Surgeon's Certificate No. A 48720 Respondent	)	Case No. 02-2013-231688

DECISION

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

This Decision shall become effective at 5:00 p.m. on February 16, 2018.

IT IS SO ORDERED: January 17, 2018.

MEDICAL BOARD OF CALIFORNIA

Kristina Lawson, J.D., Chair
Panel B

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

In the Matter of the First Amended Accusation Against: NADINE HELMY YASSA, M.D. Physician and Surgeon's Certificate No. A 48720 Respondent.	Case No. 02-2013-231688 OAH No. 2016030977

PROPOSED DECISION

This matter was heard before Administrative Law Judge Marcie Larson, Office of Administrative Hearings, State of California, on December 12, 13, and 16, 2016, and August 9 through 11, 2017, in Sacramento, California.

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

Robert Zimmerman, Attorney at Law, represented respondent Nadine Helmy Yassa, M.D., who was present at the hearing.

Evidence was received, and the record was held open for the submission of written closing briefs. On October 23, 2017, the parties closing briefs were received. On October 27, 2017, the parties reply briefs were received.[1] The record was closed and the matter was submitted for decision October 27, 2017.

[1] Complainant's closing brief was marked for identification as Exhibit 51. Respondent's closing brief was marked for identification as Exhibit C. Complainant's reply brief was marked for identification as Exhibit 52. Respondent's reply brief was marked for identification as Exhibit D.

FACTUAL FINDINGS

1. On October 9, 1990, the Board issued respondent Physician and Surgeon's Certificate No. A 48720 (certificate). The certificate was current at all times pertinent to this matter. It will expire on July 31, 2018, if not renewed or revoked.

2. On July 26, 2016, complainant, acting in her official capacity, signed and thereafter filed the First Amended Accusation against respondent.[2] Complainant seeks to impose discipline on respondent's certificate, based on her alleged conduct in connection with her treatment of four patients: V.A., B.A., R.C., and D.K.[3] Generally, complainant alleged respondent misdiagnosed V.A., B.A., and R.C., performed unnecessary and excessive diagnostic procedures, failed to maintain adequate and accurate treatment records, and failed to consider drug interactions in medications that she prescribed to B.A. and R.C. Complainant also alleged that respondent failed to keep adequate treatment records to support her diagnosis of D.K., billed for services that were not substantiated by the treatment records, and failed to provide a complete and certified record of D.K.'s treatment records to the Board.

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

Respondent's Background

4. Respondent was born and raised in Alexandria, Egypt. She completed an undergraduate degree at the School of Science and then attended the School of Medicine both at Alexandria University in Egypt. Respondent graduated with her medical degree in 1980. She then completed a one-year rotating internship at Alexandria. In 1982, respondent was married and moved to Roseville, California. She had four children between 1982 and 1989, and made the decision to put her medical career on hold.

5. In 1989, respondent returned to the medical profession. She was accepted into a pediatric residency program in San Francisco. She completed one year of the program and decided to practice in a field that was more intellectually challenging. In 1990, respondent

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[2] At hearing, complainant amended the First Amended Accusation. At page 10, line 12 from "Respondent" to line 13 at "criteria" was stricken. Page 15, line 7 was amended to read: "Respondent improperly diagnosed multiple sclerosis and failed to recognize symptoms and findings of partial transverse cervical myelopathy." Page 16, line 1 starting at "She" continuing to all of line 2 and footnote 12, was stricken. Page 16, line 9 the following sentence was added: With respect to patient V.A. she diagnosed migraine without establishing diagnostic criteria.

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

was accepted into the University of California (UC), Davis East Bay residency program in adult neurology. She primarily practiced at the Veteran's hospital in Martinez. In 1994, she completed the residency program and began a one-year fellowship in child neurology through UC Davis Medical Center. Respondent completed the program and obtained her certification with the American Board of Psychiatry and Neurology, in the medical specialty of neurology with a special qualification in child neurology. In 2013, respondent also obtained board-certification in sleep medicine.

6. In 1995, respondent started a private practice in Roseville, which she still maintains. Respondent treats adults and children with neurological conditions, including autism, seizure disorders, epilepsy, headaches, multiple sclerosis (M.S.), stroke, and Parkinson's disease. Approximately 30 to 40 percent of her patients are children. Respondent has received recognition from insurance companies for her patient care and between 2004 and 2011, was recognized as one of "America's Top Physicians."

Investigation Conducted by Investigator Anna Vanderveen

PATIENTS V.A. AND B.A.

7. On March 18, 2014, Anna Vanderveen, an Investigator for the Department of Consumer Affairs, was assigned to investigate respondent's care and treatment of V.A. and B.A. Investigator Vanderveen issued an Investigation Report dated June 12, 2015, and testified at hearing. As part of her investigation, Investigator Vanderveen obtained respondent's patient records for V.A. and B.A., and interviewed V.A.'s mother L.A. Investigator Vanderveen also participated in an interview of respondent conducted on April 16, 2015 (Board Interview). Respondent was represented by counsel and Deputy Attorney General Jannsen Tan and Dr. Slyter were also present at the interview.

8. Investigator Vanderveen sent her Investigation Report, the medical records of B.A. and V.A. and a transcript and compact disk containing respondent's April 16, 2015 interview, to Board expert reviewer Jack Florin, M.D. On May 25, 2015, Dr. Florin issued a report in which he opined that respondent's care and treatment of V.A. and B.A. departed from the standard of care.

PATIENT R.C.

9. On April 23, 2013, the Central Complaint Unit (CCU) for the Board received a patient complaint from R.C., regarding the care and treatment respondent provided to her in 2012 and 2013. On September 23, 2013, Investigator Vanderveen was assigned to investigate the complaint. She prepared an Investigation Report dated June 12, 2015. As part of her investigation, Investigator Vanderveen obtained respondent's patient records for R.C., and interviewed R.C. Respondent was also questioned concerning her treatment of R.C., during the Board Interview.

10. Investigator Vanderveen sent her Investigation Report, R.C.'s medical records and a transcript and compact disk containing respondent's Board Interview, to Dr. Florin. On May 24, 2015, Dr. Florin issued a report in which he opined that respondent's care and treatment of R.C. departed from the standard of care.

PATIENT D.K.

11. On March 28, 2014, the CCU received a patient complaint from D.K., regarding the care and treatment respondent provided to him on March 27, 2014. On May 27, 2014, Investigator Vanderveen was assigned to investigate the complaint. She prepared an Investigation Report dated June 12, 2015. As part of her investigation, Investigator Vanderveen obtained some of respondent's patient records for D.K., and interviewed D.K. Respondent was also questioned concerning her treatment of D.K., during the Board Interview.

12. Investigator Vanderveen sent her Investigation Report, the incomplete medical records of D.K. and a transcript and compact disk containing respondent's Board Interview, to Dr. Florin. On May 25, 2015, Dr. Florin issued a report in which he opined that respondent's care and treatment of D.K. departed from the standard of care.

Treatment History of Patient V.A.

13. In September 2009, V.A. was a nine-year old girl with a two-month history of headaches and difficulties at school. V.A.'s mother L.A. testified that V.A.'s third grade teacher expressed concern that V.A. was having difficulty in math and reading comprehension. In January 2009, V.A. was tested for learning disabilities. In July 2009, V.A. became sick with flu-like symptoms. She suffered from a headache and a temperature for more than two weeks. After a month passed and V.A. was still suffering from headaches, L.A. requested from V.A.'s pediatrician, a referral to a neurologist to have a neurological examination conducted. L.A. located respondent and made an appointment for V.A.

SEPTEMBER 10, 2009 VISIT

14. On September 10, 2009, V.A. had her first appointment with respondent. L.A. completed a "Review of Symptoms" form and noted that V.A. was suffering from headaches and neck and back pain. During the examination, L.A. reported to respondent that V.A. had been complaining of daily headaches since July 2009, after she had a viral infection. The headaches lasted all day. V.A. reported to respondent that she had tension and pressure of her head. She reported her pain level as "3-4" on a 10-point scale. V.A. also reported that she had difficulty concentrating due to her headaches, and that she had nausea, but not vomiting. Respondent noted that V.A. reported "photophobia" (light sensitivity), but denied any "phonophobia," (sound sensitivity). V.A. reported that she did not suffer any type of head trauma, loss of weakness on either side of her body, vision issues, or a throbbing headache.

15. Respondent conducted a neurological examination on V.A. Under the Assessment and Plan portion of V.A.'s medical record, respondent diagnosed V.A. with: (1) childhood migraine; (2) neoplasm, cerebral, rule out; (3) aneurysm, cerebral, rule out; and (4) adverse effect of med correctly given, rule out. She prescribed V.A. 10 milligrams (m.g.) of Amitriptyline and 100 m.g. of Imitrex tablets to treat the migraine headache. Respondent also ordered a Magnetic Resonance Imaging (MRI) of the brain to "rule out any structural lesions." Respondent wanted to ensure that the headaches were not caused by an anomaly in the brain and the MRI would provide that information. L.A. testified that she never gave V.A. the Imitrex, because she believed it was not an appropriate medication to give a child.

16. A few days after V.A.'s initial appointment, respondent ordered a video electroencephalogram (EEG), which was performed on September 18, 2009, at respondent's office. Respondent did not document why she ordered a video EEG. Respondent testified that an EEG is "very commonly used" in child neurology to observe a patient's brain waves. If there is a cerebral anomaly the EEG will typically be abnormal.

The technician who performed the EEG noted that V.A. had sharp and slow abnormal waves on the EEG. Respondent also reviewed the EEG results and identified abnormalities, including elevated spikes, sharp waves and vocal slowing. Respondent testified that the isolated sharp waves she observed may have implied generalized epilepsy and the focal slowing may have implied that V.A. was suffering from seizures. However, respondent contended that an "abnormal EEG does not mean a whole lot." Other factors must be considered when making a diagnosis.

SEPTEMBER 30, 2009 VISIT

17. On September 30, 2009, V.A. saw respondent for follow-up appointment. Respondent noted in V.A.'s medical record that a brain MRI "indicates an arachnoids cyst post fossa." Respondent also wrote that the EEG was an "abnormal awake and drowsy study. There was generalized polyspike and wave which was synchronous bilaterally over both hemispheres which is highly suggestive of a generalized seizures disorder." Respondent informed L.A. that it appeared from the EEG that V.A. was having "petite seizures." L.A. had never observed V.A. have any event that looked like a seizure.

18. Under the Assessment and Plan, respondent listed: (1) arachnoid cyst, post fossa; (2) generalized epilepsy, rule out; (3) adverse effect of medications correctly given; (4) neoplasm, cerebral, ruled out; (5) headaches, childhood headaches; and (6) learning disability. Respondent ordered a neurosurgery consultation, due to the MRI findings. She prescribed 250 m.g. of Depakote twice a day (b.i.d) and discontinued the Amitriptyline due to the "seizures on EEG." Respondent testified that contrary to the medical record note, she did not prescribe the Depakote to treat V.A. for epilepsy or seizures. Rather, the Depakote was prescribed for "headache prevention." Respondent testified that if she was treating V.A. for epilepsy or seizures she would have prescribed 500 m.g. or 750 m.g. twice per day.

NOVEMBER 4, 2009 VISIT

19. On November 4, 2009, V.A. saw respondent for a follow-up visit. L.A. was present in the examination room with V.A. Respondent noted in the medical record for the visit that V.A. was "having a lot of trouble with learning on math and comprehension." V.A. denied having any "auras" which is a general word that describes symptoms that are precursors to a seizure, and there was no witnessed seizure activity reported. Respondent noted that V.A.'s Depakote level was "72." A therapeutic level of Depakote is between 50 and 100.

20. Under the Assessment and Plan, respondent listed: (1) learning disability; (2) childhood headaches; (3) generalized epilepsy; (3) arachnoid cyst, middle cranial cyst; and (4) seizures, breakthrough. Respondent ordered a repeat video EEG to "rule out any epileptogenic foci." During the Board Interview, respondent could not recall why she documented that V.A. had a breakthrough seizure. However, at hearing, she testified that she listed "seizures, break through" as an "alert" for her to make sure that she did not "miss" a breakthrough seizure, because there were indications that V.A. may have seizures, including the "anomaly on the MRI," "learning problems," daily headaches for two months, and "seizures on the EEG."

Respondent also contended that she ordered the repeat EEG because she needed to determine if V.A. had a seizure disorder. Respondent was concerned that V.A.'s learning challenges were related to "subclinical" seizure activity or the arachnoid cyst. Respondent explained that "subclinical" seizure activity can only be seen "on paper," without outward signs such as shaking or falling.

21. The repeat EEG was performed on November 25, 2009. The technician did not note any abnormal findings. However, respondent issued a report that stated there was an "abrupt onset of generalized polyspike and slow waves . . . over both hemispheres synchronously is highly suggestive of generalized epilepsy" and "[l]ocalized slowing was noted in the left temporal area." Respondent observed a pattern of slowing brain waves after V.A. was induced to hyperventilate. Respondent testified that this finding was significant to conclude that there was a "high possibility of generalized seizure" disorder.

DECEMBER 7, 2009 VISIT

22. On December 7, 2009, V.A. saw respondent for a follow-up visit. Respondent noted that V.A. still reported headaches and "no improvement with the Imitrex." Respondent also noted that V.A. was receiving tutoring for her learning challenges. V.A. denied having any "auras" and there was no witnessed seizure activity reported.

23. Respondent conducted an examination of V.A., with L.A. present in the examination room. Respondent documented that V.A. had an "episode of a staring spell during the exam" and respondent "clapped loudly but this did not snap the patient out of the staring spell." Respondent testified that the staring spell was suggestive of a seizure. L.A.

credibly denied that no such an event occurred during the examination. L.A. did not observe V.A. have a staring spell, nor did she observe respondent clap loudly. Respondent testified that only an "experienced eye" could have detected the staring spell.

24. Under the Assessment and Plan, respondent listed: (1) generalized epilepsy; (2) learning disability; (3) arachnoid cyst, middle cranial cyst; (4) childhood headaches; and (5) adverse effect of medication correctly given, rule out. Respondent increased the Depakote to 250 m.g. in the morning and 500 m.g. in the evening, for a total of 750 m.g. per day. She also ordered V.A. to obtain a check of her Depakote level prior to her next visit.

25. Respondent testified that she increased the Depakote to treat V.A.'s headaches, not to treat her for epilepsy or seizures, because she did not have enough information to make a diagnosis of epilepsy. Respondent further contended that in order to diagnosis a patient with epilepsy, at least two epileptic episodes must be observed. Respondent explained that V.A. had "suggestive EEGs" but she could not diagnosis her with epilepsy based on the EEGs and the staring spell she observed.

FEBRUARY 11, 2010 VISIT

26. On February 11, 2010, V.A. saw respondent for a follow-up visit. V.A. continued to report learning challenges. Respondent noted in the medical record that V.A. reported that she "shuts off and forgets." V.A. denied having any "auras" and there was no witnessed seizure activity reported. There was no information documented regarding the status of V.A.'s headaches. Respondent noted that V.A.'s Depakote level was "53." She also noted that V.A. had a neurosurgery consultation. The neurosurgeon opined that V.A. did not have an arachnoid cyst. He believed that the MRI showed a normal variant in her brain. The neurosurgeon recommended a repeat MRI in six months if V.A.'s headaches continued.

27. Under the Assessment and Plan, respondent listed: (1) learning disability; (2) generalized epilepsy; (3) adverse effect of medication; and (4) arachnoid cyst, middle cranial cyst. Respondent increased V.A.'s Depakote to 1,000 m.g. per day. She also ordered V.A. to obtain a check of her Depakote level prior to her next visit. Respondent testified that she was concerned that V.A.'s report of "shutting off" implied that she may be having seizures.

MAY 11, 2010 VISIT

28. On May 11, 2010, V.A. saw respondent for a follow-up visit. V.A. reported that she was still having difficulties with comprehension and math. V.A. also reported that she had gained eight pounds since her last visit. L.A. had not observed V.A. have any seizures. L.A. wanted V.A.'s medication changed to address the weight gain.. Respondent conducted a neurologic examination which was normal.

29. Under the Assessment and Plan, respondent listed: (1) generalized epilepsy; (2) childhood headaches; (3) adverse effect of medication correctly given; and (4) learning

disability. Respondent discontinued the Depakote. She prescribed 500 m.g. of Keppra once per day. Keppra is an anti-epileptic medication. Respondent also ordered a repeat video EEG to "rule out seizures." Respondent testified that she ordered the EEG because she changed V.A.'s medication and she needed to "make sure" that V.A. did not have "anymore seizures."

Respondent also ordered a Brainstem Auditory Evoked Response (BAER) test, to be performed at respondent's office, to "rule out hearing loss." The BAER test measures the timing of electrical waves from the brainstem in response to clicks in the ear. Respondent conceded that the BAER test can detect deafness but it is not a good measure for subtle hearing loss. An audiogram is a better test of whether there is subtle hearing loss. Respondent does not have an audiogram machine in her office. V.A. did not have the BAER test conducted because her hearing had been tested in November 2009.

