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

In the Matter of the Accusation against:

PETER EDWARD DROUBAY, M.D., Respondent

Case No. 800-2016-024837

OAH No. 2019071061

DECISION AFTER NON-ADOPTION

Danette C. Brown, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter on June 8, and August 3 to 5, 2020, in Sacramento, California.

Ryan J. Yates, Deputy Attorney General (DAG), represented Complainant Kim Kirchmeyer (Complainant), former Executive Director of the Medical Board of California (Board).

Lawrence S. Giardina, Attorney at Law, represented Peter Edward Droubay, M.D. (Respondent), who was present at hearing.

Evidence was received, the record was closed, and the matter was submitted for decision on August 5, 2020. The ALJ issued a proposed decision on September 4. 2020.

On November 19, 2020, Panel A of the Board issued an Order of Non-Adoption of Proposed Decision. Oral argument on the matter was heard by Panel A on February 3, 2021, with ALJ Heather Rowan presiding. DAG Ryan Yates appeared on behalf of the Complainant. Respondent was present and was represented by Lawrence S. Giardina, Attorney at Law. Panel A, having read and considered the entire record, including the transcript and the exhibits, and having considered the written and oral argument, hereby enters this Decision After Non-Adoption.

FACTUAL FINDINGS

Licensing History

1. On August 6, 1974, the Medical Board of California (Board) issued Respondent's Physician's and Surgeon's Certificate No. G27705. The certificate will expire on February 28, 2021, unless renewed or revoked.

Board's Accusation

2. On October 17, 2017, Complainant Kimberly Kirchmeyer, former Executive Director for the Board, filed an Accusation alleging Respondent: (1) committed sexual abuse and misconduct constituting unprofessional conduct, in the care and treatment of Patients A, B, and C; (2) committed gross negligence in his care and treatment of Patients A, B, and C; (3) committed repeated negligent acts in his care and treatment of Patients A, B, and C; and (4) engaged in unprofessional conduct which breached the rules or ethical code of the medical profession, demonstrating an unfitness to practice medicine. In aggravation, Complainant alleged Respondent received a public reprimand in a prior disciplinary action by the Board, in that

Respondent committed gross negligence, and failed to maintain adequate and accurate medical records in the care and treatment of a patient.

3. Respondent timely filed a Notice of Defense, pleading the affirmative defenses of collateral estoppel, laches, and statute of limitations. An evidentiary hearing was held before an OAH ALJ, pursuant to Government Code section 11500 et seq.

Respondent's Education and Work History

4. Respondent received his Doctor of Internal Medicine degree in 1973 from the University of Minnesota. He completed a rotating internship at San Francisco General Hospital in 1974, and completed his residency in 1976 at Martin Luther King Jr. General Hospital in Compton, California. He received his Master of Science degree in Public Health Nutrition at the University of California, Los Angeles School of Public Health. He completed a nutrition fellowship in 1979 at the University of California, Davis Medical Center.

5. Respondent is currently retired. He has held board certifications in internal medicine and critical care medicine. He was last employed in August 2018, as a physician for Sutter Medical Group. His practice included providing medical care at the following skilled nursing facilities: (1) Courtyard Health Care Skilled Nursing Facility (Courtyard) in Davis, California; (2) Woodland Nursing and Rehabilitation Skilled Nursing Facility in Woodland, California; (3) Cottonwood Skilled Nursing Facility in Woodland, California; (4) Stollwood Skilled Nursing Facility (Stollwood) in Woodland, California; and (5) Alderson's Skilled Nursing Facility in Woodland, California.

6. Respondent served as the Medical Director for Woodland Skilled Nursing Facility from January 2012, until his retirement, and as the Medical Director for

Courtyard from January 1998 to March 2016. From 1994 to 2003, Respondent was employed as a hospitalist for Sutter Davis Hospital, and as an internal medicine provider at Sutter West Medical Group. From 1979 to 1994, Respondent was in private practice as an internal medicine physician.

Board's Investigation

7. The Board began its investigation at Courtyard on February 22, 2017, after Courtyard informed the Board of Respondent's examinations of Patients A and B. During the course and scope of its investigation, the Board obtained the Controlled Substance Utilization Review and Evaluation (CURES), Davis Police Department investigation reports, and certified medical records for Patients A and B. The Board interviewed Patients A and B, Respondent, and Courtyard staff. The Board issued a Report of Investigation dated March 4, 2019, which was admitted in evidence.

8. The Board began its investigation at Stollwood on December 4, 2017, after Stollwood notified the Board in October 2017, of Patient C's complaint of sexually inappropriate contact by Respondent. The Board interviewed Stollwood staff, Patient C, and Respondent, and obtained Patient C's certified medical records. The Board issued a Report of Investigation dated March 4, 2019, which was admitted in evidence.

Patient A

9. The Board interviewed Patient A on February 26, 2018. She also testified at hearing, consistent with her account to the Board. Patient A is 45 years old, and was

diagnosed with Stiff-Person Syndrome[1] in the late 1990s. The syndrome is characterized by body spasms, and has rendered her completely disabled. She was treated at UC Davis Medical Center (UCDMC) due to difficulties in swallowing and was "retching" white foam from her mouth and throat. After treatment at UCDMC, and while at home, she overmedicated herself after her caretaker was confused by the medication instructions. She went back to UCDMC immediately and was discharged one week later, then transferred to Courtyard on a Friday. She believed that Respondent was to meet her there when she arrived. However, Respondent was not there.

10. That Monday, June 27, 2016, Respondent walked into her room and introduced himself. The curtain was closed and Patient A was lying in her bed at a 45-degree angle. Without offering or having a chaperone present, Respondent reached into her pajama top with his bare hand and "shook" her left breast. He did not describe what he was going to do. Patient A was "utterly mortified." Respondent did not say anything. He then placed his hand on her right breast and shook it. Respondent did not wear gloves, and did not sanitize his hands before or after. He commented to Patient A that she had breast implants. Respondent placed his stethoscope at the top of her neck to listen to her heart and lungs, although Patient A did not believe Respondent was actually listening. Respondent then put his stethoscope away and walked out.

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[1] Stiff-person syndrome is a rare neurological disorder with features of an autoimmune disease. It is characterized by fluctuating muscle rigidity in the trunk and limbs and a heightened sensitivity to stimuli such as noise, touch, and emotional distress, which can cause muscle spasms.

11. Patient A had numerous breast examinations over the years, and none were like the examination that Respondent performed. Her prior doctors did not grab the entire breast and shake it. Respondent did not use his fingers to palpate her breasts like other providers. Respondent shook each breast for approximately 10 seconds.

