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

In the Matter of the Accusation Against: Madhu Jodhani, M.D. Physician's and Surgeon's Certificate No. A 50459 Respondent.	Case No.: 800-2018-045892

DECISION

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

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

IT IS SO ORDERED: October 14, 2021.

MEDICAL BOARD OF CALIFORNIA

Laurie Rose Lubiano, J.D., Chair
Panel A

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

In the Matter of the Accusation against:

MADHU JODHANI, M.D., Respondent

Agency Case No. 800-2018-045892

OAH No. 2021010276

PROPOSED DECISION

Danette C. Brown, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter by video conference on July 26 to July 28, 2021, from Sacramento, California.

John S. Gatschet, Deputy Attorney General, represented complainant William Prasifka, Executive Director, Medical Board of California (Board), Department of Consumer Affairs (DCA).

Robert B. Zaro, Attorney at Law, Zaro & Sillis, represented Madhu Jodhani, M.D., who was present at hearing.

Evidence was received, the record closed, and the matter was submitted for decision on July 28, 2021.

FACTUAL FINDINGS

Jurisdictional Matters and Disciplinary History

1. On February 25, 1992, the Board issued to respondent Physician and Surgeon's Certificate No. A 50459 (certificate). The certificate expires on June 30, 2023, unless renewed or revoked. Pursuant to a Board Decision issued in Case No. 02-2012-226060, referenced below, respondent was publicly reprimanded and ordered to complete a medical record keeping course and prescribing practices course within 60 days of the effective date of the Decision. On November 6, 2020, complainant filed the instant Accusation.

2014 Accusation, Case No. 02-2012-226060

2. On April 29, 2014, Kimberly Kirchmeyer, a former Board Executive Director for the Board, acting in her official capacity, signed and thereafter filed an Accusation, Case No. 02-2012-226060, against respondent. The Accusation alleged cause to discipline respondent's certificate based on gross negligence, repeated negligent acts, aiding and abetting the unlicensed practice of medicine, failure to follow infection control guidelines, failure to label dangerous drugs, violation of statute regulating dangerous drugs, failure to maintain adequate and accurate medical records, and violation of provisions of the Medical Practice Act.

3. With respect to respondent's failure to maintain adequate and accurate medical records, the Board alleged that respondent made notes in a patient's medical record that were largely illegible, and that respondent was unable to decipher some of the entries made in his own handwriting.

4. On February 13, 2015, respondent signed a Stipulation for Settlement and Disciplinary Order (stipulation) that was adopted as the Board's Decision and Order effective May 8, 2015. The stipulation ordered that respondent be publicly reprimanded, and that he complete a medical record keeping course and prescribing practices course within 60 calendar days of the date of the Decision.

Present Accusation

5. On November 6, 2020, complainant filed an Accusation in his official capacity against respondent, alleging two causes for discipline: (1) repeated negligence; and (2) inadequate and inaccurate medical record keeping. Specifically, complainant alleges that respondent kept inadequate and inaccurate medical records for Patient A by documenting a series of handwritten progress notes, from December 23, 2013, to May 4, 2018, provided a typed version of a May 4, 2018 progress note that contained substantially different amounts of information than was contained in the original handwritten note, and treated H.B. in a rude and unprofessional manner. In aggravation, the Board alleged respondent was previously publicly reprimanded (Case No. 02-2012-226060) regarding his medical record keeping.

6. Respondent timely filed a Notice of Defense to the charges, objecting to the Accusation upon the grounds that it did not state acts or omissions upon which the Board may proceed, and to the form of the Accusation in that it is so indefinite or uncertain that respondent cannot identify the transaction or prepare a defense pursuant to Government Code section 11506, subdivision (a)(3). He further pled the affirmative defenses of laches and statute of limitations. The matter was set for an evidentiary hearing before an ALJ of OAH, pursuant to Government Code section 11500 et seq.

AMENDMENT OF ACCUSATION BY INTERLINEATION

7. On July 28, 2021, complainant amended the Accusation by interlineation as follows:

(a) Page 4, line 13, the caption under the First Cause for Discipline is changed to: "Repeated Negligence and/or General Unprofessional Conduct."

(b) Page 4, lines 14 and 15, paragraph 11 is changed to: "Respondent's license is subject to disciplinary action under section 2234, subdivisions (a) and (c), in that he committed repeated negligence and/or general unprofessional conduct."

(c) Page 4, lines 18 and 19, paragraph 13 is changed to: "Respondent committed the following negligent acts during the care and treatment of Patient A and/or general unprofessional conduct in the following ways:"

(d) Page 4, line 24, paragraph 13(c) is changed to: "by treating [H.B.] in a rude and unprofessional manner."

Board Complaint

8. On July 13, 2018, H.B. filed a complaint with the Board, explaining that his mother (Patient A) unexpectedly passed away on May 7, 2018, after experiencing a severe cough for a week and seeing respondent on May 4, 2018. Three to four weeks after his mother's death, H.B. requested medical records from Rideout Hospital, the Sutter County Coroner's Office, and respondent's office. He obtained the records, but was unable to read respondent's medical records because respondent's "penmanship is illegible."