30. A video EEG was performed on June 28, 2010. The technician did not note any abnormal findings on the EEG. Respondent issued a report which stated that the "video monitored EEG session is not diagnostic of Epilepsy." She also noted that there was "no EEG changes with any clinical event." Respondent wrote that "[i]f seizures are still highly suspected, a more prolonged EEG tracing with sleep deprivation should be considered." Respondent testified that she took the normal EEG "with a grain of salt, exactly like an abnormal EEG."

JULY 12, 2010 VISIT

31. On July 12, 2010, V.A. saw respondent for a follow-up visit. V.A. denied having headaches, or "dropping of objects." She reported losing five pounds since her last visit. Respondent noted in the medical record that V.A. was working with a reading specialist and "doing extra math with the computer." Respondent noted that V.A.'s EEG was normal and that no "epileptogenic foci" was seen. L.A. had not observed V.A. have any seizures. Respondent conducted a neurologic examination which was normal.

32. Under the Assessment and Plan, respondent listed: (1) generalized epilepsy; (2) adverse effect of medication correctly given; (3) learning disability; and (4) childhood headaches. Respondent ordered for V.A. a 72-hour ambulatory EEG. During the Board Interview, respondent stated the she ordered the 72-hour ambulatory EEG because she was concerned about V.A.'s poor grades and the possibility she was "missing seizures." At hearing, respondent testified that she ordered the 72-hour ambulatory EEG because she was concerned that V.A. may have a sudden onset of death at night "secondary to seizures." Respondent contended that the normal EEG "may or may not have caught the seizure activity." L.A. did not schedule the EEG for V.A.

JANUARY 19, 2011 VISIT

33. On January 19, 2011, V.A. saw respondent for a follow-up visit. Respondent noted in the medical record that V.A. was tested at "SAC STATE" and "all was normal."

Respondent also noted that V.A.'s math and history tests were "still low" and that V.A. was receiving tutoring for all subjects but "still gets F's on her grades." L.A. credibly denied that she told respondent that the testing for learning disabilities performed on V.A. at California State University, Sacramento, was normal. The testing revealed that V.A. had areas where she was below average. Respondent also noted that there was "no witnessed seizures" and that V.A. was tolerating the Keppra. Respondent conducted a neurologic examination which was normal.

34. Under the Assessment and Plan, respondent listed: (1) arachnoid cyst, middle cranial cyst; (2) generalized epilepsy; (3) learning disability; (4) childhood headaches; (5) seizures, break through, rule out; and (6) adverse effect of medication correctly given, rule out. Respondent prescribed V.A. Strattera capsules for "generalized epilepsy." Respondent testified that Strattera is commonly used for Attention Deficit Disorder (ADD). Respondent did not believe that V.A. had ADD, but she prescribed the medication as a way to exclude the diagnosis. Respondent testified that she did not want to "waste the kid's time waiting until [she could] confirm a diagnosis." L.A. refused to give V.A. the Strattera and indicated that she wanted to take V.A. off of all medication. Respondent learned that L.A. had not scheduled the ambulatory EEG. She asked her to do so that she could get more information before considering whether to take her off the medication.

35. On February 18, 2011, V.A. had a four-day ambulatory EEG. The technician did not note any abnormal findings on the EEG. Respondent issued a report and noted that the EEG was to "rule out seizures." Respondent wrote that V.A. had an "arachnoid cyst, middle cranial cyst. Generalized epilepsy, childhood epilepsy, seizures disorder [rule out] though doubt, learning disability." Respondent noted that the four-day EEG was performed "as part of the evaluation of possible seizures versus other movement disorders." Respondent noted that no "epileptiform abnormalities" were detected. She further wrote that the ambulatory EEG was "not diagnostic of Epilepsy" and that the "absence of any interictal discharges over the recording, does not preclude the patient from being at risk for seizures/epilepsy." She added that "[i]f seizures are highly suspected, a repeat EEG with more prolonged tracing would be recommended."

MARCH 14, 2011 VISIT

36. On March 14, 2011, V.A. saw respondent for her last follow-up visit. Respondent noted in V.A.'s medical record that her four-day ambulatory EEG was normal. L.A. reported that V.A. was still struggling with math. L.A. had not observed V.A. have any seizures. L.A. informed respondent that she wanted her daughter taken off medication. L.A. had concerns about medicating her daughter, but she also was concerned about risk of seizure. Respondent discontinued the Keppra and Imitrex.

37. Under the Assessment and Plan, respondent listed: (1) arachnoid cyst, middle cranial cyst; (2) generalized epilepsy; (3) learning disability; and (4) adverse effect of medication correctly given. Respondent testified that she never diagnosed V.A. with

generalized epilepsy, despite repeatedly listing it under the Assessment portion of V.A.'s medical records.

EVENTS AFTER MARCH 14, 2011

38. V.A. stopped all medication. L.A. switched medical groups and found a new neurologist for V.A. The neurologist reviewed respondent's treatment records for V.A. The neurologist informed L.A. that V.A. did not need a repeat EEG and never had any seizures. L.A. obtained a second opinion from another neurologist to ensure V.A. was not having seizures that were contributing to her learning issues as respondent had advised. The second neurologist reviewed the treatment records and ordered an EEG, in which he found no evidence of seizure activity. He also referred V.A. to a neurophysiologist for extensive learning disability testing.

Treatment History of Patient B.A.

AUGUST 10, 2009 VISIT

39. In August 2009, B.A. was a 14-year-old girl with a four-year history of seizures. B.A. first saw respondent on August 10, 2009, after her family moved from Florida to California. B.A.'s mother completed a neurology questionnaire, in which she wrote that B.A. had her first seizure when she was 10 years old. The seizure occurred on February 21, 2006, early in the morning. Her second seizure occurred in December 2008, when her medication was switched. The "big seizures" involved loss of consciousness. B.A.'s mother reported that B.A. was prescribed and taking Klonopin 0.5 m.g. in the evening, Depakote 750 m.g. in the morning and evening and Vistaril 10 m.g. in the evening. Respondent noted that B.A.'s medical record indicated that an MRI was conducted in October 2008. An EEG performed at the same time noted "3-13 seizures."

40. Respondent conducted a neurological examination of B.A. She noted that B.A. had two "café au lait spots on the back and on the face fading away." Respondent documented under B.A.'s mental history that she had "suicidal thoughts." She also noted that B.A. "trips a lot." Under the Assessment and Plan, respondent listed: (1) juvenile myoclonic epilepsy; (2) adverse effect of medication correctly given, rule out; (3) insomnia unspecified; (4) depressive disorder OT; and (5) café au lait spots x2. Respondent listed under the "prescribed medications" Klonopin 0.5 m.g., q.h.s., Depakote 500 m.g. b.i.d., Depakene 250 m.g. b.i.d., and Vistaril 10 m.g. q.h.s. Depakene is similar to Depakote.

41. Respondent testified that she obtained the diagnosis of "insomnia unspecified" from B.A.'s past neurologist treatment records. B.A. had a polysomnogram test for insomnia which was normal. Respondent did not ask B.A. any questions to ascertain whether B.A. was suffering from insomnia. Respondent also testified that she noted the café au lait spots because more than five spots can be an indication of neurofibromatosis, which can cause a brain tumor called a Schwannomas typically found on the "eighth nerve," that affects balance and hearing. Respondent contended that a tumor could have explained B.A.'s report of

"tripping a lot." Respondent ordered a video EEG to "rule out any epileptogenic foci." Respondent explained that because B.A. was a new patient, she needed an EEG to establish a "baseline." Respondent also ordered B.A. to obtain a check of her Depakote level two days prior to her next visit.

42. On August 12, 2009, a video EEG was performed. The technician noted sharp and slow waves and spike and slow waves on the left side at "F3-C3." Respondent issued a report and noted that B.A. had a "normal awake and drowsy" EEG, with no epileptiform discharges seen. She also noted that if "seizures are still highly suspected, a more prolonged EEG tracing with sleep deprivation should be considered." A BAER was also performed the same day of the EEG, although respondent did not order the BAER. The BAER test printout noted that B.A. had a history of "hearing loss, dizziness."

43. During the Board Interview, respondent explained that history of "hearing loss, dizziness" listed for the BAER test, was a description used for billing purposes to obtain approval for the test. Respondent explained that she did not know if B.A. had a history of hearing loss or dizziness. However, at hearing respondent testified that the BAER was performed to determine whether B.A. had a nerve lesion on the eighth nerve. Respondent did not document any concern about a brain lesion in B.A.'s medical record and it was not listed as a diagnosis.

AUGUST 31, 2009 VISIT

44. On August 31, 2009, B.A. saw respondent for a follow up examination. Respondent noted that B.A.'s Depakote level was "101" and she was tolerating the medication. Respondent noted that B.A. reported she was tired and "then during eating, the parmesan cheese fell off her hand." Respondent testified that she noted the falling of the cheese from B.A.'s hand because it could be an indication of a seizure. However, respondent did not document any report of seizures. Respondent also noted that B.A.'s EEG and BAER were both normal. Respondent again documented that B.A. had suicidal thoughts. Respondent testified that B.A. was evaluated and treated by a psychologist in Florida for her mental health condition and "they said she was fine." Respondent explained that depression can be part of epilepsy so she noted "suicidal thoughts" in each of B.A.'s visit records to "remind herself over and over and over never to miss" asking B.A. whether she has suicidal thoughts.

45. Respondent conducted a neurological examination of B.A. which was normal. Under the Assessment and Plan, respondent listed: (1) seizures, break through; (2) adverse effect of medication correctly given, rule out; (3) juvenile myoclonic epilepsy; and (4) café au lait spots x2. Respondent discontinued the Klonopin and Vistaril. Respondent prescribed Topamax Sprinkles 25 m.g. to increase to 50 m.g. morning and night. Respondent testified that she changed B.A.'s medication because she did not believe the medications were "optimal." Vistaril is used to treat nausea and can cause central nervous system problems and Klonopin is an anti-seizure medication which can become addictive. Respondent testified that she also wanted to get B.A.'s Depakote to a "therapeutic level." Respondent

substituted one of the doses of Depakote to Topamax, which is a medication used to treat seizures and headaches.

NOVEMBER 2, 2009 VISIT

46. On November 2, 2009, B.A. saw respondent for a follow up examination. Respondent noted in the medical record that B.A. was "losing some weight with the Topamax" and that B.A. was tolerating the Depakote well. Respondent testified that she discussed with B.A. the "value" of lowering her Depakote and B.A. indicated that she wanted to lower the dosage. B.A. denied any "auras or witnessed seizure activity." Respondent noted that B.A. had suicidal thoughts.

47. Respondent conducted a neurological examination of B.A. which was normal. Under the Assessment and Plan, respondent listed: (1) juvenile myoclonic epilepsy; (2) seizures, grand mal x2; (3) circadian cycle problems, insomnia; and (4) adverse effect of medication correctly given, POS. Respondent decreased B.A.'s Depakote to 500 m.g. twice per day.

Respondent testified that she decreased the Depakote because B.A. was "child-bearing" age, and Depakote can cause birth defects to a fetus. Respondent intended to take her off Depakote and prescribe a new medication without the same side effects. There is no indication in the medical record that respondent had any discussion with B.A. or her mother about the risks of lowering the Depakote. Respondent also ordered a repeat EEG to "rule out any epileptogenic foci" and instructed B.A. to obtain her Depakote level two days prior to her next visit. Respondent explained that she ordered the repeat EEG because she adjusted B.A.'s medication.

48. On November 23, 2009, the repeat EEG was performed. The technician documented abnormal spike and slow waves and sharp and slow waves. Respondent issued a report documenting that the EEG was normal. The report contained virtually identical language to the August 12, 2009 EEG report.

MAY 3, 2010 VISIT

49. On May 3, 2010, B.A. saw respondent for a follow up examination. B.A. reported that the Depakote and Topamax were "well tolerated." There was no documentation that any laboratory tests were performed to check B.A.'s Depakote level. B.A. denied any falls or "auras or witnessed seizure activity." Respondent again noted that B.A. had suicidal thoughts. Respondent conducted a neurological examination which was normal.

50. Under the Assessment and Plan, respondent listed: (1) seizures, grand mal x2; (2) juvenile myoclonic epilepsy; (3) circadian cycle problems, insomnia; and (4) adverse effect of medication correctly given, POS. Respondent discontinued the Topamax due to "memory problems." Respondent testified that Topamax can cause memory problems, so

she took B.A. off the medication. B.A. was still taking 500 m.g. of Depakote twice per day. Respondent ordered laboratory tests to check B.A.'s Depakote level and "CBC" two days prior to her next visit.

Respondent ordered a third EEG to "rule out seizures" and a 72-hour ambulatory EEG. The third EEG was taken on June 4, 2010, and was normal. Respondent issued a report regarding the third EEG which was virtually identical to the two previous reports. The four-day ambulatory EEG was performed on July 6, 2010, and was normal. Respondent ordered the third EEG to make sure B.A. was "stable" before tapering her off the Topamax. Respondent also contended that because B.A. was 15 years old at the time, she was concerned that she would be driving soon, and she had to ensure that she was seizure free.

JUNE 8, 2010 VISIT

51. On June 8, 2010, B.A. saw respondent for a follow up visit. Respondent documented in B.A.'s patient record that she was "having problems off the Topamax with improvement in the memory but headaches recurred." B.A. reported daily headaches. Respondent again noted that B.A. had suicidal thoughts. Respondent conducted a neurological examination which was normal.

52. Under the Assessment and Plan, respondent listed: (1) juvenile myoclonic epilepsy; (2) hypopigmented skin lesion; (3) depressive disorder OT; and (4) circadian cycle problems, insomnia. Respondent prescribed Amitriptyline 10 m.g. and Imitrex 100 m.g. There was no reference to B.A.'s Depakote level. Respondent did not order any laboratory tests to check B.A.'s Depakote level before the next appointment.

July 29, 2010 Visit

53. On July 29, 2010, B.A. saw respondent for a follow up visit. Respondent noted that the four-day ambulatory EEG was performed on July 6, 2010; and was normal. Respondent also noted that B.A. had "elavil x2 days with more headaches and increased frequency of the twitches." The "elavil" referred to the Amitriptyline. Respondent again noted that B.A. had suicidal thoughts. Respondent conducted a neurological examination which was normal.

54. Under the Assessment and Plan, respondent listed: (1) juvenile myoclonic epilepsy; (2) seizures, grand mal x2; (3) adverse effect of medication correctly given, POS; and (4) circadian cycle problems, insomnia. Respondent discontinued the amitriptyline, although respondent did not believe it was the cause of the twitches. There was no reference to B.A.'s Depakote level. Respondent did not order any laboratory tests to check B.A.'s Depakote level before the next appointment.

AUGUST 23, 2010 VISIT

55. On August 23, 2010, B.A. saw respondent after she suffered two "back to back" seizures on August 11, 2010, and bad headaches. Respondent noted that B.A.'s mom reported that she had left B.A. at their home to take her other child to school. When she returned home, she found B.A. in the "post ictal stage and a bad tongue bite." B.A.'s mother called 911 and B.A. was taken to the emergency room. B.A.'s labs indicated her Depakote level was "61." B.A.'s mom also reported that B.A. also had "a lot of twitching since the last seizure, mainly in the early morning." Prior to the August 11, 2010 seizures, she had not had a seizure in approximately three years.

56. Respondent conducted a neurological examination which was normal. Respondent documented that B.A. has suicidal thoughts. Under the Assessment and Plan, respondent listed: (1) seizures, break through, history of; (2) juvenile myoclonic epilepsy; (3) circadian cycle problems, insomnia; and (4) depressive disorder OT. Respondent discontinued the Imitrex. Respondent added Lamictal 100 m.g. b.i.d. Respondent added the Lamictal to address the breakthrough seizures. Respondent did not order any laboratory tests to check B.A.'s Depakote level before the next appointment. Respondent also ordered an EEG.

57. Respondent testified that she did not raise the dosage of Depakote because of her concern that if B.A. became pregnant, the Depakote would affect the fetus. There is no documentation in any of B.A.'s treatment records from respondent that there was discussion with B.A. or her mother about respondent's concern about the continued use of Depakote. Respondent also explained that Lamictal is a "tricky" medication. She introduced the medication slowly by prescribing B.A. one pill every other day for two weeks. Respondent explained that the manufacturer of the medication provides a "titration kit." Respondent documented on B.A.'s medical record that she prescribed Lamictal 100 m.g. b.i.d., but B.A.'s initial titrated dosages was 25 m.g.

AUGUST 30, 2010 VISIT

58. On August 30, 2010, B.A. saw respondent for a follow up visit. B.A.'s mother reported that B.A. took her first dose of "Lamictal 25 m.g. and was very confused, had twitches and was very nervous and usually is not nervous." B.A.'s mother also reported that she stays with B.A. and watches her every morning and "feels that she still has twitches in the mornings." Respondent also documented in B.A.'s patient record that she had suicidal thoughts.