12. After Respondent walked out of the room, Patient A began crying, and called her mother. Her mother arrived at Courtyard right away, and Respondent went to the room and attempted to apologize for the "miscommunication." Respondent explained that he was checking Patient A's lymph nodes, but did not deny touching her breasts. Patient A said that Respondent's hand was on her breasts and not on the outside of the breasts where the lymph nodes are located. Patient A was in shock and horrified at what occurred. Despite Patient A requesting another doctor, Respondent continued to be her treating physician, managing her care from a distance.

13. Respondent's electronic documentation of Patient A's physical examination did not note that he examined her breasts. The physical examination checklist was a comprehensive one, consisting of the following categories: (1) General; (2) Head, Eyes, Ears, Nose, Throat (HEENT); (3) Respiratory; (4) Cardiac; (5) Abdomen; (6) Genitourinary; (7) Extremities/Integumentary; (8) Neurological; and (9) Psychological. Respondent noted negative findings under the Respiratory and Cardiac categories. There were ample areas for Respondent to enter additional notes to document a breast examination.

14. Patient A conceded she had pain medication in her system during Respondent's examination, but they did not interfere with her recall or cognitive abilities, nor do they now. She asserted she has a photographic memory, but had difficulty recalling specific dates. She currently takes morphine, Valium, Baclofen for

spasms, Prilosec for her stomach, hydroxyzine for heat intolerance, and Gabapentin for seizures. Patient A did not have any concerns with her breasts prior to Respondent's examination, and Respondent did not describe a medical need for the breast examination prior to performing the breast examination. Patient A asserted that she had no reason to fabricate her allegations against Respondent. The incident has affected her emotionally in that she has nightmares and wakes up crying.

15. On July 1, 2016, Courtyard requested Respondent have a nurse or other medical practitioner present when performing physical examinations for the protection of himself and facility residents. Respondent agreed that this would be a good idea, and would do so going forward.

Patient B

16. On December 14, 2017, the Board interviewed Patient B at home. She also testified at hearing consistent with her account to the Board. Patient B is 78 years old. In July 2016, she fell and broke her right leg and ankle. She had surgery on her tibia at North Bay Medical Center, and was transferred the following day, July 20, 2016, to Courtyard for rehabilitation.

17. On approximately the third day after her arrival, Patient B was sleeping in her room, lying on her back wearing a cotton gown. At the time, Patient B had never met or received care from Respondent. Patient B was awakened by Respondent, who was wearing normal clothes, standing over her, and massaging her breasts. He was "palming" her breasts, stroking downward. He did not say anything while he was stroking her breasts, including the area around and under her breasts. He stared at her breasts the entire time he was touching her. There was no chaperone, and Respondent did not have gloves on. She asked Respondent who he was and what he was doing. He

remained silent. She asked for his business card, and he dropped his card on the bed and left. He did not wash his hands.

18. Patient B called her daughter and told her about the incident. Patient B then reported the incident to the Davis Police Department, with the following inconsistencies: (1) the incident occurred at approximately 2:30 p.m., not 10:00 a.m. to 11:00 a.m., as she reported to the Board; (2) Respondent touched her breasts for approximately 15 minutes, then she changed the time frame to eight to nine minutes, not three to four minutes as she reported to the Board; and (3) during the touching, Respondent stared out of the window the entire time, rather than staring at her breasts the entire time, as she reported to the Board.

19. Like Patient A, Respondent's electronic documentation of Patient B's physical examination did not note that he examined her breasts. He used the same physical examination checklist, entered negative findings under the Respiratory and Cardiac categories, and entered notes under various categories. There was no entry on the physical examination checklist that he performed a breast examination.

20. Patient B's daughter told the Board that it was approximately one week before she realized Patient B was not taking her regularly prescribed Lyrica for fibromyalgia. The daughter believed Patient B was suffering from withdrawals during her first week at Courtyard because she seemed more confused than normal.

21. Patient B remembers the incident very well despite taking oxycodone with acetaminophen for pain at that time. Her CURES report showed that Respondent prescribed oxycodone with acetaminophen and Lorazepam, a sedative, in July 2016; he prescribed Norco, a pain medication, and continued prescribing Lorazepam in August 2016. Like Patient A, Patient B also stated she has a photographic memory. And, like

Patient A, Patient B also had previous breast examinations, and stated that Respondent's examination was different because he did not palpate around her breasts, nor did he introduce himself or tell her the purpose of the examination. She believes Respondent touched her breasts for self-gratification. Patient B had no reason to fabricate her allegations, and believes she was "molested" by Respondent.

22. On July 25, 2016, Courtyard required Respondent to have a nurse or other medical practitioner present for all resident physical examinations for the protection of himself and facility residents. Respondent agreed, and signed a document reflecting the agreement.

Patient C

23. On February 15, 2018, the Board interviewed Patient C at Stollwood. Her testimony at hearing was consistent with her account to the Board. Patient C is 70 years old. She had been Respondent's patient since the late 1970s until her appendix ruptured in the early 1990s, at which time she switched to a different doctor because she felt Respondent's office did not listen to her concerns. After hip replacement surgery in June 2017 at Sutter Davis Hospital, she was transferred to Woodland Nursing and Rehabilitation, then to UCDMC. On August 3, 2017, she was admitted to Stollwood. Upon her arrival, she was sitting in the dining room, Respondent saw her, walked over, rubbed her back, and said "Hello." Patient C did not have a problem with the back rub, as it was done to get her attention.

24. The next interaction with Respondent was when Respondent evaluated her for a urinary tract infection (UTI) by palpating her abdomen. Nothing of concern occurred.

25. The next interaction with Respondent occurred during a medical evaluation for symptoms of a UTI. Respondent listened to her lungs and chest. Respondent initiated a hug at the end of the examination, and Patient C reciprocated, then attempted to pull away from the hug. Respondent continued to hold Patient C, squeezing her longer and tighter. He then gave Patient C a "peck" on the cheek, and Patient C reciprocated with a "peck" back to Respondent because she felt obligated. Patient C felt "disgusted" kissing Respondent's cheek. Patient C then asked a nurse for a different doctor, but she was not sure that the nurse reported her request to anyone, as Respondent continued to be her physician.

26. The next interaction with Respondent occurred when Patient C was in the dining room/common area. Respondent came up to Patient C sitting in a wheelchair and said "Hello." They engaged in "small talk," and at the end of the conversation, Respondent hugged Patient C goodbye. Respondent leaned toward her, and she thought Respondent was going to kiss her on the cheek. Instead, Respondent moved his mouth and lips directly toward her lips, kissing Patient C with an open mouth which lasted for a "couple of seconds." Stunned, Patient C pulled away. Respondent stood up, and walked away.

