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

In the Matter of the Second Amended Accusation Against: Daniel Miguel Bethencourt, M.D. Physician's and Surgeon's License No. C41588 Respondent	Case No. 800-2017-033231

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 April 16, 2021.

IT IS SO ORDERED: March 19, 2021.

MEDICAL BOARD OF CALIFORNIA

Ronald H. Lewis, M.D., Chair
Panel A

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Attorney General of California
JUDITH T. ALVARADO
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: **DANIEL MIGUEL BETHENCOURT, M.D.** **18035 Brookhurst Street, Suite 1300** **Fountain Valley, CA 92708-6738** **Physician's and Surgeon's Certificate No. C 41588** Respondent.	Case No. 800-2017-033231 OAH No. 2019090611 **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 Edward Kim, Deputy Attorney General.

2. Respondent Daniel Miguel Bethencourt, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, whose address is: Doyle Schafer McMahon, LLP, 5440 Trabuco Road, Irvine, CA 92620.

3. On or about October 1, 1984, the Board issued Physician's and Surgeon's Certificate No. C 41588 to Daniel Miguel Bethencourt, 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 Second Amended Accusation No. 800-2017-033231, and will expire on March 31, 2022, unless renewed.

JURISDICTION

4. Second Amended Accusation No. 800-2017-033231 was filed before the Board, and is currently pending against Respondent. The Second Amended Accusation and all other statutorily required documents were properly served on Respondent on December 30, 2019. Respondent timely filed his Notice of Defense contesting the original Accusation.

5. A copy of Second Amended Accusation No. 800-2017-033231 is attached hereto 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 Second Amended Accusation No. 800-2017-033231. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Second Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his 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 Second Amended Accusation No. 800-2017-033231, if proven at a hearing, constitute cause for imposing discipline upon his 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 the First, Second, Third, Fourth, Fifth, Sixth, Seventh, Eighth, Ninth, Tenth and Twelfth Causes for Discipline, inclusive, in the Second Amended Accusation No. 800-2017-033231, a true and correct copy of which is attached hereto as Exhibit A, and Respondent hereby gives up his right to contest those charges. Respondent has thereby subjected his Physician's and Surgeon's Certificate No. C 41588 to disciplinary action.

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

CONTINGENCY

12. 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 his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his 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.

13. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in the First, Second, Third, Fourth, Fifth, Sixth, Seventh, Eighth, Ninth, Tenth and Twelfth Causes for Discipline, inclusive, in the Second Amended Accusation No. 800-2017-033231 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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. C 41588 issued to Respondent DANIEL MIGUEL BETHENCOURT, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on 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 Second Amended 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 Second Amended 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.

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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(s), Second Amended Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (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 Second Amended Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Second Amended Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Second Amended 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(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.

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. PROHIBITED PRACTICE. Until Respondent has successfully completed the Clinical Competence Assessment Program as set forth in condition 4 above, and has been so notified by the Board or its designee in writing, Respondent is prohibited from performing any robotic surgery or robot-assisted surgery (i.e., surgical procedures which are done using robotic systems, which may allow doctors to perform many types of complex procedures, including those usually associated with minimally invasive surgery), provided that, notwithstanding the

foregoing, Respondent shall be permitted to function as an assistant surgeon (during robotic or robot-assisted surgery) under the supervision of the primary surgeon. After the effective date of this Decision, and during the time that this condition is in effect:

(a) All patients being treated by the Respondent shall be orally notified that the Respondent is prohibited as set forth above, and any new patients must be provided this notification at the time of their initial appointment; and

(b) Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire time that this condition is in effect.

7. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Second Amended 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, subdivision (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 Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws;

General Probation Requirements; and Quarterly Declarations.

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.

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18. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in the First, Second, Third, Fourth, Fifth, Sixth, Seventh, Eighth, Ninth, Tenth and Twelfth Causes for Discipline, inclusive, in the Second Amended Accusation No. 800-2017-033231 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon. 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.

DATED: 1/25/2021

DANIEL MIGUEL BETHENCOURT, M.D.
Respondent

I have read and fully discussed with Respondent Daniel Miguel Bethencourt, 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: January 26 2021

RAYMOND J. MCMAHON
Attorney for Respondent

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ENDORSEMENT

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

DATED: 1/27/21

Respectfully submitted,

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

EDWARD KIM
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Second Amended Accusation No. 800-2017-033231

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

In the Matter of the Second Amended Accusation Against: **DANIEL MIGUEL BETHENCOURT, M.D.** 18035 Brookhurst Street, Suite 1300 Fountain Valley, California 92708-6738 Physician's and Surgeon's Certificate C 41588, Respondent.	Case No. 800-2017-033231 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Christine J. Lally (Complainant) brings this Second Amended Accusation (Accusation) solely in her official capacity as the Interim Executive Director of the Medical Board of California (Board).

2. On October 1, 1984, the Board issued Physician's and Surgeon's Certificate Number C 41588 to Daniel Miguel Bethencourt, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2020, unless renewed.

JURISDICTION

3. This Second Amended Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless

otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

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

"(b) The administration and hearing of disciplinary actions.

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

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

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

"(f) Approving undergraduate and graduate medical education programs.

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

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

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

5. Section 2220 of the Code states:

"Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

"(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining

order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

"(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

"(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon."

6. 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."

7. Section 2229 of the Code, states:

"(a) Protection of the public shall be the highest priority for the Division of Medical Quality[1], the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.

"(b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, the division, or the California Board of Podiatric Medicine, shall, wherever 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.

"(c) It is the intent of the Legislature that the division, the California Board of Podiatric Medicine, and the enforcement program shall seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies. Where rehabilitation and protection are inconsistent, protection shall be paramount."

8. 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.

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[1] Pursuant to Code section 2004, all references to the "Division of Medical Quality" are deemed to refer to the Board.

"(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."

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

10. 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."

11. Section 2261 of the Code provides:

"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."

DEFINED TERMS

12. As used herein, the following terms shall have the following meanings:

"AKI" means acute kidney injury, which is a sudden episode of kidney failure or kidney damage that happens within a few hours or a few days. AKI causes a build-up of waste products in the blood and makes it hard for the kidneys to keep the right balance of fluid in the body.

"Atrial fibrillation" or "AFib" means an irregular and often rapid heart rate that can increase your risk of stroke, heart failure and other heart-related complications. During atrial fibrillation, the heart's two upper chambers (the atria) beat chaotically and irregularly - out of coordination with the two lower chambers (the ventricles) of the heart. Atrial fibrillation symptoms often include heart palpitations, shortness of breath and weakness.

"August 15 Subject Interview" means the Board's subject interview with the Respondent on or about August 15, 2018

"August 16 Subject Interview" means the Board's subject interview with the Respondent on or about August 16, 2018

"AI" means aortic insufficiency.

"AS" means aortic stenosis.

"AVR" means aortic valve replacement.

"CABG" means coronary artery bypass graft surgery, which is a surgical procedure to restore normal blood flow to an obstructed coronary artery. A normal coronary artery transports blood to and from the heart muscle itself, not through the main circulatory system. There are two main approaches. In one, the left internal thoracic artery, (LITA) is diverted to the left anterior descending branch of the left coronary artery. In this method, the artery is "pedicled" which means it is not detached from the origin. In the other, a great saphenous vein is removed from a leg; one end is attached to the aorta or one of its major branches, and the other end is attached to the obstructed artery immediately after the obstruction to restore blood flow.

"CAD" means coronary artery disease.

"CCU" means cardiac care unit.

"CCCU" means Cardiac/Coronary Care Unit.

"CEA" means carotid endarterectomy, which is a surgical procedure performed by vascular surgeons used to reduce the risk of stroke by correcting stenosis (narrowing) in the common carotid artery or internal carotid artery.

"CICU" means Cardiac Intensive Care Unit.

"CPB" means cardiopulmonary bypass.

"CRRT" means continuous renal replacement therapy.

"CT scan" means a computerized tomography (CT) scan which combines a series of X-ray images taken from different angles around a human body and uses computer processing to create cross-sectional images (slices) of the bones, blood vessels and soft tissues inside a human body.

"CTS" means cardiothoracic surgery.

"CVICU" means cardiovascular intensive care unit.

"CVNP" means cardiac-vascular nurse practitioner.

"DNR" means Do Not Resuscitate.

"EF" means ejection fraction.

"EKG" or "ECG" means an electrocardiogram which is a recording of the electrical activity of the heart. It is a simple, noninvasive procedure where electrodes are placed on the skin of the chest and connected in a specific order to a machine that, when turned on, measures electrical activity all over the heart.

"Endarterectomy" is the removal of material on the inside of an artery.

"IABP" means intra-aortic balloon pump. An IABP is a mechanical device that increases myocardial oxygen perfusion and indirectly increases cardiac output through afterload reduction.

"Including" means including, without limitation.

"LAD" means left anterior descending artery.

"LBMH" means Long Beach Memorial Hospital.

"LIMA" means left internal mammary artery.

"LITA" means left internal thoracic artery.

"LV" means left ventricular.

"LVH" means left ventricular hypertrophy.

"LVOT" means left ventricular outflow tract.

"Maze" procedure or ablation means a surgical treatment for atrial fibrillation, which is a type of surgery that changes electrical patterns in the heart to stop atrial fibrillation (AFib). A doctor creates a pattern of scar tissue (the maze) in the upper chambers of the heart by applying heat (radiofrequency energy) or cold (cryoablation). Or, the doctor uses a scalpel to make several precise incisions. This method is more complex and takes longer.

"MC" means medical consultant.

"MIBI" means a Myocardial Perfusion Imaging test (nuclear stress test) shows how well blood flows through or perfuses the heart. It can show both the areas of the heart muscle that are not getting enough blood flow and how well the heart is pumping.

"MIDCAB" means Minimally Invasive Direct Coronary Artery Bypass, which is a surgical treatment for coronary heart disease that is a less invasive method of coronary artery bypass surgery (CABG). MIDCAB gains surgical access to the heart with a smaller incision than other types of CABG. MIDCAB is sometimes referred to as "keyhole" heart surgery because the operation is analogous to operating through a keyhole. MIDCAB is a form of off-pump coronary artery bypass surgery (OPCAB), performed "off-pump" - without the use of cardiopulmonary bypass (the heart-lung machine). MIDCAB differs from OPCAB in the type of incision used for the surgery; with traditional CABG and OPCAB a median sternotomy (dividing the breastbone) provides access to the heart; with MIDCAB, the surgeon enters the chest cavity through a mini-thoracotomy (a 2-to-3 inch incision between the ribs).

"Milrinone" means a vasodilator that works by relaxing the muscles in the blood vessels to help them dilate (widen). This lowers blood pressure and allows blood to flow more easily through the veins and arteries. Milrinone is used as a short-term treatment for life-threatening heart failure.

"MRSA" means Methicillin-resistant Staphylococcus aureus, which is a bacterium that causes infections in different parts of the body. It's tougher to treat than most strains of staphylococcus aureus -- or staph -- because it's resistant to some commonly used antibiotics.

"NP" means nurse practitioner.

"NSTEMI" means non-ST segment elevation myocardial infarction.

"PCI" means Percutaneous Coronary Intervention (formerly known as angioplasty with stent) is a non-surgical procedure that uses a catheter (a thin flexible tube) to place a small structure called a stent to open up blood vessels in the heart that have been narrowed by plaque buildup, a condition known as atherosclerosis.

"Pneumonitis" means an inflammation of lung tissue.

"POD" means postoperative day.

"PRBC" means packed red blood cells.

"RCA" means right coronary artery.

"ROSC" means return of spontaneous circulation.

"SIP" means single incision port.

"STEMI" means ST segment elevation myocardial infarction, which is a very serious type of heart attack during which one of the heart's major arteries (one of the arteries that supplies oxygen and nutrient-rich blood to the heart muscle) is blocked. ST-segment elevation is an abnormality detected on the 12-lead ECG.

"STS" means Society of Thoracic Surgeons.

"ST segment" means the interval between ventricular depolarization and ventricular repolarization. It is identified on an EKG as the end of the QRS complex to the beginning of the T wave.

"TAVI" means transcatheter aortic valve implantation. A TAVI is a procedure considered when a patient is a poor candidate for standard aortic valve replacement via open thoracotomy or sternotomy.

"TAVR" means transcutaneous aortic valve replacement.

"TEE" means transesophageal endoscopic echocardiogram, which is a test that uses sound waves to create high-quality moving pictures of the heart and its blood vessels.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Patients A and B)

13. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in the care and treatment of patients.[2] The circumstances are as follows:

Patient A

14. On or about March 16, 2012, Patient A, an 82-year-old man, presented to LBMH with a history of an aortic valvular problem, joint replacement, hypertension, inflammatory bowel disease, chronic renal disease, prostate disorder, prostatectomy, steroid therapy, hypothyroidism, spinal cord injury, chest pain, benign prostatic hypertrophy, cancer, colostomy, and history of neck fusion times three with rods in the cervical spine to T2. Patient A was admitted to LBMH with chest pain and aortic stenosis. Sometime prior to his admission, Patient A had a cardiac workup at an "outside hospital" with 3D echocardiogram, cardiotomy CT and coronary arteriography. The workup included consideration of a TAVI. Respondent saw Patient A and his initial note stated, "CT surg [cardiothoracic surgery] Pt seen. Plan AVR Mon. Cath on Way. Plan echo today." There is no documentation that the actual coronary angiographic, CT scan and echocardiographic images or hemodynamic data were obtained from the outside hospital and reviewed by Respondent or any other LBMH physicians involved in Patient A's care. There is no documentation by Respondent of an analysis of the outside hospital studies other than: "Workup has revealed aortic valve diseases. Cardiac catheterization demonstrated normal coronary arteries and AS. Cardiac risk factors include none." All of the specific data as to the severity of the aortic valve disease and the functional status of the patient's heart are absent from Respondent's documentation.

15. On or about March 17, 2012, Respondent performed a surgical consultation on Patient A. His note referenced a cardiac catheterization. Since no cardiac catheterization was performed at LBMH on this patient, the reference must be to the workup at the outside hospital. Respondent noted seventeen past medical problems which constituted significant comorbidities

[2] Patients are hereinafter referred to by letters. The identities are known to Respondent.

which could increase the risk of any type of aortic valve intervention. Respondent failed to document the severity of the many illnesses and failed to note two key comorbidities, specifically, asthma and vocal chord paralysis secondary to neck fusion surgery. In the Patient History and Information form filled out by Patient A, the patient indicated a history of smoking, asthma and shortness of breath. Neither Respondent's notes, nor any other LBMH physician notes, reference asthma. The patient's history of spinal chord injury is noted by Respondent but reference to, and discussion of, the vocal chord paralysis co-morbidity and any possible secondary effect on airway patency, is absent from Respondent's past medical history section in his notes in the medical record. The physical exam section of Respondent's initial consult note lists vitals followed only by the notation, "Normal male exam." There is no documentation of a cardiopulmonary examination. Respondent's initial cardiac consult notes, "Plan: Surgery Planned: Aortic Valve replacement." There is no documentation by Respondent of his follow-up analysis or discussion of the results of the echocardiogram he ordered. There is no documentation that the outside hospital images and studies were obtained and reviewed by Respondent. Respondent did not document any opinion on the option of the TAVI approach for Patient A or the indications in Patient A's situation for a TAVI approach. Respondent did not document how the increased risk of the patient's significant co-morbidities impacted Respondent's decision-making and informed consent processes. [3]

16. On or about March 19, 2012, at LBMH, Respondent performed an Aortic Valve replacement with a tissue valve on Patient A via a right thoracotomy. A right pleural chest tube for drainage was placed. The operation went well and postoperative cardiac readings showed improvement with the bio-prosthetic aortic valve functioning well with no pericardial effusion present. The patient was extubated in the operating room and transferred to the CICU at 6:30 p.m. He was initially stable but later developed significant bleeding and coagulopathy, intermittent hemodynamic instability as well as hypoxia, bronchospasm and respiratory failure.