59. Respondent conducted a neurological examination which was normal. Under the Assessment and Plan, respondent listed: (1) juvenile myoclonic epilepsy; (2) adverse effect of medication correctly given, POS; (3) depressive disorder OT; and (4) circadian cycle problems, insomnia. Despite B.A.'s report of confusion and side effects from her medication, respondent testified that she continued to "push" the Lamictal. Respondent noted in the medical record that she discontinued the "Depakote ER Tablets 500 m.g."

Respondent explained that the Depakote had been written twice in the medical record in error, so she discontinued one of the entries. Respondent did not order any laboratory tests to be performed before the next appointment.

NOVEMBER 4, 2010 VISIT

60. On November 4, 2010, B.A. saw respondent for the last time. Respondent noted in B.A.'s patient record that the EEG performed on September 3, 2010, was normal. B.A. reported that she was unable to sleep at night and that she was having trouble with coordination and balance. B.A. also reported that she "keeps forgetting everything," drinks lots of water, has "cotton mouth" and is missing a lot of school. She also reported muscle twitches and cramps at night. Respondent again noted the B.A. had suicidal thoughts.

61. Respondent conducted a neurological evaluation which was normal. Under the Assessment and Plan, respondent listed: (1) juvenile myoclonic epilepsy; (2) adverse effect of medication correctly given, POS; (3) depressive disorder OT; (4) seizures, grand mal x2; and (5) depressive disorder not elsewhere classified. Respondent noted that B.A. was taking Depakote 500 m.g. b.i.d. and Lamictal 100 m.g. b.i.d. Respondent did not order any laboratory tests to be performed before the next appointment.

62. Respondent prescribed B.A. Prozac 20 m.g. one time per day. Respondent testified that she prescribed the Prozac to improve B.A.'s quality of life. Respondent was aware that Prozac had a "black box" warning on prescribing the drug for patients with suicidal thoughts. Respondent contended that although B.A. had a history suicidal thoughts, she never had any "suicidal ideation" while respondent was her physician. Respondent testified that it was her practice to orally advise her patients and their parents of the risks of Prozac. Respondent did not document that she discussed with B.A. or her mother the risks or side effects of Prozac.

Respondent noted in the medical record for the November 4, 2010 visit that B.A.'s mother came into respondent's office later and stated that her daughter was having side effects from the prescribed medication. B.A.'s mother stated that she was keeping her daughter home from school because she feared she would have a breakthrough seizure.

Treatment History of Patient R.C.

63. In 2012, R.C. was a 56-year-old woman referred by her primary care physician (PCP), to see respondent for a neurologic evaluation. R.C. filed a written complaint against respondent dated April 21, 2013, and testified at hearing. On November 2, 2012, R.C. saw her PCP and complained of neck pain and numbness of her upper extremities, which was greater on her left side than her right side. The symptoms had been ongoing for one year. As a result, her PCP ordered an x-ray and MRI of the cervical spine. The x-ray performed on November 5, 2012, showed moderate degenerative changes.

The MRI performed on November 14, 2012, indicated that R.C. had "abnormal signal intensity in the posterior columns of the upper cervical cord extending from C2 to C3," which "could account for [B.A.'s] arm numbness and tingling." The MRI report further stated that the "radiographic possibilities include, but are not limited to, demyelinating disease, post-traumatic myelomalacia, vitamin deficiency disorders and early infectious process."

DECEMBER 10, 2012 VISIT

64. On December 10, 2012, R.C. had her first appointment with respondent. R.C. completed a "Medical History Questionnaire" and a "Review of Symptoms." R.C. wrote that in 1982 she had "disc surgery." R.C. also wrote that she was not taking any medications. R.C. listed under her "present problems" "back problems-surgery." On the "Review of Symptoms" questionnaire, R.C. was given a list of symptoms to review and circle as applicable. She circled headache, fatigue, dizzy spells, difficulty concentrating and neck and back pain. She did not circle stroke, seizures, memory problems, loss of bladder function, or hearing loss. R.C.'s medical records from her treating physician indicated that she was prescribed several medications, including Lisinopril, Lyric, Flexeril, Mobic and Nexium. However, R.C. listed on the intake form at respondent's office that she was not taking any medication.

65. After R.C. completed the required paperwork, respondent spoke to R.C. and completed an examination. Respondent noted that R.C. had "not been feeling good and felt that 'her neck was killing her," that R.C. had "left sided neck and arm numbness and numbness of the right arm and right knee," that she "started losing her urine." Respondent noted that R.C. had generalized weakness on the left, dizzy spells several times a day, and "feels that she may have a stroke." Respondent also noted that R.C. complained that "at time feels that the hips on down is dead." Respondent did not note any discussion regarding memory loss.

66. R.C. credibly testified that her complaints of current symptoms to respondent were about neck pain, not numbness of her arms or right leg or knee. R.C. had occasional numbness in her hands and left leg numbness and tingling. R.C. also explained that respondent questioned her about urine loss and she told respondent that her urine issues were "no more than anybody else for [her] age." R.C. explained that if she had to use a bathroom, she could wait until the last minute. R.C. denied that she told respondent that she started to lose her urine.

R.C. also credibly denied that she told respondent that she felt like she was having a stroke. R.C. had a past history of vertigo, four or five years before she saw respondent, which she disclosed to respondent during the examination. R.C. did not complain to respondent that she had any current dizzy spells, or memory loss. R.C. also denied that she ever complained about numbness or tingling of her face. She had past numbness and tingling of her arms and legs. Furthermore, the issue with her "dead" hip was related to a muscle

spasm in her hip that lasted for several days after completing physical therapy. The "dead" feeling in her hips lasted for a short period of time.

67. Respondent conducted a neurological examination of R.C. which was normal. Respondent told R.C. that she had M.S. and more testing was needed. Under the Assessment and Plan, respondent listed: (1) demyelinating disease, rule out disease of the central nervous system; (2) paresthesia of face and or extremity; (3) vertigo; and (4) memory loss. Respondent ordered several tests, including an "EMG/NCV LE," a MRI, a "Neuromuscular Junction Test (with EMG)," a "BrAEP (Vestibular testing)" which is the same as a BAER, "EP, visual evoked," "EEG overnight," and "EEG, Awake and Sleep."

68. Respondent testified that she ordered the EEG studies because of the dizzy spells and intermittent incontinence reported by R.C. Respondent contended that incontinence is a significant problem for patients with M.S. It can also be an indication of spinal cord compression. Respondent stated during the Board Interview that an indication for the EMG and nerve conduct tests was generalized neuropathy or polyradiculopathy. At hearing, respondent testified that she ordered the EMG (electromyogram) with the nerve conduction studies to obtain more information about the sharp pain R.C. experienced on the left upper extremity. Respondent wanted to determine if the pain was from a central nerve from the brain versus a peripheral nerve problem.

TESTING BETWEEN DECEMBER 27, 2012, AND FEBRUARY 6, 2013

69. On December 27, 2012, an awake and drowsy video EEG was performed. The technician noted that hyperventilation was used, but R.C. did not recall any hyperventilation during the procedure. The technician did not note any abnormal waves. Respondent also prepared a report concerning the EEG. She wrote the EEG was performed "as part of the evaluation for possible seizure disorder." Respondent noted that the EEG was normal, but "[i]f seizures are still highly suspected, a more prolonged EEG tracing with sleep deprivation should be considered." A BAER test was performed to test based on a report of "visual disturbance," dizziness and to rule out hearing loss. The results were normal.

70. On December 28, 2012, R.C. had an MRI of her brain. The radiological report referenced a comparison of the MRI to a previous MRI on July 1, 2007 (2007 MRI). The findings of the December 28, 2012 MRI, "again demonstrates some scatter small nonspecific FLAIR hyperintensities of the cerebral white matter and subcortical regions as well as involving the right basal ganglia and right subinsular region, these are probably very slightly more numerous than on the prior MRI scan from 2007." The report noted that there were "approximately 20" FLAIR hyperintensities.

The report further stated that "[s]ome of the described lesions are adjacent to the surfaces of the lateral ventricles. There may be a small lesion involving the anterior portion of the corpus callosum to the right midline. . . ." Under the "Impression" section of the report, the radiologist opined that "the possibility of a tiny lesion in the corpus callosum raises the possibility of a demyelinating process such as [M.S]. Other possibilities could

include premature mild small vessel ischemic disease, previous infectious process, etc. Clinical correlation is recommended."

71. On January 3, 2013, R.C. had an upper extremity Electromyogram test and Nerve Conduction Study (EMG/NCV). Four motor nerves, five sensory nerves and "F waves" were tested. All muscles of the upper extremities were tested. The results of the test were normal. There was "no electrographic evidence of entrapment neuropathy, diffuse polyneuropathy, cervical radiculopathy, brachial plexopathy or myopathy."

72. On January 10, 2013, R.C. had a lower extremity EMG/NCV. Four motor nerves, six sensory nerves, two "H reflexes" and bilateral "F waves" of motor nerves were tested. The report that was issued noted that "[e]valuation of the Left peroneal motor nerve showed reduced amplitude. The Right peroneal motor, the Left tibial motor, the Right tibial motor, the Left sural sensory, and the Right sural sensory nerves were unremarkable."

73. On February 5 and 6, 2013, R.C. underwent an ambulatory EEG. When R.C. was fitted with the EEG equipment at respondent's office, she was told by the technician not to stand in front of a working microwave while she was wearing the EEG equipment. R.C. wore the EEG equipment for approximately 24 hours. R.C. completed a "Patient Event Diary" documenting her activities while she was wearing the EEG equipment. R.C. noted on the event diary that on February 6, 2013, between approximately 6:30 and 7:00 a.m. she stood in front of her working microwave for 30 seconds. A copy of the Patient Event Diary was provided to respondent's office and included in R.C.'s medical record.

74. Respondent prepared a report concerning the ambulatory EEG. Respondent referred to the test as an "overnight 2 day ambulatory EEG." Respondent wrote that the EEG was performed on R.C. "as part of the evaluation of possible seizures versus other movement disorders." Respondent opined that the EEG results demonstrated an "abnormal awake and sleepnight" EEG. Respondent further opined that "[i]solated sharp wave [sic] were noted in the frontal left hemispheric area. The isolated sharp waves may be epileptogenic in nature."

FEBRUARY 26, 2013 VISIT

75. On February 26, 2013, R.C. saw respondent for a follow up visit to discuss her test results. Prior to the appointment, R.C. had obtained copies of her test results. During the examination, respondent then told R.C. that she had M.S. and that she would be on medication for the rest of her life. R.C. told respondent that the MRI findings indicated that she "could have" M.S. Respondent became angry and informed R.C. that she had a seizure on February 6, 2013. Respondent showed her the EEG test results. R.C. asked respondent what time she had the seizure. Respondent stated that the seizure occurred at 6:21 a.m. R.C. informed respondent that she had been standing in front of her working microwave at that time. Respondent did not reply to the information. R.C. requested that respondent order a spinal tap. Respondent replied by saying "You think you are pretty smart, don't you." R.C. believed that a spinal tap could help to provide further information about whether she had

M.S. After R.C. requested the spinal tap, respondent took her to a staff person to obtain a prescription for Depakote, to treat her seizures.

76. Respondent documented in R.C.'s medical record for the appointment that her two-day ambulatory EEG was abnormal with "generalized polyspike and wave in the frequency of [blank] which was synchronous bilaterally over both hemispheres which is highly suggestive of a generalized seizures disorder." During the Board Interview, respondent stated that she did not know what, if any significance standing in front of a working microwave would have on an EEG result. Respondent also admitted that she was "confused about the EEG and how to interpret it." However, at hearing, respondent testified that when she interpreted the EEG results, she took into account that R.C. stood in front of a working microwave.

77. Respondent also wrote on R.C.'s medical record that the "MRI of the brain indicates a lesion in the corpus callosum which is highly suspicious [*sic*] demyelinating disease." Respondent testified that the MRI confirmed that R.C. had M.S., because of the lesion in the corpus callosum. Respondent contended that based on the location of the lesion, R.C. had M.S. "until proven otherwise." Respondent also testified that she consulted with "Dr. Knudtson" neuro-radiologist who reviewed the 2007 and 2012 MRIs and confirmed that the MRI findings were consistent with M.S. Respondent wrote on the 2007 MRI radiology report that "more than 15 lesions, supra and infratentorial consistent with multiple sclerosis." Respondent testified she obtain the information she wrote on the 2007 MRI report from Dr. Knudtson. However, the radiology report does to refer to any infratentorial lesions. Specifically, the "Impression" section of the 2007 MRI report, read:

> A few nonspecific scattered punctate foci of increased T2 signal in the subcortical white matter of the bilateral cerebral hemisphere of unlikely clinical significance. This may represent premature small vessel ischemic changes or sequela of prior other ischemic, infectious, inflammatory or post-traumatic etiologies. No vestibular schwannoma is identified.

Respondent did not discuss with R.C. the findings of the 2007 MRI or the reason or symptoms that prompted R.C. to obtain a MRI of her brain. However, the radiology report noted that R.C.'s history included "recent vertigo and left-sided dizziness."

78. Under the Assessment and Plan, respondent listed: (1) demyelinating disease, rule out disease of the central nervous system; (2) paresthesia of face and or extremity; (3) vertigo; and (4) memory loss. Respondent prescribed R.C. Depakote 500 m.g. Respondent prescribe the Depakote because of the results the EEG and to address R.C.'s numbness and tingling on her left side. Respondent believed that R.C.'s neck pain could be caused by M.S. plaque, which she believed the Depakote would relieve. Respondent noted that R.C. was not taking any "active" medication. Respondent did not document any discussion with R.C. regarding any medications past medications. Respondent did not order any baseline

laboratory tests to determine if R.C. had any medication in her system that might affect the efficacy of the Depakote.

Respondent also ordered a test to detect Lyme disease, and a lumbar puncture.[4] Respondent ordered R.C.'s Depakote level, "CBC" and liver function to be tested two days prior to her next visit. During the Board Interview, respondent explained that she ordered the tests to detect Lyme disease and lupus, because "they were on her mind."

EVENTS BETWEEN MARCH 12 AND 14, 2013

79. On the evening of March 12, 2013, R.C. went to the Sutter General Emergency Room (ER), because she had nausea and vomiting. R.C. had been nauseous the entire two weeks she was taking the Depakote. Blood work was performed at the ER. R.C.'s Depakote level was 108.4. She was diagnosed with Depakote toxicity and told to stop taking the Depakote and to follow up with respondent. R.C. was schedule to have a lumbar puncture the next day. She was instructed by the ER physician to keep her appointment.

80. On March 13, 2013, R.C. had a lumbar puncture. The next morning R.C. awoke feeling sick. She was examined by respondent, who noted that R.C. reported that she was throwing up and nauseated. Respondent handwrote on R.C.'s medical record that R.C. reported sharp pain from her head to her feet. R.C. credibly denied that she complained of such pain, or that she complained of throwing up.

81. Respondent informed R.C. that the dose of Depakote she prescribed R.C., was the same amount she prescribed children and it should not have caused her illness. Respondent again told R.C. that she had a seizure in February during the ambulatory EEG. Respondent told R.C. that in addition to the seizure in the morning at around 6:00 a.m., she also had a seizure in the evening around 8:30 p.m. R.C. denied that she ever had a seizure. Respondent instructed her to not take the Depakote. Under the Assessment and Plan, respondent listed: (1) Depakote toxicity; (2) memory loss; (3) vertigo; and (4) adverse effect of unspecified drug medicinal and biological substance.

MARCH 26, 2013 VISIT

82. On March 26, 2013, R.C. saw respondent for the last time. Respondent documented that R.C. told her that she felt good the first day she had the lumbar puncture, but the following morning developed a bad headache which improved when she laid down. Respondent also wrote that R.C. learned from the ER that she had a "leak" caused by the lumbar puncture and she was told to rest. R.C. also reported that she felt nauseated "almost daily."

83. Respondent also noted that she has information from the lumbar puncture. She wrote that "[o]libocolobal [*sic*] bands is negative but the IgG synthesis is abnormal,"

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[4] Lumbar puncture is also referred to as a spinal tap.

which was incorrect. The IgG synthesis was normal. Respondent informed R.C. that her lumbar puncture was abnormal. R.C. believed that because the oligoclonal bands were negative, she did not have M.S. R.C. received a copy of the test results. Under the Assessment and Plan portion of the medical record, respondent listed: (1) Depakote toxicity; (2) memory loss; (3) vertigo; and (4) adverse effect of unspecified drug medicinal and biological substance.

84. During the Board Interview, respondent admitted that her finding the IgG synthesis as abnormal was incorrect. She had misread the lab report. Respondent contended that the mistaken reading did not affect her diagnosis. At hearing, respondent testified that after she discovered that the IgG synthesis was normal, she contacted R.C. and told her that the IgG synthesis was normal.