27. At the next medical evaluation on October 7, 2017, Respondent came into Patient C's room and listened to her heart and lungs. Without offering or having a chaperone present, Respondent performed a breast examination under Patient C's shirt, including examining her nipples. Patient C felt that the breast examination was "normal and not normal at the same time," and felt that Respondent wanted to "get a quick feel real quick." Respondent then palpated her abdomen, and Patient C told Respondent she was still having UTI symptoms. Respondent said that she should not still be having issues. Respondent pulled Patient C's pants down to her mid-thigh area

without asking. He then inserted one finger from his ungloved right hand into Patient C's vagina and moved his finger back and forth, and up and down. While doing this, Respondent was looking down at Patient C's vaginal area. Patient C believed that Respondent's finger was inserted into her vagina for three to five seconds. She saw Respondent's face, and he looked "pleased." Respondent told Patient C he did not believe she had a yeast infection. While this was occurring, Patient C attempted to rationalize what was happening. She tried to convince herself that Respondent was a doctor and that there was a medical reason for his actions. She was in shock and felt that Respondent inserted his finger into her vagina for self-gratification. After speaking with her therapist, Patient C informed Stollwood of the incident.

28. Respondent's documentation of Patient C's physical examination did not note that he examined her breasts. His electronic progress notes were detailed, showing Patient C's vital signs, and that he performed examinations of the neck, chest, cardiac, abdomen, and neurological areas. He also noted that he examined the genital area, finding no evidence of "any candida or yeast around urethra; atrophic changes." Respondent did not note a pelvic examination of Patient C's vagina despite noting "atrophic changes." There was no entry that he examined Patient C's breasts.

29. In late October or early November 2017, Stollwood conducted an internal interview with Respondent. Respondent informed Stollwood that he and Patient C were "old friends," did not confirm or deny the allegation that he hugged Patient C during a medical evaluation, and admitted he conducted a digital pelvic examination of Patient C because she requested it due to pelvic pain. Respondent was "shocked" by the allegations, and asserted that he never had inappropriate allegations made against him before. Respondent did not mention the previous complaints by Patients A and B at Courtyard.

30. Physicians at Stollwood were not allowed to perform vaginal examinations without a nurse present. Respondent did not comply with this requirement. After its internal investigation, Stollwood "strongly suggested" to Respondent that he have an assistant present when examining female patients after receiving Patient C's complaint.

Board's Expert Mohammad Yusufzai, M.D.

31. The Board retained Mohammad Yusufzai, M.D. as an expert in this case. Dr. Yusufzai is board certified in Internal Medicine, with training emphasis on critical care and procedures. Since May 2015, Dr. Yusufzai has been the attending physician at Windsor Health Skilled Nursing Facility, and is the Chief Executive Officer and Provider for the Rancho Cordova Medical Clinic and Urgent Care. Dr. Yusufzai obtained his medical degree in 2008 from St. George's School of Medicine in Grenada, and completed his residency in Internal Medicine at San Joaquin General Hospital in French Camp, California.

32. Dr. Yusufzai reviewed the consumer complaints, CURES reports, Davis Police Department reports, billing records, Respondent's curriculum vitae, interview transcript, and other documents provided by Respondent. Dr. Yusufzai memorialized his expert opinion in two reports. One report contained his expert opinion for Patients A and B. The second report contained his expert opinion for Patient C. Both reports were dated December 16, 2018, and admitted in evidence. Dr. Yusufzai's testimony was consistent with the contents of his expert reports.

33. Dr. Yusufzai summarized his understanding of the general standard of care, and simple and extreme departures from the standard of care. He opined that the general standard of care is that "level of skill, knowledge, diagnosis and treatment

[provided] by a reasonably careful and prudent physician in the same or similar circumstances at the time in question." He explained that a simple departure from the standard of care is a "deviation" from that standard, and that an extreme departure is "reckless behavior." In his expert report dated December 16, 2018, he wrote that the standard of care in this case is "timely appropriate physical and assessment of new patients admitted to a skilled nursing facility."

34. The medical issue presented by Dr. Yusufzai was whether a breast examination is part of an admission physical in a skilled nursing facility for a new admission patient. Dr. Yusufzai opined that for a "new admit" the standard of care is to evaluate the patient in a timely manner for clinical reasons as necessary, and that the examination "must focus on the issue at hand and has to be relevant." Performing a physical examination in a timely manner is expected of the attending physician, and a reasonable physician under similar circumstances would not proceed with a breast examination as part of the patient's admission evaluation if there are no relevant symptoms to warrant such an examination.

Many patients in skilled nursing facilities "have primary care physicians (PCP) who are responsible for their annual wellness examinations and age appropriate malignancy workup." Their expected stay is short-term, and are expected to follow up with their PCP upon discharge. The focus and priority in medical care for the patient is a "problem-oriented approach with emphasis on acute issues hindering discharge."

For example, a requirement for a breast examination on a patient who is admitted to the facility for occupational therapy after a knee operation is "not relevant for the standard of care," and breast cancer screening "would be deferred to their

PCP." Dr. Yusufzai concluded that conducting a breast examination on Patients A, and B[2] was a simple departure from the standard of care.

35. The other medical issue presented by Dr. Yusufzai was the lack of a chaperone for the breast examinations performed by Respondent. Dr. Yusufzai wrote:

> The official [American Medical Association] guidelines state, "From the standpoint of ethics and prudence, the protocol of having chaperones available on a consistent basis for patient examinations is recommended." (Underlining in original.)

He further wrote:

> The American Medical Association (AMA) in 1998 adopted Opinion 8.21 which provides for "the protocol of having chaperones available on a consistent basis for patient examinations is recommended."

36. Dr. Yusufzai opined that the AMA makes recommendations that influence the standard of care. Here, the breast examinations of Patients A and B were performed without the presence of a chaperone, and:

> A reasonable physician under similar circumstances would offer, if not require a chaperone, during examination of

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[2] Dr. Yusufzai did not provide an opinion on the breast examination of Patient C.

> sensitive areas to help prevent miscommunication and misunderstanding.

At hearing, Dr. Yusufzai explained that a reasonable physician should explain to the patient what he is doing, and ensure that the patient understands what he is doing. The reasonable physician should obtain the patient's consent to perform the breast examination, and protect the patient's privacy by using a screen or isolated room. Providing a chaperone is included in these steps. Dr. Yusufzai concluded that Respondent's lack of a chaperone for the breast examinations of Patients A and B[3] was a simple departure from the standard of care.

37. As to Patient C, Dr. Yusufzai summarized her complaint as follows:

> The patient has alleged progressively increased physical contact with her from hugging, kissing on the cheeks to kissing on the lips. The patient also reported breast exam and vaginal exam with ungloved finger penetration, without a third person present. The physician denies kissing, hugging, digital penetration or breast exam, but does report visual inspection of perineum without a chaperone.