9. Shortly after his mother's death, H.B. called respondent's office and requested to see respondent at the end of the day to go over his mother's medical records. The reception said "that will be fine." H.B. arrived and waited until respondent finished his last appointment. He saw respondent and asked if respondent could tell him what he wrote in his May 4, 2018 notes. Respondent asked why, and H.B. responded that his "mother passed and would [like] to know what was [respondent's] diagnosis." Respondent abruptly said, "get an attorney." H.B. then left his office.

10. On July 9, 2018, H.B. dropped off a Primary Care Physician's Statement Form and the death certificate to respondent's office, so that respondent could complete the form. On July 12, 2018, H.B. called respondent's office to check whether the form was completed and ready for pickup. The receptionist advised H.B. that respondent had not completed the form because he needed a copy of the autopsy report. When H.B. said the form did not require the autopsy report, the receptionist responded that she was "just following the doctor's orders." Later that day, after 5:00 p.m., H.B. went to respondent's office and patiently waited for respondent in the lobby. Respondent met with H.B. and told him that he was not required to complete the form "because it does not apply to him." When H.B. asked respondent why not, respondent stated "angrily" that he is "not required to complete it, it does not apply to [his] work." He then asked H.B. to leave and "do not ever come back."

11. H.B. further stated in his complaint:

> [Respondent] is very uncompassionate, rude, disrespectful and unprofessional. It is difficult to cope with someone [*sic*] as it is, but [respondent] is causing it to be more difficult.

> By being the next of kin/heir of estate [*sic*], I do not need a conservatorship of [*sic*] power of attorney to request medical records from [respondent]. It is my legal right.

H.B.'s Testimony

12. H.B. testified at hearing consistent with the contents of his complaint to the Board. He added that he is a licensed civil engineer, that Patient A was 65 when she passed away in 2018, and that she lived with him at his house. Patient A and H.B.'s father saw respondent as their primary care physician.

13. On May 6, 2018, at approximately 11:00 p.m., H.B.'s wife took Patient A to the Rideout Emergency Department (Rideout) in Marysville, California, believing Patient A was having a heart attack. H.B.'s wife returned home at 3:30 a.m. while Patient A remained at the hospital. At 4:00 a.m., H.B. received a call from Rideout, instructing him to go to hospital because Patient A's condition had worsened. At approximately 5:00 a.m., Patient A died.

14. H.B. was sad and upset that Patient A had died so quickly and unexpectedly. He was the only living member of his family, and the sole heir to Patient A's estate. Although Patient A did not have a will or trust, H.B. handled Patient A's affairs after her death, including arranging for her funeral on May 13, 2018. H.B. decided he wanted to see his mother's medical records. Three to four weeks later, he received Patient A's records from Rideout, the coroner's office, and respondent's office. He described the records from Rideout and the coroner's office as "straightforward." However, respondent's records, particularly a patient note from May 4, 2018, were "not legible."

15. Shortly thereafter, H.B. called respondent's office and requested to see respondent so that respondent could read what he wrote in his May 4, 2018 note. H.B. was still emotional from Patient A's death but was calm and patient when he arrived at respondent's office around 5:15 p.m. Respondent came out to the waiting room, and took H.B. to a patient room to talk privately. H.B. told respondent he could not read the note and, as next of kin, he believed he was entitled to respondent's translation of his note. Respondent's body language was defensive, and he told H.B. to get an attorney. H.B. left and said "I'll see you soon" in a normal tone of voice. As he left, H.B. decided that he needed to get the Board involved to get an independent third-party review of the care and treatment respondent provided to his mother.

16. H.B. visited respondent's office a second time when he dropped off an IMG life insurance policy form for respondent to complete, along with a copy of Patient A's death certificate. The form contained instructions and was to be completed by Patient A's primary care physician. After a couple of days, H.B. called respondent's office to check on the form. His office receptionist informed H.B. that he could pick up the form, but that respondent was not going to fill it out. Upset by this response, in July 2018, H.B. went to respondent's office. Respondent met with H.B. in the waiting room, and H.B. asked respondent why he would not complete the form. In an "aggressive" and "raised voice," respondent asked H.B. to leave and never come back. H.B. left respondent's office and notified the insurance company. After respondent refused to "decipher" his medical note, and refused to complete the insurance form, H.B. filed his complaint with the Board.

Board Investigation

17. After receiving H.B.'s complaint, the Board wrote to respondent, requesting certified copies of Patient A's medical records, his response to H.B.'s

allegations in his complaint, and a typed transcription of his May 4, 2018, progress note. On January 9, 2019, the Board wrote to respondent acknowledging receipt of his response, stating:

> However, additional information is needed from you. You did not address the issue of the illegible writing as it is hard to determine the information provided in the patient's medical record. (Failure to maintain adequate medical records due to illegible notations of physical findings, etc.) The patient's son requested information from you but could not read them due to your penmanship. Please provide the decedent's son with a **typed version of the record** that is legible as he is unaware of your diagnosis of his mother before her passing.

(Bold emphasis added.)

The Board instructed respondent to comply by January 29, 2019.

18. On January 21, 2019, respondent responded to the Board's request as follows:

> I am actively exploring options to resolve the issue regarding illegible handwriting.

> I have electronic billing, prescription and EHR[1] in place. I am using billing and prescription since few years and I am planning to start using EHR as well. Hopefully this should resolve the issue.
>
> Enclosed is the typed version of record of the office visit in question . . .

(As stated in original.)