AUGUST 5, 2013 LETTER TO THE BOARD

85. In response to a July 24, 2013 letter from the Board, respondent provided a letter of explanation regarding the treatment she provided R.C. Respondent explained that R.C. was referred to her for an abnormal lesion at the C2-3 as reflected on a MRI of her cervical spine. She contended that R.C. complained of "numbness and tingling of the left side of her body, urinary incontinence, generalized fatigue and dizzy spells." Respondent wrote that her "work up" was "directed to rule out a demyelinating disease." Respondent listed her "differential diagnosis" as: cervical myelopathy, seizure disorder, Lyme disease, cervical radiculopathy, lumbosacral radiculopathy, generalized neuropathy and lupus. These diagnoses were not the same as those listed in R.C.'s medical records.

86. Respondent further explained in part that based on the 2007 and 2012 MRIs, and other symptoms, on February 26, 2013, respondent met with R.C. and explained the test findings. Respondent explained to R.C. that she "meets the criteria of relapsing and remitting M.S. and is probably suffering from an acute exacerbation." Respondent further wrote that R.C.'s testing and symptoms fit the diagnosis of "definite M.S. according to the McDonald Criteria." Respondent attached literature concerning the McDonald Criteria. She further explained the "lesions on the MRI explain the symptoms of fatigue and the numbness on the left side and urinary incontinence, indicating more likely than not an acute exacerbation of M.S." Additionally, respondent wrote that R.C.'s ambulatory EEG "indicated abrupt onset of sharp waves of small amplitude, lasting 1-2 seconds indicating muscle tension which was [seen] while drowsy."

Treatment History of Patient D.K.

87. In March 2014, D.K. was a 51-year old male. D.K. testified at hearing that he was injured in August 1995, while remodeling a home. His lumbar spine and wrist were injured. He underwent back surgery in 1997, to fuse his lumber spine from the "L2 to S1." A total of 12 titanium screws were inserted into his spine. Sometime after the surgery at least four of the screws broke and the fusion of his spine failed. As a result, he is bound to a wheelchair most of the time and takes a significant amount of narcotic pain medication to

control his pain, including Norco. D.K. has been receiving Social Security Disability since 2000.

88. In 2013, D.K. began obtaining medical treatment at Chapa-De Indian Health Clinic (Clinic). The Clinic did not prescribe narcotic pain medication. As a result, the Clinic prescribed D.K. Tramadol for his pain. D.K. was prescribed Tramadol 100 mg. four times per day. In approximately February 2014, D.K.'s treating physician assistant referred him to respondent due to his neuropathy, which manifested as pain, tingling and burning of his feet and hands. D.K.'s medical records from the Clinic also noted that he suffered from obesity, major depressive disorder, familial tremor, shoulder pain, excessive daytime sleepiness, and congestive heart failure.

MARCH 27, 2014 VISIT

89. On March 27, 2014, D.K. saw respondent for an initial evaluation. D.K.'s mother and father took him to the appointment. D.K. arrived at approximately 9:15 a.m. and waited over an hour to see respondent. When respondent arrived in the examination room she was agitated and spoke very quickly. D.K. told respondent that he had numbness and tingling in his hands, feet and legs. Respondent conducted a neurological examination. She asked D.K. to stand and lift his toes. Respondent steadied D.K. while he stood. She also had D.K. squeeze her hands. She checked his reflexes and sensation.

90. D.K. told respondent about his failed back surgery. Respondent told D.K. that he should stop taking Tramadol. D.K. believed that respondent was going to force him to stop taking his Tramadol. The total examination time with respondent was approximately 15 minutes. Respondent completed a medical note for the visit. Respondent documented that she performed a neurological examination, including sensory examination, checked his reflexes, and performed a coordination finger to nose test. Respondent noted that the neurological examination was normal. Respondent diagnosed D.K. with neuropathic pain, restless legal syndrome, obesity, carpal tunnel syndrome, low back pain, and tremor. The "plan" portion of the medical note to address the diagnoses was "Vitamin B12" and "Ferritin."

91. Respondent noted in D.K.'s medical record that "more than 40 minutes were spent face to face with the patient during this visit. More than 50% of the visit was spent providing education and/or counseling to the patient (and the family if present) regarding the issues documented in this note." Respondent noted that the examination and visit ended at approximately 11:11 a.m. Respondent billed the visit as a "Level 5" which requires extensive counseling of the patient and/or his family regarding his diagnosis and treatment plan. During the Board Interview, respondent stated that other than the 40 minutes she spent with D.K., she could not account for the time he spent at her office between 9:15 and 11:11 a.m.

92. After respondent and D.K. left the examination room, D.K. spoke to a receptionist because he was not sure what to do next. He was not provided any information

regarding whether he should return for a follow up visit. D.K. was concerned that if respondent discontinued his Tramadol he would lose his Social Security benefits. The next day, D.K. called respondent's office to find out what he should do to follow up with respondent. He was told by the receptionist that respondent did not accept notes, phone messages or emails

93. On March 28, 2014, D.K. filed a complaint against respondent with the Board. He was concerned that he would lose his Social Security benefits and he was angry that he was required to wait for two hours. He also felt that respondent ignored his complaints of pain and her conduct towards him was unprofessional and rude.

94. During the Board Interview, respondent initially stated that she had no "independent recollection" of D.K. Later in the interview, respondent contended that she recalled that she was afraid of D.K. because he was a big man. She was also concerned about D.K.'s use of Tramadol. Respondent stated that she did not like to prescribe Tramadol because it can cause seizures, and that it was not appropriate for neuropathic pain. Respondent believed that D.K. was drug seeking. Respondent was asked if she ran a CURES (Controlled Substance Utilization Review and Evaluation System) report to determine what medication D.K. had been prescribed by other providers. Respondent stated that she was not familiar with CURES. She did not run a report to confirm whether D.K. was engaging in drug seeking behavior and she did not utilize CURES in her practice.

95. During the Board Interview, respondent also explained that she recommended that D.K. come back to her office for an EMG and nerve conduction study of the upper and lower extremities. She explained that the recommended tests were to rule out neuropathy versus radiculopathy, and to rule out carpal tunnel versus neuropathy versus "CIDP maybe."[5]

96. At hearing, respondent contradicted the statement she made during the Board Interview. Respondent testified that D.K. was only referred to her for an EMG nerve conduction study, not to take over his care. At the time she examined D.K. she assumed he was referred to her for a full consultation, not just testing. On the day of the examination, after she reviewed the referral and spoke to D.K. she realized she was only seeing him for EMG testing. Respondent contended that she tried to move him into an examination room used for EMG testing, but D.K. "had a different agenda." He wanted a refill of his Tramadol so that he could continue to receive Social Security Disability benefits.

Respondent further contended that she told D.K. that he was only referred to her for an EMG study, but they "could not see eye to eye." Respondent decided that she had to "accommodate" D.K. Respondent contended that she told D.K. that she did not want him to continue taking Tramadol because it can exacerbate Restless Leg Syndrome. Respondent further contended that she was not making any diagnosis of D.K. She relied on his past medical history to list his conditions and to determine if it was appropriate to give him Tramadol.

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[5] CIDP stands for chronic inflammatory demyelinating polyneuropathy.

REQUEST FOR D.K.'S MEDICAL RECORDS

97. On or about September 17, 2014, D.K. signed a Release of Medical Information and forwarded it to Investigator Vanderveen. By letter dated November 3, 2014, Investigator Vanderveen requested from respondent a certified copy of the complete medical records for D.K and included in the letter a copy of the Release of Medical Information signed by D.K. The letter stated:

> **PURSUANT TO BUSINESS AND PROFESSIONS CODE SECTIONS 2225(e) AND 2225.5 (referenced on the back side of this Compliance Advisory), FAILURE TO PRODUCE THE COMPLETE MEDICAL RECORDS BY *11/19/14* MAY RESULT IN A CITATION AND FINE OR ASSESSMENT OF CIVIL PENALTIES OF $1,000.00 PER DAY.**
>
> (Bolding, capitalization and italics in original.)

98. On November 11, 2014, respondent's officer manager signed a certification of records, certifying that 13 pages of D.K.'s medical records provided to Investigator Vanderveen, was his complete medical record.

99. During the Board Interview, respondent brought D.K.'s medical record to reference. Investigator Vanderveen noticed that respondent had more records than the records provided on November 11, 2014. Respondent was notified that the medical records provided by her office were not complete. Respondent was requested to provide a complete certified copy of D.K.'s records. Investigator Vanderveen provided respondent's attorney with certification forms to complete and include with D.K.'s records.

100. On or about August 9, 2016, Investigator Vanderveen received a letter from respondent's attorney and 22 pages of medical records for D.K. Investigator Vanderveen compared the 22 pages of records from respondent's office, to records she obtained from Chapa-De that were sent to respondent's office as part of the referral. The 22 pages of records respondent sent to Investigator Vanderveen did not include the records from Chapa-De. Additionally, respondent failed to produce all billing records.

101. Respondent testified that her office had difficulty providing a complete copy of D.K.'s record to the Board because she implemented a new electronic record keeping system in 2013. The new system did not allow for easy retrieval of patient records. When the Board first requested D.K.'s records, respondent requested her office staff to send a complete copy to the Board. Respondent learned several months later at the Board Interview that a complete copy had not been received by the Board. Respondent believes that her office has produced all records for D.K.

Complainant's Expert

102. Jack Florin, M.D. testified as a medical expert on behalf of complainant. Dr. Florin is board-certified in neurology with the American Board of Psychiatry and Neurology. In 2004, he became certified as a M.S. Certified Specialist. In 2007, Dr. Florin obtained his certification in the subspecialties of headache medicine. Between 1996 and 2006, he was certified in clinical neurophysiology. He is licensed by the Board to practice medicine in California. In 1970, Dr. Florin graduated from Cornell Medical College, Albert Einstein College of Medicine (Cornell). He then completed a one year internship at the University of California (UC), San Francisco, at the Mt. Zion Medical Center. Thereafter, he completed a three-year residency in neurology at Cornell.

Dr. Florin has practiced neurology in California since 1974. He operates a solo practice where he treats adults and children with neurological conditions, such as headache, migraine, epilepsy, and M.S. Approximately 15 to 20 percent of his practice includes treating pediatric patients. He is the founder and Medical Director of the Fullerton Neurology and Headache Center, the Medical Director of the National M.S. designated Comprehensive M.S. Center and the Director of the Children's Headache Foundation certified center. He also serves as a clinical professor at the University of Southern California, School of Medicine. Dr. Florin has served as an expert witness for the Board on approximately 10 to 15 cases.

103. Following referrals from Investigator Vanderveen, Dr. Florin authored three detailed and thorough reports concerning his evaluation of respondent's conduct related to the treatment of patients V.A., B.A., R.C., and D.K. In the reports, Dr. Florin listed the documents he reviewed to reach his opinions and conclusions. Dr. Florin reviewed in part, the certified medical records for the patients including test results, respondent's curriculum vitae, the transcripts of respondent's Board Interview, and the complaints filed by R.C. and D.K. Dr. Florin testified at hearing concerning his opinions, which were consistent with his reports.

OPINIONS REGARDING PATIENT V.A.

104. Dr. Florin opined that the standard of care requires a specialist and subspecialist in child neurology to have expertise in the diagnosis of epilepsy and to make such a diagnosis based upon accepted criteria. Dr. Florin defined that standard of care as the practices that are established in the community of physicians in California. Factors that are taken into consideration when determining whether a physician departed from the standard of care include the actual or potential for harm to a patient.

Dr. Florin opined that respondent departed from the standard of care by diagnosing V.A. with epilepsy. Dr. Florin contended that V.A. had no history of seizures. During the initial visit, V.A.'s mother reported that V.A. was suffering from headache, neck pain and back pain. She did not report any loss of consciousness of any type. V.A.'s chief complaint was headache and secondary complaint was learning disability. Dr. Florin opined that even

if V.A.'s EEG results indicated epileptiform findings, epilepsy is never diagnosed on the basis of an EEG only.

105. Dr. Florin also opined that if V.A. had absence or petite seizures, as respondent contended, this type of seizure is "extremely frequent." They can occur many times a day and the seizures are observed by family and teachers. Dr. Florin agreed that if absence seizure is not treated the seizures can affect a child's ability to learn. Dr. Florin contended that an EEG would show abnormalities in the patient's brain waves "strikingly often" up to one abnormality every ten seconds. Additionally, hyperventilation during the EEG would trigger a prolonged EEG abnormality. There was no evidence in V.A.'s EEGs of such abnormalities. Additionally, he explained that two to four percent of children have abnormal epileptiform EEG and will never have a clinical seizure. Even if a child has an abnormal EEG, the standard of care requires the treating physician to obtain more information from the child's history and symptoms to support a diagnosis of epilepsy.

106. Additionally, respondent made a diagnosis of breakthrough seizures, but V.A.'s medical records, consistently demonstrated that there was no report of auras or seizures, to support her diagnosis. Dr. Florin opined that this was not an oversight by respondent, but rather a "diagnosis deliberately made to justify excessive testing of EEGs." Dr. Florin explained that diagnosis of a patient with epilepsy "carries great implications and should be made with great caution." Dr. Florin opined that it is better to err on the side of not making a diagnosis of epilepsy for several reasons, including the stigma attached with the condition, and the medications that the child was prescribed. Dr. Florin opined that respondent's misdiagnosis of epilepsy constitutes an extreme departure from the standard of care.

107. Dr. Florin also opined that respondent misdiagnosed V.A. with migraine, which was a simple departure from the standard of care. The standard of care requires that a neurologist have expertise in the diagnosis of headaches, which is the "most common disorder seen by neurologist." Dr. Florin opined that V.A.'s headaches did not fit the diagnostic criteria for migraine. In order to make a diagnosis for migraine, certain criteria must be met. The first part of the criteria requires that the symptoms of the patient meet two of four of the following criteria: "moderate to severe, unilateral, throbbing" and "worse with motion."

108. V.A. did not report any of the symptoms in the first criteria. There is no evidence that her head pain was unilateral, throbbing, worse with movement or moderate to severe. V.A. indicated that the pain level of her headaches was a "3-4" on a 10-point scale, which is considered mild. V.A. had a new headache each day following a viral illness. Dr. Florin opined that "[t]his is a well recognized syndrome, usually improves spontaneously and is associated with normal neuroimaging and that was the case with [V.A.]." He further opined that a "less likely" diagnosis is that she had a tension-type headache.

109. Dr. Florin opined that the standard of care requires a physician to prescribe medications with proper indication and balancing of the risks and benefits of the efficacy and

adverse effect of the medication. Respondent misdiagnosed V.A. with epilepsy and migraine. As a result of the misdiagnoses, she prescribed V.A. Depakote. V.A. gained weight as a result the medication. After V.A. complained of the side effects from Depakote, respondent prescribe her Keppra, again to treat epilepsy, which was also not indicated. Dr. Florin opined that the unnecessary prescribing of Depakote and Keppra, due to the misdiagnosis of epilepsy and migraine, was an extreme departure from the standard of care.

110. Concerning respondent's uses of repeat EEGs and the BAER, Dr. Florin opined the standard of care requires physicians to "order tests that are medically indicated and have relevance to diagnosis and management." Dr. Florin contended that there was no medical evidence to support V.A.'s diagnosis of epilepsy. Despite the lack of clinical support to justify a diagnosis of epilepsy, respondent ordered four EEGs, including a four-day ambulatory EEG. Dr. Florin opined that V.A. suffered from headaches. Dr. Florin opined that an EEG is not indicated for treatment of headache. Dr. Florin's opinion is supported by studies endorsed by the Neurological Academy and the American Board of Internal Medicine, which have shown that there is no benefit in using an EEG to diagnosis headache.

111. Respondent also ordered a BAER to check for hearing loss, despite the lack of complaint of hearing issues by V.A. or her mother. Dr. Florin opined that if there was a concern about hearing loss, the proper test would have been an audiogram. Additionally, respondent contended that she routinely ordered the BAER test when a patient is struggling with learning issues. Dr. Florin opined that this is not within the standard of care, because there was no clinical indication for the BAER.

112. Dr. Florin opined that respondent appropriately ordered an MRI for V.A., which was indicated for a report of new daily headaches. However, he contended that the posterior fossa arachnoid cyst finding on the MRI did not support repeat EEGs. Dr. Florin noted that respondent incorrectly documented in V.A.'s medical records that the cyst was located in the middle cranial fossa, not the posterior fossa. Additionally, he explained that arachnoid cysts rarely grow and if there is concern about growth, a repeat MRI can be performed. Dr. Florin opined that an arachnoid cyst in the posterior fossa area of the brain does not push on any "structures," effect the brain function in any way, or cause seizures.

113. Dr. Florin opined that ordering four EEGs for V.A. with no medical evidence supporting a diagnosis of epilepsy, and ordering the BAER, with no clinical indication for the tests, is an extreme departure from the standard of care.

OPINIONS REGARDING PATIENT B.A.

114. Dr. Florin opined that respondent departed from the standard of care by ordering excessive testing for B.A. The standard of care requires a physician to order tests for valid clinical indications, with the "expectation that they would lead to establishing or changing a diagnosis or treatment." Respondent ordered four video EEGs and a BAER over an approximately 14-month period, without medical indication.

115. An EEG was performed after B.A.'s initial appointment with respondent on August 10, 2009, even though there is no record that the test was ordered. The first EEG performed on August 12, 2009, was normal. Dr. Florin opined that the first EEG was appropriate and within the standard of care, given B.A.'s medical history.