17. On or about March 20, 2012, at 5:00 p.m. Respondent examined Patient A and an

[3] This process involves the discussion between the patient and the doctor, including a description of, the indications for, and alternatives to, the surgery; materials risks and benefits and consequences of the patient's decisions, as well as the capacity of the patient to consent.

echocardiogram was obtained that Respondent charted as showing "small effusion." The official LBMH reading of the echocardiogram reflected "moderate pericardial effusion." Also present was a low cardiac output state with pulmonary hypertension not seen earlier in the morning. There was persistent drainage over the eleven-hour course prior to Respondent seeing the patient at 5:00 p.m., and the moderate pericardial effusion indicated undrained fluid or thrombus was present. Respondent chose not to return to the operating room but to continue volume replacement with fresh frozen plasma and platelets.

18. Subsequent to Respondent's decision not to return Patient A to the operating room, Patient A's bleeding did not improve. He hemorrhaged 1270 ml prior to 5:00 p.m. and another 730 ml after that. Patient A's blood pressure was labile; he continued to be intermittently hemodynamically unstable, especially after 6:00 a.m. Patient A's respiratory status changed significantly. At 6:45 a.m. he was receiving 5 l/min oxygen per a nasal cannula but his arterial blood gas showed a very low pulse oxygen reading so his oxygen flow was increased to 15 l/min and he was placed on 100% non-rebreather mask. During the period between 5:23 a.m. and 7:47 a.m., Respondent was not at the bedside and the CICU nurses documented a difficult time locating and communicating with him. Respondent even ordered the cardiac operating room staff to prepare for his next case.

19. Patient A arrested at 7:47 a.m. Thereafter, intubation was repeatedly unsuccessfully attempted. Respondent did not document that an open tracheostomy was attempted. An airway could not be established. The family expressed a desire to discontinue heroic measures and the patient was declared dead at 8:50 a.m.

20. Respondent reported the death to the Los Angeles County Coroner's Office and on or about March 23, 2012, Respondent listed the cause of death on Patient A's death certificate as asthma followed by valvular heart disease and inflammatory bowel disease, which inaccurately described the cause of death.

21. On or about April 5, 2012, two weeks after the patient's death, Respondent completed a Discharge Summary which failed to document the severity of several conditions that contributed to the patient's death, including, the severity of the bleeding (a total of two liters of

chest tube drainage), the ongoing resulting hemodynamic instability, the associated requirement of transfusing two cryoprecipitate packs, three fresh frozen plasma packs, three plateletpheresis packs and six units of packed red blood cells. There was also no mention of the severe anemia. There was no mention of the contributing factors of neck fusion surgery, paralyzed vocal chord, progressive hypoxia and the diagnosis of asthma. There is also no mention of the inability to intubate and the inability to obtain a surgical airway.

22. On or about August 6, 2012, the death certificate was amended to read immediate cause of death: postoperative hemorrhage present for hours before death as a complication of aortic valve surgery. The manner of death was listed as an accident.

23. On or about March 17, 2012, Respondent was grossly negligent when he failed to timely and accurately document in his history of Patient A's present illness, or otherwise in LBMH medical records for Patient A, the cardiac and other evaluation information of the outside hospital, the patient's history of asthma and the patient's history of vocal chord paralysis secondary to neck fusion surgery, a cardiopulmonary examination, his decision making process supporting his decision to perform the aortic valve replacement surgery on Patient A, any opinion on the option of the TAVI approach for Patient A, or the indications in Patient A's situation for a TAVI approach, and how the increased risk of the patient's significant co-morbidities impacted Respondent's decision-making and informed consent processes.

24. On or about March 20, 2012, Respondent was grossly negligent when, after Respondent's decision at or around 5:00 a.m. not to take the patient back to surgery and the patient's status continued to deteriorate, he failed to carefully monitor and treat Patient A for postoperative instability that might require medical and/or surgical intervention.

Patient B

25. On or about December 15, 2015, Respondent saw Patient B, a 67-year-old woman (with a history of paroxysmal atrial fibrillation, SIP ablation of atrial fibrillation on or about September 14, 2010, at Good Samaritan Hospital by Dr. H.), for paroxysmal atrial fibrillation and mitral valve stenosis, and he discussed a robot assisted Cox-Cryomaze operation with her. Based upon the patient's records from her cardiologist, Dr. S.T., she also had been diagnosed with atrial

flutter, mitral valve stenosis, aortic valve stenosis and her history included rheumatic heart disease, essential hypertension, obesity and hypothyroidism. Patient B in the days before the surgery, lived an active life, including, hosting events, playing golf, driving on trips out of town with her grandchildren and attending the theater.

26. Respondent's medical records for Patient B are inadequate and inaccurate. For example, in respect of Patient B's admission history and physical, Respondent's records are very brief. They include an outline of Patient B's basic problem of recurrent atrial fibrillation (the clinical problem proposed to be addressed by the robot assisted Cox-Cryomaze) and mention the mitral valve gradient associated with the moderate mitral stenosis diagnosis. However, Respondent failed to document Patient B's potential coronary artery disease or any testing for it, despite the referring cardiology records, from Dr. S.T.'s office, which state in the plan after the August 25, 2015, visit that, "she has had no recent stress test, so will have her do a lexiscan MIBI." In addition, Respondent's admission note for Patient B is confusing because he wrote, "All reports and films obtained for this visit have been reviewed." However, Respondent failed to specify which reports and films he purportedly reviewed. Furthermore, below that note, he wrote, "Time Spent: 60 minutes spent, over 50% of the time was spent face-to-face counseling the patient. Total time spent reviewing records and films: 0 minutes."

27. On or about February 10, 2016, Respondent performed elective surgery on Patient B. At that time, she was classified by the anesthesiologist as risk class ASA 3. Respondent reported that he performed the following procedures: an "operative tissue ablation and reconstruction of atria, extensive (complete biatrial Maze procedure[4] with cardiopulmonary bypass), Right thoracoscopy diagnostic robot-assisted, repair blood vessel, direct, lower extremity, right femoral artery." The operative case was complicated by bleeding from a coronary sinus perforation in or around the later portion of the procedure. This required putting the patient back on the pump for several hours, opening the sternum (which was what the original surgery was intended to avoid),

[4] The Cox maze procedure, also known as maze procedure, is a type of heart surgery for atrial fibrillation. "Maze" refers to the series of incisions arranged in a maze-like pattern in the atria. Today, various methods of minimally invasive maze procedures, collectively named minimaze procedures, are used.

and management of persistent hypotension requiring fluids and presser agents throughout the case. She also required presser agents when leaving the operating room to maintain pressure and her cardiac index was 1.3 on arrival in the CCU. Respondent reported having performed a "Median sternotomy for persistent bleeding repair and repair of coronary sinus perforation by direct suture, closure of pericardial defect with Xenograft implant patch-CorMatrix, repair of sternal gap with Sternalock plates and screws, intraoperative TEE." Although not listed as a procedure on the operative note, Respondent also purportedly performed a mitral commissurotomy and a partial trans-atrial resection of asymmetric septal hypertrophy.

28. In or around the first 12 hours after this surgery, Patient B required multiple transfusions and bicarbonate infusions, and was hemodynamically unstable requiring multiple inotropic infusions. Thereafter, the patient's declining course was as follows:

A. On or about February 11, 2016, Dr. F.S. performed an open exploratory laparotomy to repair a laceration of the right lobe of Patient B's liver and evacuate seven (7) liters of intraperitoneal blood and thrombus.

B. On or about February 16, 2016, Respondent performed surgery on Patient B, including closure of the sternum with SternaLock plates and screws, system 360, placement of new mediastinal chest tubes and left pleural tube, and a transesophageal echocardiogram.

C. Over the course of Patient B's post-operative hospitalization, she suffered multi-system organ failure, including multiple days of multi-drug inotropic support, ventilator dependent hypoxic respiratory failure, possible enterococcus, proteus and stenotrophomonas pneumonia, acute kidney injury requiring CRRT, then hemodialysis, severe anemia, thrombocytopenia, coagulopathy, shock liver failure, junctional tachycardia rhythm, rapid atrial fibrillation and gram-negative sepsis. Patient B received steroids, broad spectrum antibiotics, TPN, chest tubes for acute pneumothorax and late pressor support for sepsis, but she continued to decline.

D. On or about February 26, 2016, Patient B expired at 7 a.m. Her primary cause of death included cardiac arrest and asystole, and her secondary causes of death were respiratory failure, AKI, sepsis, pneumonia, and shock on pressors.

E. Respondent signed Patient B's death certificate on or about March 1, 2016, and listed her immediate cause of death as cerebral edema or bleed, and listed her underlying causes of death as diffuse bleeding, liver failure due to renal failure, acute kidney failure post heart surgery and post cardiac surgery bleeding.

29. On or about February 10, 2016, and thereafter, Respondent committed gross negligence in connection with the performance and/or documentation of his surgical procedures on Patient B. His record keeping was extremely inadequate and made it very difficult to assess his actual conduct during the operation and calls into question Respondent's skills and knowledge as a surgeon. Respondent's official operative report included six parts (although he listed seven) of the operation, each of which was problematic, as discussed below:

A. First listed was, "Operative tissue ablation and reconstruction of atria, extensive (complete biatrial Maze procedure with cardiopulmonary bypass)." In this note, there was no description of any of the ablation lesions and techniques, any resection or reconstruction of the atria and location or technique of cannulation for cardiopulmonary bypass, conduct of the technique of cardiopulmonary bypass, including even the administration of heparin and protamine, cross-clamping technique, if any, and cannulation for and performance technique of myocardial preservation, including possible use of or non-use of antegrade and/or retrograde cardioplegia for myocardial preservation. All of these items are techniques that involve surgical choices and options associated with each of them and Respondent was required to include in his operative reports what, when, where and how each surgical techniques was chosen and utilized during the cardiac surgery. Further, Respondent was required to document any unusual occurrences or abnormalities encountered during an operation, including, discussion about why it was unusual and what modifications of technique if any, were performed. However, Respondent's record of his surgery failed to adequately document these items. Indeed, his records were nearly completely devoid of any surgical technique.

B. The second part stated, "Right thoracoscopy diagnostic robot assisted." Respondent's records contained no further information in the operative note on this subject.

There was no comment regarding the technique of port placement, confirmation of trocar placement vision, thoracoscopic vision, technique in placement of stay sutures, pericardiotomy, atriotomies, thoracoscopic findings, etc. He failed to document the subject of thoracoscopy in the operative note, except for one sentence included after the sternotomy portion of the operation and it read in its entirety: "The endoscopic port was closed with continuous 3-0 Vicryl."

C. The third part of the operative report stated, "Repair blood vessel, direct, lower extremity, right femoral artery." In this item, Respondent's operative note failed to contain any documentation on the subject of a femoral artery repair. He failed to document whether this was a repair of an artery used for cannulation, or if there was an injury or dissection of the artery in a cannulation attempt. His operative report was completely lacking on this subject.

D. The fourth and fifth parts stated respectively, "Median sternotomy for persistent bleeding repair and repair of coronary sinus perforation by direct suture;" and "Closure of pericardial defect with Xenograft implant patch-CorMatrix." Although, both of these subjects were mentioned in his operative note, they were in a form which was more abbreviated than typical. For example, Respondent included no rationale, nor technique for closure of the pericardial defect, despite the fact that the rationale is important because surgeons are reluctant to do any extra maneuver, such as closing the pericardium, that might further complicate a case that has already required a return to cardiopulmonary bypass via yet another (sternotomy) incision to treat the complication of persistent bleeding. Closing the pericardium here was not required, and this closed a space that later could contribute to compression of the heart if there was intrapericardial bleeding or tissue edema would occur. Indeed, here, hours later, when the patient was hemodynamically unstable, Respondent re-opened the patient's sternotomy incision, and explored for tamponade to relieve such compression of the heart. He also removed the CorMatrix patch and stented the sternal bone open.

E. The final sixth and seventh parts of the procedure were incorrectly numbered

and listed as: "5. [sic] Repair of sternal gap with Sternalock plates and screws. [mis-numbered in original note] and 6. [sic] Intraoperative TEE." Although these items were described in the body of the operative note, here, the procedure list failed to mention two other additional parts of the operation, the mitral commissurotomy and the resection of the sub aortic muscle.

F. In Respondent's "Immediate Op Note," the shorter typed summary note completed immediately after the operation, he wrote: "Operative Findings: Cox Cryomaze with biatrial lesions, NSR postop, Preop MS 8 mm Hg -2 mmHg postop, No MR postop, Sub AS unchanged, Good LV function post, Bleed after initial procedure was due to CS puncture - repaired via mid sternotomy. CPB173, XC 68 . . . Specimen Removed: small amt of septal muscle." This note documented that only a small amount of septal muscle was resected and the subaortic stenosis was unchanged - which would be expected given the limited exposure afforded the surgeon when the anterior leaflet of the mitral valve was not detached, per the intraoperative judgement of the surgeon. However, here Respondent provided no other details of the surgical technique and outcome documented by the surgeon in either the operative note or in the immediate postop note.

G. Despite this lack of detail in his documentation, three years later, Respondent, during his Subject Interview with the Board on or about May 16, 2018, described his surgical technique to the Board's medical consultant in a manner that contradicted what he documented. In response to questioning at the Subject Interview, Respondent attributed the inadequate documentation to human error.

30. Respondent committed gross negligence in connection with his failure to adequately assess and address Patient B's intra-abdominal hemorrhage postoperatively in a timely manner. He failed to adequately monitor this postoperative patient for instability. He failed to adequately explore the patient for hemorrhage and address hemodynamic instability after surgery, through appropriate diagnostic testing and surgical exploration without undue delay in order to minimize the potential for further complications such as multi-system organ failure and death. The circumstances are as follows:

A. On or about February 10, 2016, Respondent performed the cardiac surgery operation discussed above on Patient B. He utilized thoracoscopy and the surgical robot for a surgical approach through the patient's right chest. A separate sternotomy was necessary as well as a return to cardiopulmonary bypass for the suture repair of bleeding from the coronary sinus. Thus, Respondent recognized that Patient B suffered from an intraoperative hemorrhage from the coronary sinus and repaired intraoperatively via a sternotomy, which meant the patient needed a second major incision. However, after that primary operation on or about February 10, 2016, Patient B later suffered from a postoperative hemorrhage, which was not appropriately recognized nor repaired in a timely fashion as discussed below.