19. On June 24, 2019, H.B.'s complaint was referred to Investigator Sean Cogan of the Division of Investigation, Health Quality Investigation Unit (HQIU). Investigator Cogan conducted an interview of respondent with his attorney, Mr. Zaro, present. HQIU's District Medical Consultant, Umer Malik, M.D., was also present during the interview.

20. Respondent acknowledged that he provided a typed version of his May 4, 2018 handwritten note to the Board and H.B. However, he denied altering or changing any information when transcribing his handwritten note to typewritten form. He acknowledged that he "elaborated on the vitals," but that "none of them was meaningfully altered." Respondent further asserted that the information on the typed note was also on the original handwritten note, and denied entering additional information in the typed note that was not on the original handwritten note.

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[1] Electronic Health Record.

Board's Medical Expert – Kenneth B. Johnson, M.D., FACP[2]

21. Kenneth B. Johnson, M.D., is board-certified in Internal Medicine, and is a Diplomat in Hematology and Medical Oncology. He has been licensed by the Board since 2002. Dr. Johnson received his medical degree in 1994 from Georgetown University School of Medicine in Washington, DC. In 1997 he completed his residency in Internal Medicine at the National Naval Medical Center in Bethesda, Maryland. In 2000, he completed a fellowship in Hematology/Oncology at the National Naval Medical Center and Walter Reed Army Medical Center.

22. Dr. Johnson currently works in a small practice with his medical partner on the campus of Sharp Chula Vista Medical Center. He has hospital privileges at Paradise Valley Hospital, Sharp Memorial Hospital, and Scripps Hospital in the San Diego area. He is also a preceptor at Midwestern University Arizona College of Osteopathic Medicine. Dr. Johnson has performed expert reviews for the Board since 2019.

23. The Board retained Dr. Johnson to review respondent's medical records for Patient A, and to render an opinion whether respondent's record keeping and treatment of H.B. were within the standard of care. Dr. Johnson reviewed materials including: H.B.'s complaint; Patient A's medical records provided by respondent; respondent's typed transcription of his May 4, 2018 handwritten progress note; and the digital recording and transcript of respondent's May 5, 2020 interview with Investigator Cogan and Dr. Malik. Dr. Johnson memorialized his finding and opinions

[2] Fellow of the American College of Physicians.

in a written report, dated June 1, 2020. He testified at hearing consistent with his report.

24. Dr. Johnson summarized that Patient A first saw respondent in October 2013, and saw respondent at regular intervals until May 4, 2018, when she saw respondent for a cough and headache. Dr. Johnson could not read respondent's notes for that day because they were illegible. Upon reviewing respondent's typed version of the handwritten note, Dr. Johnson summarized that respondent treated Patient A for an upper respiratory infection and heel pain. He prescribed her with Ventolin, Phenergan with codeine, ibuprofen, and a Z-pak. He also gave her an intramuscular injection of Kenalog. He advised Patient A to call with any problems but otherwise to follow up in three to four months.

25. On May 6, 2018, Patient A went to the emergency room and died the following morning from an apparent pulmonary embolism. H.B. requested the medical records, and there was a disagreement between respondent and H.B. regarding release of those medical records. Once H.B. obtained the records, he filed a complaint with the Board due to illegible physician notes. He also complained of unprofessional conduct by respondent.

STANDARD OF CARE FOR MEDICAL RECORD KEEPING

26. Dr. Johnson defined standard of care as "the level of care in diagnosis and treatment ordinarily possessed by providers done by other reasonably prudent providers in the same circumstance at the same time in question." He further defined negligence as "[t]he failure to use skill and care in the diagnosis and treatment of patients that other reasonably careful doctors would use." Finally, a simple departure

from the standard of care constitutes simple negligence; and an extreme departure, or want of even scant care, is gross negligence.

27. Dr. Johnson explained that the standard of care requires physicians to maintain adequate and accurate medical records. He further noted in his report that "federal mandates were implemented in the recent past requiring the use of electronic medical records," and that "use of electronic health records is now the accepted standard of care."

28. Dr. Johnson noted that respondent's treatment and care are not at issue here, and that the only cause for concern is respondent's record keeping. He did not believe respondent's claim in his recorded interview that his typed note contained the same information as his original handwritten note. In addition to being completely illegible, the handwritten note contained approximately 47 words, whereas respondent's typed note contained over 200 words. When comparing the two documents, Dr. Johnson discerned "it appears that [respondent] misrepresented what was actually recorded in the handwritten note." He therefore concluded that respondent's record keeping failed to meet the standard of care because his handwritten notes throughout the entire medical record, specifically his May 4, 2018 progress note, were completely illegible, and thus they were not adequate or accurate. Respondent further departed from the standard of care because he did not use electronic medical record keeping.

29. At hearing, Dr. Johnson conceded that there are no federal or state mandates requiring the use of electronic medical records, and that handwritten medical records are still acceptable. He added that respondent generated his typed note "after the fact, after the complaint was filed." The typed note was completely

different than the handwritten note, was "a completely embellished, altered record," and "did not look like anything resembling the handwritten note."

30. Dr. Johnson explained the potential harm from respondent's illegible patient notes. If Patient A's family wanted to review respondent's handwritten progress notes, they would not be able to do so. If a second opinion was required for Patient A, "no one is there to interpret these things." Continuity of care allows other physicians to refer to a patient's medical records, be able to read them, and rely on them as accurate. Here, a reviewing physician would not know whether respondent's typed note is an accurate reflection of his original illegible handwritten note, or whether it has been altered.