A BAER test was also performed on August 12, 2009, although Dr. Florin found no evidence that respondent had ordered the test during the initial visit. The diagnosis justifying the test was listed as "hearing loss, dizziness." The results of the BAER were normal. Dr. Florin opined that the BAER was not medically indicated, as respondent admitted during her Board Interview that the referring diagnosis of hearing loss and dizziness was for billing purposes. Additionally, B.A. did not complain of hearing loss and if she had, an audiogram would have been the appropriate test.

116. During the next visit on August 31, 2009, respondent noted that B.A. was tired and that the "Parmesan cheese fell out of her hand while eating." Dr. Florin opined that "this may not be significant and at worse would be a myoclonic jerk, which would be unusual given a high therapeutic Depakote level and a normal EEG." Dr. Florin also explained that "myoclonic jerks tend to occur early in the morning only, and [respondent] did not try to obtain that information." Dr. Florin opined that respondent incorrectly diagnosed B.A. with breakthrough seizures, without a report of seizure.

117. On November 2, 2009, respondent ordered another EEG, with no medical indication. B.A. had been "seizure free" and had no myoclonic jerks. A third EEG was ordered on May 3, 2010, that was also normal. Despite the normal EEG, a four-day-ambulatory EEG was performed on July 3, 2010. After B.A. had seizures in August 11, 2010, respondent ordered a fourth EEG.

118. Dr. Florin opined that B.A. had a "clear diagnosis of juvenile myoclonic epilepsy." As result, repeated EEGs were not necessary to rule out "epileptogenic focus" as respondent contended. Dr. Florin also opined that an EEG is not necessary when a patient "clearly has breakthrough seizures," when a patient is seizure free, or when a patient has "adverse effects of a medication." He explained that an EEG can be normal after a breakthrough seizure. A physician needs to consider whether the breakthrough seizure was caused by medication doses that were too low, whether the patient is taking the medication or whether there are drug interactions. Then the physician should formulate a treatment plan. Dr. Florin opined that respondent's repeated acts of excessive testing constituted an extreme departure from the standard of care.

119. Dr. Florin also opined that the standard of care requires a neurologist "to be competent to have sufficient expertise to diagnosis and treat common neurological disorders." He further opined that respondent, who has a subspecialty in child neurology, should have competence in treating pediatric patients with epilepsy. Dr. Florin contended that respondent did not have the knowledge and did not consider the "important interactions between Depakote and Lamitcal." He explained that when one of the drugs is added to the other and the doses are "not extremely low" for both drugs, and the titration of the drugs are

not "very slow" there is an increase in the levels of both drugs, which depending on the starting doses, can lead to toxicity.

120. During the July 29, 2010 examination, respondent noted that B.A. was having twitches. Dr. Florin opined that that B.A. was likely having myoclonic jerks. Respondent should have recognized that the 1,000 m.g. per day dose of Depakote that respondent had prescribed was too low. B.A. had been on 750 m.g. of Depakote twice per day, as prescribed by her previous treating physician. The result was a therapeutic Depakote level of 101 and over two years without a seizure. When B.A. was seen at the ER on August 11, 2010, her Depakote level was 61. Dr. Florin opined that the best course of action would have been for respondent to increase the Depakote to 750 m.g. twice per day, since that dose had previously worked and was well tolerated.

Instead, respondent added Lamictal, another anti-epileptic drug. Dr. Florin opined that B.A. suffered from toxicity after respondent added Lamictal. B.A. reported that she was confused, had twitching and was nervous. He opined respondent failed to recognize that B.A.'s symptoms were caused by a possible medication adverse effect, rather than breakthrough seizures. Dr. Florin explained that Depakote can cause the Lamictal level to be "unexpected" and higher than what would be anticipated, because the Depakote slows down the Lamictal, which "accumulates" in the body. Respondent failed to order any laboratory testing for B.A. on August 23, 2010, to monitor the effects of the Depakote and Lamictal, and determine whether the medications were in a therapeutic or toxic range.

121. Additionally, Dr. Florin opined that respondent departed from the standard of care by prescribing B.A. Prozac, despite the black box warning that the medication can cause an increase in suicidal ideation in adolescents. Respondent documented in B.A.'s medical record that she had a history of suicidal thoughts. Despite this information, on August 30, 2010, respondent prescribed B.A. Prozac. Dr. Florin opined that the standard of care required respondent to be certain of her diagnosis of depression, and to have discussion with B.A. and her parents about the risk of taking the medication. There is no evidence in the medical records that respondent obtained information from B.A. to support a diagnosis of depressive disorder, or that she had such a discussion with B.A. and her parents regarding the risks of taking Prozac.

122. He also did not find evidence in the medical records to support respondent's diagnosis of circadian sleep disorder. Dr. Florin contended there is no evidence that respondent asked B.A. about symptoms to support a diagnosis of insomnia. Additionally, the medical records respondent obtained from Florida for B.A.'s past treatment included a polysomnogram that was normal, which further disputes respondent's diagnosis.

123. Dr. Florin opined that respondent's actions related to her failure to consider the interactions of Depakote and Lamictal, the symptoms of adverse effects of medication, the diagnosis of circadian sleep disorder without any evidence in the record, and the prescribing of Prozac to a patient with a history of suicidal thoughts, constituted an extreme departure from the standard of care.

OPINIONS REGARDING PATIENT R.C.

124. Dr. Florin opined that the standard of care requires that diagnostic procedures utilized by a physician should be limited to those necessary to diagnose a specific condition. He further opined that it is a departure from the standard of care for a physician to engage in "repeated acts of clearly excessive use of diagnostic and treatment facilities."

125. Dr. Florin opined that it was within the standard of care for respondent to order the brain MRI, the lumbar puncture and the Visually Evoked Potential (VEP), as diagnostic tests to obtain information to assist in determining whether R.C. had M.S. If the brain MRI showed findings that were consistent with M.S., then a diagnosis of M.S. may have been appropriate. A lumbar puncture test was also within the standard of care for assisting in the diagnoses of M.S. The test measures the spinal cord fluid. Dr. Florin explained that 85 to 90 percent of patients who have M.S. have a finding of oligoclonal bands detected through the lumbar puncture test. He opined that if a patient has a spinal cord abnormality and a lumbar puncture that is abnormal, then there is a very high probability that the patient has M.S. Additionally, a VEP can also be used as a diagnostic tool to test inflammation of the optic nerve. Dr. Florin explained that two-thirds of patients who have M.S. will show abnormal findings on the VEP test.

126. Dr. Florin opined that there was no medical indication for the other studies respondent ordered and when they were done, "they were done in excessive fashion." Dr. Florin opined that the ordering of excessive and unnecessary tests was an extreme departure from the standard of care. Dr. Florin contended that there was no medical indication for the EMG studies of the upper and lower extremities and the number of nerves and muscles tested were "excessive for any diagnosis." Respondent stated during the Board Interview that an indication for the tests was generalized neuropathy or polyradiculopathy. Dr. Florin opined that because R.C.'s neurological examination was "entirely normal" there was no basis to order the EMG.

Additionally, Dr. Florin opined that there was no medical indication for the video or ambulatory EEG. Respondent ordered both EEGs on the initial visit, without knowing whether the video EEG would be normal. Dr. Florin opined R.C. had no symptoms of "alteration of consciousness of any type, such as syncope or seizures" which would be the type of symptoms which would be "generally accepted indication for EEG." Additionally, after the video EEG was normal, it was a departure from the standard of care to proceed with the ambulatory EEG.

127. Dr. Florin explained that M.S. is a condition that is "commonly seen by general neurologist." The standard of care requires that a general neurologist have sufficient training, knowledge, and experience to evaluate patients with possible M.S. Additionally, a physician should recognize if she does not have the knowledge to evaluate a patient she should refer the patient to an appropriate subspecialist. Dr. Florin opined that respondent's misdiagnosis of M.S. and lack of knowledge in several areas constituted an extreme departure from the standard of care.

128. Specifically, Dr. Florin opined that when R.C. was referred to respondent, she had "symptoms and MRI findings of partial transverse cervical myelopathy," which is an abnormality within the spinal cord. Dr. Florin opined that R.C.'s 2007 MRI showed "a few nonspecific scattered punctate of unlikely clinical significance." The report did not raise M.S. as a cause. Dr. Florin opined that R.C. had a history of hypertension and the 2007 MRI findings were consistent with hypertension and age. He noted that respondent failed to ask R.C. any questions about her symptoms during the period that she had the 2007 MRI.

The 2012 MRI demonstrated a slight worsening, which would be consistent with a "5-year interval." The shape, size and location were "nonspecific" and did not show findings consistent with M.S. Additionally, the results of the lumbar puncture demonstrated that R.C. did not have oligoclonal bands and R.C.'s VEP test was normal. Dr. Florin also opined that respondent erroneously believed that IgG synthesis obtained from the lumbar puncture could indicate active or inactive M.S. He explained that there is no spinal fluid test that gives any indication about whether M.S. is inactive or active.

129. Dr. Florin opined that respondent failed to recognize that R.C. had partial transverse cervical myelopathy and "almost all symptoms could be accounted for by that lesion, with these being sensory symptoms in the upper and lower extremities, bladder symptoms; which were likely caused by neurogenic/overactive bladder; and a Lhermitte's symptom," which can occur when a patient has a spinal cord lesion. When the patient bends her neck, it causes an electrical feeling from the neck to one or both arms and sometimes down the back of both legs. He contended that a neurologist is "expected to recognize this" and respondent failed to do so.

130. Dr. Florin also contended that based upon respondent's August 5, 2013 letter to the Board respondent stated that she diagnosed R.C. with M.S. on the basis of the McDonald criteria. However, she did not provide any explanation to the Board as to how R.C. symptoms and findings fit the McDonald criteria. Dr. Florin explained that the McDonald Criteria was established to assist physicians in making an earlier diagnosis of M.S., utilizing MRI results as a substitute for clinical symptoms. In applying the McDonald criteria, the location of the lesions in the infratentorial area brain, which separates the front to the back of the brain, is critical and must be met for a diagnosis of M.S. Respondent wrote on the 2007 MRI report that 15 infratentorial and supratentorial lesions were discovered. However, the radiology report does not refer to any lesions infratentorial area of the brain, and does not raise M.S. as a possible concern.

131. Dr. Florin also opined that respondent "erroneously believed that M.S. plaque could cause severe neck pain." He explained that the brain and spinal cord does not feel pain and M.S. plaque would not cause neck pain. Dr. Florin opined that R.C.'s neck pain was from arthritis and her cervical disk problems, which respondent failed to recognize. She also ordered laboratory tests for possible Lyme disease or lupus, and a monophasic cervical myelopathy which he contended "would be exceedingly unlikely to be caused by any of those disorders."

132. Dr. Florin explained that making a diagnosis of M.S. has very serious implications. Once a diagnosis is made, the patient is typically treated with "disease-modifying drugs" that can have serious side effects, some of which are life-threatening. He opined that if a physician is not certain of a diagnosis, the standard of care requires the physician to obtain a second opinion. Dr. Florin opined that respondent's misdiagnosis of M.S., and lack of knowledge in several fundamental areas set forth above was an extreme departure from the standard of care.

133. Dr. Florin opined that the standard of care requires a physician to make an appropriate diagnosis based upon the medical history and appropriate testing. He opined that respondent departed from the standard of care by also diagnosing R.C. with epilepsy and incorrectly reading R.C.'s EEG results. He also opined that respondent raised the issue that R.C. may have epilepsy, without R.C. reporting any symptoms to support such a diagnosis. Additionally, respondent misinterpreted R.C.'s ambulatory EEG. Dr. Florin opined that the determination made by respondent that R.C. had epileptiform finding on her ambulatory EEG, were "clearly artifact from exposure to a microwave."

134. In R.C.'s medical record, respondent documented that the EEG showed "generalized polyspike and wave in the frequency" which she opined was "highly suggestive of a generalized seizures disorder." In her August 5, 2013 letter to the Board, she "implied" that she thought the "abrupt onset of sharp waves of small amplitude" were a result of muscle tension. When questioned during the Board Interview about the effect of R.C.'s exposure to the microwave to her EEG results, respondent did not know what the effect would be on the results.

135. Dr. Florin opined that a neurologist who reads an EEG result "is expected to be competent in doing so." He opined that "[t]here are great implication in making a diagnosis of epilepsy regarding driving privileges, employment and others. Diagnosis should be made with great caution and with supporting evidence." Dr. Florin opined that respondent's misdiagnosis of epilepsy and her lack of competence in reading R.C.'s ambulatory EEG results, constituted an extreme departure from the standard of care.

136. Dr. Florin also opined that the standard of care requires physicians to prescribe medications for proper indications and to know safety, adverse effects and possible drug interactions. Dr. Florin opined that respondent prescribed R.C. Depakote for an unsubstantiated diagnosis of epilepsy. Respondent failed to document any medications R.C. was taking at the time that she prescribed the Depakote.

Dr. Florin noted that the medical records from R.C.'s treating PCP, that were included in respondent's records for R.C., listed several medications R.C. had been prescribed in November 2013, including Lisinopril, Lyrica, Flexeril, Mobic and Nexium. Dr. Florin opined that each of those drugs could have possible interactions with Depakote. Dr. Florin opined that R.C.'s "toxic level of 108, despite being given an appropriate dose of 500 m.g. twice daily, was because there were drug interactions, which caused elevated Depakote

levels." He opined that it was an extreme departure from the standard of care to prescribe R.C. Depakote without considering the possible drug interactions.

OPINIONS REGARDING PATIENT D.K.

137. Dr. Florin opined that the standard of care requires a physician to maintain accurate, complete, and timely medical records. Dr. Florin reviewed D.K.'s medical records completed by respondent. D.K.'s symptoms were foot pain, burning and possible Restless Leg Syndrome. Respondent also noted that the neurological examination was normal. Dr. Florin opined that there was not sufficient information in the medical records to support respondent's diagnosis of neuropathic pain, Restless Leg Syndrome, obesity, carpel tunnel syndrome (CTS), low back pain, or tremor.

Dr. Florin also noted in respondent's Board Interview she "raised the possibility" that D.K. could have CDIP. Dr. Florin opined that a diagnosis of CDIP could only be made based on specific symptoms and abnormalities on the neurological examination. Respondent did not document any symptoms consistent with a diagnosis of CDIP and D.K.'s neurological examination was normal. Respondent also made a diagnosis of tremor, but there was not documentation indicating any examination findings to support the diagnosis of tremor.

138. Dr. Florin also opined that respondent's medical records did not support her recommended that D.K. return for an EMG and nerve conduction study of the upper and lower extremities. Respondent contended that the reason she recommended the tests was to rule out neuropathy versus radiculopathy, and to rule out carpal tunnel versus neuropathy versus "maybe CIDP." However, she did not document the physical findings to support those diagnoses. Dr. Florin opined that respondent's failure to keep accurate and complete medical records regarding D.K. was a simple departure from the standard of care.

139. Dr. Florin opined that the standard of care requires a physician to code the services they provide to patients for purposes of billing, to the level of service that is supported by the medical records. Dr. Florin noted that respondent billed for a "Level 5" examination of D.K., which Dr. Florin explained requires a "14-point review of systems and a neurological and certain aspects of a general physical examination." He further opined that a Level 5 examination "requires a higher level of complexity as well as evidence of sufficient 'counseling' of the patient regarding the multiple diagnoses and the treatment plan." Dr. Florin opined that the medical records for respondent's examination of D.K. did not support a Level 5 code. There was no evidence that respondent conducted a 14-point review of systems, or "extensive counseling" explaining to D.K. his diagnoses and the plan for treatment. Dr. Florin opined that respondent's coding and billing for a level of services not substantiated in the medical record constituted a simple departure from the standard of care.

140. Concerning respondent contention that D.K. was engaged in drug-seeking behavior, Dr. Florin opined that CURES has been available to physicians in California since 2003. The standard of care in 2014, required physicians to be aware of CURES and to utilize

the database on a regular basis when caring for patients who take controlled medication. In 2016, it became mandatory for physicians who prescribe controlled substances to utilize CURES.

141. Dr. Florin opined that accessing CURES would have provided respondent "valuable information" to assist her with concern about D.K.'s Tramadol use. She would have been able to determine if there was evidence he was "multisourcing," meaning going to multiple physicians for prescriptions or early renewals, which would have assisted respondent in a decision of whether to continue the medication. Dr. Florin opined that respondent's failure to know about CURES or utilize it in her practice was a simple departure from the standard of care.

Respondent's Expert

142. Peter Cassini, M.D. testified as a medical expert on behalf of respondent. Dr. Cassini is board-certified in neurology. He attended Ohio State University and studied neuroscience anatomy. He then completed medical school at the Medical College of Ohio. After graduating from medical school, he completed a one-year internship in internal medicine at UC Davis, and a three-year residency program at Stanford, where he was Chief Resident. Thereafter, he then completed a one-year fellowship in neuromuscular diseases, which are diseases that affect the nervous system starting at the nerves as they leave the spinal cord, all the way out to their communication with the muscles. In 1993, he obtained his license to practice medicine in California. Up until 2011, Dr. Cassini taught medical school residents during rotations at Stanford Hospital and Clinics and the Veteran's Hospital.