B. At 5:49 p.m. hours post-surgery in the CVICU, a cardiovascular nurse, K.W., noted that Patient B had a low cardiac index on infusions of dopamine, levophed and milrinone, and a hematocrit of 31.5. The plan was for more intravenous volume infusion and continued intubation. At 6:39 p.m. Respondent noted essentially the same findings of hypovolemia[5] and decreasing blood pressure and he attributed the hypovolemia to third space losses. Nurse P.T. made summary notes at bedside that Respondent was updated about Patient B's status at 9:00 p.m. and again at 1:00 a.m. (Respondent was then told about the patient's abdomen being unusually large).[6]

C. On or about February 11, 2016, at 1:25 a.m., Patient B received her seventh unit of PRBC and infusions of Epinephrine and Dobutamine, but the Dobutamine was stopped because her blood pressure dropped to the low 80's. Respondent was at beside and "Aware of increased abdominal girth, stated it to be 2/T edema." The patient's instability

[5] Hypovolemic shock is a medical emergency and an advanced form of hypovolemia due to insufficient amounts of blood and/or fluid inside the human body to let the heart pump enough blood to the body. More specifically, hypovolemic shock occurs when there is decreased intravascular volume to the point of cardiovascular compromise. The hypovolemic shock could be due to severe dehydration through a variety of mechanisms or from blood loss. People with hypovolemic shock have severe hypovolemia with decreased peripheral perfusion. If left untreated, these patients can develop ischemic injury of vital organs, leading to multi-system organ failure.

[6] More than one nurse reported that Respondent was notified multiple times about Patient B's abdomen being unusually big and hard and should be investigated. But Respondent indicated that he believed it was from the fluids she was given. Indeed, when Respondent was asked if an abdominal ultrasound could be done just to rule out any kind of bleed or fluid in the abdomen, he belayed such requests because he believed it was fluid related.

continued and at 3:15 a.m. in the CCCU Respondent performed a "Reexploration of median sternotomy with planned delayed sternal closure" for the "Preoperative and Postoperative Diagnosis of Pericardial compression, status post cardiac surgery" after a stat echocardiogram showed "poor filling of both the left and right ventricles with no pericardial fluid." The chest was left open to "provide maximum expansion of the heart . . . the patient remained in intensive care in critical condition." Thereafter, the patient continued to be unstable; the nighttime bedside RN P.T. documented that the patient had received "14 Amps Bcarb given overnight, 8 units PRBC, 2 FFP 1 Pit" and that "Urine output continues to be low . . . [Respondent] updated [and] Returned to the bedside and order received for CRRT [continuous renal replacement therapy]."

D. At an interview with an investigator for the Board, nurse P.T. stated, "this definitely was one of -- one of the most difficult cases [he's] had in --in quite a long time [because] "it's not normally this hectic" and "[he] just remembered this night in particular because [he hadn't] sat down [and] [nurse R.W.] was with [him, and nurse M.M.] was with [him and this was a] three-to-one case [with three] nurses [who were] just trying to keep this patient stable . . . after surgery." In addition, he remembered that Respondent was told at least three times that the patient had abdominal distension.

E. Similarly at an interview with an investigator for the Board, nurse R.W. stated that she told Respondent when he came to the bedside and pointed out to him that Patient B's abdomen was "pretty big and hard," and inquired whether he thought they "should check it out?" To which Respondent told her, "it's all just from the fluids that we've given the patient." She inquired of Respondent further asking him whether they should obtain "an abdominal ultrasound just to rule out any kind of bleed or fluid in the abdomen." But he rejected the suggestion, explaining to her that it was "because it's all fluid related."

F. In similar fashion, at an interview with an investigator for the Board, nurse M.M. explained that Respondent was informed about Patient B's abdominal girth three times. Nurse M.M. stated that nurse R.W. "was the first one who told him," and she said "[Respondent] I'm fat, but my stomach is not that hard." Nurse M.M. stated:

"And so I said do you want to have any chest -- uh -- any - anything, ultrasound, and then he said there's no need. I even asked him, are you sure you did not touch anything behind the chest? And he said no."

Nurse M.M. asked him a second time and then they asked him together.

G. Later around 7:00 a.m. or 7:30 a.m., daytime nurse M.A.F. documented that Respondent was at bedside inserting Quinton catheter and that the patient's abdomen remains distended and Respondent was aware. During this time the patient remained on five inotropic drugs for cardiovascular support: Dopamine, Milrinone, Neosynephrine, Levophed and Epinephrine which is unusual support for a patient who had good pre-operative ventricular function and who underwent an elective transatrial operation such as this one. The instability continued and the CRRT procedure could not remove fluid. Orders for 3 more units of blood were given as well as 10 units of cryo, 2 FFP and 1 unit of platelets.

H. On or about February 11, 2016 (post op day 1), at 10:00 a.m. nurse K.W. noted plans for an abdominal ultrasound examination, which was done at 1:15 p.m. At an interview with an investigator for the Board, nurse K.W. (the cardiac surgery nurse who had seen the patient immediately after surgery and then came off duty and went home, and returned the next morning), stated, "when I saw her in the morning, though, I was kind of shocked . . . I was shocked that the report was they had to open her chest . . . she was very unstable through the night . . . the nurse had asked [Respondent] for a CT scan because she felt that her abdomen was very distended and he said no." She further stated that she "remember talking to [nurse M.M.] to say, [nurse M.M.], if you felt like the patient had a distended abdomen, how come you didn't call me . . . [a]nd I could've ordered a bedside ultrasound." When asked what nurse M.M.'s response was, nurse K.W. replied, "She said [Respondent] said he didn't want a CT scan." And, then she stated, "But I said, . . . this is not taking her anywhere . . . [w]e could've just easily did a bedside ultrasound . . . could've been a lot faster at her diagnosis if we would've did the bedside ultrasound . . . [b]ut, again, when you have a surgeon saying no to a request, then he's kind of the like the final word . . .

[Respondent] didn't want to pursue any additional testing." She further indicated that it was difficult to get in contact with Respondent in the past. Finally, when nurse K.W. returned the next morning she ordered a stat ultrasound and contacted Dr. F.S., a general surgeon. Further, nurse K.W. explained that "with the correlated -- uh -- hematocrit and there's no other reason why we can't maintain a blood pressure, there's no other reason why she's not making urine, there's no other reason why we can't hold a blood pressure -- um --that would be the reason, blood [and] [s]he's got probably most likely a liver laceration." Dr. F.S. also told nurse K.W. at the time regarding liver lacerations that Patient B was now the third or fourth one involving Respondent.

I. On or about February 11, 2016, after Dr. F.S. was "consulted for stat exploration of the abdomen," at 2:15 p.m., Patient B was transported to the operating room (OR) and returned back from the OR at 5:45 p.m. At time of surgery a significant amount of serosanguinous fluid was present and abdominal insufflation was attempted but visualization was poor so laparoscopy was abandoned and open exploratory laparotomy was necessary. Frank intraperitoneal blood was present and evacuated and ultimately "a small laceration was noted on the superior right lateral lobe of the liver" which was "cauterized until hemostasis was obtained." Respondent assisted at the abdominal operation and he noted "Abdominal bleed confirmed. 7 L evacuated. And bleeder controlled."

J. At an interview with an investigator for the Board, Dr. F.S. stated that when he was called, Patient B "was in critical condition" and "had obviously" had postoperative bleeding after a robotic cardiac procedure. She was "severely unstable" when Dr. F.S. got involved and he agreed that she needed to go immediately to surgery to try to control bleeding in the abdomen. Dr. F.S. also stated that given Respondent's other cases where the patients had a little punctate bleeding from the liver after robotic procedure, there was really nothing to make him think any different on this case. In the other cases, he was able to do them laparoscopically, but when he tried to put a laparoscope in for Patient B, her intra-abdominal pressure was so great that they could not clear any working space in the belly for laparoscopic procedure. Thus, he had no choice but to do an open procedure. And, during

the surgery, Dr. F.S. saw the same thing, "A little area of the liver that was bleeding." He cauterized it, left some drains, and she was returned to the ICU. However, in light of her weakened state, Dr. F.S. stated that she was already experiencing some multisystem organ failure going into the surgery. Thus, unfortunately, despite aggressive postoperative efforts to try to turn the situation around, her situation was too critical, and her multisystem organ failure could not be reversed. This was in marked contrast to the first liver laceration complication Dr. F.S. treated who had an "excellent outcome."[7] When asked what was different about Patient B's case, Dr. F.S. stated,

> "what seemed to be a little different than the others was -· it seemed like I got called later in the process, rather than earlier in the process. Which was, to me, I . . . I had just·· I was -- I was really . . . um . . . kind of dumbfounded and curious as to why I didn't get called earlier. Because this was not·· you know, this was like the fourth time this had happened . . . I don't understand why I got called so late in the process."[8]

Dr. F.S. further explained that the right time to obtain an abdominal ultrasound was "the minute she·. . . showed signs of instability and bleeding . . . and if that ultrasound had been negative, but she still showed signs of bleeding, then I would have repeated the ultrasound because you know . . . um . . . you know, after an hour or so . . . because sometimes you . . . if you do an ultrasound too early, you maybe won't see the bleeding." Finally, Dr. F.S. did "recall somewhere along the way" that Respondent told him "that he had changed [his technique] to do some things differently, to try to avoid, you know, hitting that liver . . . to avoid that in terms of the way – how he was placing that stitch."[9] Physicians and acute care practitioner colleagues conveyed information about the event to the Chief of Thoracic Surgery at LBMH, who in turn sent a letter dated March 16, 2016, to the Chief Medical

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[7] Time is of the essence because the hemorrhage should be addressed before a prolonged hypoperfusion of tissues and the onset of severe multi-system organ failure.

[8] Generally, patients tolerate a laparoscopic, minimally invasive procedure better physiologically as compared to open laparotomy.

[9] At his Subject Interview, Respondent explained that he used a suture to retract the liver because the liver is in the way and he is always having to deal with it.

Officer of LBMH, stating that the "liver laceration following a robotic cardiac surgery [on patient B was] the fourth one that [he was] aware of," and that "Liver lacerations in robotic cases, in the opinion of most people, should never occur."

K. The patient remained quite ill with multi-system complications, although on or about February 15, 2016, Respondent was able to close Patient B's sternotomy incision. The patient continued to suffer from multi-system organ failure including acute kidney injury requiring dialysis, adult respiratory distress syndrome requiring intubation, anemia, and probable multi-bacterial pneumonia with sputum cultures positive. She was treated with broad spectrum antibiotics and anti-fungal agents. She continued with shock requiring pressors.

L. Notwithstanding the foregoing, Respondent failed to document any concern for Patient B's large and continuous need for transfusions overnight, the ongoing acid-base problem and his failure to adequately consider the possibility of bleeding even after the nurses kept calling his attention to the abdomen. Instead, Respondent seemed to be focused on the patient's chest, despite the echo showing no pericardial effusion, to account for the poor ventricular filling. Indeed, Respondent failed to adequately document in any of his notes after 4:39 p.m. on February 10, 2016, any mention of abdominal girth or an abdominal examination, nor any attribution of third space edema, including the notes on February 11, 2016, at 12:54 p.m., 2:21 p.m. and 2:41.

M. Respondent also failed to adequately consider any concept of sub-diaphragmatic blood loss despite the nursing suggestions and requests. The is egregious because there are not many large spaces in a patient that could have absorbed so much blood (7 liters) if the blood did not remain in the chest or drain out the chest tubes. Respondent had at least two options to examine the patient, an abdominal CT or abdominal ultrasound. However, neither was done for 12 hours after the abdominal girth question was first raised by the ICU nurses; those 12 hours of slow but continued active hemorrhage were excessive.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts – Patients A and B)

31. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent engaged in repeated negligent acts in the care and treatment of patients. The circumstances are as follows:

32. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth.

33. Each of the alleged acts of gross negligence set forth above in the First Cause for Discipline is also a negligent act.

Patient A

34. On or about March 17, 2012, Respondent was negligent when he failed to timely and accurately document in his history of Patient A's present illness, or otherwise in LBMH medical records for Patient A, the cardiac and other evaluation information of the outside hospital.

35. On or about March 17, 2012, Respondent was negligent when he failed to timely and accurately document in his history of Patient A's present illness, or otherwise in LBMH medical records for Patient A, the patient's history of asthma and the patient's history of vocal chord paralysis secondary to neck fusion surgery.

36. On or about March 17, 2012, Respondent was negligent when he failed to timely and accurately document in his history of Patient A's present illness, or otherwise in LBMH medical records for Patient A, a cardiopulmonary examination.

37. On or about March 17, 2012, Respondent was negligent when he failed to timely and accurately document in his history of Patient A's present illness, or otherwise in LBMH medical records for Patient A, his decision making process supporting his decision to perform the aortic valve replacement surgery on Patient A.

38. On or about March 17, 2012, Respondent was negligent when he failed to timely and accurately document in his history of Patient A's present illness, or otherwise in LBMH medical records for Patient A, any opinion on the option of the TAVI approach for Patient A or the indications in Patient A's situation for a TAVI approach.

39. On or about March 17, 2012, Respondent was negligent when he failed to timely and accurately document in his history of Patient A's present illness, or otherwise in LBMH medical records for Patient A, how the increased risk of the patient's significant co-morbidities impacted Respondent's decision-making and informed consent processes.

40. On or about March 20, 2012, Respondent was negligent when he failed to return to the operating room to re-explore Patient A for postoperative hemorrhage and hemodynamic instability.

41. On or about March 20, 2012, Respondent was negligent when he failed to document that an open tracheostomy was attempted.

42. On or about April 5, 2012, Respondent was negligent when he failed to document in the Discharge Summary the severity of several conditions that contributed to the patient's death, including the severity of the bleeding, the ongoing resulting hemodynamic instability, the associated requirement of transfusing blood products, the severe anemia, the contributing factors of neck fusion surgery, paralyzed vocal cord, progressive hypoxia and the diagnosis of asthma, the inability to intubate and the inability to obtain a surgical airway.

43. On or about March 23, 2012, Respondent was negligent when he failed to properly list the cause of death in Patient A's death certificate, noting that it was asthma followed by valvular heart disease and inflammatory bowel disease, which inaccurately described the cause of death.

Patient B

44. On or about December 15, 2015, and thereafter, Respondent committed negligence when he failed to adequately perform and/or document, a preoperative assessment of Patient B, who presented with possible coronary artery disease and with associated potential risk factors for a patient with coronary artery disease undergoing an open cardiac operation. The circumstances are as follows:

A. On or about December 15, 2015, and thereafter, Patient B presented to Respondent with essential hypertension and a family history for heart disease and stroke. Respondent was required to perform some type of assessment for coronary artery disease

such as a stress test or Lexiscan. And, based on the results of that testing, more invasive testing such as coronary arteriography, could have been indicated. Further, those test results could have affected the preoperative decisions regarding the timing and approach to the elective Cox Cryomaze procedure as a standalone or concomitant cardiac procedure. Additionally, if no assessment for coronary artery disease was performed, the reasoning behind that decision should have been contained in the medical record. However, no such discussion or any assessment for coronary artery disease was present in the medical record.

B. The failure to adequately document in a timely manner, the above referenced pertinent information in the medical records, represents negligence.