38. The medical issue presented by Dr. Yusufzai as to Patient C was whether conducting a pelvic examination without a chaperone fell within the standard of care as set forth in the AMA guidelines above. Dr. Yusufzai noted that Patients A and B

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[3] Dr. Yusufzai did not provide an opinion on the lack of a chaperone for Patient C's alleged breast examination.

alleged improper behavior at Courtyard, and that Respondent was required to have a chaperone at that facility during patient examinations thereafter. Thus:

> A reasonable physician under similar circumstances, after being accused of improper behavior the prior year resulting in chaperoned exams at another facility, would request a chaperone during a pelvic exam to avoid further allegations, prevent miscommunication and misunderstanding.

Dr. Yusufzai concluded that the lack of a chaperone at Stollwood during the pelvic examination of Patient C was a simple departure from the standard of care.

39. In an addendum dated February 2, 2019, Dr. Yusufzai provided the following additional expert opinions:

> (1) If allegations of hug and kiss on the lips with tongue involvement are proven to be true, this would be consistent with extreme departure from standard of care.
>
> (2) If allegation of digital penetration of vagina with ungloved hand is proven to be true, this would be consistent with extreme departure from standard of care.
>
> (3) Greeting kiss of long standing patient with a peck on the cheek, although not encouraged, is not uncommon among some older physicians and therefore is not a departure from standard of care.

At hearing, Dr. Yusufzai added that he did not provide an opinion on inappropriate touching of Patient C's vagina, but opined that if a patient has delirium,

as presented by Patient C, the physician needs consent to proceed with, in this case, a pelvic examination. If the patient is "altered," she cannot give consent, and the "next of kin" should be contacted, and a chaperone should be present. Dr. Yusufzai did not provide an opinion on whether Respondent departed from the standard of care for failing to obtain Patient C's consent to perform a pelvic examination. Lastly, Dr. Yusufzai opined that a visual inspection of Patient C's perineum[4] would have been within the standard of care for a complaint of a UTI problem.

Respondent's Expert Gary W. Steinke, M.D.

40. Gary W. Steinke, M.D. is a contract physician at Santa Clara Valley Medical Center's Department of Medicine, Primary Care Division, Geriatrics Medicine Section. Dr. Steinke has held this position since 2007. He also holds medical director positions for a residential care facility for the elderly and a skilled nursing facility, and is a medical consultant for the Terraces of Los Gatos, a nursing home. Dr. Steinke received his medical degree in 1971 from Temple School of Medicine in Philadelphia, Pennsylvania, and completed his internal medicine residency in 1974 at the University of Michigan. He is board certified in Internal Medicine.

41. Dr. Steinke provided his expert opinion in this case, and wrote a report dated December 1, 2019. His report was admitted in evidence. Dr. Steinke testified at hearing consistent with the contents of his report.

42. Dr. Steinke reviewed both of Dr. Yusufzai's expert reports and curriculum vitae, the relevant medical records for Patients A, B, and C, the Board's Investigation

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[4] The perineum is the area between the anus and vulva in women. (https://www.medicinenet.com/script/main/art.asp?articlekey=4836.)

Report, the Davis Police Department reports, the audio file and transcripts of Respondent's Medical Board interview, and other documents provided by Respondent.

43. Although Dr. Steinke did not articulate the applicable standard of care in his report or at hearing, he concluded:

> It is within the standard of care for an attending physician to perform a physical examination, including a breast examination as part of their admission evaluation. The failure to do so could miss relevant physical data important to the future care of such a patient. It is within the standard of care for [Respondent] to have performed a physical examination, including a breast examination under these circumstances.

As to the chaperone issue, Dr. Steinke concluded:

> It is not a departure from the standard of care to perform a physical examination, including a breast examination without the presence of a chaperone.

Addressing the medical issue as to Patient C, Dr. Steinke concluded:

> It is within the standard of care for a physician to examine a patient's perineum . . . The standard of care does not require the presence of a chaperone in regards to the performance of a breast examination or an examination of a patient's perineum. There was not a departure from the standard of care. A reasonable physician under similar

circumstances is not required by the standard of care to have a chaperone present during a visual inspection of a perineum or breast examination. I have reviewed Dr. Yusufzai's reports . . . and disagree with his analysis and conclusions.

Respondent's Testimony/Other Evidence

RESPONSE TO PATIENT A'S ALLEGATIONS

44. On June 27, 2016, Respondent entered Patient A's room to perform an examination. He told Patient A that he wanted to examine her chest, front and back. Patient A opened up her pajama top. Respondent began with a breast examination. Respondent does not wear gloves when performing a breast examination, and examines the patient in a supine position. He checked Patient A's breasts by first checking both armpits, then used a flat hand to press against her breasts. Respondent denied shaking her breasts, and denied commenting about her breast implants. Respondent characterized the breast examination as a cursory one that only took a few seconds. He later spoke with Patient A's mother, who told him that Patient A suffered from post-traumatic stress disorder due to past abuse, and that Patient A was very sensitive about her breasts.

45. Respondent was Patient A's hospitalist at Sutter Davis 20 years ago. At the time, Patient A saw Respondent for intravenous immunoglobulins to treat her stiff-man syndrome. When he entered her room to examine her on June 27, 2016, they became reacquainted, and Patient A told Respondent that he "left [her] to die" 20 years ago. Believing that Patient A was heavily medicated, Respondent reassured

Patient A that he did not leave her to die, and that he needed to proceed with the examination of her neck, chest, abdomen, and legs.

46. After the examination, Patient A wanted Respondent to increase her morphine due to her pain, and Respondent told her that he needed to speak to her mother, who was Patient A's primary caretaker. Patient A's mother informed Respondent later that Patient A did not like his breast examination because someone abused her in the past, and she was sensitive to someone touching her breasts. Patient A said nothing about her past abuse during the examination, and gave Respondent full permission to proceed with the examination.

RESPONSE TO PATIENT B'S ALLEGATIONS

47. Regarding Patient B, on July 22, 2016, Respondent walked into Patient B's room at 3:00 p.m. She was awake and alert, and they talked about her fall and past medical history. He told Patient B that he needed to examine her neck, chest, heart, abdomen and legs. He asked if this was okay, and Patient B said yes. He listened to her heart, then asked if it was okay to check her axilla, breasts and abdomen. Patient B assented. He felt her axilla for any lymph node enlargement, and did a brief flat hand compression of both breasts to check for any lumps, then manually palpated her upper and lower abdomen. He did not examine her groin area. He proceeded to check her lower extremities, and concluded the examination. She asked for a business card, which he provided. Respondent then left.