STANDARD OF CARE IN COMMUNICATING WITH PATIENT'S FAMILY

31. Dr. Johnson opined at hearing that the standard of care for contact between the physician and a member of the patient's family is to encompass the entire family unit in the care and treatment of the patient. He explained that the physician is "not just treating the patient, you are treating the whole family unit, because family members have a vested interest in how their loved one is doing." It is "ridiculous" for a physician to say that he has no responsibility to the family. He added that when a patient dies unexpectedly, the physician should provide support, comfort, and empathy to the grieving family. Here, "that did not happen." It "would have been a simple gesture [on respondent's part] to show some compassion and empathy." If respondent had done that, "we may not be here right now." Greeting a family member with rude and unprofessional behavior is "unthinkable," negligent, and constitutes unprofessional conduct.

32. With respect to respondent's refusal to complete the life insurance form for H.B., Dr. Johnson stated that "if you are that person's doctor that passed away, you have an obligation to fill that out to the best of your ability." Dr. Johnson did not know what a physician should do if he is concerned about being sued, but asserted that "paperwork that comes by my desk is filled out promptly."

CONCLUSION

33. Dr. Johnson concluded that each of the following were simple departures from the standard of care: (1) respondent's illegible handwriting on the May 4, 2018 progress note; (2) respondent's typed version of his original handwritten note; and (3) respondent's unprofessional and rude behavior towards H.B. after his mother's death.

Respondent's Evidence

MEDICAL EDUCATION

34. Respondent completed his medical education in India. He obtained his Doctor of Medicine degree from Saurashtra University in 1978, and his Master of Surgery degree from Sheth K.M. School of Post Graduate Medicine and Research Gujarat University in 1982. In 1987, respondent completed his residency in General Surgery at Brooklyn-Caledonian Hospital in Brooklyn, New York, and in 1990, he completed his residency in Internal Medicine, also at Brooklyn-Caledonian Hospital. Respondent was previously board-certified in Internal Medicine.

CURRENT EMPLOYMENT AND MEDICAL DOCUMENTATION PROCEDURES

35. Respondent works as a solo practitioner treating internal medicine/primary care patients, and hematology/oncology patients. For his internal medicine and primary care patients, he handwrites his progress notes during the

patient visit. He uses abbreviations for efficiency and finishes the notes while still with the patient. For his hematology and oncology patients, respondent dictates his notes and sends them to a transcription service. The transcribed notes are then sent to the referring physicians. Respondent has sent his dictations for transcription since 1993.

36. Respondent does not utilize electronic medical record keeping. He tried electronic medical record keeping before, but found it inefficient because he does not know how to type. When he does type, it takes a long time for him to finish his notes, and there are a lot of typing errors. He tried Dragon Speak dictation software, but because of his accent, the software could not recognize his speech. However, respondent dictates his notes at the hospital with a voice recognition program.

PRIOR MEDICAL RECORD KEEPING COURSE

37. In July 2015, as part of his prior discipline with the Board, respondent completed a medical record keeping course through the UC San Diego School of Medicine's Physician Assessment and Clinical Education (PACE) Program. As part of the program, he provided his PACE evaluators with his handwritten medical charts. He could not remember if the evaluators critiqued his use of handwritten charts, or their legibility. However, he recalled they recommended he improve his handwriting.

38. Respondent did not recall reviewing the continuity of care as part of the medical record keeping course. However, he understands the continuity of care to mean when a patient transfers to another practice, the patient's care continues, and he sends a copy of the patient's medical record to the next provider. If asked, he will dictate or type his handwritten notes. If he becomes incapacitated, the next provider "would not be able to go back and refer to the records because they are illegible." That provider will conduct a physical examination and assessment, and "will look at the

lab reports, X-rays, and scans, and come to a conclusion," rather than referring to the previous provider's notes.

MAY 4, 2018 HANDWRITTEN PROGRESS NOTE

39. On January 9, 2019, respondent received a letter form the Board asking him to provide a typed version of his May 4, 2018 handwritten note because H.B. could not read the note and did not know his mother's diagnosis. He provided to the Board a longer, typed note that was not an exact transcription of his original handwritten note because English is not his first language, and he understood the Board's request as wanting him to send the progress note to H.B. in a form that H.B. could understand about his mother's treatment and diagnosis. He authored a longer, typed note to provide H.B. with a complete picture of what occurred during his mother's office visit. He acknowledged that the longer, typed note was not a word-for-word transcription of his original handwritten note.

40. Respondent then typed his original handwritten progress note of May 4, 2018, word-for-word, and provided it to his attorney prior to hearing. This typed note was substantially shorter than respondent's longer typed note provided to the Board and H.B. The word-for-word typed note contained medical abbreviations and misspellings, and did not clearly document Patient A's diagnosis. In contrast, respondent used complete sentences and provided more robust explanations and descriptions in his longer, typed note to the Board. Nonetheless, respondent contends that the information in his longer, typed note to the Board was not substantially different than the information in his original handwritten note.

MEETINGS WITH H.B.