45. On or about December 15, 2015, and thereafter, Respondent committed negligence in connection with his inadequate performance and/or documentation of the informed consent process for surgery for Patient B. His written informed consent for Patient B was generic and lacked key information, including but not limited to, the actual other treatment options and potential specific complicating events such as sternotomy, multi-system organ failure and death; all of which did occur. Furthermore, no estimations of the likelihood of any risks were included in the documentation.

46. On or about February 10, 2016, and thereafter, Respondent committed negligence when he failed to maintain timely, adequate and accurate medical records in connection with Patient B's California Certificate of Death signed on or about March 1, 2016, and/or her discharge summary note dated March 11, 2016, including, the failure to accurately document the final cause of death in the discharge summary and the progression from surgical bleeding complications leading to death. The circumstances are as follows:

A. Patient B was declared dead at 1:37 a.m. on or about February 26, 2016. Dr. R.K. pronounced her dead and prepared the following note in her record: "Examination: Absence of respiratory effort, absence of pulse, pupils fixed and nonresponsive. Cause of Death: Primary Cause: cardiac arrest, asystole; Secondary Causes or Diagnosis: respiratory failure, AKI, sepsis, pneumonia, shock on pressors."

B. In contrast to the cause of death note by Dr. R.K., Respondent's Discharge

Summary note dated March 11, 2016 stated, "On Post Operative Day # 16 patient had onset of systemic acidosis, coagulopathy, thrombocytopenia, and shortly after she developed signs of cerebral herniation with new fixed and dilated pupils and hypotension. She rapidly progressed to with poor cardiac output and asystole and expired." This implied that the cause of death was cerebral herniation. However, Dr. R.K.'s cause of death note did not mention signs of cerebral herniation with new fixed and dilated pupils at all.

C. Similarly, in the Certificate of Death signed by Respondent on or about March 1, 2016, the list of the "Immediate Cause (Final disease or condition resulting in death)" in Item 107(A) is "Cerebral Edema or Bleed." However, the pronouncement of the immediate cause of death as cerebral edema or bleed is incorrect since there is no confirming objective evidence that the fixed and dilated pupils finding was, in fact, due to a cerebral edema or bleeding process. There could be other causes.

D. Moreover, on or about February 23, 2016, a neurologist, Dr. N.P., consulted when Patient B's pupils were suspected to be asymmetric and enlarged. His impression was: "Encephalopathy: Very complex case and clearly this could all be from her current sedation and paralytics in addition to her acute illness and multiorgan injury with renal, lungs and liver. Suspect there may be additional potential for hypoxic/ischemic CNS injury but hard to asses with current factors. Focal CNS pathology also possible but no reason to suspect that. At some time CT head would be helpful." His recommendations included, "EEG as quick and portable evaluation but Head CT when possible."

E. On or about February 24, 2016, Dr. N.P. noted: "SUBJECTIVE: No new neuro issues. EEG done and shows expected diffuse low voltage slowing with no focal abnormalities. Still sedated and paralyzed. No new reccs . . . EEG showed nonspecific diffuse slowing but ? If due to meds, metabolic encephalopathy or Primary CNS insult."

F. On or about February 25, 2016, a Head CT was obtained less than 24 hours before the patient's death which showed: "No mass effect is noted. No areas of acute infarction or acute hemorrhage are noted. NO ACUTE INTRACRANIAL ABNORMALITY NOTED."

G. Therefore, there was no hard evidence of a cerebral mass effect caused by cerebral edema or bleed. Instead, the patient had several active processes that may have caused the pupillary changes, including hypothermia, cardiac arrest and acute anoxia. Thus, in her final stages, Patient B was dying from multi-system failure and while cerebral herniation was not an impossibility, there was no need to invoke another over-riding process as the cause of death with no definitive evidence of that process.

H. Several entries and non-entries on the Certificate of Death by Respondent result in it being inaccurate. Although Patient B's immediate cause of death was multi-system organ failure (respiratory, hepatic and renal), and sepsis ultimately all secondary complications to severe postoperative hemorrhage from the intraoperative liver laceration requiring exploratory laparotomy, liver laceration and laparotomy are not even mentioned on the Certificate of Death form, nor is the primary atrial fibrillation diagnosis and the primary cardiac operation listed; only the re-exploration of median sternotomy with delayed primary closure is listed which was performed partially in the intensive care unit. Post cardiac surgery bleeding is listed only in Item 12, and is the only entry in that item which is meant for "SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN ITEM 107."

I. Accordingly, Respondent negligently, inappropriately and inaccurately failed to describe on the Certificate of Death, Patient B's liver laceration with the associated prolonged period of hemodynamic instability, hypoperfusion and ultimately multi-system organ failure (which was a result of the delayed diagnosis).

THIRD CAUSE FOR DISCIPLINE

(Patient C – Repeated Negligent Acts)

47. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent engaged in repeated negligent acts in the care and treatment of patients. The circumstances are as follows:

48. On or about July 19, 2016, paramedics transported Patient C, a 61-year-old Filipino man, to LBMH's emergency department with complaints of severe chest pain, nausea,

diaphoresis and vomiting, and the diagnosis of an anterior ST segment elevation myocardial infarction. Immediate catheterization revealed a right coronary artery dominant system with proximal tubular 90% and mid focal 80% stenosis that was treated with two drug eluting stents. There was a 95% proximal LAD stenosis thought to be the culprit lesion, which the interventional cardiologist could not stent. The patient's past medical history included hypertension, hyperlipidemia, diabetes mellitus, and kidney stones s/p ureteral stenting the week prior to the myocardial infarction.

49. Respondent performed MIDCAB with a LIMA to LAD graft, diagnostic left thoracoscopy, robot assist for initial takedown of mammary artery, and end-to-end repair of LIMA graft externalized using direct suture and intraoperative TEE. The patient's immediate postoperative course was complicated by heavy bleeding and hemodynamic instability, and therefore, he was returned to the operating room for re-exploration, evacuation of clot and control of several bleeding sites on the LIMA pedicle and chest wall. After the procedure, the patient developed pulmonary and renal dysfunction. He was evaluated by nephrology and the renal dysfunction resolved without dialysis. Thereafter, his postoperative pulmonary dysfunction improved also and he was discharged home on POD eight.

Preoperative

50. On or about July 19, 2016, and thereafter, Respondent negligently failed to adequately perform and/or document his personal examination (including an evaluation and assessment) of Patient C prior to performing his initial surgery on the patient. On or about July 19, 2016, Patient C was seen at 9:58 a.m. by a physician assistant and again at 10:50 a.m. by a certified registered nurse practitioner (CRNP). Both of the two notes for these visits were cosigned by Respondent at 7:36 p.m., which was after the patient arrived in the Cardiac Care Unit postoperatively at 6:50 p.m. However, Respondent inadequately stated, "I have seen and evaluated the patient [and] reviewed the note and have discussed it with the Physician Assistant [and] I concur with the documentation." Indeed, the Board's MC during the August 15 Subject Interview, questioned Respondent about his lack of documentation that the patient was seen before the operation by Respondent. However, no such preoperative surgeon's note exists.

Therefore, Respondent committed negligence when he failed to adequately document a preoperative evaluation of Patient C.

Intraoperative

51. On or about July 19, 2016, and thereafter, Respondent negligently failed to adequately assess the patient, engage in the informed consent process, perform his procedures, and/or document his actions, in respect of the procedure he performed on Patient C, including, the need for immediate surgery due to an emergency, addressing the risks and benefits associated with urgent surgery, the likelihood of success of the procedure and/or the possible complications, associated with the proposed surgery. Respondent proceeded with immediate surgery on Patient C with concomitant increased risks of hemorrhage and operating in an emergency situation. At the August 15 Subject Interview, Respondent stated that he "agreed that the patient should have emergency revascularization of his LAD." However, Respondent's Operative Report failed to contain language that stated the operation was being performed on an emergency or urgent basis. Further, he failed to adequately address, and/or document, that he discussed the benefits and increased risks of an emergency operation with the patient. Therefore, Respondent committed negligence in connection with his alleged emergency surgery on the patient and/or intraoperative documentation related thereto.

Postoperative

52. On or about July 19, 2016, and thereafter, Respondent negligently failed to adequately participate in the post-operative care of the patient for the first few days, and/or failed to adequately maintain timely and accurate medical records of the postoperative care of Patient C. At the August 15 Subject Interview, the MC questioned Respondent about:

> "some postoperative complications for the patient that occurred . . . I'd like to see -- uh -- what your participation was in the postoperative care of the patient. And I did not find any note of yours, but I found documentation that you did actively participate in the first two days after the operation. Now, please correct me if I'm wrong, I want to make the record straight. Is there any documentation showing that you participated in the care of the patient after the first two days?"

Notwithstanding the fact that Respondent stated at the August 15 Subject Interview that he did see the patient after the first two days, the one postoperative note authored by Respondent alone was on postoperative day (POD) 5, July 24, 2016, when the patient was still in the CCU. The day before, POD 4, the patent was also still in CCU, but the chart for that day did not have any note attributed to anyone on the cardiac surgery team. The remainder of the patient's POD care had associated notes authored by members of the cardiac surgery team other than Respondent and he co-signed some of them, but not all versions. Out of 25 post-operative chart notes, he only authored one, and Respondent's co-signature status appeared on only eight, three of which were five (5) days after the discharge of the patient. This was notwithstanding the fact that his co-signature was needed on all, but they were not co-signed by him. Although the remaining notes that were signed by PA's or NP's had written reminder notations that a co-signature from Respondent was needed for each, those remaining notes did not have his co-signatures. Thus, most of the patient's postoperative medical chart notes failed to contain Respondent's co-signature, and the few that did, were not co-signed in a timely manner. Therefore, Respondent negligently failed to see the patient in a timely manner after the surgery, and/or failed to maintain timely, adequate and accurate medical records in connection with the patient's postoperative care.

FOURTH CAUSE FOR DISCIPLINE

(Patient D – Gross Negligence and Repeated Negligent Acts)

53. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent engaged in repeated negligent acts in the care and treatment of Patient D. The circumstances are as follows:

54. On or about November 2, 2015, Patient D, a 67-year-old man, was transferred to LBMH from another hospital, where Patient D presented with atrial fibrillation and rapid ventricular response, congestive heart failure, pneumonitis, severe mitral regurgitation and he reportedly had blood culture results that were positive for MRSA. His past medical history included hypertension, hypothyroidism, congestive heart failure, depression, hyperlipidemia, anxiety, anemia and history of coronary artery bypass grafting and mitral valve repair in 1997.

55. On or about November 3, 2015, Respondent performed the following procedures on

Patient D, a mitral valve replacement, a Maze procedure and a left atrial appendage ligation via a right thoracoscopic (robot assisted) approach on Patient D. Postoperatively, the patient had reduced responsiveness with twitching and a stroke "code" was called. A CT imaging study of the patient's head showed no edema or hemorrhage. However, an MRI showed abnormal increased signal intensity and restricted diffusion of the cortex of the parietal, occipital and part of frontal lobes bilaterally, highly suggestive of hypoxic cortical infarction. The patient was extubated and seizures were controlled. Thereafter, Patient D showed some neurologic improvement and a percutaneous feeding gastrostomy tube was placed. Antibiotics for pneumonia were discontinued after 10 days. On or about November 20, 2015, the patient was transferred to a rehabilitation facility for additional recovery. Respondent's record keeping for this patient evince a general and pervasive lack of attention and care constituting negligence.

Preoperative

56. On or about November 3, 2015 and thereafter, Respondent negligently failed to perform an adequate assessment of the patient, including the risks and benefits associated with surgery, and/or likelihood of success of procedure and possible complications, and/or failed to adequately inform the patient about the benefits/risk associated with the proposed surgery, and/or failed to maintain timely, adequate and accurate medical records for the procedure he performed on Patient D. Respondent committed multiple acts of negligence in connection with his record keeping during the preoperative period in connection with his inadequate assessments and/or documentation of key attributes of Patient D's conditions, including a failure to adequately document the patient's coronary artery disease, mitral valve disease and severity of associated congestive heart failure, atrial fibrillation, review of systems, MRSA bacteremia, [10] active pneumonitis, an assessment of perioperative risks and benefits associated with urgent surgery, the risks and benefits and likelihood of success of a Maze procedure, the possible diagnosis of endocarditis, and/or the urgent need for surgery. Respondent failed to adequately document the

[10] Bacteremia (presence of bacteria within the blood stream) is a very serious diagnosis (common with endocarditis) and should be addressed in determining the timing and the risk of any operation, and Respondent should have adequately documented attempts to prove or disprove the diagnosis with multiple blood cultures and the input of Infectious Disease consultation.

etiology of the patient's valve problem, and cardiac functional status. Such information should be conveyed to the patient before the patient gives informed consent because it would materially affect the risk of the operation. Moreover, the patient's documentation of a pre-operative estimated mortality rate of 2-3 percent conflicted specifically with the "urgent nature" and "high risk" surgery that Respondent stated existed for the patient during his August 16 Subject Interview

Cardiac Status and Bypass Grafts.

57. First, Respondent negligently failed to adequately assess and/or document an adequate amount of detail regarding Patient D's cardiac status, including the presence or absence of prior coronary artery surgery, current status of potential coronary and graft disease/patency, failure to determine/interpret cardiac functional status by either obtaining outside hospital records or current studies of potentially complicating cardiac diagnoses including the MRSA bacteremia diagnosis, and/or possible active endocarditis status. Respondent's reference to cardiac catheterization failed to clearly indicate whether or not that cardiac catheterization was performed during the preoperative period at LBMH; and if not, copies of those outside records should have been obtained, especially in light of the Past Medical History listing of the patient's CABG[11] and mitral valve repair operations in 1997. The then current 2015 status of the patient's coronary artery disease and coronary artery bypass graft(s) was critical preoperative information necessary for Respondent because he was required to review and directly interpret the actual cine-angiograms. However, the records here failed to document that the actual coronary angiographic images were received at LBMH and directly reviewed by Respondent, and if not, that information should have been documented as well. The only mention of the mitral valve disease by

[11] The status of the native coronary arteries and the bypass graft(s) was critical. First, if the received report of "normal coronary arteries" was in error and there was significant native coronary artery disease or graft disease, then repeat CABG could be indicated. There was no information provided in the LBMH medical record as to who performed the cardiac catheterization, at what institution, when it was done. Second, if a re-operative CABG was needed then a sternotomy would have been a more standard elective approach. Potential problems may (or may not) affect the choice of surgical approach; they should have been considered and documented. Thus, Respondent's statement, "Cardiac catheterization demonstrated normal coronary arteries." failed to answer any of the questions that should have been raised.

Respondent in describing the History of Present Illness was: "Workup has revealed mitral valve disease." However, this vague statement did not include any further detail. Respondent also wrote that the patient "demonstrated normal coronary arteries" in one place and "CABG 1997 LBM" in another. This is confusing and inaccurate and constitutes negligence.

Atrial Fibrillation.