48. Respondent asserted that he talked to Patient B for a long time before examining her. She forgot who he was and why he was there due to her pain medication. He knew that she had episodes of delirium, confusion, and anxiousness,

and believed that Patient B could have been delirious when he spoke to her. However, he believed that Patient B was coherent enough to give consent to his examination.

49. Regarding lack of a chaperone during his examination of Patient B, Respondent explained that he could have found one, but did not think one was needed at the time.

RESPONSE TO PATIENT C'S ALLEGATIONS

50. Regarding Patient C, on October 7, 2017, Respondent examined Patient C for her continued complaints of UTI symptoms, after receiving urinalysis results that did not support a UTI. She was in bed wearing sweatpants. Respondent discussed the negative urinalysis, and wanted to make sure that she did not have any yeast in her groin or around her labia. Patient C pulled down her sweatpants, and Respondent performed a short visual inspection, finding no redness or evidence of yeast in her groin or around her urethra. Respondent denied putting his finger in her vagina. He also denied giving Patient C a hug, kiss on the cheek, or kiss on the lips with an open mouth. Respondent also denied performing a breast examination on Patient C, as she did not have any breast tissue. He also denied pinching her nipples. However, he admitted during his interview with the Board that he palpated under her armpits.

51. Respondent did not have a chaperone when he examined Patient C because he felt that he had a rapport with her, and that she trusted him. He did not feel that he needed to call someone else into the room.

52. During his interview with the Board, Respondent indicated that he was aware of Patient C as an anxious, depressed female, based on her medical records. He also knew she had a complete psychotic break prior to her arrival at Stollwood. Patient C's UC Davis health records show that psychiatrist Hallie Foster, M.D. performed a

psychiatric assessment of Patient C on August 3, 2017, the day before Patient C was transferred to Stollwood. Patient C's mental status examination revealed that Patient C had a normal rate of speech, fearful mood, had often illogical responses to questions, no delusions or bizarre thoughts, and stable memory in that she was able to give some details of her medical history and remote history. Dr. Foster's diagnostic impression listed, in part, a past history of bipolar disorder, schizoaffective disorder, dissociative identity disorder, and altered mental state due to a slip and fall. She further wrote:

> Current presentation is consistent with delirium given alternating level of consciousness visible during interview, waxing/waning concentration, and reported past high-functioning status. Still with symptoms of UTI, which is likely cause of acute decompensation.

Dr. Foster's diagnosis was "delirium due to acute infection (UTI) and/or electrolyte imbalance."

BREAST EXAMINATION ARTICLES

53. Received in evidence were several articles on the importance of breast examinations, to support the necessity of Respondent performing such examinations on his patients.

(a) An article entitled "Well-Woman Visit," which informs the reader that around age 21, women need regular pelvic, exams, Pap tests, and breast examinations.

(b) An article entitled "Clinical Breast Exam," by the Susan G. Komen organization which states that the exam is a physical exam done by a health care provider, often done during a woman's regular medical check-up. A trained

provider will carefully feel the patient's breasts, underarm, and area just below the clavicle for any changes or abnormalities.

(c) A 2017 article from the American College of Obstetricians and Gynecologists (ACOG) recommending women begin annual mammography screening at age 40, along with a clinical breast exam. The breasts are examined with the patient laying on her back with her arms behind her head, and the physician examines the breasts with the pads of his or her fingers to detect lumps or other changes.

(d) A 2018 article entitled, "Touch and the Practice of Medicine," by R. Christopher Searles, M.D., Director of the UC San Diego Physician Assessment and Clinical Education Physician Boundaries Program. The article discusses touch as a form of communication, and sets forth "Rules of the Road" for use of social and procedural touching during a patient visit. Procedural touch is to be used with a verbal explanation of what the physician is doing and why, especially if the examination involves sensitive areas of the body.

The articles are helpful in determining when and how a breast examination is to be conducted, and the importance of verbal explanations when touching patients in sensitive areas. The "Well Woman Visit" and "Clinical Breast Exam" articles support Dr. Yusufzai's opinion that breast examinations occur during wellness checks or during a woman's regular medical checkup, rather than during an admission physical for a skilled nursing facility. The latter two articles support Respondent's testimony that he performed the breast examinations in accordance with ACOG's recommendations, and that he used "touch" as a form of communication.

Analysis

MEDICAL EXPERTS

54. Both experts examined the issues of whether: (1) a breast examination is part of an admission physical in a skilled nursing facility (SNF) for a "new admit;" and (2) a lack of a chaperone during a breast or pelvic examination fell within the standard of care. Dr. Yusufzai properly articulated the general standard of care as that "level of skill, knowledge, diagnosis and treatment [provided] by a reasonably careful and prudent physician in the same or similar circumstances at the time in question." In this case the standard of care was the "timely appropriate physical and assessment of new patients admitted to a skilled nursing facility," with a focus on the patient's medical presentation. Dr. Yusufzai opined that a breast examination was not warranted for Patients A and B because they did not have relevant symptoms to warrant such an examination, and that the patients could go to their PCP for their annual wellness examinations given their short-term stay at the SNF.

55. Dr. Steinke disagreed, opining that it was within the standard of care to include breast examinations in the physical examination of a "new admit." Although he did not articulate what the standard of care was, it appears that he used the standard of care provided by Dr. Yusufzai in performing his expert analysis.

56. Respondent used an electronic form to document his examinations of Patients A and B at Courtyard. The format provided check boxes for the areas to be examined: (1) General; (2) Head, Eyes, Ears, Nose, Throat (HEENT); (3) Respiratory; (4) Cardiac; (5) Abdomen; (6) Genitourinary; (7) Extremities/Integumentary; (8) Neurological; and (9) Psychological. At Stollwood, Respondent's electronic progress notes had the same listing of categories. Neither breast examinations nor genital

examinations were listed as areas to be examined. This is strong evidence that breast examinations were not required as part of "new admit" physical examinations at the facilities, and Dr. Yusufzai's opinion that patients could go to their PCP for clinical breast examinations, and that breast examinations were not warranted without relevant symptoms, was persuasive. Respondent's breast examinations of Patients A and B were a simple departure from the standard of care.

57. Dr. Yusufzai followed the AMA guidelines for the use of chaperones in setting forth the standard of care, in that a reasonable physician under similar circumstances would offer or require a chaperone during examination of sensitive areas to prevent miscommunication and misunderstanding. Moreover, the reasonable physician would explain to the patient what he is doing, and ensure that the patient understands. The reasonable physician would obtain the patient's consent, and protect the patient's privacy by using a screen or isolated room, and use a chaperone.

58. Dr. Steinke articulated his version of the standard of care regarding use of chaperones as the opposite of Dr. Yusufzai's, in that the standard of care did not require the presence of a chaperone when performing a breast or perineum examination.