41. Respondent testified that H.B. came to his office to pick up Patient A's medical records. H.B. wanted to speak to respondent and have respondent read his May 4, 2018 handwritten note to him. Respondent made an appointment for H.B. to come to the office on another date. H.B. returned and sat in the waiting room. Respondent greeted him and took him into one of the exam rooms. They sat down and respondent told H.B. that he was sorry for his loss. Respondent asked H.B. why he wanted respondent to read the record to him. He then asked H.B. if he was taking legal action against him. H.B. said yes. Respondent, thinking it would be unwise to talk to H.B. any further, told H.B. he would not be able to talk to H.B. and directed him to talk to an attorney. H.B. said thank you and left the room.

42. On the second occasion, H.B. dropped off an insurance form and death certificate for him to review. Respondent was uncomfortable filling out the form because of the threat of litigation and the "issue with the death certificate," which showed the cause of death as "pending toxicology." Respondent explained that he was unsure what happened to Patient A, her demise, and course of treatment, and that he was unable to fill out the form. When H.B. returned to his office to pick up the form, respondent greeted H.B. in the waiting room and said "hi." He told H.B. that he looked at the form and "could not fill it out for now." Respondent told H.B. to come back another time. Respondent asserted, "I was polite as I can be," and denied being rude to H.B.

RESPONDENT'S EXPERT – PHILIP E. BICKLER, M.D., PH.D.

43. Philip E. Bickler, M.D., Ph.D., is a board-certified Anesthesiologist. He has been licensed by the Board since 1988. Dr. Bickler received his medical degree in 1986

from the University of California, San Diego (UCSD) School of Medicine, and completed his residency in 1988 at the University of California, San Francisco (UCSF). Dr. Bickler received his Ph.D. in 1981 at the University of California Los Angeles, and completed postdoctoral fellowships at UCSD, Scripps Institution of Oceanography (1983), UCSD Department of Physiology (1985), and UCSF Cardiovascular Research Institute and Anesthesiology Research (1987).

44. Dr. Bickler is currently the Director of the Department of Anesthesia, Human Studies Laboratory at UCSF, and is also a Professor of Anesthesia at UCSF. He runs one of the largest laboratories in the world that test pulse oximeters, and advocates improvements in technology. Dr. Bickler last practiced internal medicine in the 1980s. He is not board-certified in internal medicine, hematology, or oncology.

45. Dr. Bickler reviewed respondent's medical records, the Board complaint, Dr. Johnson's expert report, the Board's January 9, 2019 letter, and respondent's response to that letter. Dr. Bickler memorialized his findings and opinions in a written report, dated June 3, 2021, and testified at hearing consistent with his report.

46. Dr. Bickler defined negligence as a doctor's failure "to use skill, knowledge, and care [that a] similarly competent physician [would use] to arrive at a diagnosis and treatment plan." Dr. Bickler opined that respondent's documentation is "not a standard of care issue," and that there is "clearly no negligence" because "it is evident from the records that respondent used the skill, care, and knowledge to arrive at an appropriate diagnosis and treatment of the patient." He opined that the standard of care related to medical documentation is that the doctor's diagnosis and plan must be legible. He conceded that respondent's original May 4, 2018 handwritten note is illegible.

47. In addition, Dr. Bickler opined that "substantially different amounts of information" in respondent's longer, typed note are not a deviation from the standard of care because the diagnosis and treatment are present in respondent's typed word-for-word transcription of his original handwritten note. Respondent's use of abbreviations and acronyms did not make a substantial difference in the diagnosis or treatment, and the longer, typed note "does not lead one to a different diagnosis or treatment." Dr. Bickler asserted that the "shorter [typed word-for-word] note and longer note are identical."

48. With respect to respondent's behavior towards H.B., Dr. Bickler specified in his report that H.B. was not a patient, and thus there was no physician/patient relationship. Absent that special relationship, "any unprofessional conduct claim would not apply to a Medical Board matter." However, at hearing, Dr. Bickler elaborated and provide examples where unprofessional conduct could be found even in the absence of a physician/patient relationship. For instance, it would be unprofessional conduct if: respondent had punched H.B.; a doctor barred a family member from coming to visit a patient because the family member is gay; or a doctor punched a scrub tech during surgery. In this case, however, Dr. Bickler opined that the lack of a physician/patient relationship precluded a finding of unprofessional conduct.

Letters of Support

49. Respondent provided two letters from medical practitioners who have referral relationships with respondent.

(a) Yash Gagan D. Singh Brar, M.D., is an internist who has had a referral relationship with respondent for 15 years. Respondent has sent over 100 hematology and oncology patients to Dr. Brar. Dr. Brar described respondent as "always available

for consultations, . . . regularly reports back to our office regarding the patient's status," and "continues to provide quality care to our patients."

(b) Jasbir Singh Kang, M.D., is an internist who has maintained a referral relationship with respondent for 25 years. Respondent has also sent hundreds of hematology and oncology patients to Dr. Kang. Dr. Kang described respondent as demonstrating "compassionate and caring" qualities with his patients and "does not turn away Medicaid or MediCal insureds despite inadequate reimbursement rates." Respondent regularly "takes consultations after hours." Dr. Kang has received complimentary comments about respondent's treatment and professional demeanor.

Analysis

MAY 4, 2018 PROGRESS NOTE

50. Complainant established by clear and convincing evidence that respondent's May 4, 2018 handwritten progress note, as well as his other handwritten notes in the record from 2013 to 2018, were illegible such that H.B. or any other physician could not understand them. The evidence further established that respondent inappropriately refused to read the note for H.B., and refused to complete the insurance form, because he was concerned about potential litigation.