58. Second, Respondent negligently failed to adequately assess and/or document the patient's atrial fibrillation. The only reference to atrial fibrillation is in his plan to perform a Maze procedure. His surgeon's note lacks any detail, such as the length of time the patient had experienced atrial fibrillation, the size of the left and right atria, which data could affect the potential risks and success rate of the planned procedure and the informed consent process. The patient's chart failed to explain how the assessment was made, and merely announced the patient's mitral valve functional problem as regurgitation, with no reference to an infectious etiology or diagnostic study. The chart failed to address the patient's arrhythmia and atrial fibrillation that Respondent documented that he planned to treat surgically with the "MAZE," while only documenting the patient's "normal sinus rhythm." Respondent failed to adequately perform and/or document a directed Review of Systems, which should have included inquires and responses about prior strokes or transient ischemic attacks, which are problems often associated with hypertension or atrial fibrillation. Moreover, the actual diagnosis was not even mentioned in Respondent's own preoperative initial consultation. Additionally, his note failed to include an update with any historical study based atrial fibrillation information even after he co-signed the NP note.[12]

[12] There was another preoperative note that did contain some pertinent preoperative information on this patient, prepared by CVNP K.W., written the day before (November 2, 2015 at 11:12 am). However, that NP note which documented (very minimally), an evaluation that mentioned a recent (no date provided) echocardiogram showing mitral regurgitation, and a history that mentioned a current EKG showing atrial fibrillation was only co-signed after Respondent already updated his own two notes immediately prior to the operation. Neither of Respondent's own notes, nor the co-signed (by Respondent) NP note, had any specifics as to the coronary arteriography, cardiac catheterization, hemodynamics, history of atrial fibrillation, size of the left atrium, biventricular function or even mention of the LBMH CT scan of the chest and abdomen findings (ordered as part of the preoperative evaluation). Respondent's note of November 3, 2015, at 7:32 am stated that he had "seen and evaluated the patient," "reviewed the note and have discussed it with the resident," and "concur with the documentation." However, K.W. is a CVNP, not a resident.

Pneumonitis and MRSA

59. Third, Respondent negligently failed to adequately assess and/or document Patient D's pneumonitis and/or MRSA. An active pneumonitis could likely cause potential complications in Patient D, such as a prolonged ventilation, particularly with a thoracoscopic approach and a period of single-lung ventilation. The preoperative evaluation record failed to adequately address the pneumonitis diagnosis reportedly made outside of LBMH, which could delay the planned surgery. Pneumonitis could also affect the surgical approach in light of the pulmonary complications / failure occasionally associated with the single-lung ventilation method used in robotic-assisted surgery. MRSA should have been adequately assessed and documented by Respondent. But, discussion was very limited, including a note by nurse practitioner K.W., which merely stated, "#6 MRSA blood. Vanco (Los al notes states last dose 11/1/15)."

Emergency

60. Fourth, Respondent negligently failed to adequately assess and/or document that there existed an emergency or urgent need for the surgery, including a discussion of Patient D's conditions/comorbidities and why it was necessary to proceed despite the higher risks given the patient's active problems. Respondent should have addressed and/or documented an adequate assessment of the perioperative risks and benefits associated with the urgent surgery, the risks and benefits (informed consent process) and likelihood of success of the Maze procedure and possible diagnosis of endocarditis. Respondent failed to address and/or document specific risks in the informed consent portions of the preoperative notes. At his August 16 Subject Interview, Respondent explained that "without surgery," the patient had "no chance to survive." However, there were two informed consent notes where the second note failed to mention any mortality risk at all. The notes also failed to adequately document that "this re-operation was a high-risk procedure."

Intraoperative Documentation

61. On or about November 3, 2015 and thereafter, Respondent committed negligence in connection with his intraoperative actions and/or record keeping. Respondent indicated at his August 16 Subject Interview that the plan was for an urgent replacement of the valve and that the

patient had MRSA bacteremia and right sided pneumonitis. Furthermore, he stated the patient had endocarditis until proven otherwise. However, Respondent negligently failed to adequately address and/or document in the official operative report, and/or immediate op note, that the operation should proceed on an emergency or urgent basis and/or explain why there was an emergency. Further, Respondent negligently failed to adequately address and/or document in his findings whether or not the patient had bacterial endocarditis and whether it was related to the patient's MRSA, including whether it was a preoperative diagnosis and/or ongoing issue, and how the intraoperative findings could affect the post-operative decisions.

A. At LBMH only two preoperative blood cultures were obtained and both were negative for bacterial growth. The Respondent was required to inspect the valve and associated prosthesis, the 1997 mitral ring in this case, and any other structures for possible vegetation or masses or leaflet perforations and document his findings as consistent, not consistent, or indeterminate for endocarditis. The diagnosis as to the presence or absence of endocarditis is very important to a patient with cardiac valvular failure such as the mitral regurgitation of Patient D. Further, if the patient had the infection, he would need a multi-week course of intravenous antibiotic treatment.

Intraoperative Conduct- Endocarditis –Gross Negligence

62. On or about November 3, 2015 and thereafter, Respondent committed gross negligence and/or negligence when he failed to adequately address and/or assess the patient's suspected valve infection, including by attempting to perform routine microbiologic studies in connection with his operation on a patient with possible or suspected endocarditis. Respondent failed to render an opinion on the diagnosis, failed to perform swabbing of tissue to gram stain and culture for bacteria and to determine bacterial sensitivities and to request a pathology consultant to inspect tissue microscopically for possible infection, in addition to gram staining and culture. If such examinations were positive for bacteria present or cultured growth, the important diagnosis of endocarditis would have been confirmed and the patient would have to be treated. However, there is no record that any of the following occurred or had been requested by Respondent: intraoperative cultures, gram stains on swabs or resected tissue by the surgeon,

microbiology staff, or pathology staff. Thus, they were not done, despite Respondent stating at his August 16 Subject Interview that the patient had endocarditis until proven otherwise, thereby constituting gross negligence.

Postoperative – Gross Negligence.

63. On or about November 3, 2015, and thereafter, Respondent committed gross negligence and/or negligence, when he failed to adequately, assess, treat, and/or failed to document the patient's infection with endocarditis in the postoperative care, including by initiating a multi-week course of antibiotic treatment and documenting the same in his notes and discharge summary note. However, the patient was discharged to another facility without such treatment, notwithstanding a discharge summary diagnosis of "Bacterial Endocarditis."

A. Patient D suffered significant postoperative neurologic impairment possibly due to hypoxic cortical infarction. This clinical problem dominated his care. Yet, the patient's records, including the preoperative notes, operative reports and postoperative notes, failed to mention the potential for endocarditis. Indeed, the records lacked any documentation of endocarditis, suspicion for endocarditis, intraoperative inspection for endocarditis, intraoperative testing for cultures or staining for endocarditis, or any positive LBMH study such as a blood culture or pathologic specimen findings consistent with endocarditis. The lack of documentation and interpretation in the medical record, including the discharge summary regarding a possible diagnosis of endocarditis as the etiology of the patient's clinical problem was especially egregious given the patient's presentation with severe mitral regurgitation and alleged MRSA bacteremia at the outside hospital.

FIFTH CAUSE FOR DISCIPLINE

(Patient E – Repeated Negligent Acts)

64. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent engaged in repeated negligent acts in the care and treatment of Patient E. The circumstances are as follows:

65. On or about March 10, 2016, Patient E, an 89-year-old woman, was admitted to

LBMH with aortic stenosis, and she developed acute congestive heart failure and cardiogenic shock with systemic acidosis. A consult note in her chart by cardiologist B.W. indicated that he had been previously following her asymptomatic aortic valvular stenosis, and during a routine follow-up, an echocardiogram revealed an increased valve gradient and worsening valve area. Three weeks prior to her admission (and a week after her echo), she developed mild exertional shortness of breath and chest tightness. A cardiac catheterization within the prior two weeks showed fairly normal coronary arteries with the exception of a 50% ramus stenosis, normal ejection fraction, valve area of 0.3, and a mean gradient of 70. A surgical consultation by Respondent was arranged, but she developed near syncope and congestive heart failure (CHF) and was admitted to LBMH (as noted above) through the emergency department of Los Alamitos Medical Center. Although surgery was planned for noon, before her transfer to LBMH, she developed more severe shortness of breath. At LBMH, given Patient E's declining clinical state (she was too tenuous to transfer for catheter-based therapy), surgery could not be delayed. An emergency surgery with pre-incisional initiation of peripheral femoral-femoral bypass to maintain circulation was contemplated and the OR schedule was changed to accommodate the patient's immediate need for surgery.

66. Thereafter, on or about March 10, 2016, Respondent performed an emergency aortic valve replacement with 19 mm Trifecta bio-prosthetic valve via the right anterior thoracotomy. The operation was performed on cardiopulmonary bypass, using preoperative peripheral cannulation and cardioplegic blood cardioplegic arrest, and was complicated by excessive hemorrhage from the aortic root. A transverse sternotomy and replacement of the aortic root with a #23 Medtronic Freestyle bio-prosthetic valve conduit and reimplantation of the coronary arteries was necessary to control the hemorrhage. The patient required significant inotropic support, and her preoperative acidosis persisted postoperatively. She had a significant coagulopathy resistant to multiple blood products and developed severe hemorrhage. Cardiac arrest occurred and after a brief resuscitation attempt, her family requested termination of the resuscitation efforts. Patient E was pronounced dead at 1:57 a.m. on or about March 11, 2016.

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Informed Consent

67. On or about March 10, 2016, Respondent committed negligence in connection with his provision of services to Patient E, including in connection with his inadequate performance and/or documentation of the informed consent process for surgery for Patient E. Regarding informed consent, Respondent admitted at a later date, that his documented mortality risks were significantly lower than they actually were and were only an initial "guestimate" of risks. Indeed, his documentation of a 4-5% chance of mortality was grossly underrated. At his August 15 Subject Interview, years after the event, he recalculated the risk as 11% (and a 50% statistic). Inexplicably, Respondent also said during his subject interview that he does not use or quote numbers to his patients regarding the risk of death, even though his record did in fact quote numbers. He also failed to discuss with the patient and/or document the risks for severe hemorrhage and postoperative renal failure (both of which did occur with Patient E). The low quoted risk (4-5% mortality) in his record is troubling given the patients' state as an elderly, frail, steroid treated woman who was too tenuous to transfer to the radiology suite, much less to another institution for TAVR consideration. Thus, Respondent's informed consent process and documentation was inadequate and factually inaccurate for Patient E, who faced an emergency procedure and much higher risks than were documented by Respodnent. He should have discussed the risks and complications of the heart surgery with the patient, including severe hemorrhage and multi-system organ system failure, which should have been listed specifically and clearly documented. This failure constitutes negligence.

Postoperative – Discharge and Hemorrhage

68. On or about March 10, 2016, Respondent committed negligence by failing to adequately perform and/or document his services to Patient E, in connection with his inadequate and/or inaccurate postoperative medical record documentation and vital information record. First, he negligently failed to address, assess and/or accurately document the complications of intraoperative and postoperative hemorrhage and the other diagnoses such as aortic root calcification leading to or contributing to the ultimate cause of death on the California Certificate of Death signed by him on or about March 16, 2016. Second, he negligently failed to perform

and/or accurately document in the Discharge Summary portion of the medical record critical information regarding the patient's final cause(s) of death and/or Final Diagnoses.

A. Respondent's records in the post-operative period were inaccurate and/or inadequate,[13] including regarding the rate of hemorrhage. After undergoing over eight (8) hours of anesthesia time followed by an additional period of CPB for the complete aortic root replacement with coronary replantation, the patient suffered severe deterioration postoperatively – she had active medical problems, particularly bleeding. She arrived at the postoperative CCU quite ill (as documented by the 7:43 p.m. note of the CVNP, K.W., and by other providers (cardiogenic shock, anuric renal failure in need of CRRT, persistent acidosis and hypoxia and severe pulmonary edema requiring 100% oxygen per ventilator)), and she had already developed multi-system organ failure of the heart, lungs, kidneys and her acid-base balance in the immediate postoperative hours. However, similar to his preoperative records for this patient, his records for the postoperative period were puzzling, conflicting and confusing, and even more questionable. Respondent inaccurately documented the patient's rate of hemorrhage (mediastinal drainage) at 100 ml/hour. On the other hand, in contrast to Respondent's documentation, the patient's higher rate of hemorrhage recorded by other providers corroborated Dr. D.Y.'s

[13] This inaccurate record for this patient follows a pattern in Respondent's records which demonstrate several inconsistencies and omissions which were needlessly puzzling and conflicting. His initial consultation operative report includes two CTS INITIAL CONSULT NOTES (dated March 10, 2016 signed at 8:40 am and March 13, 2016, at 8:05 p.m.), and the patient's condition was variable in the documentation. For instance, in the physical examination section of both of notes, the vital signs are identical, but in the March 10, 2016 note, he described her as a "Thin frail woman in NAD" [meaning No Acute Distress]. Yet in his Assessment/Plan section of that same note, he wrote: "Surgery represents the best option for treating this patient's aortic stenosis AVA 0.3 Pt is in acute distress and had rapid deterioration this AM. Minimally invasive approach still possible but best to initiate CPB peripherally prior to skin incision. And possibly prior to induction." Yet, the plan of that same note sounded fairly routine: "Surgery Planned: Aortic Valve replacement with initial CPB support and minimally invasive approach if possible or sternotomy. And, even more conflicting was the Operative Report phrase stating: "She was considered for transcatheter valve replacement, but her general status was good in that she was not frail and she was very much in favor of a minimally invasive approach." And, the patent was described in the physical examination portion of the other March 13, 2016 note, as follows: "Pt is alert and conversant. SOB but not distressed." But in that note, the operation was then declared an emergency: "Planned: Emergency AVR on CPB with possible sternotomy." Thus, Respondent's records were equivocal as to whether the patient was frail or not, nor whether it an emergency or not.

assessment of hemorrhagic shock.[14] Further, based only on the mediastinal drainage,[15] the drainage was 1740 ml in 1.75 hours (994/hour) - ten times higher than the rate Respondent recorded. Clearly, the chest tube drainage showed that the hemorrhage was massive. The Massive Transfusion Protocol was activated, and the Code Blue physician, Dr. Y. felt the patient was in a state of hemorrhagic shock "throughout the evening." However, Respondent's documentation egregiously failed to adequately and accurately reflect the significance and severity of the hemorrhage. The nocternist, Dr. D.Y., documented that she was on the scene from 10:00 p.m. to and through the Code Blue until she pronounced the patient dead, and clearly documented that the patient was in a state of hemorrhagic shock.

B. Similarly, Respondent's medical record failed to include any labeled death note with a primary cause of death and possible secondary conditions that contributed to the patient's death, which is unusual. Respondent's last note for this patient failed to include any such determinations. The complications of the heart surgery noted above, including the severe hemorrhage and multi-system organ system failures, should have been listed in a death note by the attending surgeon or at least in the Final Diagnoses of the Discharge Summary. They were not. Further, generally, if a death occurs after surgery, a note documenting communication by the attending surgeon with the coroner's office is usually present. Here, the record does not include any documentation of such surgeon to coroner communication. Also, each of the following significant items - severe aortic root calcification, intraoperative hemorrhage and postoperative hemorrhage, coagulopathy, acute anuric renal failure, and hypoxemia - should have been listed under the Final Diagnoses, but, instead, were conspicuously absent from Respondent's Discharge Summary. Indeed, the intraoperative hemorrhage was associated with the prolonged eight-hour operation (with repeated episodes of CPB), and the postoperative hemorrhage required activation of the Massive Transfusion Protocol and was associated with

[14] Furthermore, hemorrhagic shock is known to be a potential cause of Pulseless Electrical Activity noted in the Code Blue Note.