59. Dr. Yusufzai's opinion was supported by the AMA guidelines, and Dr. Steinke's was not. Physicians need to be keenly aware of patient boundaries, patient privacy, patient empathy, and patient communication and involvement in their treatment and care. Dr. Yusufzai's recitation of the standard of care and what a reasonable physician would do in performing examinations of sensitive areas is not only persuasive, it is a prudent and smart practice. Respondent's breast examinations of Patients A and B without a chaperone was a simple departure from the standard of

care. Respondent's examination of Patient C's pelvic area without a chaperone was a simple departure from the standard of care.

CREDIBILITY DETERMINATION

60. If the factual basis for the decision includes a determination based substantially on the credibility of a witness, the statement shall identify any specific evidence of the observed demeanor, manner, or attitude of witness that supports the determination. (Gov. Code, § 11425.50.)

61. Patients A, B, and C testified in a forthright and honest manner. Patient A testified from her bed in front of a computer, demonstrated some discomfort, needed a break, and towards the end of her testimony she appeared to tire, appeared sleepy, and her speech slowed due to her medications. Nevertheless, she clearly explained her interaction with Respondent but could not recall all of the precise dates asked of her. She was upset that this happened to her. It has affected her emotionally, and she wakes up crying. She stated, "he got a good feel for everything." She had no reason to make up the allegations, and clearly believes she is a victim.

62. Patient B testified from home in front of a computer. She was well-groomed, pleasant and alert, and articulated the incident very clearly although she could not provide precise dates. She did not appear to be heavily medicated, or delirious. She had no reason to make up the allegations, and felt violated.

63. Patient C also testified at home in front of a computer, was well-groomed, pleasant and alert, and articulated her interactions with Respondent very clearly. She did not appear to be heavily medicated, psychotic, or delirious. She felt "molested" by Respondent.

64. Respondent had three separate and distinct patients accusing him of inappropriate touching. All three patients' interactions with Respondent were upsetting for them. They were firm in their convictions that the interactions occurred as they described them. Even if the patients were medicated or delirious, their strong intuition, past experience with breast and physical examinations, and acute awareness of their own bodies told them that something was amiss when examined by Respondent. The patients' credibility was given great weight.

65. Respondent's calm and cool composure at hearing demonstrated an air of subtle control, power, and superiority. He testified very matter of factly, and did not express emotion when he denied the allegations in dispute. He did not appear to have any empathy for Patients A, B, and C. The evidence established that he ignored the order to have a chaperone at Courtyard, and he did not exercise good medical judgment when failed to use a chaperone with Patient C at Stollwood a year later. He falsely told a Davis Police detective that he changed how he does exams on female patients by having a female employee in the room, yet he did not do so with Patient C. He ignored Stollwood's requirement that a nurse be present during vaginal examinations. He demonstrated a resistance to change in the way he conducted his examinations to make him a better doctor. Respondent's attitude was that the Board's Accusation is an attack on his reputation, and attributed the allegations to the patients' medication and/or delirium. Respondent completely failed to acknowledge and appreciate any of the patients' concerns in this case. Respondent's credibility was given less weight.

SEXUAL ABUSE AND MISCONDUCT

66. The evidence established that Respondent touched the breasts of Patients A, B, and C under the guise of performing breast examinations. If he had

performed proper breast examinations, he should have documented them, as he did for the other examination categories. The patients did not express problems with their breasts, and according to the standard of care, instead of performing breast examinations, Respondent was required to treat Patients A, B, and C with an emphasis on their acute issues hindering their discharge from the facility.

67. All three patients independently and credibly testified that Respondent's breast examinations were not like the examinations performed by their previous doctors. Patient A was sitting at a 45-degree angle on her bed when Respondent examined her breasts. Respondent testified that he performs breast exams with the patient in a supine position, and uses his flat hand to press around the breasts. He did not do this with Patient A. Patient B, despite some inconsistencies in her account to the Board and to the Davis Police regarding time frames, was confident in her testimony that that Respondent stroked her breasts with his palm, stroking downwards. Patient C testified that Respondent's breast examination was "normal and not normal at the same time." Respondent felt her breasts and nipples for a few seconds. Respondent's inclusion of breast examinations for Patients A and B during a physical examination during admission were a single simple departure from the standard of care, as persuasively concluded by Dr. Yusufzai.

68. The evidence also established that Respondent helped Patient C to pull her sweatpants down so that he could visually examine her vaginal area for a UTI infection. Given Patient C's physical condition, it would have been difficult for her to pull her sweatpants down by herself while in bed. Respondent indicated that Patient C's urinalysis came back negative for a UTI infection, but he checked Patient C's vaginal area anyway due to her continued complaints. Respondent admitted during Stollwood's investigation that he conducted a digital pelvic examination because she

requested it due to pelvic pain. During the Board's interview and at hearing, he denied putting his finger in her vagina. The only plausible explanation for Respondent inserting his ungloved finger into Patient C's vagina was for self-gratification. Respondent's digital penetration with an ungloved hand is an extreme departure from the standard of care.

69. It is undisputed that Respondent conducted the breast examinations, and the pelvic examination of Patient C without a chaperone. The standard of care was to offer, if not require a chaperone during examination of sensitive areas. Dr. Yusufzai persuasively opined that there was a simple departure from the standard of care for unchaperoned breast examinations of Patients A and B, and another simple departure from the standard of care for the unchaperoned vaginal examination of Patient C.

70. Respondent admitted during his interview with Stollwood that he and Patient C were "old friends," and that he may have hugged Patient C during a medical evaluation (he did not confirm or deny this). At hearing, he denied the hugs and kisses. The evidence was not clear and convincing that Respondent hugged and kissed Patient C on one occasion, and hugged and kissed her with an open mouth on another occasion.

71. The evidence established that Respondent committed acts of sexual misconduct on Patients A, B, and C by touching, shaking, and massaging their breasts, touching Patient C's nipples, and digitally penetrating Patient C's vagina.

GROSS NEGLIGENCE

72. The evidence established that Respondent committed an extreme departure from the standard of care, constituting gross negligence, as determined by Dr. Yusufzai, when Respondent digitally penetrated Patient C's vagina.

REPEATED NEGLIGENT ACTS

73. The evidence established that Respondent committed repeated negligent acts by committing three simple departures from the standard of care by performing unwarranted breast examinations of Patients A and B, failing to provide a chaperone for the breast examinations of Patients A and B, and failing to provide a chaperone for the vaginal examination of Patient C.

BREACH OF RULES OR ETHICAL CODE/CONDUCT UNBECOMING

74. The evidence established that Respondent engaged in conduct unbecoming to a member in good standing of the medical profession, as evidenced by the Factual Findings as a whole.