MEDICAL EXPERTS

51. Dr. Johnson is board-certified in Internal Medicine, and is a Diplomat in Hematology and Medical Oncology. He works in a small practice with a partner and has hospital privileges. Dr. Johnson works in the same medical discipline with a similar practice as respondent. On the other hand, Dr. Bickler is a board-certified

Anesthesiologist who runs a laboratory and is a professor at UCSF. Thus, Dr. Bickler is not in the same or similar medical discipline or practice as respondent.

52. Both experts considered respondent's May 4, 2018 handwritten progress note to be illegible. Moreover, both experts correctly articulated the general standard of care and the definition of negligence. Dr. Johnson opined in his report that the standard of care for medical records is required use of electronic medical records as mandated by the federal government. He conceded at hearing that there are no federal or state mandates requiring electronic medical records, and that handwritten records are still acceptable. Therefore, respondent did not violate the standard of care by handwriting his notes.

53. Drs. Johnson and Bickler disagreed whether respondent's illegible May 4, 2018 handwritten note constituted a departure from the standard of care. Dr. Johnson asserted the note is illegible, and that the longer, typed note contains substantially more information. Therefore, both records are inadequate or inaccurate. Dr. Bickler, on the other hand, opined that respondent's documentation was not a standard of care issue, and that it was evident from the records that respondent used the skill, care and knowledge to arrive at an appropriate diagnosis and treatment of the patient. Dr. Bickler's focus was on diagnosis, care and treatment, rather than the form of the documentation memorializing the diagnosis, care and treatment. He conceded that a doctor's diagnosis and plan must be legible. Thus, respondent's illegible May 4, 2018 handwritten note departed from the standard of care.

In addition, when asked by the Board to provide a typed version of his May 4, 2018 progress note, respondent provided a much longer, "completely embellished, altered record . . . that did not look like anything resembling the [original] handwritten note." Dr. Johnson opined that this is concerning because later reviewers cannot rely

upon the longer, typed note as an accurate reflection of respondent's illegible handwritten note, or whether it has been altered from the original.

Dr. Bickler disagreed, opining that respondent's longer, typed note is not a deviation from the standard of care because the information in the longer, typed note and the shorter, typed word-for-word note are identical, and do not lead one to a different diagnosis and treatment. However, Dr. Bickler admitted that he could not read the original handwritten note, relying on the typed word-for-word version of that note that respondent provided to his attorney prior to hearing. But for this typed word-for-word version, Dr. Bickler would not have be able to make a comparison between the contents of respondent's original handwritten note and his longer, typed note. Dr. Johnson's analysis was more persuasive in this regard.

54. With regard to respondent's communication with H.B., Dr. Johnson opined that the standard of care is to encompass the entire family unit in the care and treatment of the patient because families have a vested interest in the care and treatment of their loved one. A physician has a responsibility to the family to provide support, comfort, and empathy. Dr. Johnson concluded that respondent violated the standard of care in this regard, by not cooperating with H.B. requests, and treating H.B. in an unprofessional and rude manner with his aggressive manner and raised voice.

Dr. Bickler opined that in order to allege unprofessional conduct, there must exist a physician/patient relationship. Here, H.B. was not a patient of respondent. Therefore, respondent cannot be charged with unprofessional conduct.

CONCLUSION

55. The testimony and opinions of the medical experts were carefully considered and weighed. Both experts are highly qualified and accomplished in their

respective fields. However, Dr. Johnson's opinions were more persuasive than Dr. Bickler's. He is in the same specialty as respondent, and Dr. Bickler is not. Although it may be argued that medical documentation and professionalism are general aspects of medical practice that any practitioner can provide an opinion on, Dr. Johnson interacts more with patients and families, while Dr. Bickler interacts mainly with medical students and laboratory scientists. Thus, Dr. Johnson has more insight into medical documentation and communication with patients and their families.

56. Dr. Johnson's opinion that the standard of care requires adequate and accurate documentation throughout the medical record is given greater weight. Dr. Bickler opined that the medical record is adequate and accurate if the diagnosis, treatment and care, are present in the record and readable. While that may be true, there are other types of information in a medical record that also must be adequate, accurate and readable. Respondent's illegible handwriting is unacceptable in a medical record, and he simply cannot continue this practice.

57. While respondent may understand his own handwriting, no one else can. Even his typed word-for-word transcription of his original handwritten note is difficult to understand by anyone outside of the medical field. It is understandable that English is not respondent's first language, and that he may have misinterpreted the Board's instructions in its January 9, 2019 letter. However, respondent has been licensed since 1992, and could have sought clarification with the Board on its instruction.

58. Respondent did not provide to the Board and H.B. an exact typed version of the May 4, 2018 progress note, rather, he provided an "embellished" one that had substantially different amounts of information from the original. Dr. Johnson persuasively concluded that respondent's long, typed version of the note he provided

to the Board and H.B. was inaccurate or inadequate. It is clear that his original handwritten note was both.

59. Dr. Johnson's opinion that respondent violated the standard of care by failing to encompass the family in the care and treatment of Patient A is given great weight. It is a good, prudent, and compassionate practice for a physician to provide support, comfort, and empathy, regardless of whether the physician is notified that he may be sued. A physician must display professionalism at all times, and not be colored by anger and defensiveness. Dr. Bickler's opinion that unprofessional conduct only applies when there is a physician/patient relationship is unsupported by the evidence, and nonsensical. His own examples of unprofessional conduct articulated at hearing did not involve a physician/patient relationship.