Since 1998, Dr. Cassini has operated a general neurology solo practice in Palo Alto, California, where he treats adults and children with neurological conditions related to the "brain, spinal cord, nerves and muscles." Dr. Cassini's explained that his pediatric practice is limited. He treats pediatric patients with neuromuscular disease. He treats adolescents with learning disabilities, issues associated with head injuries and sleep disturbances. Dr. Cassini does not treat children who have epilepsy.

143. Dr. Cassini was asked to serve as an expert witness to render opinions regarding whether respondent's care and treatment of patients V.A., B.A., R.C. and D.K., was within the standard of care. He testified at hearing, but did not prepare a report of his opinions. Dr. Cassini testified that the standard of care is the "common practice in the community." He explained harm to a patient due to "inappropriate care would be below the standard of care." However, there can be a departure from the standard of care without harm to a patient. Dr. Cassini testified that he did not know how to "define extreme or departure versus below standard of care."

Dr. Cassini reviewed respondent's medical records for the four patients. He reviewed V.A.'s EEG studies, but did not review any EEG studies for B.A. or R.C. He also reviewed the testimony and reports issued by Dr. Florin, the transcript of respondent's Board Interview, and letters sent by respondent to the Board. Dr. Cassini also met with respondent

for approximately two hours and had a telephone conference with her that lasted a "couple of hours" to discuss her care and treatment of the patients. Some of his opinions are based upon the information respondent provided him during their conversations. However, he explained that most of the answers to his questions were "nonresponsive" and "not terribly informative."

OPINIONS REGARDING PATIENT V.A.

144. Dr. Cassini did not find any departures in the standard of care related to respondent's care and treatment of V.A. He explained that V.A. presented to respondent with a history of a viral infection and a headache that had lasted for longer than a month. He opined that there was a concern that V.A.'s headache could have been a symptom of a viral infection, such as viral encephalitis or viral meningitis. He opined that a viral infection would be a physician's "main concern." Dr. Cassini testified that it was "appropriate" for respondent to order an EEG test for V.A. during the initial examination, because there would be a concern that the virus damaged the central nervous system, which the EEG may have detected.

145. Dr. Cassini opined that the first EEG results indicated "focal slowing, and sharp waves." He explained that the information should have affected the way respondent interviewed V.A. and her mother concerning other symptoms, in order to establish a diagnosis. He opined the EEG results suggested that V.A. was "at risk for neurologic conditions or problems, and really nothing more." Dr. Cassini also opined that the MRI findings of the "structural lesion" on V.A.'s brain also put her at risk and required a physician to consider epileptic events, when coupled with reports from V.A. mother about learning difficulties. He did not explain why the structural lesion put V.A. at risk for seizures. He opined that respondent appropriately considered that "epileptic events" were the source V.A.'s learning difficulties.

146. Dr. Cassini also opined that it was within the standard of care for respondent to order the second EEG, after she placed V.A. on medication. Additionally, V.A. continued to have symptoms that may be "epileptic in origin." He opined that the second EEG was also abnormal. As a result of the second abnormal EEG, and the staring spell that respondent documented she witnessed, respondent was appropriately concerned that V.A. was still having seizures. Therefore, an increase in Depakote on December 7, 2009, from 500 m.g. per day to 1,000 m.g. per day was within the standard of care to address the possible seizure activity.

147. Dr. Cassini also opined that the third EEG in June 2010, was within the standard of care because respondent made a "major medication change" when she switched V.A. from Depakote to Keppra. He opined that the EEG would allow respondent to see how V.A. responded to the change. Even though the third EEG was normal, it was within the standard of care for respondent to order an ambulatory EEG based on her concern that she may have "missed something" on the June EEG. He explained that an extended EEG

increased the "yield or potential for capturing an abnormality" or increasing the confidence of the normal EEG in June.

148. Dr. Cassini also opined that it was within the standard of care for respondent to order the BAER test for V.A. He explained that the test is useful when a physician is concerned about a patient's ability to cooperate with an audiogram and when looking for the nerve relay. The BAER tests how long it takes sounds to travel through the brain. He opined that respondent demonstrated "thoughtfulness" by ordering the BAER, after attempts were made to improve V.A.'s "scholastic performance through treatment of the potential for epilepsy." He opined that respondent felt that the BAER was another tool in helping her find a diagnosis.

149. Dr. Cassini did not opine whether respondent departed from the standard of care by diagnosing V.A. with migraine. Dr. Cassini disagreed with Dr. Florin that diagnosing V.A. with epilepsy was an extreme departure from the standard of care. He opined that V.A.'s medical records "clearly reflect" that respondent was working with a diagnosis of epilepsy "the entire time." He explained that V.A. had two abnormal EEGs, reports of learning difficulties, possible seizure activity and the "arachnoid cyst in the background," which he contended was "never ruled out as a potential player in some of the problems V.A. was experiencing." He opined that respondent appropriately increased the Depakote to address the seizure activity seen on the EEGs, changed medication to address side-effects, monitored V.A. and attempted to rule out other causes for her symptoms through testing with the BAER.

150. He acknowledged that a child should not be diagnosed with epilepsy based upon two abnormal EEGs, because children can have abnormal EEGs and not have a seizure disorder. He opined that even if V.A. did not have epilepsy, the increase in Depakote was within the standard of care because of V.A.'s history of viral infection and poor performance in school. He contended that respondent tracked V.A.'s school performance and used medication "diagnostically." He opined that if V.A. was having absence seizures, the Depakote could address the seizures, which would improve V.A.'s school performance. Dr. Cassini also opined that respondent's documentation of "break through seizure" suggested that she was concerned that V.A.'s trouble with math and comprehension was a result of epileptic events that were not controlled.

OPINIONS REGARDING PATIENT B.A.

151. Dr. Cassini opined he did not find any departures in the standard of care related to respondent's care and treatment of B.A. He opined that it is within the standard of care for a physician to order an EEG test when a change in medication is made for a patient with epilepsy. The EEG provides information about the efficacy of the medication. He opined that all of the EEGs that were performed on B.A. were within the standard of care, because the tests were ordered as a result of changes to medication.

152. Dr. Cassini also opined that the BAER test was also appropriate and within the standard of care, because respondent was concerned that the café au lait spots she observed on B.A. could put her at risk for specific types of nerve tumors that could be detected with a BAER.

153. Concerning the addition of Lamictal, Dr. Cassini contended that respondent was attempting to take B.A. off Depakote because B.A. was child-bearing age and she was concerned of the effect on a possible fetus. As a result, the addition of Lamictal was an appropriate medication to use to transition B.A. off Depakote. He also opined that respondent did not need to order laboratory tests for B.A. after she prescribed Lamictal because the drug does not cause organ damage. He also opined that the standard of care did not require respondent to order a laboratory test when she changed the dose of Depakote. The timing of the laboratory testing is within the discretion of the prescribing physician. He did not offer any opinion as to whether respondent failed to consider the interactions between Depakote and Lamitcal.

154. Concerning respondent's diagnosis of circadian sleep disorder, he did not opine whether respondent provided sufficient documentation in B.A.'s medical records to support the diagnosis. Dr. Cassini testified that he did not spend "a lot of time" looking at the issue of whether respondent had appropriately documented the basis for her diagnosis. However, he contended that the only symptom needed to support the diagnosis was the patient's complaint about sleeping. Dr. Cassini was aware based on his review of B.A.'s records that B.A. had a sleep study performed by her previous treater. He opined that the standard of care did require respondent to document the findings of the sleep study. However, he opined that if respondent made a diagnosis of circadian sleep disorder, and there is no documentation of the patient's history related to the diagnosis and there was no testing to support the diagnosis, then failure to include that information would be a simple departure from the standard of care.

155. Dr. Cassini also opined that prescribing Prozac to an epileptic patient should be considered using a risk benefit analysis. He opined that it is not below the standard of care to prescribe Prozac to an epileptic patient, but Prozac can affect the patient's seizure threshold level, so the physician should "proceed with caution." He also opined that it would be within the standard of care for respondent to discuss the risks of taking Prozac with B.A. and her mother.

Dr. Cassini did not see any documentation in B.A.'s medical record that respondent advised her or her mother about the risks of taking Prozac. He did not know whether respondent's failure to document the conversation was a departure from the standard of care or a medical record violation. He also did not opine whether B.A.'s report of suicidal thoughts was a factor she needed to consider and discuss with B.A. and her mother when prescribing B.A. Prozac.

OPINIONS REGARDING PATIENT R.C.

156. Dr. Cassini did not find any instances when respondent's care and treatment of R.C. departed from the standard of care. Specifically, he disagreed with Dr. Florin's opinion that EMG and EEG tests respondent ordered were not medically indicated or excessive. He opined that based on R.C.'s 2007 and 2012 MRI reports, respondent appropriately considered that R.C. may have M.S. He opined that the lesion on R.C.'s cervical spine was consistent with a diagnosis of M.S. The findings of the MRI required respondent to perform a "large workup" and required a "high degree of confidence prior to going forward with treatment." He explained that treatment for M.S. involves the use of "immunomodulating drugs" that are "somewhat discriminant, but not entirely so." The drugs can put a patient at a higher risk of life-threatening infection. He opined that the standard of care requires a physician to have a "great deal of confidence" in making a diagnosis of M.S.

157. Dr. Cassini also opined that part of the process of determining whether a patient has M.S., is to rule out any conditions that might mimic the disease. It is crucial for the treating physician to obtain a patient history, conduct a physical examination, order appropriate testing and have a list of differential diagnosis. He opined that respondent ordered an EMG and nerve conduction study to help rule out any diseases that might mimic M.S. He opined that the tests were medically indicated and within the standard of care.

158. Dr. Cassini explained that patients with M.S. have a higher risk for epilepsy. As a result, epilepsy should have been high on respondent list of differential diagnosis. An EEG test was medically indicated to check for any evidence of abnormities. He opined that the first EEG was normal. Dr. Cassini did not know why respondent ordered the ambulatory EEG at the same time she ordered the first EEG. He noted that R.C.'s medical record stated that the ambulatory EEG test was abnormal, which was incorrect. He did not find any documentation that the mistake was corrected. However, he contended that respondent did not render any care or treatment to R.C. as a result of an incorrect reading of the ambulatory EEG, so she did not depart from the standard of care.

159. Dr. Cassini conceded that it would be a departure from the standard of care for respondent to prescribe R.C. Depakote for seizures she observed on R.C.'s ambulatory EEG, because the EEG was normal and there was no evidence that R.C. suffered from seizures. Dr. Cassini contended that respondent prescribed the Depakote for neuropathic pain and that respondent's reference to M.S. plaque as the potential cause of the pain, was actually a reference to the cervical lesion, which he contended could cause R.C.'s pain.

160. Dr. Cassini disagreed with Dr. Florin's opinion that respondent misdiagnosed R.C. with M.S. and failed to recognize symptoms of partial transverse cervical myelopathy. Dr. Cassini opined that cervical myelopathy occurs in patients with M.S. and that R.C. did not have any structural abnormalities in her neck that put her at risk for cervical myelopathy that was not caused by M.S. He contended that respondent appropriately relied on the 2007 and 2012 MRI results and characterization of the lesions on the MRIs when making the diagnosis of M.S. Dr. Cassini further opined that respondent consulted with Dr. Knudson,

who specialized in reading the imaging of the brain and spinal cord, and he opined that the lesions were "compatible with M.S." He contended that it was within the standard of care for respondent to rely on the information provided to her by Dr. Knudson, when determining whether R.C. had M.S.

Dr. Cassini acknowledged that the MRI report does not reference lesions in the infratentorial portion of R.C.'s brain, as noted by respondent on the 2007 MRI report. However, he contended even if the lesions were not located in the infratentorial portion the lesion in the corpus callosum was "significant." Additionally, he contended that establishing whether a patient meets the McDonald criteria for diagnosing and treating patients with M.S., is not the standard of care. He explained that patients are diagnosed with M.S. who do not fit the McDonald criteria and are diagnosed solely on the basis of an MRI finding.

Additionally, he contended that 20 to 30 percent of patients have a "clean" lumbar puncture, and still have M.S. Dr. Cassini opined that even though respondent incorrectly read the IgG findings from the lumbar puncture, she complied with the standard of care when she contacted R.C. and provided her the correct information.

161. Dr. Cassini also disagreed with Dr. Florin's opinion that respondent had failed to consider the potential drug interactions between Depakote and R.C.'s other medications. Dr. Cassini opined that R.C.'s Depakote level of 108.4, when she went to the ER, was not a toxic level. Dr. Cassini did not see any information in R.C.'s PCP records or respondent's records related to other medications prescribed to R.C. that may interact with the Depakote. He acknowledged that the records were also not clear as to if she was taking any medication other than the Depakote.

162. Dr. Cassini opined that the standard of care required respondent to obtain a careful history of R.C.'s medications and to obtain baseline laboratory tests for R.C. at the time she prescribed the Depakote. Dr. Cassini found no evidence that respondent ordered baseline testing or that there was a review of R.C.'s medication by respondent when she prescribed the Depakote. He opined that if respondent was not aware of any other medications taken by R.C., her conduct was a simple departure from the standard of care, because Depakote is commonly prescribed without obtaining baseline laboratory testing or reviewing a patient's medication.

OPINIONS REGARDING PATIENT D.K.

163. Dr. Cassini opined that respondent's care and treatment of D.K. was not below the standard of care. His opinion was based on his conversations with respondent, that there was confusion concerning the purpose of D.K.'s appointment with respondent. Dr. Cassini contended that due to the confusion, respondent examined and approached her treatment of D.K. as a new patient as opposed to a patient only referred to her for testing. Dr. Cassini conceded that there was nothing in D.K.'s treatment records from respondent's office that supported his opinion that respondent was confused about the reason for D.K.'s examination.

164. Dr. Cassini also opined that there was no reason why respondent "should or should not document tremors" as part of her examination of D.K. He contended that respondent obtained the information about D.K.'s history of tremors from his prior medical records and the information "ended up" in the medical record she prepared regarding her examination. Dr. Cassini did not offer any opinions as to whether respondent included adequate substantiation for coding and billing a Level 5 examination.

165. Dr. Cassini disagreed with Dr. Florin that the standard of care in 2014 required respondent to be aware of CURES and utilize it in her practice. He opined that if a physician was "not managing addiction" and only "managing pain" the standard of care did not require the physician to access CURES to check a patient's narcotic history. Dr. Cassini contended that respondent's lack of knowledge of CURES and her failure to access CURES to confirm her suspicion that D.K. was drug seeking, before she considered taking him off Tramadol, was not below the standard of care. He contended that respondent was not prescribing D.K. narcotics so the standard of care did not require her to utilize CURES.

Discussion of Allegations

166. The opinions rendered by Dr. Florin were in all instances more persuasive than Dr. Cassini for several reasons. Dr. Florin has practiced neurology for over 40 years. He has extensive knowledge in the treatment of adults and children with neurological conditions, including M.S., headache, and epilepsy. He is certified as a Multiple Sclerosis Certified Specialist; and has a certification in the subspecialties of headache medicine.

167. In contrast, Dr. Cassini's treatment of pediatric patients is limited to children with neuromuscular disease. He treats adolescents with learning disabilities and issues associated with head injuries and sleep disturbances. Dr. Cassini does not treat children who have epilepsy. He also does not have any specialized experience diagnosing, or treating patients with M.S. Additionally, Dr. Cassini did not understand the distinction of how an extreme departure from the standard of care differed from conduct that was "below the standard of care." Finally, some of his opinions were based upon conversations he had with respondent, rather than information that was substantiated through the patients' medical records, which he acknowledged were in some instances inconsistent.

PATIENT V.A.

168. Complainant alleged that respondent misdiagnosed V.A. with migraine and epilepsy, made a diagnosis of breakthrough seizures with no basis, and ordered three video EEGs, an ambulatory EEG, and a BAER, with no medical indication for the tests. Complainant alleged that respondent's treatment of V.A. constituted an extreme departure from the standard of care, repeated acts of negligence, excessive use of diagnostic procedures, and that respondent failed to keep complete and accurate medical records concerning the care and treatment she rendered to V.A.

169. The evidence established that V.A. was referred to respondent after she suffered from a post-viral headache that lasted two months. On the first visit, respondent diagnosed V.A. with migraine headache, without establishing that V.A.'s headaches met the appropriate criteria. Dr. Florin persuasively testified that the standard of care requires that a neurologist have expertise in the diagnosis of headaches.

In order to meet the criteria for migraine, the patient must report at least two symptoms that meet the first diagnostic criteria, which includes unilateral pain, throbbing, pain that is worse with movement or moderate to severe pain. V.A. did not report any symptoms that met the first criteria. Rather, V.A. described what respondent should have recognized as a post-viral infection headache, that Dr. Florin explained was a well-recognized syndrome that usually improves spontaneously. Respondent failed to do so, and incorrectly diagnosed V.A. with migraine. As a result, complainant established that respondent's diagnosis of migraine, without establishing the appropriate diagnostic criteria, was a simple departure from the standard of care and a failure to maintain adequate and accurate medical records.