[15] Which is not logical clinically because drainage is drainage.

hemorrhagic shock. The renal failure was to be treated with CRRT and the respiratory failure/pulmonary edema with nitric oxide had the patient survived longer. All of the above diagnoses contributed to some degree to her death including the coagulopathy which contributed to the hemorrhage. Coagulopathy alone, however, was unlikely to be the primary problem.

C. Respondent failed to accurately document the complications of intraoperative and postoperative hemorrhage, and the other diagnoses such as aortic root calcification leading to or contributing to the ultimate cause of death on the California Certificate of Death, dated March 16, 2016. In it, in the "Immediate Cause (Final disease or condition resulting in death)" in Item 107(A), he wrote "Diffuse Intravascular Coagulopathy,"[16] and in Item 107(B), he wrote "Systemic Acidosis," and in 107(C), he wrote, "Cardogenic Shock" and (D) is blank. Those Items are associated with the instructions "Sequentially, list conditions, if any, leading to cause on Line A: "Item 112 Other Significant Condition Contributing to Death But Not Resulting in the Underlying Cause in 107" lists "AORTIC STENOSIS." Item 113 instructions ask that any operation be listed for any of the conditions listed in Items 107 or 112 and in this case only "Aortic Valve Replacement 3/10/2016" is listed. This patient's problems with intraoperative hemorrhage and postoperative hemorrhage are severe and occurred as a complication of the Aortic Valve Replacement operation listed in ITEM 113. But, hemorrhage should not be completely absent from ITEM 107 – where the cause(s) of death were required to be listed.

D. Respondent's records documented that after the initial AVR, severe hemorrhage from the aortic root occurred, which necessitated another immediate operation. However, that operation, the aortic root replacement with coronary artery button replantation, was inexplicably absent from any entry item in the Certificate of Death including Item 113 where it clearly belonged. Thus, Respondent failed to

[16] While it is likely the coagulopathy contributed to the rapid hemorrhage, other explanations such as tissue or suture failure cannot be excluded without evidence from a surgical exploration or autopsy. From the time of the initial removal of the aortic cross-clamp following the initial AVR, hemorrhage was always a very significant complicating factor in the patient's course and should have been listed.

adequately and accurately report on the California Certificate of Death, and this is the third instance of documented misrepresentations associated with postoperative hemorrhage on an official death certificate signed by Respondent.

SIXTH CAUSE FOR DISCIPLINE

(Patient F – Repeated Negligent Acts)

69. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent engaged in repeated negligent acts in the care and treatment of Patient F. The circumstances are as follows:

70. The allegations of the First Cause through Sixth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

71. On or about February 28, 2017, at approximately 4:10 p.m., Patient F, a 64-year-old woman, arrived at LBMH on an emergency basis with severe epigastric pain radiating to her left chest. Upon evaluation, she was diagnosed with an NSTEMI heart attack. Her past history included gastroesophageal reflux, two cesarean sections, childhood asthma, and having been diagnosed with severe symptomatic aortic stenosis in the Philippines in December 2015 and having been advised to have an AVR. However, she did not pursue that surgery. An echocardiogram showed severe critical aortic stenosis, mild aortic valve insufficiency, severe LVH, and normal left ventricular systolic function. Cardiac catheterization showed severe calcification on aortic cusps, severe aortic regurgitation (3+ to 4+) and non-obstructive coronary artery disease.

72. On or about March 6, 2017, Respondent performed an aortic valve replacement with St. Jude Medical Trifecta bio-prosthetic valve, size 21, enlargement of aortic root with Hemashield patch gusset, repair of rib fracture separation with SternaLock plates and screws, intraoperative TEE and placement of transvenous temporary pacemaker lead with fluoroscopic guidance. Shortly after the operation the patient suffered a ventricular fibrillation arrest, was reintubated, received cardiopulmonary resuscitation and multiple defibrillation attempts before reviving (ROSC). On or about March 7, 2017, she was extubated, but later that day required emergency reintubation due to severe metabolic acidosis. The patient developed multi-system

organ failure. On or about March 9, 2017, the patient expired.

Preoperative and Intraoperative

73. On or about March 1, 2017, and thereafter, Respondent negligently failed to adequately assess, address and/or document a key attribute of the patient's condition, the patient's aortic status. Thus, Respondent failed to maintain adequate and accurate preoperative and intraoperative medical records for this patient. The facts are as follows:

A. Respondent was notified about Patient F on or about March 1, 2017, and prepared a note in the chart signed on or about March 2, 2017, stating, "64 patient Jehovah's witness with severe AS and LVH, Cath is pending in AM, but patient meets indications for AVR." Later, after the heart catheterization, a more complete Initial CTS Consult Note was done and updated by K.D. The CTS Physician Assistant, dated March 2, 2017, which included the following note, "Impression: -Non-obstructive coronary artery disease (see above for details) . . . Severe aortic regurgitation (3+ to 4+)." Respondent countersigned the preop note stating "I concur with the documentation, on or about March 3, 2017 at 6:20 am." However, by signing this attestation, Respondent implied that he felt there was no plan for CABG given the lack of obstructive coronary artery disease, which resolved that issue. However, there was no acknowledgement that the aortic root injection had also shown severe aortic regurgitation (AR) which was in conflict with the March 1, 2017, preoperative transthoracic echocardiogram which showed only mild AI.[17] However, he failed to adequately document the resolution of the AR severity, and his diagnostic error subsequently continued in the record. Thus, three days later (on the day of surgery), Respondent entered his updated note which stated, "H & P was reviewed, the patient was assessed, and no change has occurred in the patient's condition since the H & P was completed." Respondent should have addressed how the severe aortic regurgitation diagnosis had been further evaluated to confirm or reject that severity of the regurgitation in the operating room prior to the incision (because the degree of AR could make the pre-incisional echocardiogram (TEE) even more important – e.g., if the TEE did show severe

[17] AI and AR are equivalent terms.

AR, then the surgeon might change the planned method of cardioplegic protection of the heart and/or change to a full sternotomy incision). Instead, Respondent failed to document any plan to even evaluate the "Severe aortic regurgitation (3+ to 4+)." Respondent's awareness of the catheter-based diagnosis of AR is not documented anywhere in the medical record. Even Respondent's operative report failed to mention the severity of the AR which should have been evident on TEE. And, if Respondent's findings at TEE affect the course of the decisions of the case, then they should be documented at that time in the record. They were not, and had to be resolved at his August 15 Subject Interview years later. Here, the patient's documentation contained a major diagnostic error by the referring cardiologist, which should have been properly corrected by simple documentation in the operative note by Respondent as the operating surgeon.[18]

Informed Consent

74. On or about March 1, 2017, and thereafter, Respondent negligently failed to perform an adequate assessment, examination, and informed consent process, and/or adequately document the same, including obtaining an adequate history and performing an adequate examination and adequately discussing the risks and benefits associated with urgent surgery, and/or the likelihood of success of the procedure and possible complications, and/or failing to adequately inform the patient about the risks and benefits associated with the proposed surgery and alternatives, and/or failing to maintain timely and adequate and accurate medical records for the procedure he performed on Patient F. The facts are as follows:

A. At the August 15 Subject Interview, Respondent could not recall whether the patient spoke English and said he would have used an interpreter if the patient did not speak English. However, the medical record showed (a) no concerns on the part of any hospital or medical staff in contact with the patient during the hospitalization regarding the patient's ability to speak English, (b) "English" is listed as the patient's primary language, on the

[18] Respondent's failure to resolve and correct the preoperative diagnosis of severe aortic regurgitation in the operative report and/or postop would have a domino effect where the consultants in Hematology, Critical Care, Internal Medicine, among others, including the cardiac surgery team continued to list severe aortic regurgitation in their postoperative notes.

initial physical assessment by the RN dated February 28, 2017, and (c) apparently the patient completed in English, and signed her LBMH Health Questionnaire herself. Therefore, the issue of the patient's ability to give informed consent due to a possible inability to understand English was not a problem for this patient.

B. Respondent failed to adequately address and/or document whether the patient heard and understood the true risks and benefits of her cardiac surgery. A physician assistant note, dated March 2, 2017, listed risk percentages for Surgical AVR from the National STS database. Respondent attested to that note on or about March 3, 2017. However, in another note dated March 6, 2017, Respondent wrote, "History and Physical: H & P was reviewed, the patient was assessed, and no change has occurred in the patient's condition since the H & P was completed, and included a generic informed consent note." There are several issues with the patient's documentation. The record does not specify what risks, benefits, and/or alternatives were discussed with the patient at each encounter. For example, was a TAVR considered? This is noteworthy because a TAVR could have been a reasonable option for a Jehovah's Witness patient who refused blood transfusions. Further, the patient's religious convictions may have affected the options of blood transfusions, but Respondent's records lack any specific determination of how and by how much the risks were increased by the limited transfusion of only some blood products available to Jehovah's Witness patients. Clearly, the cardiac surgery mortality risk was increased for a Jehovah's Witness patient who refused blood products as compared to a similar population that allowed transfusions.[19]

C. Further, Respondent's updated note, signed before the operation began, failed to document or even mention mortality, much less any percentage risk. Thus, it is not clear if the morbidity percentages were even specifically conveyed to the patient. Moreover, Respondent stated at his subject interview that he does not "use numbers for patients because they really don't mean a lot." Respondent failed to make an effort to even

[19] Jehovah's Witnesses believe that the Bible prohibits ingesting blood and that Christians should not accept blood transfusions or donate or store their own blood for transfusion.

document in the medical record what was specifically said to the patient, qualitatively if not quantitatively. Respondent negligently failed to document what was said to the patient to assist the patient with the informed consent process and decision-making. Instead, Respondent negligently attempted to explain or clarify his medical documentation for this patient at a Medical Board Subject Interview at a much later date.

Code Blue

75. On or about March 1, 2017, and thereafter, Respondent negligently failed to adequately address and/or document a normal Code Blue or resuscitation note for Patient F. The facts are as follows: On or about March 6, 2017, Respondent performed an aortic valve replacement surgery on Patient F. Respondent left the room at 4:12 p.m., and the patient was extubated in the OR by the anesthesiologist at 5:13 p.m. and transferred to the CCU at 5:15 p.m. At 6:11 p.m., bedside nurses documented rhythm change and arrest in the patient and a code was initiated. Although the patient improved briefly, and was extubated on March 7, 2017, she required emergency reintubation later that day due to severe metabolic acidosis. Respondent failed to address and/or document the details usually found in a Code Blue note for Patient F, including, the adequacy and length of time of CPR, other medications tried, lab values, cardiac arrest, respiratory arrest, code note, etc. The medical records do not include any physician or surgeon authored Code Blue Note. However, at his August 16 Subject Interview, Respondent stated, "I personally resuscitated her. I personally gave her this amp of -- um -- or not amp but I gave -- I gave her the metoprolol that got her heart back." However, Respondent failed to adequately document in the chart, a pertinent note written immediately afterwards, that the patient suffered a code and what happened in connection therewith, particularly in this case where the heart appeared to respond to Respondent's administration of a beta blocker.

SEVENTH CAUSE FOR DISCIPLINE

(Patient G – Repeated Negligent Acts)

76. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent engaged in repeated negligent acts in the care and treatment of Patient G. The circumstances are as follows:

77. The allegations of the First Cause through Sixth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

78. On or about March 3, 2017, at 6:17 a.m., Respondent admitted Patient G, a 67-year-old woman, to LBMH. She had a history of having been followed by her cardiologist for over 15 years for a cardiac murmur and a bicuspid aortic valve with complaint of acute hypoxemic respiratory failure. She developed progressive symptoms of shortness of breath and fatigue. Her past medical history included obesity, hypertension, osteopenia, a 1990 breast reduction, breast cancer s/p 2010 bilateral mastectomy, left arm lymph node dissection and chemotherapy, and s/p 1992 cholecystectomy. In addition, on or about June 29, 2016, a transthoracic echocardiogram showed that the patient had a normal LV chamber size and systolic function, EF of 62%, moderate to severe AS, left atrial enlargement, dilated ascending aorta and decreased LV compliance. On or about January 18, 2017, a Coronary Angiogram showed no significant coronary artery disease and catheterization hemodynamics showed normal right heart pressures with exception of elevated right ventricular pressure to 48/4/9 mmHg. Cardiac output/ Index by thermodilution were normal at 6.23 L/min and 3.12 L/min/m2. The patient allegedly saw Respondent as an outpatient.

79. On or about March 3, 2017, Respondent performed the following procedures on the patient: First, a replacement of her aortic valve with cardiopulmonary bypass, #23 St. Jude Medical Trifecta GT bioprosthetic valve; second, a right anterior thoracotomy;[20] third, an Intraoperative TEE; and fourth, a repair of rib fracture separation with SternaLock plates and screws. The patient's post op care was complicated by respiratory acidosis, heart block, pulmonary edema and hypotension. Consults from pulmonology, and cardiology were requested. A chest xray demonstrated a questionable right sided infiltrate suspicious for pneumonia. She was started on intravenous antibiotics, and she underwent a bronchoscopy by the pulmonary service, and was eventually weaned to extubation on POD eight. She also required a permanent pacemaker due to complete heart block. The patient was transferred to Memorial West rehab center to continue her recovery on POD eleven, March 14, 2017.

[20] Thoracotomy is a surgical incision into the chest wall.

Preoperative

80. On or about March 3, 2017, and thereafter, Respondent negligently failed to perform an adequate assessment, informed consent process, and/or document the same, with respect to Patient G, including obtaining a history, performing an examination, discussing the risks and benefits associated with surgery, and/or likelihood of success of the procedure and possible complications, and/or failing to adequately inform the patient about the risks and benefits associated with the proposed surgery and alternatives, and/or failing to maintain timely and adequate and accurate medical records for the procedure he performed on Patient G. There was no adequate documentation by Respondent.

A. Respondent failed to prepare a "CTS Initial Consult Note" as the attending cardiac thoracic surgeon. Although LBMH's medical records did have a "CTS NP Preoperative History & Physical," note dated February 24, 2017, (7 days prior to the patient's admission), it was signed by a different doctor as the Medical Director, and was not signed by the attending surgeon. LBMH's medical records did not include any outpatient attending cardiothoracic surgeon's consultation note. Therefore, the medical record documentation lacked the preoperative documentation expected and required from the attending surgeon providing an opinion for an operation planned during that hospitalization. Notwithstanding this missing preoperative record, Respondent signed a note dated March 3, 2017, stating, "H & P was reviewed, the patient was assessed, and no change has occurred in the patient's condition since the H & P was completed" ("Update Note"). In addition, the informed consent portion of the note was very generic. The Update Note failed to contain any specific information about the patient, the disease(s), the operation, the specific risks and benefits or anything remotely specific to the specialty of cardiac surgery. Furthermore, it referred to a review of an "H & P," meaning a history and physical examination that was not present in the chart and the note above contained the conclusion there was no change in that absent history and physical examination. This generic note (lacking substantive detail) is an example of a repeated pattern in Respondent's record keeping practice.