60. Respondent's letters of support from Drs. Brar and Kang describe respondent as a reliable practitioner who refers hundreds of patients to them. Their bias makes their letters less persuasive. Moreover, Drs. Brar and Kang did not express knowledge of the allegations in the Accusation, or whether they knew of respondent's previous Board discipline. Thus, the letters are given little weight.

61. Lastly, respondent completed a medical record keeping program through PACE on July 30 to 31, 2015, as required by the Board in a previous disciplinary case. Respondent could not remember anything about the course or share what he learned. He simply said, "they said to improve the handwriting." Respondent clearly did not do so, as demonstrated by his May 4, 2018 handwritten progress note.

62. Respondent failed to provide any insight into why his illegible handwritten notes are unacceptable forms of medical documentation, and did not express any motivation for improvement, stating that he does not know how to type,

and that dictation software cannot recognize his speech due to his accent. Interestingly, for his hematology and oncology patients, respondent dictates his notes and sends them to a transcription service, then sends the typed notes to referring physicians. This practice demonstrates that respondent is aware that he can incorporate dictation and transcription into the rest of his practice. In addition, respondent uses a voice recognition program at the hospital, which he can also incorporate into the rest of his practice if so inclined. The public safety will be served by respondent repeating a medical record keeping course.

APPROPRIATE DISCIPLINE

63. Respondent was charged in a previous case with failing to maintain adequate and accurate medical records, among other violations. Despite being given a second chance to improve his medical documentation, respondent has demonstrated he is not open to change or improvement in his medical record keeping related to his handwritten notes. Such obstinacy makes him a danger to the public. Furthermore, continuity of care is compromised, and patients and family members viewing his notes cannot read them.

64. The Board's Disciplinary Guidelines provide the recommended minimum and maximum penalties for Business and Professions Code violations. For violations of Business and Professions Code sections 2234 (general unprofessional conduct), 2234 subdivision (c) (repeated acts of negligence), 2266 (failure to maintain adequate and accurate records), the minimum penalty is stayed revocation and five years of probation with conditions designed to protect the public. The maximum penalty is revocation. Based on the totality of the evidence, the public protection is ensured by placing respondent's certificate on probation for five years, with terms and conditions.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The Medical Practice Act is set forth in Business and Professions Code section 2000 et seq. The purpose of the Medical Practice Act is to ensure the high quality of medical practice. (*Shea v. Bd. of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.)

Burden and Standard of Proof

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

Applicable Law

VIOLATIONS OF MEDICAL PRACTICE ACT

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

> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

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

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

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

UNPROFESSIONAL CONDUCT

4. Business and Professions Code section 2234 provides that the Board shall take action against any licensee found to have engaged in unprofessional conduct, which includes but is not limited to the following:

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

(b) Gross negligence.

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

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

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

(d) Incompetence.

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

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

NEGLIGENCE

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

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

RECORDS MAINTENANCE

7. Under Business and Professions Code section 2266, a licensee's failure to maintain adequate and adequate patient records also constitutes unprofessional conduct.

Causes for Discipline

8. Complainant established by clear and convincing evidence that respondent engaged in repeated acts of negligence and/or general unprofessional conduct, as set as set forth in Factual Findings 50 through 62. Therefore, cause exists to discipline respondent's certificate pursuant to Business and Professions Code section 2234, subdivisions (a) and (c).

9. Complainant established by clear and convincing evidence that respondent failed to maintain adequate and accurate records, as set as set forth in Factual Findings 50 through 62. Therefore, cause exists to discipline respondent's certificate pursuant to Business and Professions Code section 2266.

Conclusion

10. The objective of an administrative proceeding relating to licensing is to protect the public. Such proceedings are not for the primary purpose of punishment. (*Fahmy v. Medical Bd. of California* (1995) 38 Cal.App.4th 810, 817.) When all of the evidence is considered, public safety demands that respondent's certificate be placed on probation with appropriate terms and conditions.

ORDER

Physician's and Surgeon's Certificate No. A 50459, issued to respondent Madhu Jodhani, M.D., is revoked, the revocation is stayed, and respondent is placed on probation for five years on the following terms and conditions:

1. 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 months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the continuing medical education (CME) requirements for renewal of licensure.

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

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

2. 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 California Code of Regulations, title 16, 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 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 year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this

condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

3. Notification

Within seven days of the effective date of this Decision, respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

4. Supervision of Physician Assistants

During probation, respondent is prohibited from supervising physician assistants.

5. 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.

6. 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 no later than 10 calendar days after the end of the preceding quarter.

7. General Probation Requirements

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision, including:

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 to 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 of 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 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.

8. 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.

9. 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 in California 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 or its designee shall not be considered non-practice. 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 a clinical training 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 years.

10. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) no later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

11. 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.

12. License Surrender

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

13. 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.

DATE: August 27, 2021

Danette C. Brown

DANETTE C. BROWN

Administrative Law Judge

Office of Administrative Hearings

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Attorneys for Complainant

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

In the Matter of the Accusation Against:	Case No. 800-2018-045892
Madhu Jodhani, M.D. P.O. Box 1224 Yuba City, CA 95992 Physician's and Surgeon's Certificate No. A 50459, Respondent.	**ACCUSATION**

PARTIES

1. William Prasifka ("Complainant") brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about February 25, 1992, the Medical Board issued Physician's and Surgeon's Certificate Number A 50459 to Madhu Jodhani, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2021, unless renewed.