170. The evidence also established that respondent misdiagnosed V.A. with epilepsy and breakthrough seizures with no basis to support the diagnosis and findings. V.A. had no history of seizures. Rather, she reported symptoms of headache, neck and back pain. She had a history of learning challenges that pre-dated her onset of headaches in July 2009. Respondent ordered an EEG for V.A., which was taken on September 18, 2009, to check for a cerebral anomaly. Respondent interpreted the results of the EEG to imply generalized epilepsy and seizures. While respondent contended that the abnormal EEG did not "mean a whole lot," during V.A.'s first appointment after the EEG on September 30, 2009, respondent noted that the EEG was "highly suggestive of generalized seizures disorder." She also informed L.A. that it appeared from the EEG that V.A. was having "petite seizures." Additionally, respondent included in the Assessment and Plan "generalized epilepsy, rule out." She also prescribed V.A. Depakote, which is used to treat seizures, and discontinued the Amitriptyline due to "seizures on the EEG."

171. Dr. Florin disagreed that there were abnormal findings on V.A.'s September 18, 2009 EEG. However, he persuasively testified that even if V.A.'s EEG had epileptiform findings, epilepsy is never diagnosed on the basis of an EEG only. Additionally, if a patient is suffering from absence or petite seizures, the seizures would occur extremely frequent, would typically been seen every ten seconds on an EEG and would be observed by family members or teachers. No such seizures were ever observed on the EEG or reported by V.A.'s family or teachers.

172. After the September 30, 2009 appointment, respondent changed V.A.'s diagnosis from "generalized epilepsy, rule out" to "generalized epilepsy," which remained V.A.'s diagnosis until her last appointment. Respondent continued to treat V.A. for seizures and documented "breakthrough seizures" despite no evidence to support the finding. Respondent's explanation that she listed "breakthrough seizures" as an alert to her so that she did not miss a breakthrough seizure, was not credible.

173. Additionally, on December 7, 2009, respondent increased V.A.'s Depakote, after respondent contended V.A. had another abnormal EEG and a "staring spell." V.A.'s mother credibly denied that V.A. had a staring spell. Respondent's explanation that identifying the staring spell took a "trained eye" that V.A.'s mother failed to notice was not credible. If such a staring spell occurred, then the expectation would have been for respondent to have a lengthy conversation with L.A. concerning her observations and concerns about the possible cause of the event. Respondent should have educated L.A. about what to look for and report in the event that such a staring spell occurred again. There is no evidence that such a conversation occurred.

174. Dr. Cassini agreed that respondent was working with a diagnosis of epilepsy. He opined that doing so was not a departure from the standard of care, due to the abnormal EEGs, V.A.'s learning difficulties and the arachnoid cyst. His opinion was not persuasive for several reasons. Dr. Cassini does not treat children with headache or epilepsy, nor does he have any specialized experience in treating headache. Additionally, the evidence established that V.A.'s learning difficulties pre-dated her headaches, the MRI findings regarding the possible arachnoid cyst were inconclusive and Dr. Florin persuasively testified that the location and type of cyst described would not cause seizure activity, which Dr. Cassini failed to recognize.

175. Additionally, Dr. Cassin's opinion that and that even if V.A. did not have epilepsy, the prescribing of Depakote "diagnostically" was within the standard of care, was not persuasive. Dr. Florin persuasively testified that the standard of care requires a physician to prescribe medications with proper indication and balancing of the risks and benefits of the efficacy and adverse effect of the medication. Respondent prescribed V.A. based on a misdiagnosis of epilepsy. V.A. suffered side effects, and respondent prescribed another anti-seizure medication.

176. The standard of care requires a specialist and subspecialist in child neurology to have expertise in the diagnosis of epilepsy and to make such a diagnosis based upon accepted criteria. Respondent diagnosed V.A. with epilepsy based on EEG results, which is a departure from the standard of care. She also documented breakthrough seizures, with no medical evidence to support the finding. The evidence established that respondent's misdiagnosis of epilepsy and breakthrough seizure, was an extreme departure from the standard of care, repeated acts of negligence, and failure to maintain adequate and accurate medical records. Diagnosing and treating a child for epilepsy carries significant implications and risks, as demonstrated with the treatment respondent rendered V.A.

177. The evidence also established that respondent ordered three video EEGs, an ambulatory EEG and a BAER with no medical indication. The standard of care requires physicians to order tests that are medically indicated and have relevance to diagnosis and management of the condition. V.A. suffered from headaches. Respondent appropriately ordered an MRI to rule out any brain anomaly. However, Dr. Florin persuasively opined that an EEG is not indicated for treatment of headaches. Respondent justified the initial and repeated EEGs based on a misdiagnosis of epilepsy, despite the lack of symptoms to support

such a diagnosis. Additionally, respondent ordered the BAER to check for hearing loss, despite no evidence that V.A. had complained of difficulties hearing. Respondent's ordering of unnecessary and excessive EEGs and the BAER, was an extreme departure from the standard of care, repeated acts of negligence, excessive use of diagnostic procedures, and failure keep complete adequate and accurate medical records.

PATIENT B.A.

178. Complainant alleged that respondent's treatment of B.A. departed from the standard of care, because there was no medical indication for the four video EEGs or the BAER. Complainant also alleged that respondent lacked the knowledge or failed to consider the interactions between Depakote and Lamictal, improperly diagnosed B.A. with circadian sleep disorder, and prescribed B.A. Prozac despite the black box warning concerning the effects the medication may have on a patient with a history of suicidal thoughts. Complainant alleged that respondent's care and treatment of B.A. constituted an extreme departure from the standard of care, repeated acts of negligence, excessive use of diagnostic procedures, and that respondent failed to keep complete adequate and accurate medical records.

179. Dr. Florin persuasively opined that the standard of care requires a physician to order tests for valid clinical indications, with the "expectation that they would lead to establishing or changing a diagnosis or treatment." B.A. was diagnosed with juvenile myoclonic epilepsy several years before she was treated by respondent. The first EEG respondent performed on August 12, 2009, after the first visit was within the standard of care based on B.A.'s history of epilepsy and because she was a new patient. However, the subsequent EEGs were not medically indicated.

180. Respondent ordered a repeat EEG on November 2, 2009, to "rule out any epileptogenic foci" even though B.A. had been seizure free and had no myoclonic jerks. Respondent contended that she ordered the repeat EEG because she reduced B.A.'s Depakote. However, the laboratory tests respondent ordered to check B.A.'s Depakote level, would have indicated if her level was in the therapeutic range. A third EEG was ordered on May 3, 2010, to "rule out seizures." However, B.A. had not reported any auras or seizures and indicated that she was tolerating the Depakote and Topamax. The results were also normal. Despite the normal EEG, a four-day-ambulatory EEG was performed on July 3, 2010, to make sure that B.A. was "stable" before tapering her off the Topamax. The results were normal. A fourth EEG was ordered after B.A. had seizures on August 11, 2010.

181. Dr. Florin persuasively opined that repeated EEGs were not necessary to rule out "epileptogenic focus" as respondent contended. Nor is an EEG necessary when a patient "clearly has breakthrough seizures," when a patient is seizure free, or when a patient has "adverse effects of a medication." Rather, the standard of care required respondent to consider whether B.A.'s medication was appropriately treating her condition and to determine whether B.A.'s breakthrough seizure on August 11, 2010, was caused by medication doses that were too low, whether the patient is taking the medication or whether

there are drug interactions. Testing of B.A.'s Depakote level would have provided that information. However, respondent failed to obtain B.A.'s Depakote levels after her August 31, 2009 appointment, despite lowering the dose of her Depakote.

182. Dr. Cassini's opinion that the four EEGs, including the ambulatory EEG were within the standard of care to measure the efficacy of the medication, was not persuasive. He failed to explain how the EEG would test for the efficacy of the medication, or how the EEG would provide the necessary information for respondent to determine whether B.A.'s medication was at a therapeutic level.

183. Dr. Florin also persuasively testified that the BAER test was not medically indicated. The written justification for the test was hearing loss and dizziness. B.A. did not report either symptom. At the Board Interview, respondent admitted that the report of hearing loss and dizziness to justify the BAER was for billing purposes. At hearing, respondent contended that the BAER was ordered to rule out a tumor that effects balance and hearing, based on her concern that B.A.'s two café au lait spots may be an indication of neurofibromatosis. Respondent's justification for the BAER was not persuasive, based on her acknowledgement that a patient with five or more café au lait spots can be at risk for neurofibromatosis. There was no medical indication that B.A. met the criteria neurofibromatosis to justify the use of the BAER.

184. The evidence established that respondent ordered four EEGs and a BAER over a 14-month period, with no medical indication. Complainant established that respondent's ordering of four EEGs and a BAER without medical indication, was an extreme departure from the standard of care, repeated acts of negligence, excessive use of diagnostic procedures, and failure keep complete adequate and accurate medical records.

185. The evidence also established that respondent lacked the knowledge or failed to consider the important interactions between Depakote and Lamictal. Dr. Florin persuasively opined that the standard of care requires a neurologist "to be competent to have sufficient expertise to diagnose and treat common neurological disorders." He further opined that respondent, who has a subspecialty in child neurology, should have competence in treating pediatric patients with epilepsy. This includes understanding the effects of medication that is prescribed to treat patients with epilepsy.

186. On November 2, 2009, respondent reduced B.A.'s Depakote from 1,500 m.g. per day to 1,000 m.g. per day and added Topamax. B.A. had been taking 1,500 m.g. of Depakote for several years and remained seizure free, with a Depakote level of 101 in August 2009. Respondent contended that she reduced the Depakote because she was concerned that B.A., who was 14 years old, was "child-bearing age" and that the Depakote could harm a fetus should B.A. get pregnant. Respondent failed to document any conversation she had with B.A. or her mother regarding whether B.A. was sexually active or whether B.A. understood the potential risk of lowering the medication. Despite lowering the medication, and discontinuing the Topamax on May 3, 2010, without replacing it with any

other anti-epileptic medication, respondent did not obtain any laboratory tests checking B.A.'s Depakote level after August 31, 2009.

187. Dr. Florin persuasively testified that respondent should have recognized during the visit on July 29, 2010, when B.A. reported that she was having "twitches," that she was suffering from myoclonic jerks as a result of the decrease in her Depakote level. Respondent failed to recognize this important symptom and did not increase B.A.'s Depakote or prescribe any other anti-epileptic medication. The result was that B.A. suffered serious back-to-back seizures on August 11, 2010. Her Depakote level was 61.

Additionally, when respondent added Lamictal to B.A.'s medications on August 23, 2010, she failed to recognize that B.A. was having adverse effects from the drug. B.A. reported that she was confused, had twitching and was nervous. Dr. Florin persuasively opined respondent failed to recognize B.A.'s symptoms were caused by possible adverse effects from medication, rather than breakthrough seizures. Respondent admitted that she continued to "push" the Lamictal, despite B.A.'s adverse reaction. Respondent also failed to order any testing for B.A. on August 23, 2010, to monitor the effects of the Depakote and Lamictal, to determine whether the medications were in a therapeutic or toxic range.

188. Dr. Cassini's opinion that respondent acted within the standard of care by transitioning B.A. off Depakote onto Lamictal, because she was child-bearing age was not persuasive for several reasons. Respondent did not transition B.A. from Depakote to Lamictal. She reduced the Depakote in November 2009. She added Topamax, but discontinued it in May 2010, after B.A. experienced adverse effects from the new medication. Respondent did not add the Lamictal until B.A. had seizures on August 11, 2010.

Additionally, Dr. Cassini's opinion that the standard of care did not require respondent to obtain laboratory tests when she changed the dose of Depakote and later added the Lamictal, was also not persuasive. The laboratory testing was vital to determining whether B.A.'s Depakote level was in a therapeutics or toxic range. Had respondent obtained that information before B.A. had seizures on August 11, 2010, and after she prescribed the Lamictal, she could have made adjustment to her medication that could have prevented the adverse effects that B.A. suffered.

189. The evidence also established that respondent departed from the standard of care by prescribing B.A. Prozac, despite the black box warning that the medication can cause an increase in suicidal ideation in adolescents. B.A. had a history of suicidal thoughts and respondent diagnosed B.A. with depression. Both experts opined that the standard of care required respondent to be certain of her diagnosis of depression, and to have discussion with B.A. and her parents about the risk of taking Prozac, due to the black box warning. There is no evidence in the medical records that respondent obtained information from B.A. to support a diagnosis of depressive disorder, or that she had such a discussion with B.A. and her parents regarding the risks of taking Prozac.

190. There was also no evidence to support respondent's diagnosis of circadian sleep disorder. There is no evidence in the medical records respondent prepared that she asked B.A. if she had symptoms to support a diagnosis of insomnia. B.A.'s medical records from Florida indicated that she had a polysomnogram sleep study that was normal and found no evidence of sleep disorder. Both experts agreed diagnosing circadian sleep disorder, without documentation of the history, symptoms or testing to support the diagnosis, is a departure from the standard of care.

191. Complainant established that respondent's failure to consider the interactions between Depakote and Lamictal, diagnosing B.A. with circadian sleep disorder and prescribing B.A. Prozac without evidence that she discussed the black box warning and risks with B.A. and her parents, constituted an extreme departure from the standard of care, repeated acts of negligence, and failure keep adequate and accurate medical records.

PATIENT R.C.

192. Complainant alleged that respondent improperly diagnosed R.C. with M.S. and epilepsy, failed to recognize findings of partial transverse cervical myelopathy, ordered EEGs and an EMG with a nerve conduction study without medical indication. Complainant also alleged that respondent lacked the knowledge to read EEG results, and had no knowledge or did not consider the drug interactions between Depakote and R.C.'s other medications.

Complainant also alleged that respondent lacked knowledge in several fundamental areas, demonstrated by her failure to recognize Lhermitte's symptoms, her erroneous opinions that M.S. plaque could cause severe neck pain and that lumbar puncture IgG synthesis findings could indicate whether R.C. had active or inactive M.S. Additionally, respondent contended that she diagnosed R.C. on the basis of the McDonald criteria without providing any information on how R.C.'s findings fit the criteria, failed to question R.C. about her symptoms at the time the 2007 MRI was conducted, and ordered laboratory testing for Lyme disease or "lupus," without medical indication.

Complainant alleged that respondent's care and treatment of R.C. constituted an extreme departure from the standard of care, repeated acts of negligence, excessive use of diagnostic procedures, and that respondent failed to keep adequate and accurate medical records.

193. Dr. Florin persuasively opined that the standard of care requires that diagnostic procedures utilized by a physician should be limited to those necessary to diagnose a specific condition. Both experts agreed that the MRI, lumbar puncture and VEP, were all tests that were appropriate and within the standard of care to assistant respondent in determining whether R.C. had M.S.

194. However, Dr. Florin persuasively opined there was no medical indication for the EMG with nerve conduction studies of the upper and lower extremities and the number

of nerves and muscles tested were excessive. Respondent contended that she ordered the EMG with nerve conduction studies to obtain more information about the sharp pain R.C. experienced on the left upper extremity. However, R.C.'s neurological evaluation was normal, and respondent should have recognized that R.C.'s symptoms were caused by the partial transverse cervical myelopathy.

Additionally, Dr. Florin's opinion that the EEG studies were also not medically indicated was persuasive. Respondent ordered a video EEG and ambulatory EEG during the first examination. R.C. did not report any symptoms of alteration of consciousness of any type, such as syncope or seizures, which would be the type of symptoms which would be indicated for an EEG. Respondent's contention that she ordered the EEG because R.C. reported dizzy spells and incontinence was not supported by the evidence. R.C. credibly testified that she was referred to respondent for neck pain and that she did not report dizzy spells or incontinence. Additionally, despite the normal findings on the first EEG, respondent proceeded with the ambulatory EEG, again without medical indication.

195. Dr. Cassini's opinion that respondent did not depart from the standard of care by ordering the EEGs and EMG with nerve conduction study, was not persuasive. Dr. Cassini opined that the MRI finding require respondent to perform a "large workup" and to rule out any diseases that might "mimic" M.S. He opined that the EMG and nerve conduction studies would help respondent check for "mimickers" and identify other potential sources of her symptoms. He failed to explain what other symptoms he was referring to and how the EMG would provide that information, given R.C.'s normal neurological evaluation.

Dr. Cassini noted patients with M.S. have a higher risk for epilepsy. As a result, he opined that it was within the standard of care for respondent to order the EEG to check for "evidence of abnormities." However, respondent ordered the EEG before she had any sufficient information to diagnosis R.C. with M.S. Additionally, R.C. did not report any symptoms that were consistent with a diagnosis of epilepsy, to justify the EEGs.

196. The evidence established that respondent's ordering of the EEGs and EMG with nerve conduction studies, was an extreme departure from standard of care, repeated acts of negligence, represented repeated acts of clearly excessive use of diagnostic testing and a failure to maintain adequate and accurate medical records.