EQUITABLE DEFENSES

75. Respondent's affirmative defenses of collateral estoppel, laches, and statute of limitations were considered, but were not established at hearing. Respondent failed to provide any evidence or arguments at hearing to support these equitable defenses.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

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

Burden and Standard of Proof

2. Complainant has the burden of proving each of the grounds for discipline alleged in the Accusation, and must do so by clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence is evidence that leaves no substantial doubt and is sufficiently strong to command the unhesitating assent of every reasonable mind. (*In re Marriage of Weaver* (1990) 224 Cal.App.3d 478, 487.)

Applicable Law

3. Business and Professions Code[5] section 726 states:

> (a) The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for the disciplinary action for any person licensed under this or any initiative act referred to in this division.
>
> (b) This section shall not apply to consensual sexual contact between a licensee and his or her spouse or person in an equivalent domestic relationship when that licensee provides medical treatment, to his or her spouse or person in an equivalent domestic relationship.

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[5] All statutory references refer to the Business and Professions Code, unless otherwise specified.

4. Section 2227 provides in pertinent part that a licensee that has been found "guilty" of violations of the Medical Practice 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.

5. Section 2234 provides that the Board shall take action against any licensee found to have engaged in unprofessional conduct, which includes but is not limited to the following:

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

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

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

(2) When the standard of care requires a change in the diagnosis, act, or omission that 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.

6. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the

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

Causes for Discipline

7. Complainant established by clear and convincing evidence that Respondent committed acts of sexual abuse and misconduct with Patients A, B, and C, constituting unprofessional conduct, as set forth in Factual Findings 7 through 30, and 66 through 71. Therefore, cause exists to discipline Respondent's certificate pursuant to sections 2227, 2234, and 726.

8. Complainant established by clear and convincing evidence that Respondent committed gross negligence in his care and treatment of Patient C, as set forth in Factual Findings 23 through 30, 39 and 72. Therefore, cause exists to discipline Respondent's certificate pursuant to section 2234, subdivision (b).

9. Complainant established by clear and convincing evidence that Respondent committed repeated negligent acts in his care and treatment of Patients A, B, and C, as set forth in Factual Findings 31 through 38, 54 through 59, and 73. Therefore, cause exists to discipline Respondent's certificate pursuant to section 2234, subdivision (c).

10. Complainant established by clear and convincing evidence that Respondent engaged in conduct that breached the rules or ethical code of the medical profession, or conduct that is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as set forth in the Factual Findings as a whole. Therefore, cause exists to discipline Respondent's certificate pursuant to sections 2227 and 2234.

Degree of Discipline

11. The Board's Disciplinary Guidelines provide the recommended minimum and maximum administrative penalties for violations of the Business and Professions Code. For violation of section 726, the minimum penalty is stayed revocation and seven years' probation. The maximum penalty is revocation with conditions designed to protect the public. For violation of sections 2234 (general unprofessional conduct), 2234, subdivision (b) (gross negligence), 2234, subdivision (c) (repeated negligent acts), the minimum penalty is stayed revocation and five years' probation with conditions designed to protect the public. The maximum penalty is revocation. There is no basis here to deviate from the Disciplinary Guidelines.

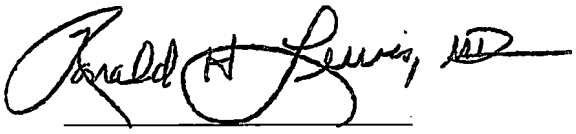
12. The evidence demonstrated that Respondent refused to comply with facility requests and requirements that he use a chaperone, putting his judgment and ability to comply with terms of probation into doubt. Further, he made dishonest statements to the Davis Police detective and the Board's investigator, which also raises concerns for public protection if Respondent were permitted to continue practicing on probation. With such serious misconduct and no evidence of rehabilitation, allowing Respondent to continue practicing under the terms and conditions of probation would not sufficiently protect the public nor the public's confidence in the medical profession. Consequently, the proper level of discipline in this matter is revocation.

ORDER

Physician and Surgeon's Certificate No. G27705, issued to Peter Edward Droubay, M.D., is REVOKED.

The Decision shall become effective at 5:00 p.m. on April 1, 2021.

IT IS SO ORDERED this 2nd day of March, 2021.



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

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
RYAN J. YATES
Deputy Attorney General
State Bar No. 279257
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-6329
Facsimile: (916) 327-2247

Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO June 13 2019
BY [illegible] ANALYST

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

In the Matter of the Accusation Against: **Peter Edward Droubay, M.D.** **3428 Morro Bay Ave.** **Davis, CA 95616** **Physician's and Surgeon's Certificate No. G 27705,** Respondent.	Case No. 800-2016-024837 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about August 6, 1974, the Medical Board issued Physician's and Surgeon's Certificate No. G 27705 to Peter Edward Droubay, 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 February 28, 2021, 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 provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

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

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

6. Section 726 of the Code states:

"(a) The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this or under any initiative act referred to in this division.

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

FIRST CAUSE FOR DISCIPLINE

(Sexual Abuse and Misconduct)

7. Respondent, Peter Edward Droubay, M.D., is subject to disciplinary action under sections 2227, 2234, and 726, of the Code, in that he committed an act or acts of sexual abuse and misconduct with Patients A, B, and C. The facts are as follows:

Patient A:

8. On or about June 24, 2016, Respondent was working as the Medical Director at Courtyard Healthcare Skilled Nursing Facility (Courtyard) in Davis, California. Patient A,[1] a forty (40) year old female, was admitted to Courtyard after being administered too much medication regarding her chronic stiff person syndrome (a rare neurological disorder and autoimmune disease, characterized by fluctuating muscle rigidity in the trunk and limbs).

[1] To protect the privacy of all patients involved, patient names have not been included in this pleading. Respondent is aware of the identity of the patients referred to herein.

9. On or about June 27, 2016, Respondent performed an initial examination on Patient A in her bedroom. During the examination, Respondent reached into Patient A's gown with his bare hand and "shook" Patient A's left breast for approximately ten (10) seconds. Respondent then shook Patient A's right breast for approximately ten (10) seconds. During the examination, Respondent never palpitated Patient A's breasts, which would have been consistent with a breast examination. Respondent briefly used a stethoscope to listen to Patient A's heart and lung function, before concluding the examination and leaving the room.

10. Prior to the breast examination, Respondent failed to retain a chaperone and/or discuss the option of retaining a chaperone with Patient A. Moreover, due to Patient A's status as a short-term patient at Courtyard, a breast examination was unnecessary as part of her admission physical.