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JURISDICTION

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

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

5. Section 2234 of the Code, states in pertinent part:

> 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.
>
> ...
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> ...

6. Section 2266 of the Code, states in pertinent part:

> The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

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FACTUAL ALLEGATIONS

7. On or about May 4, 2018, Patient A[1] saw Respondent for a complaint of cough. The Respondent prescribed medications and treated her cough. The Respondent documented his May 4, 2018, visit with Patient A in a handwritten progress note. In addition, between December 23, 2013, and May 4, 2018, Respondent documented a series of other handwritten progress notes documenting Patient A's care. All of the progress notes, including the May 4, 2018, notes are illegible. The May 4, 2018, progress note appears to contain 47 words and/or abbreviations. A reader is unable to learn about Patient A's health complaints, Respondent's plans of treatment and any other medically relevant information that would shed light on Respondent's treatment of Patient A between December 23, 2013, and May 4, 2018.

8. On May 7, 2018, Patient A died. Approximately four weeks after Patient A's death, Patient A's son, Witness B, obtained Patient A's medical records from Respondent's medical office. Witness B discovered that the medical records were illegible. On or about June 2018, Witness B went to Respondent's office to have Respondent decipher the May 4, 2018, progress note. Witness B waited until Respondent was finished with his final appointment of the day and met with the Respondent. Witness B asked Respondent to decipher his progress note from May 4, 2018. Respondent asked Witness B why he was asking those questions and Witness B stated he wanted to know Respondent's diagnosis. Respondent abruptly told Witness B to hire an attorney and Witness B left his office.

9. On July 9, 2018, Witness B returned to Respondent's medical office and dropped off a Primary Care Physician's Statement and a copy of Patient A's death certificate for completion of a life insurance form. On or about July 12, 2018, Witness B returned to Respondent's clinic and patiently waited to see Respondent. Respondent's receptionist had told Witness B earlier in the day that Respondent would not fill out the form without first seeing the autopsy report. In between patients, Respondent approached Witness B and told him that he was not required to complete the form. Witness B requested a reason why Respondent was not required to complete

[1] Patient and Witness names have been made confidential to protect privacy. All witnesses will be fully identified in discovery.

the form. The Respondent angrily stated that he is not required to complete the form, the form does not apply to his work, and, in a rude tone, that Witness B needed to leave his office and never come back.

10. Witness B made a complaint to the Board regarding Respondent's record keeping and rude interactions. On or about September 26, 2018, and October 8, 2018, the Medical Board requested a summary of care from Respondent and a copy of Patient A's certified medical records. On or about October 18, 2018, Respondent provided a summary of care and Patient A's certified medical records. On or about January 9, 2019, the Board requested that Respondent provide a typed version of the May 4, 2018, progress note. On or about January 21, 2019, Respondent provided an undated typed progress note for the May 4, 2018, visit with Patient A that contained more than 200 typed words.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligence) and/or General Unprofessional Conduct

11. Respondent's license is subject to disciplinary action under section 2234, subdivision[s] a & (c), in that he committed repeated negligence. The circumstances are as follows:

12. Complaint realleges paragraphs 7 through 10, and those paragraphs are incorporated by reference as if fully set forth herein.

13. Respondent committed the following negligent acts during the care and treatment of Patient A: and/or general unprofessional conduct in the following ways:

a) by keeping inadequate and inaccurate medical records for Patient A;

b) by providing a typed version of the May 4, 2018, progress note to the Board that contained substantially different amounts of information than was contained in the original handwritten note; and,

c) by treating Witness B in a rude and unprofessional matter.

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SECOND CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Medical Record Keeping)

14. Respondent's license is subject to disciplinary action under section 2266, in that he committed repeated acts of keeping inadequate and inaccurate medical records. The circumstances are as follows:

15. Complaint realleges paragraphs 7 through 10, and those paragraphs are incorporated by reference as if fully set forth herein.

DISCIPLINARY CONSIDERATIONS

16. To determine the degree of discipline, if any, to be imposed on Respondent Madhu Jodhani, M.D., Complainant alleges that on or about April 9, 2015, in a prior disciplinary action titled, *In the Matter of the Accusation Against Madhu Jodhani, M.D.*, before the Medical Board of California, in Case Number 02-2012-226060, Respondent's license was publically reprimanded pursuant to Business and Professions Code section 2227, subdivision(a)(4) as follows:

> "An investigation by the Medical Board of California revealed that you failed to maintain an office with sufficient emphasis on cleaning and disinfection of surfaces most likely to come in close proximity to patients, and failed to label chemotherapy solutions with the patient's name, the drug name, the administration route, lot number, total volume of administrative of the dose, and the time and date of administration of the preparation. These actions are in violation of California Business and Professions Code section 2234(a), violation of the Medical Practice Act."

As part of the public reprimand, the Board ordered Respondent to complete a Medical Record Keeping Course and a Prescribing Practices Course. That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 50459, issued to Madhu Jodhani, M.D.;

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

3. Ordering Madhu Jodhani, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: NOV 0 6 2020

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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