197. The evidence also established that respondent improperly diagnosed R.C. with M.S. and failed to recognize symptoms and findings of partial transverse cervical myelopathy. Dr. Florin persuasively opined that the standard of care requires that a general neurologist have sufficient training, knowledge, and experience to evaluate patients with possible M.S. When R.C. was referred to respondent, she had symptoms and MRI findings of partial transverse cervical myelopathy. Her 2007 MRI findings showed a few non-specific scattered punctate of unlikely clinical significance and M.S. was not raised as a cause. Despite respondent's contention to the contrary, there was no evidence on R.C.'s 2007 MRI that she had any lesions in the supra and infratentorial area of the brain.

During R.C.'s first appointment respondent appropriately ordered a MRI and VEP to obtain further information. The VEP results were normal. The 2012 MRI results demonstrated a slight worsening, consistent with the passage of five years since the last MRI. The radiologist opined that "the possibility of a tiny lesion in the corpus callosum raises the possibility of a demyelinating process such as [M.S]. Other possibilities could include premature mild small vessel ischemic disease, previous infectious process, etc. Clinical correlation is recommended." Dr. Florin persuasively opined that the shape, size and location of the abnormalities were "nonspecific" and did not show findings consistent with M.S.

Despite the inclusive MRI findings, during R.C.'s second appointment, respondent told R.C. that she had M.S. R.C. requested a lumbar puncture which was performed on March 13, 2013. The results were that she did not have oligoclonal bands and the IgG synthesis was normal. Respondent incorrectly told R.C. that the IgG synthesis was abnormal and would indicate whether R.C. had active or inactive M.S. Dr. Florin persuasively opined that 85 to 90 percent of patients who have M.S. have a finding of oligoclonal bands, found through the lumbar puncture test. Likewise, Dr. Cassini also acknowledged that only "20 to 30 percent" of patient who have a "clean" lumbar puncture, have M.S. Additionally, there is no test that can determine whether M.S. is active or inactive.

198. Additionally, respondent contended in her August 5, 2013 letter to the Board that she diagnosed R.C. with M.S. on the basis of the McDonald criteria. However, she failed to provide any information in R.C.'s medical record or her letter that explained how R.C.'s symptoms fit the McDonald criteria. At hearing, respondent contended that Dr. Knudtson told her that there were "more than 15 lesions, supra and infratentorial consistent with multiple sclerosis" on the 2007 MRI. However, there were no findings on the 2007 or 2012 MRI reports indicating that R.C. had more than 15 supra and infratentorial lesions consistent with M.S.

Dr. Cassini's opinion that respondent did not depart from the standard of care because she appropriately relied on the information provided to her by Dr. Knudtson to assist in her diagnoses of R.C., was not persuasive. Most significantly, the information respondent wrote on the 2007 MRI report about the location of the lesions is not reflected in the MRI reports or any of R.C.'s medical records. Additionally, the results of the VEP and lumbar puncture provided significant information which respondent should have factored into her diagnoses.

199. The evidence established that respondent's misdiagnosis of M.S. and failure to recognize symptoms and findings of partial transverse cervical myelopathy were an extreme departure from the standard of care. A diagnosis of M.S. has very serious implications, including exposure to life threatening drugs. Respondent made the diagnosis before she conducted appropriate testing and the testing that was performed did not support respondent's diagnosis.

Additionally, respondent demonstrated a lack of knowledge in several respects, which also represented an extreme departure from the standard of care. She did not recognize

Lhermitte's symptoms, believed the M.S. plaque could cause severe neck pain, failed to document how R.C.'s symptoms fit the McDonald criteria and erroneously opined that the IgG synthesis could indicate active or inactive M.S.

200. The evidence also established that respondent departed from the standard of care by also diagnosing R.C. with epilepsy and incorrectly reading R.C.'s EEG results. Dr. Florin persuasively opined that the standard of care requires a physician to make an appropriate diagnosis based upon the medical history and appropriate testing. After the February 5 and 6, 2013 ambulatory EEG, respondent documented in R.C.'s medical record the EEG showed "generalized polyspike and wave in the frequency" which she opined was "highly suggestive of a generalized seizures disorder." Additionally, respondent prescribed R.C. Depakote due to the "seizures" on the EEG. Both experts agreed that it was a departure from the standard of care for respondent to prescribe R.C. Depakote for seizures she observed on R.C.'s ambulatory EEG, because the EEG was normal and there was no evidence that R.C. suffered from seizures.

Dr. Florin also persuasively opinion that that a neurologist who reads an EEG result "is expected to be competent in doing so." When respondent was questioned during the Board Interview, about what effect R.C.'s exposure to the microwave to her EEG results, respondent did not know what the effect would be on the results. The evidence established that respondent was not competent in reading R.C.'s EEG.

201. Complainant established that respondent's misdiagnosis of epilepsy and failure to correctly read R.C.'s EEGs results, was an extreme departure from the standard of care, constituted repeated acts of negligence, and failure to maintain adequate and accurate records. There are significant implications to a diagnosis of epilepsy including effects on driving privileges and exposure to unnecessary medication. Respondent failed to exercise the level of care that is expected of a physician who treats neurological conditions.

202. The evidence also established that respondent lacked the knowledge or failed to consider the drug interactions between Depakote and other medications R.C. had been prescribed by her PCP. The standard of care requires physicians to prescribe medications for proper indications and to know safety, adverse effects and possible drug interaction. R.C. had been prescribed several medications by her PCP. R.C. indicated during her first appointment with respondent, that she was not taking any medication.

203. Both experts agreed that the standard of care required respondent to obtain a history of R.C.'s medication and consider that information when prescribing her new medication. Dr. Cassini opined that respondent should have obtained baseline laboratory test to determine whether there was anything in R.C.'s system that may affect the efficacy of the Depakote. Respondent prescribed R.C. Depakote for an unsubstantiated diagnosis of epilepsy. Respondent also failed to consider that R.C.'s other medication may have caused R.C.'s toxic level of Depakote.

204. Although Dr. Cassini opined that respondent should have obtained a baseline laboratory test, Dr. Florin's opinion that respondent's failure to consider the possible drug interactions was an extreme departure from the standard of care was more persuasive. Respondent's conduct resulted in actual harm to R.C. Additionally, respondent's failure to document any medications R.C. was taking at the time that she prescribed the Depakote, or to note that she had a discussion with R.C. about whether she was taking medication, was a failure to maintain adequate and accurate medical records.

PATIENT D.K.

205. Complainant alleged that respondent failed to maintain adequate and accurate records related to her treatment of D.K., coded and billed for Level 5 services that were not substantiated, and was not aware of CURES and did not utilize the database in her in her practice. Complainant alleged that respondent's treatment of D.K. constituted repeated acts of negligence, and failure to maintain adequate and accurate medical records. Additionally, complainant alleged that respondent failed to timely comply with a Board request to provide certified copies of D.K.'s medical records.

206. The evidence established D.K. was referred to respondent due to complaints of neuropathy, which manifested as pain, tingling and burning of his feet, legs and hands. During the examination on March 27, 2014, D.K. told respondent his symptoms and explained his failed back surgery. He also stated that he took Tramadol for pain. She conducted neurological examination, which was normal. Respondent's diagnosed D.K. with neuropathic pain, Restless Leg Syndrome, obesity, CTS, low back pain, and tremor. Respondent recommended that D.K. return for an EMG and nerve conduction study of the upper and lower extremities. The examination lasted approximately 15 minutes. Respondent coded and billed the examination as a Level 5.

207. Dr. Florin persuasively opined that the standard of care requires a physician to maintain accurate, complete, and timely medical records. Dr. Florin persuasively testified that respondent diagnosed D.K. with tremor, without examination findings to support the diagnosis. Respondent failed to document any information in the medical record that explained how she diagnosed the condition. Respondent also stated during the Board Interview that she recommended that D.K. come back to her office for an EMG and nerve conduction study of the upper and lower extremities, to rule out neuropathy versus radiculopathy, and to rule out carpal tunnel versus neuropathy versus "CIDP maybe." There was also no physical finding to support those diagnoses.

208. Dr. Cassini's opinion that there was no reason why respondent "should or should not document tremors" as part of her diagnosis of D.K. and that respondent did not depart from the standard of care by including the diagnosis as part of her examination, was not persuasive. The evidence did not support respondent's contention that she did not diagnosis D.K., but rather was relying on his past medical history to list his conditions and to determine if it was appropriate to give him Tramadol. There are no notations in the medical records respondent completed that indicated the list of diagnoses was "by history" or was in

reference to his past medical records. The evidence established that respondent's failure to keep accurate and adequate medical records regarding her treatment and diagnosis of D.K. was a simple departure from the standard of care, and failure to maintain adequate and accurate medical records.

209. Dr. Florin also persuasively testified that standard of care requires a physician to code the services they provide to patients for purposes of billing, to the level of service that is supported by the medical records. Respondent billed her examination of D.K. as a Level 5, which required at which 14-point review of systems, a neurological examination, certain aspects of a general physical examination and counseling D.K. regarding the multiple diagnoses and the treatment plan. Respondent spent approximately 15 minutes with D.K.

There was no evidence that respondent performed a 14-point review of systems, or a physical examination. She also did not conduct extensive counseling explaining to D.K. his diagnoses and the plan for treatment, to substantiate the Level 5 coding and billing. Dr. Cassini did not render any opinion regarding whether respondent's documentation substantiated a Level 5 billing. Respondent's coding and billing for a level of services not substantiated in the medical record constituted a simple departure from the standard of care and failure to maintain accurate and adequate medical records.

210. Dr. Florin persuasively opined that the standard of care in 2014, required physicians to be aware of CURES and to utilize the database on a regular basis when caring for patients who take controlled medication. Dr. Cassini's opinion that if a physician was "not managing addiction" and only "managing pain" the standard of care did not require the physician to access CURES to check a patient's narcotic history, was not persuasive. CURES is designed to provide physicians who prescribe pain medication to patients, to access the database to determine if the patient is obtaining prescriptions in a manner that suggests drug-seeking behavior.

211. Whether the physician is managing pain or addiction is irrelevant. Respondent contemplated taking D.K. off Tramadol, based on her concern D.K. was drug seeking. Respondent was not aware of CURES and she did not utilize CURES in her practice, which prevented her from obtaining important information about D.K.'s drug use that may have informed her clinical judgment. Respondent's failure to be aware of CURES and utilize it in her practice was a simple departure from the standard of care.

212. Complainant also established that respondent failed to timely provide a certified copy of D.K.'s medical record to the Board. On November 3, 2014, Investigator Vanderveen sent respondent a letter requesting a certified copy of D.K.'s medical record to be produced by November 19, 2014. On November 11, 2014, respondent's office sent an incomplete copy of D.K.'s medical records to Investigator Venderveen.

213. During the Board Interview in April 2015, Investigator Vanderveen learned that respondent had not provided her a complete copy of D.K.'s medical record. She requested respondent to provide her a complete certified copy. She provided respondent's

attorney a copy of the certification form to complete and attach to the records. No records were provided until August 9, 2016, and the records were still not complete. The evidence established that respondent's failure to provide a certified complete copy of D.K.'s medical record to the Board was a violation of Business and Professions Code sections 2225, subdivision (e), and 2225.5.

Appropriate Discipline

214. Complainant established all of the allegations against respondent related to her treatment of four patients, by clear and convincing evidence. The multiple violations of the Medical Practices Act that occurred over several years were serious. Respondent exposed her patients to real and potential harm, she misdiagnosed or failed to substantiate diagnoses for all four patients, repeatedly engaged in excessive use of testing, and repeatedly failed to maintain adequate and accurate medical records for the patients. She also failed to comply with the Board's requirement to timely provide a copy of D.K.'s medical record.

Most concerning is that she failed to acknowledge any culpability and failed to demonstrate insight, even when faced with the numerous inconsistencies between the patient's medical records, diagnostic results, her statements during the Board Interview, and her testimony at hearing. Respondent contended that her intention was provide quality care to her patients, and that her treatment of the patients was in furtherance of her desire to provide such care. Respondent appeared to be deeply concerned about the patients' well-being, but the evidence demonstrated that her care and treatment of the four patients departed from the standard of care.

Respondent has been licensed to practice medicine in California since 1990. She has no record of discipline with the Board. She clearly takes pride in her practice. 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 maximum discipline for an extreme departure from the standard of care, repeated acts of negligence, excessive treatment and failure to keep adequate and accurate records is revocation. Complainant recommended the minimum discipline of stayed revocation, and five years of probation, with terms and conditions of probation designed to protect the public.

215. Based on the totality of the evidence, the public protection would be served by imposing a five-year term of probation, with extensive terms and conditions of probation to ensure that respondent is safe to practice, including the requirement that respondent complete of a clinical competence assessment program which will ensure that she is competent to practice as a neurologist and will identify any deficiencies that may need to be addressed. Respondent is also prohibited from operating a solo practice while she is on probation and is

required to obtain a practice monitor who will ensure that respondent's 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 she understands her ethical obligations and her duty to maintain accurate and adequate records. Respondent is also ordered to pay the maximum civil penalty of $10,000, for failure to timely provide the Board a certified complete copy of D.K.'s medical 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. Pursuant to Business and Profession Code section 725, subdivision (a), repeated acts of clearly excessive use of diagnostic procedures as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon.

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.

7. Business and Professions Code section 2225, provides in pertinent part that:

(b) Notwithstanding any other law, the Attorney General and his or her investigative agents, and investigators and representatives of the board or the California Board of Podiatric Medicine, may inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, whichever is

applicable, and may inspect documents relevant to those investigations in accordance with the following procedures:

(1) Any document relevant to an investigation may be inspected, and copies may be obtained, where patient consent is given.

(2) Any document relevant to the business operations of a licensee, and not involving medical records attributable to identifiable patients, may be inspected and copied if relevant to an investigation of a licensee.

[¶] . . . [¶]

(e) If documents are lawfully requested from licensees in accordance with this section by the Attorney General or his or her agents or deputies, or investigators of the board or the California Board of Podiatric Medicine, the documents shall be provided within 15 business days of receipt of the request, unless the licensee is unable to provide the documents within this time period for good cause, including, but not limited to, physical inability to access the records in the time allowed due to illness or travel. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct. The board may use its authority to cite and fine a physician and surgeon for any violation of this section. This remedy is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records.

8. Business and Professions Code section 2225.5, subdivision (a)(1) provides:

A licensee who fails or refuses to comply with a request for the certified medical records of a patient, that is accompanied by that patient's written authorization for release of records to the board, within 15 days of receiving the request and authorization, shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 15th day, up to ten thousand dollars ($10,000), unless the licensee is unable to provide the documents within this time period for good cause.

Causes for Discipline

9. Complainant established by clear and convincing evidence that respondent's treatment of V.A., B.A. and R.C. constituted an extreme departure of the standard of care, as set forth in Findings 13 through 86,104 through 136, and 168 through 204. Therefore, cause was established to impose discipline on respondent's certificate pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b).

10. Complainant established by clear and convincing evidence that respondent's care and treatment of patients V.A., B.A., R.C. and D.K. constituted repeated acts of negligence, as set forth in Findings 13 through 92, 94 through 96, 104 through 141, and 168 through 211. Therefore, cause was established to impose discipline on respondent's certificate pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c).

11. Complainant established by clear and convincing evidence that respondent engaged in the excessive use of diagnostic procedures, as set forth in Findings 13 through 86, 110, 111, 114 through 118, 16, 177, 179 through 184, and 193 through 196. Therefore, cause for discipline was established pursuant to Business and Professions Code sections 2227 and 725.

12. Complainant established by clear and convincing evidence that respondent failed to maintain adequate and accurate records related to her treatment of V.A., B.A., R.C. and D.K. set forth in Findings 13 through 92, 94 through 101, 104 through 139, 168 through 209, 212, and 213. 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.

13. As set forth in Finding 97 through 101, 212, and 213, respondent failed to provide a complete certified copy of D.K.'s medical records to the Board, within 15 days of receiving the request. As a result, respondent is assessed the maximum penalty of $10,000.

Conclusion

14. 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 48720 issued to respondent Nadine Helmy Yassa 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 educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. **Medical Record Keeping Course**

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

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

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. **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, Accusation, 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 (3) and no more than five (5) 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 recommendation(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.

If respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, 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 the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the respondent did not successfully complete the clinical competence assessment program, the respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

5. **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.

6. **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.

7. **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.

8. **Supervision of Physician Assistants and Advanced Practice Nurses**

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

9. **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.

10. **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.

11. **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.

12. 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.

13. Non-practice While on Probation

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

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

Respondent's period of non-practice while on probation shall not exceed two (2) years. Periods of non-practice will not apply to the reduction of the probationary term.

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

14. 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.

15. 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.

16. License Surrender

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

17. 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.

18. Payment of Civil Penalty

Pursuant to Legal Conclusion 13, respondent shall pay the Board a civil penalty of $10,000, within 90 days of the effective date of the Decision, or pursuant to a payment plan approved by the Board.

DATED: November 27, 2017

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