11. Following Respondent's examination of her, Patient A felt that she had been inappropriately examined and immediately called her mother. Patient A's mother arrived at Courtyard shortly after, and confronted Respondent. Respondent came to Patient A's room and attempted to apologize for a "miscommunication." Respondent stated that he was checking Patient A's lymph nodes, or words to that effect, despite the fact that he had placed his hands directly on Patient A's breasts, in a manner inconsistent with a lymph node examination.

12. On or about July 1, 2016, a Courtyard Social Worker met with Respondent to discuss the June 2016, incident with Patient A. During the conversation, it was requested that Respondent have a nurse or other medical practitioner present, during future physical examinations. Respondent agreed to this proposal.

Patient B:

13. On or about July 20, 2016, Patient B, a seventy-four (74) year old female, was admitted to Courtyard for rehabilitation, following an injury to her leg.

14. On or about July 22, 2016, Patient B was sleeping in her room, when she was awakened by Respondent massaging her breasts. This was the first encounter between Patient B and Respondent. After some time, Patient B, stated, "What are you doing? Who are you?" or

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words to that effect. Respondent gave Patient B his business card, then turned and walked out of the room.

15. Prior to this meeting, Respondent never spoke with Patient B, nor received consent for the breast examination. Additionally, Respondent failed to retain a chaperone and/or discuss the option of retaining a chaperone with Patient B. Moreover, due to Patient B's status as a short-term patient at Courtyard, a breast examination was unnecessary as part of her admission physical.

16. On or about July 25, 2016, Courtyard's Executive Director and Director of Nursing met with Respondent to discuss the June 2016, and July 2016, incidents with Patient A and Patient B. During the conversation, Respondent was ordered to have a nurse or other medical practitioner present during future physical examinations. The conversation was then memorialized and signed by the parties. On or about August 12, 2016, the aforementioned parties signed a "Clarification of the July 25, 2016, discussion with Dr. Droubay," which reiterated Respondent's requirement to have a nurse or other medical practitioner present for all physical examinations. Respondent was additionally ordered to meet with Courtyard's administrator and/or Courtyard's Director of Nursing, daily, upon his arrival at the facility, to discuss residents who needed to be seen that day and who would be assisting him.

17. On or about March 27, 2017, a Davis Police Department Detective met with Respondent regarding the July 2016, incident with Patient B. During his conversation with the detective, Respondent stated that he changed the way he conducted examinations with female patients, and since the incident, he always has a female employee in the room during an examination of a female patient.

Patient C:

18. On or about August 4, 2017, Patient C, a sixty-seven (67) year old female, was admitted to Stollwood Convalescent Hospital (Stollwood) in Woodland, California. While staying at Stollwood, Patient C became reacquainted with Respondent, who was working as the Medical Director at the facility. Prior to 2017, Respondent was Patient C's physician from approximately the late 1970's to early 1990's.

19. During the course of Patient C's interactions with Respondent, between August 4, 2017, and October 7, 2017, Respondent exhibited increasingly inappropriate behavior. During a physician-patient visit, Respondent conducted an examination of Patient C. At the end of the visit, Respondent initiated a hug with Patient C. Patient C attempted to pull away from the hug, but Respondent continued to hold her tighter. Respondent then kissed Patient C on her cheek.

20. Sometime later, Respondent interacted with Patient C while she was located in the Stollwood common area. Respondent approached Patient C, as she was sitting in her wheelchair, and they engaged in a short, casual conversation. Respondent then hugged Patient C and kissed her on the lips with an open mouth, which lasted for several seconds.

21. On or about October 7, 2017, Respondent performed a medical examination on Patient C, while in her room. Respondent conducted a breast examination of Patient C, in which he reached under her shirt and felt her nipples for a few seconds. Prior to the breast examination, Respondent failed to provide Patient C with the option of having a chaperone present.

22. During the examination, Patient C stated that she was experiencing symptoms consistent with urinary tract infection, or words to that effect. Respondent performed a pelvic examination on Patient C, without first providing Patient C the option of electing to have a chaperone present. While Respondent was alone with Patient C, Respondent removed Patient C's sweatpants. He then inserted an ungloved finger into Patient C's vagina for several seconds.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

23. Respondent is further subject to disciplinary action under section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in his care and treatment of Patients A, B, and C, as more particularly alleged in paragraphs 7 through 22, and those paragraphs are incorporated by reference as if fully set forth herein.

24. Respondent committed the following acts of gross negligence during the care and treatment of Patient C:

a.) Respondent hugged and kissed Patient C with an open mouth; and

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b.) Respondent digitally penetrated Patient C's vagina, with an ungloved hand, during a pelvic examination.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

25. Respondent is further subject to disciplinary action under section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care and treatment of Patients A, B, and C, as more particularly alleged in paragraphs 7 through 24, and those paragraphs are incorporated by reference as if fully set forth therein.

26. Respondent committed the following repeated negligent acts during the care and treatment of Patient A:

a.) Respondent performed an unnecessary breast examination on Patient A, as part of a new patient physical assessment, without relevant symptoms to warrant such an examination; and

b.) Prior to performing a breast examination on Patient A, Respondent failed to offer to have a chaperone present and/or performed a breast examination without a chaperone present.

27. Respondent committed the following repeated negligent acts during the care and treatment of Patient B:

a.) Respondent performed an unnecessary breast examination on Patient B, as part of a new patient physical assessment, without relevant symptoms to warrant such an examination; and

b.) Prior to performing a breast examination on Patient B, Respondent failed to offer to have a chaperone present and/or performed a breast examination without a chaperone present.

28. Respondent committed the following repeated negligent acts during the care and treatment of Patient C:

a.) Respondent hugged and kissed Patient C with an open mouth;

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b.) Prior to performing a breast examination on Patient C, Respondent failed to offer to have a chaperone present and/or performed a pelvic examination without a chaperone present.

c.) Respondent digitally penetrated Patient C's vagina, with an ungloved hand; and

d.) Prior to performing a pelvic examination on Patient C, Respondent failed to offer to have a chaperone present and/or performed a pelvic examination without a chaperone present.

FOURTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

30. Respondent Peter Edward Droubay, M.D. is further subject to disciplinary action under sections 2227 and 2234, of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 7 through 28, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

DISCIPLINARY CONSIDERATIONS

31. To determine the degree of discipline, if any, to be imposed on Respondent Peter Edward Droubay, M.D., Complainant alleges that in a prior disciplinary action entitled, "In the Matter of the Accusation Against Peter Edward Droubay, M.D." before the Medical Board of California, in Case Number 800-2014-003735, effective March 25, 2016, Respondent was publicly reprimanded for gross negligence and failure to maintain adequate and accurate medical records, in the care and treatment of a patient. 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. G 27705, issued to Peter Edward Droubay, M.D.;

2. Revoking, suspending or denying approval of Peter Edward Droubay, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Peter Edward Droubay, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: June 13, 2019

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

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