B. When Respondent was questioned about this patient at his August 16 Subject Interview, his responses did not make any sense. Simply saying "that is my usual practice" is woefully inadequate. He should have repeated and documented the current evaluation at the admission if the prior record could not be located. Further although he refers to the other doctor's consult and nurse practitioner at the subject interview, he cannot accept a non-surgeon's consultation for heart surgery in lieu of the consultation by the operating surgeon, and the nurse practitioner note was not co-signed by him. When asked by the MC at the subject interview. "I needed to know whether you actually examined this patient," he stated that he was sure he did. However, confusion persisted despite the continued questioning. Respondent alleged that he did not have access to the records. However, originals of outpatient records are in the possession of the physician or surgeon who created the documents.

EIGHTH CAUSE FOR DISCIPLINE

(Patient H – Repeated Negligent Acts)

81. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent engaged in repeated negligent acts in the care and treatment of Patient H. The circumstances are as follows:

82. The allegations of the First Cause through Seventh Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

83. On or about May 31, 2015, Patient H, an 84-year-old woman, presented to LBMH on an emergency basis complaining of chest pain, with an acute STEMI heart attach involving the anterior LV wall. Her problem list also included, acute respiratory failure with hypoxia, stroke, systolic congestive heart failure, S/P CABG, thrombocytopenia, anemia, metabolic acidosis, acute on chronic renal failure, and septic shock. Her extensive history included peripheral vascular disease, previous carotid artery stenosis, carotid endarterectomy, chronic hypertension, hyperlipidemia, heavy smoking "most of her life" (quit 5 years prior), gout, breast cancer (she had a lumpectomy of her left breast), stage 3 chronic kidney disease, anxiety, hip surgery (2012), macular degeneration, spinal stenosis, hypothyroidism, cataract surgery, status post

cholecystectomy, and partial hysterectomy. At LBMH, she went to the catheterization laboratory for heart catheterization and coronary angiography. Findings per the operative report were: 90% occlusion in the left main CAD, 70% mid LAD, 50% proximal left circumflex, 50% proximal right and 50% mid RCA disease. The patient's left ventriculogram showed apical akinesis and apical dyskinesis, no mitral valve regurgitation and the estimated LV ejection fraction was 30% (normal 55-75%). An aortic balloon (IABP) was placed, and cardiac surgery consultation was requested. The patient also had a 1995 prehospital DNR form.

84. On or about June 1, 2015, a nurse documented that the patient requested to be a DNR and refused sternotomy. However, a MIDCAB/hybrid heart operation was offered. On or about June 1, 2015, the IABP was removed after it was pulled back and malfunctioned. The patient also had significant confusion and had received chronic and acute anti-anxiety medications on that day.

85. On or about June 3, 2015, Respondent performed the following procedures: (a) Minimally Invasive Direct Coronary artery bypass x1, single arterial graft, LIMA to LAD (MIDCAB); (b) Left thoracoscopy, diagnostic robot-assisted; (c) TEE; and (d) Injection procedure for selective opacification of in situ arterial conduit. The MIDCAB operation was complicated by a failed mammary artery to left anterior descending graft. Respondent then performed the following procedures: (aa) Aorto-coronary bypass x3 with one arterial and two venous grafts: (free) LIMA to proximal LAD, saphenous vein to distal LAD and saphenous vein to obtuse marginal: (bb) Closure of median sternotomy separation with SternaLock plates and screws:(cc) TEE: and (dd) Endoscopic vein harvest, via sternotomy and on cardiopulmonary bypass with blood cardioplegic arrest.

86. On postoperative day two, the patient had facial droop and left sided hemiparesis due to right middle cerebral gyrus infarct with later MRI showing signs of possible hemorrhagic transformation. The patient was reintubated and had multiple postoperative complications, including acute hypoxic respiratory failure, possible aspiration, systolic congestive heart failure (CHF), prolonged need for inotropic/pressor support, anemia, thrombocytopenia, septic shock, metabolic acidosis, and acute on chronic renal failure. She failed ventilator weaning several

times and received multiple antibiotics.

87. On or about June 19, 2015, the 1995 advanced directive was reviewed with the patient's daughter and DNR/Do Not Intubate (DNI) were reordered for postoperative period.

88. On or about June 24, 2015, the family requested terminal extubation with comfort care and the patient expired on or about August 28, 2015.

89. Respondent's pre and intra operative records here are very problematic and conflict with other information, including from his statements during his subject interview with the Board investigator. Such carelessness with his documentation is especially dangerous in this context because of its potential influence on patient care decisions by other medical and hospital staff personnel who could rely on such information.[21]

90. During the August 15 Subject Interview, the patient was described as elderly with a very serious acute illness - a major myocardial infarction associated with a severe left main coronary stenosis as well as 2-3 vessel coronary artery disease and a significantly reduced ejection fraction of 30 per cent. Generally, a patient with this presentation, if a surgical candidate, is almost always treated with a standard urgent multi-vessel coronary artery bypass grafting (MCABG) via a midline sternotomy incision.

91. The process of determining whether a patient is a cardiac surgery candidate depends on responses to four areas of questioning in light of the risks and benefits. First, what is the state of cardiac function going into surgery? Second, what is the condition of other organ functions, i.e., do other co-morbidities exist? Third, are there any alternative treatment(s) and the concomitant risks and benefits associated with those choices? And fourth, after full disclosure of the pros and cons of the options, what is the patient's informed decision? However, the poor documentation made it difficult to delineate the four subject areas discussed above for Patient H.

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[21] The problematic operative records (including conflicts) here may lead to reporting of inaccurate statistical results (including the STS database and LBMH's associated morbidity and mortality statistics). For instance, if the person entering the data into the database simply relies on Respondent's record that states, "Complications: None," the data may be corrupted. Were there complications with the MIDCAB case? Was it a failed MIDCAB case? Was the patient's death a MIDCAB associated death or is it a sternotomy associated MCABG death or both?

Preoperative Basic Medical Record Documentation

92. On or about May 31, 2015, and thereafter, Respondent committed negligence when he failed to adequately assess and/or document his actions in the preoperative period. The circumstances are as follows: He failed to adequately assess and/or document his knowledge and interpretation of important studies such as the LV ejection fraction, and the current status of the patient's cardiac functional status and associated comorbidities, including the patient's frailty, possible degree of renal dysfunction, possible degree of pulmonary dysfunction and even consideration of the possibility of ongoing neurologic or cognitive dysfunction in a confused patient with a history of carotid endarterectomy. The lack of documentation of his awareness of the data was ubiquitous across all aspects and sections of his preoperative consultation: the history of present illness, the past medical history, the physical examination, the assessment of the cardiopulmonary studies (ECG, chest x-ray) and other studies such as laboratory values and the 48 hour hospital course prior to surgery. The medical record also recorded that the patient "is refusing sternotomy - asked to DNR and hospice rather than that." Yet, she was recommended to have a minimally invasive bypass after she refused elected sternotomy for a multivessel graft. There was no cardiopulmonary and no neurological findings documented at all.

A. Respondent completed two preoperative records containing his patient evaluation. First, the Initial CTS Consult note, dated June 1, 2015, at 12:30 p.m., which contained a note that the patient was "refusing sternotomy - asked to DNR and hospice rather than that." He also wrote, "MIDCAB hybrid is a reasonable anatomic option." The history section was very condensed. Further, the patient had already suffered a major myocardial infarction and had a reduced left ventricular (LV) ejection fraction (EF) of 30 percent. However, here, documentation of LV function was absent from the surgeon's Consult Note. In addition, an intra-aortic balloon pump (IABP) was placed by the cardiologist at the time of the cardiac catheterization. An IABP is commonly used in this situation of a high grade left main coronary artery stenosis and is usually kept in place through the operation. However, the records did not mention the IABP. Given the patients critical state, Respondent should have documented whether he recommended keeping the

IABP in place. Instead, he had to be questioned about it at his subject interview.

B. Respondent completely failed to document many important facts. For example, although he noted significant coronary stenosis, he failed to document the status of the heart function and clinical state of the patient. His history of present illness was also very short. His past history was almost an identical "cut and paste" excerpt from the emergency physician's evaluation, and was not appropriately elaborated upon or corrected. He failed to further inquire about, or document, the patient's carotid artery aneurysm, which is an unusual diagnosis. In her patient questionnaire, she disclosed a carotid CEA,[22] (which is not an aneurysm) 10 years earlier. The patient should have undergone an appropriate preoperative evaluation because cardiac surgery patients with active neurologic symptoms are generally at higher risk for perioperative stroke than patients without such symptoms. Even if her baseline was negative for symptoms, those negative findings should have been documented. Instead, Respondent's note for his Review of Systems (ROS) only stated, "Review of Systems, Pertinent items are noted in HPI." However, his HPI was very brief and he negligently failed to elicit and/or document an adequate review of systems. The patient had a prior history of carotid endarterectomy, but he failed to question her in his ROS about possible stroke symptoms preoperatively.

C. The cursory documentation in the physical exam portion of Respondent's note was inadequate and represents negligence. It listed 17 vital sign measurements recorded over 4 hours and 45 minutes, but the only note was, "Normal female exam." Respondent alleged that he performed a physical examination at his August 15 Subject Interview, but the records conflict with this allegation. Further, he also failed to rely on cardiothoracic staff (e.g., physician assistant or nurse practitioner) to do a complete examination and document that, after reviewing, correcting, and signing off on their notes. There was no such record. Respondent negligently failed to properly evaluate the patient for a cardiovascular problem and/or document such evaluation, including documenting pertinent

[22] Given the patient's CEA history, she should have been specifically questioned about any stroke symptoms at her cardiology admission and also again later by the surgeon and/or his staff before any anticipated operation.

findings of the heart and lung examination, including any negative findings as well.

D. During his August 15 Subject Interview, in reference to the CTS consult on or about June 1, 2015, Respondent explained, with regard to the cardiovascular system, "I listen to their -- uh -- lungs and their heart and -- and their carotids to see if they've got, you know, bruits that stick out. And if there's something relevant, I will report that." However, his documentation included the following essentially useless information, as reported, "CBC: LABBRIEF [WBC, RBC, hemoglobin, hematocrit, Platelet cnt and BMP: LABBRIEF [Glucose, sodium, potassium, Chloride, CO2, BUN, Creatinine, Calcium, Magnesium." No pertinent data was delineated as normal or abnormal, and he negligently failed to document his interpretation of the data.

E. Similarly, his June 1, 2015 consult note regarding the EKG and chest x-ray, stated, "ECG: normal sinus rhythm, no blocks or conduction defects, no ischemic changes, WNL Chest X-Ray: normal." However, those results were not normal. The MC asked about this at his August 15 Subject Interview stating, "It doesn't make sense." Respondent replied, "Right . . . it's the boilerplate . . . I should have corrected that." And, when asked by Board MC about the x-ray, stating, "I didn't see any normal chest x-ray either," Respondent replied, "Yeah."

F. Regarding documenting an assessment,[23] Respondent should have summarized the patient's problems, including her acute anterior STEMI myocardial infarction, CHF, poor EF and high-grade 90% left main and 2-3 vessel CAD, status post IABP insertion, as well as her co-morbidities or other general or organ system dysfunction (e.g., her advanced age, frailty, kidney dysfunction, long smoking history, peripheral artery disease and prior carotid endarterectomy). Such information is necessary to estimate the risks for a cardiac operation. However, none of the foregoing was adequately documented constituting

[23] An assessment section documents the synthesis of "subjective" and "objective" evidence to arrive at a diagnosis. This is the assessment of the patient's status through analysis of the problem, possible interaction of the problems (in order of importance) or differential diagnosis, and changes in the status of the problems. The differential diagnosis is a list of different possible diagnosis, from most to least likely, and the thought process behind this list. This is where the decision-making process is explained in depth. Included should be the possibility of other diagnoses that may harm the patient, but are less likely.

negligence. Instead, Respondent announced that surgery represents the best option and MIDCAB with PCI of LMCA was ideal.

G. Regarding the plan, the standard multi-vessel bypass grafting for left main CAD via sternotomy was not listed. Respondent's records also failed to document whether or not a routine elective sternotomy and MCABG was offered, but rejected by the patient. Furthermore, he could not recall at his interview her exact words when she refused elective sternotomy, nor even whether he had asked her why she refused. This calls into question the accuracy of his documentation in the note that "significant alternatives to the proposed procedure have also been explained, along with the risks and benefits of the alternatives," and represents negligence.

H. Similarly, his note dated June 3, 2015, at 12:23 p.m., entitled, "History and Physical Update," (which stated that no change occurred in the patient's condition since the H & P) was inaccurate. In fact, many changes had occurred in the 48 hours since the first consult note to the Update Note on the day of operation. On or about June 1, 2015, at approximately noon, when Respondent saw the patient, no confusion was documented by him. However, later she was clearly confused, hallucinating and combative. A beside nurse documented at 6:45 p.m. that "Patient forgetful, confused & hallucinating, saying 'help, why am I against the ceiling,' emotional reassurance & psychological support given. [Respondent] at bedside & calmed patient down." At 7:15 p.m., a nurse's note described her as "confused." Later still at 11:43 p.m., a cardiology physician reported that IABP was not functioning properly and was removed and that the doctor "remained at bedside helping hold pt down to prevent bleeding and directing sedation." However, Respondent failed to document these events; they were not even mentioned in his June 3, 2015, update note. Further, he also negligently failed to mention the lack of an IABP for support during the operation, after the IABP was removed, even though an IABP is frequently in place when surgeons operate on patients with her clinical presentation. Anesthetic induction with potential blood pressure drops due to medications often results in significant instability in a patient with a high grade left main coronary lesion and that possibility may have been even

more likely for a patient like this one who already had experienced a major myocardial infarction, 30% LVEF and CHF. Also, her chest x-ray and ECG were not normal. Furthermore, the operative plan was to perform a MIDCAB off of the support of cardiopulmonary bypass, so the IABP if replaced, may have helped prevent an emergency sternotomy for instability. If Respondent had reasons for recommending against re-insertion of the IABP for the operation, he should have documented them. His failure represents negligence.

I. Respondent's two pre-operative surgeon's notes evince his failure to adequately perform and/or document a physical examination, which represents negligence. He failed to perform even a basic neurologic orientation (e.g., ask her to say her name, her location, the date and reason for hospitalization). He also failed to document that an IABP had even been placed at cardiac catheterization, which also represents negligence.

Intraoperative

93. On or about May 31, 2015, and thereafter, Respondent negligently failed to adequately perform his duties, and/or document his care for, Patient G in respect of the operative procedures he performed. After spending approximately ten hours in surgery on Patient G, Respondent dictated an "Operative Report," and a brief "Surgical Postoperative Note" in connection with each of two procedures.[24] However, there were several inconsistencies between the two documents and in his explanations at his August 15 Subject Interview. In the longer Operative Report, after describing the technique of the MIDCAB anastomosis, the poor flow in the LIMA, the revision of the MIDCAB anastomosis, the report noted the second angiogram findings and plan. At his interview, Respondent alleged that the patient "remained stable, but it was decided to proceed with a new multivessel bypass operation." However, this was precisely what the patient wanted to avoid, namely a sternotomy. At his interview, Respondent alleged that he discussed the possibility of an "emergency sternotomy" with the patient. However, he failed to explain any need to proceed to perform a lifesaving sternotomy. Indeed, the records do not

[24] An off-pump MIDCAB x1 followed immediately by the median sternotomy CABG x3 operation on-pump or on cardiopulmonary bypass (CPB).

include any reference to an emergency or urgent situation. Further, neither the long operative report, nor short operative note of the sternotomy and MCABG operation expressly stated that the operation was being done immediately to save the patient's life. Although the short note was more informative stating, "Operative Findings: poor distal vessel due to longitudinal plaque. LIMA to LAD graft initially closed then distal not open," it also inexplicably stated, "Complications: None." This was not accurate. Respondent negligently failed to adequately address and/or document the alleged emergency clinical situation, events and complications. The graft had no outflow beyond the anastomosis, and then had only retrograde flow and no antegrade flow beyond the anastomosis after the revision of the anastomosis. Furthermore, the iatrogenic dissection compromised the graft inflow, but the dissection was also not specified as a complication.

A. Two other statements in the record were similarly problematic and represent negligence. First, the second, longer Operative Report (of the MCABG operation) clearly mentioned the patient had a failed graft, but there was no mention of the dissection of the subclavian artery and LIMA ostium that resulted in impairment of inflow to the LIMA at the conclusion of the first operation.[25]

B. Second, a TEE was performed, and was listed as part of the second operation, the MCABG, "3. Intraoperative TEE." However, there was no reading, report, attestation or interpretation of the TEE included and no information in the Operative Report about who interpreted the finding; Respondent, the cardiologist, or anesthesiologist. The ultimate finding or reading of the TEE was important[26] because it showed a definitive change according to the cardiologist's note on the first postoperative day, stating, "Post op TEE showed significant decline in EF to < 20%." Furthermore, the decline in EF was present on TEE despite the newly required intraoperative inotropic support, such as milrinone. The

[25] A future reviewer would not know why Respondent "repositioned" the proximal [of the LIMA] to the aorta, when in fact the surgeon knew the graft inflow was impaired. That impairment of flow was likely due to the iatrogenic dislodgment that was documented in the first Operative Report of the MIDCAB. That information should also be part of the second Operative Report of the MCABG.

[26] Clearly, the TEE was obtained intraoperatively to provide pertinent functional information to the cardiac surgeon and anesthesiologist actively treating the patient.

latest finding in the second operation TEE should have been in the Operative Report of the MCABG via the sternotomy. Further, the TEE indicated a significant deterioration in EF, which is a reportable complication; the LV was more impaired after the operation than before.

Informed Consent

94. On or about May 31, 2015, and thereafter, Respondent negligently failed to adequately engage the patient, or her authorized representative, in the informed consent process and codes status process, including regarding (a) patient's stated desire to have or not have surgery and to have a Do Not Resuscitate (DNR) code status honored or changed, and/or (b) any decision to proceed with cardiac surgery; and/or adequately document the same. The medical record does not include any preoperative DNR discussion or code change discussion, which should have occurred with the patient, or if she was not fully competent, then with her representative.

A. The patient arrived at the emergency room in a normal mental state, and on or about June 1, 2015, at 6:10 a.m., a nursing note indicated, "Patient remain alert and slightly oriented during the shift. . . . Patient request to be an DNR and not to have the surgery. . . ." Later that same day at 6:30 a.m., another doctor wrote a phone order: "Patient states 'she is going to die, and wants to go home to die in a comfortable environment.'" However, despite this request, the patient's records also did not include any discussion with a social worker. Further, the patient's executed 1995 Durable Power of Attorney form was not even discussed until after the patient suffered multiple postoperative complications. Indeed, the first documented DNR discussion, did not occur until on or about June 19, 2015, which was postoperative day 16.

B. Respondent completed two documented records during the preoperative time period. The Initial CTS Consult note, dated June 1, 2015, at 12:30 p.m., included a minimal (other than vital signs) physical examination note which was only documented as a "Normal female exam;" no cardiopulmonary and no neurologic findings were documented at all. Respondent completely failed to examine or determine the patient's mental status,

i.e., whether she remained alert and oriented.[27] However, at the August 15 Subject Interview, Respondent alleged that he explained to the patient that she had an option of the hybrid coronary revascularization.

C. Yet, Respondent utterly failed to adequately perform and/or document an evaluation of the patient regarding whether she was alert and capable of participating in the informed consent process. The patient had executed the proper documents that indicated such were her intentions should she become incapacitated (See Executed 1995 Durable Power of Attorney for Health Care). At his interview, Respondent stated that he usually sees the patient twice, but he went ahead on June 1, 2015, after the first visit and ordered the consent for operation form be completed. However, Respondent also documented in his Initial Consult Note History, dated June 1, 2015, that the "Pt is refusing sternotomy - asked to DNR and hospice rather than that. But MIDCAB hybrid is a reasonable anatomic option."

D. The patient appeared to have periods of disorientation, confusion and or hallucinations or sedation either in the hours before, after or actually during the time of any of Respondent's communications with her. At 10:13 a.m. on or about June 1, 2015, the bedside nurse (two hours prior to Respondent's initial consult wrote: "Patient started acting very confused and started hallucinating around 1800. Ativan and Effexor XR ordered daily per Dr. [R.] since she takes it at home. 1 mg ativan, IV given per [Respondent] due to acute agitation. Similarly, at 6:45 p.m., a nursing note states that the patient was forgetful, confused and hallucinating.

E. On or about June 2, 2015, when the patient allegedly appeared to be recovering from neuro confusion and hallucinations, Respondent still failed to ask her any orientation questions. He also admitted at the subject interview that he does not do a detailed neurologic exam, but instead claimed that he reviewed her eye movements. A nursing note documented a plan for the patient's daughter to speak to Respondent prior to signing the

[27] Consider the evaluation of the ER doctor, Dr. E., who did perform such an exam on the patient.

consent for surgery. This calls into question whether the patient had the capacity to consent.

F. Further, Respondent had several days to perform and document an adequate informed consent process; the patient presented to LBMH and underwent catheterization on or about May 31, 2015, and the surgery took place on or about June 3, 2015.[28] And, if she lacked capacity to make major decisions, her proxy was available to participate in the process. Yet, the two informed consent records were inadequate and generic and the mortality and stroke risks pertained only to the chosen anesthetic/sedation and possible use of blood/blood products. The informed consent notes lacked any specific detailed reference to the patient's clearly expressed refusal for an elective sternotomy and permission for an emergency sternotomy (which presumably was the reason the patient or her proxy gave permission to proceed with the HYBRID procedure, an unusual and odd choice).

G. Respondent also alleged that the cath lab consent documented the possible sternotomy at his interview, which would be unusual. Further, the May 31, 2015, cath lab consent only stated "right and left heart catheterization with angiograms and possible [PCI] and possible emergency coronary artery bypass grafting." The "possible sternotomy" (which the patient adamantly wanted to avoid) was not mentioned. It also stated that the patient unable to sign because "Pt has taken anxiety meds." In any event, even if the cath lab consent mentioned a possible sternotomy, it would not be construed as a consent for a separate CABG surgical proceure.

H. Here, the patient did not proceed with the standard surgical treatment (namely routine sternotomy with standard MCABG) for her diseased coronary anatomy in order to avoid sternotomy. Thus, Respondent should not have proceeded with his planned MIDCAB/hybrid operation on patient without 1) establishing whether the patient or her

[28] The patient's daughter, who had been legally designated to make medical care decisions in a 1995 Durable Power of Attorney for Health Care form, was not engaged early in the informed consent process. Although she did sign the surgical consent form later, there was no documentation by Respondent that a detailed preoperative informed consent discussion was held with the daughter.

proxy clearly gave proper informed consent, and 2) documenting a proper informed consent process personally as surgeon or by co-signing a similar note authored by supervised cardiothoracic surgery staff.[29] Thus, Respondent committed additional negligence in connection with the informed consent process with Patient G. He failed to even ask her orientation questions on her day of surgery. Yet, Respondent alleged at his subject interview that the patient "did consent for the surgery with knowing, you know, sound, mind, and body. However, this is absent from the record.

NINTH CAUSE FOR DISCIPLINE

(Incompetence)

95. Respondent is subject to disciplinary action under section 2234, subdivision (d), of the Code in that Respondent displayed incompetence in the care and treatment of patients. The circumstances are as follows:

96. The allegations of the First through Eighth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

97. Respondent's poor record keeping and his performance in the care of patients demonstrate a lack of skill, ability and/or knowledge. The allegations in the Tenth Cause for Discipline below are incorporated herein by reference as if fully set forth.

98. On or about May 16, 2018, Respondent stated that coronary sinus injuries occur all the time. In fact, this is not an accurate statement and reflects incompetence.

TENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

99. Respondent is subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate and accurate records of the medical and/or surgical services he provided to patients. The circumstances are as follows:

[29] First, informed consent is not a piece of paper with a signature, but a process of providing information, eliciting a decision, and obtaining authorization to provide a service. Second, informed consent is not a single event, but an on-going process that continuously reevaluates the situation. Third, cardiothoracic surgeons do not make final decisions, patients do under the guidance of their surgeons. Fourth, surrogate/proxy decision makers should be treated with the same respect as the patient: they have ultimate decision-making power unless they are deemed incapable or untrustworthy.

100. The allegations of the First through Ninth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

101. Respondent was required to record his care and treatment of patients, including without limitation, his actions and thought processes, in an accurate and timely manner, because without a record, his actions cannot be assumed to have occurred at all. Further, an attending surgeon has an obligation to provide an accurate permanent record to inform the other consulting physicians and hospital staff caregivers so they may appropriately provide their professional care. Furthermore, Respondent is responsible for ensuring that his medical record notes are accurate and corrected before he signs them.

Patient A

102. On or about March 17, 2012 and thereafter, Respondent failed to maintain adequate and accurate records in respect of Patient A. The circumstances are as follows:

A. On or about March 17, 2012, Respondent failed to timely and accurately document in his history of Patient A's present illness, or otherwise in LBMH medical records for Patient A, the cardiac and other evaluation information of the outside hospital.

B. On or about March 17, 2012, Respondent failed to timely and accurately document in his history of Patient A's present illness, or otherwise in LBMH medical records for Patient A, the patient's history of asthma and the patient's history of vocal chord paralysis secondary to neck fusion surgery.

C. On or about March 17, 2012, Respondent failed to timely and accurately document in his history of Patient A's present illness, or otherwise in LBMH medical records for Patient A, a cardiopulmonary examination.

D. On or about March 17, 2012, Respondent failed to timely and accurately document in his history of Patient A's present illness, or otherwise in LBMH medical records for Patient A, his decision making process supporting his decision to perform the aortic valve replacement surgery on Patient A.

E. On or about March 17, 2012, Respondent failed to timely and accurately document in his history of Patient A's present illness, or otherwise in LBMH medical

records for Patient A, any opinion on the option of the TAVI approach for Patient A or the indications in Patient A's situation for a TAVI approach.

F. On or about March 17, 2012, Respondent failed to timely and accurately document in his history of Patient A's present illness, or otherwise in LBMH medical records for Patient A, how the increased risk of the patient's significant co-morbidities impacted Respondent's decision-making and informed consent processes.

G. On or about March 17, 2012, Respondent failed to timely and accurately document in his history of Patient A's present illness, or otherwise in LBMH medical records for Patient A, that an open tracheostomy was attempted.

H. On or about April 5, 2012, Respondent failed to document in the Discharge Summary the severity of several conditions that contributed to the patient's death, including the severity of the bleeding, the ongoing resulting hemodynamic instability, the associated requirement of transfusing blood products, the severe anemia, the contributing factors of neck fusion surgery, paralyzed vocal chord, progressive hypoxia and the diagnosis of asthma, the inability to intubate and the inability to obtain a surgical airway.

I. On or about March 23, 2012, Respondent failed to properly document the cause of death in Patient A's death certificate, noting that it was asthma followed by valvular heart disease and inflammatory bowel disease, which inaccurately described the cause of death.

Patient B

103. On or about February 10, 2016, and thereafter, Respondent failed to timely, accurately and adequately document his surgical procedures on Patient B. His record keeping was extremely inadequate and made it very difficult to assess his actual conduct during the operation and calls into question Respondent's skills and knowledge as a surgeon. Respondent's official operative report included six parts (although he listed seven) of the operation, each of which was problematic, as more fully set forth above.

A. On or about December 15, 2015 and thereafter, Respondent failed to timely, accurately and adequately document a preoperative assessment of Patient B, who presented

with possible coronary artery disease and with associated potential risk factors for a patient with coronary artery disease undergoing an open cardiac operation as more fully set forth above.

B. On or about December 15, 2015 and thereafter, Respondent failed to timely, accurately and adequately document the informed consent process for surgery for Patient B. His written informed consent for Patient B was generic and lacked key information, including but not limited to, the actual other treatment options and potential specific complicating events such as sternotomy, multi-system organ failure and death; all of which did occur. Furthermore, no estimations of the likelihood of any risks were included in the documentation.

ELEVENTH CAUSE FOR DISCIPLINE

(False Representations, False Medical Records and/or Dishonesty)

104. Respondent is subject to disciplinary action under sections 2261 and 2234, subdivision (e), of the Code in that Respondent made false representations in the care and treatment of patients, and/or committed acts involving dishonesty or corruption which are substantially related to the qualifications, functions, or duties of a physician and surgeon. The circumstances are as follows:

105. The allegations of the First through Tenth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

106. The death certificates and documentation of the causes of death by Respondent for each of Patient A, Patient B and Patient E demonstrated false representations.

Patient B

107. In addition, Respondent engaged in the following dishonesty or corruption. During his Subject Interview with the Board on or about May 16, 2018, Respondent described his surgical technique he used with Patient B as follows:

"I wrinkle the diaphragm, fold it over, and then put a stitch through and through the tendon portion of the diaphragm. That's -- the reason I wrinkle it is so that I don't hit the liver underneath and all -- in 1,100 robots, I've never caused an injury with that stitch."

However, Dr. F.S. reported that he had successfully managed four prior similar liver lacerations committed by Respondent using his surgical technique in earlier cases by laparoscopic visualization and control of hemorrhage. Unfortunately, Patient B's case differed from those other cases because she was in such a weakened state and had already experienced multisystem organ failure prior to going into the open laparotomy surgery. Indeed, given Patient B's state, Dr. F.S. was not able to operate on her laparoscopically – in spite of being able to do the other prior liver laceration cases of Respondent laparoscopically – because when he attempted to put a laparoscope in, her intra-abdominal pressure was so great that a working space in the belly could not be cleared for a laparoscopic procedure. Thus, Dr. F.S. had no choice but to do an open procedure. Further, when Dr. F.S. reached her liver, he observed the same liver injury as the prior four cases. A little area of the liver was bleeding. Dr. F.S. cauterized it and left some drains. However, Patient B's state was too critical, and her multisystem organ failure could not be reversed.

TWELFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

108. Respondent is subject to disciplinary action under section 2234 of the Code in that he engaged in unprofessional conduct, generally, in connection with the care and treatment of patients. The circumstances are as follows:

109. The allegations of the First through Eleventh Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number C 41588, issued to Daniel Miguel Bethencourt, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants and advanced practice nurses;

3. If placed on probation, ordering him to pay the Board the costs of probation monitoring; and

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

DATED: December 30, 2019

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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