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

In the Matter of the Accusation Against: Terry Wesley Scott, M.D. Physician's and Surgeon's Certificate No. G 54536 Respondent.	Case No.: 800-2016-028178

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 24, 2021.

IT IS SO ORDERED: October 26, 2021.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

BEFORE THE
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DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

TERRY WESLEY SCOTT, M.D.

Physician's and Surgeon's Certificate No. G 54536,

Respondent.

Case No. 800-2016-028178

OAH No. 2020100540

PROPOSED DECISION

Julie Cabos Owen, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on August 9, 10, and 11, 2021. William Prasifka (Complainant) was represented by Brian D. Bill, Deputy Attorney General. Terry Wesley Scott (Respondent) was represented by Henry Fenton and Alexandra de Rivera, with Fenton Law Group.

At the hearing, the ALJ was provided with Exhibits 3, 4, 5, 6, 7, 10 (pages 588-605), and A (pdf pages 7-10, and 69-80), which all contained confidential information protected from disclosure to the public. Redaction of the documents to obscure this information was not practicable and would not provide adequate privacy protection.

To prevent the disclosure of confidential information, concurrent with the issuance of this Proposed Decision the ALJ issued a Protective Order providing that the Exhibits 3, 4, 5, 6, 7, 10 (pages 588-605), and A (pdf pages 7-10, and 69-80), shall be placed under seal following their use in preparation of the Proposed Decision. These exhibits shall remain under seal and shall not be opened, except by order of the Medical Board of California (Board), by OAH, or by a reviewing court. A reviewing court, parties to this matter, their attorneys, or a government agency decision maker or designee under Government Code section 11517 may review the documents subject to this order provided that such documents are protected from release to the public.

Testimony and documents were received in evidence. The record closed and the matter was submitted for decision on August 11, 2021.

FACTUAL FINDINGS

Jurisdictional Matters

1. On April 8, 1985, the Board issued Physician's and Surgeon's Certificate Number G 54536 to Respondent. Complainant alleges the license was scheduled to expire on April 30, 2021, and there was no evidence to indicate whether the license has been renewed. However, the Board retains jurisdiction over this matter pursuant to Business and Professions Code section 118, subdivision (b).

2. On September 19, 2019, Complainant filed the Accusation while acting in his official capacity as the then Executive Director of the Board. Respondent filed a Notice of Defense, and this hearing ensued.

Treatment of Patient 1[1]

3. On May 24, 2013, Patient 1 sought treatment from Respondent for difficulty with breathing through her nose. Patient 1 reported bilateral nose congestion, rhinorrhea, post-nasal drip, facial pressure/pain, headaches, and resulting problems sleeping for 15 to 20 years. Patient 1 reported no prior nasal surgeries, but she had been previously treated with numerous antibiotics and decongestants. Patient 1 reported five to six episodes of sinusitis per year and a persistent nasal infection for over five months. Respondent performed a physical examination and noted Patient 1's septum was "midline." (Exhibit 4, p. 56.[2]) Respondent diagnosed Patient 1 with chronic ethmoid sinusitis, chronic frontal sinusitis, hypertrophy of the nasal turbinates, allergic rhinitis. Respondent also diagnosed Patient 1 with a "deviated nasal septum" (*Id.* at p. 57), despite having previously noted on physical examination that Patient 1's septum was midline. Respondent prescribed regular nasal washes, Ceftin (an oral antibiotic) and Flonase (a steroidal nasal spray). Respondent also ordered allergy testing, a CT scan of the patient's sinuses, tympanometry (an acoustic test of middle-ear function), and rhinomanometry (a test of nasal air pressure and airflow rate).

4. On May 30, 2013, Patient 1 returned, and Respondent performed the ordered tests. Respondent conducted a physical examination and documented a "midline" septum. (Exhibit 4, p. 65.) Respondent's diagnoses remained the same except, at this appointment, Respondent did not diagnose Patient with a deviated

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[1] Patients are identified by numbers to protect their privacy.

[2] The pagination used by Complainant is found at the top right portion of the page, designated "Complainant's Trial Exhibits Page _."

septum. The treatment plan included continued nasal irrigation and medications, and to "plan a surgical date." (Exhibit 4, p. 67.)

5. On June 6, 2013, Patient 1 was seen by Respondent during a follow-up appointment. Respondent noted "no improvement with med[ications]." (Exhibit 4, p. 68.) Respondent documented that Patient 1's septum was deviated 90% to the right, and his diagnosis included deviated nasal septum. Respondent performed a nasal endoscopy. During that June 6, 2013 endoscopy, Respondent found "the inferior and middle turbinates were enlarged" bilaterally, and he noted "the ostium of Ethmoid and Maxillary sinus had pur[u]lent deb[r]is extruding in the middle meatus." (*Id.* at p. 74.) Respondent continued Patient 1's prescription for Ceftin, and he also prescribed Medrol. Respondent did not document his rationale for changing medications.

6. On June 13, 2013, Patient 1 was again seen by Respondent. During this appointment, Respondent noted that Patient 1's septum was deviated 90% to the right, and his diagnosis included a deviated nasal septum. Respondent performed a bilateral turbinate steroid injection.

7A. On June 28, 2013, Patient 1 was seen by Respondent for a follow-up appointment. On physical examination, Respondent documented a "midline" septum. (Exhibit 4, p. 75.) During this appointment, Respondent did not diagnose Patient 1 with a deviated septum. Respondent diagnosed Patient 1 with hypertrophy of the nasal turbinates, allergic rhinitis, and chronic maxillary sinusitis. The treatment plan included the following nasal surgical procedures: "30140 submucous resection turbinate partial," "30130 excision turbinate, partial/complete," "30117 excision/destruction, intranasal lesion," and "30930 FX nasal turbinate(s), therapeutic." (*Id.* at p. 77.) Respondent prescribed Augmentin (an antibiotic) and Flonase. Respondent failed to document his rationale for changing medications.

7B. On June 28, 2013, Patient 1 signed a consent form for the following listed procedures: "Nasal Bilateral Endoscopy, Submucous Resection of Inferior Turbinate via KTP laser, Fractionate Inferior Turbinate, Excision Degenerative Nasal Mucosa, Excision of Middle Turbinate." (Exhibit 4, pp. 84-85.)

8A. On July 5, 2013, Respondent performed several surgical procedures on Patient 1. In a July 5, 2013 operative report, Respondent documented that he performed submucousal resection of the left inferior turbinate, excision of degenerative nasal mucosa on the left, and infracturing of the right inferior turbinate. Respondent set forth the indications for surgery as follows:

> This is a 45-year-old female who notes nasal obstruction, rhinorrhea, postnasal drip, facial pressure, pain, headaches, medial canthal pain, and medial eminence pain. The patient notes the problem to be persistent and ongoing over the last 5 years getting progressively worse. She had been treated with numerous antibiotics, decongestants and topical steroid sprays. Headache has been persistent and ongoing. Infection has been persistent for 4 months. She was treated for a period of 6 weeks with antibiotic. Thus, she was taken to the operating room for the above procedure.

(Exhibit 4, p. 89.)

8B. In a section of the operative report describing the "Procedure in Detail," Respondent documented:

The patient was placed on the table supine, prepped and draped in standard fashion, and placed under general anesthesia. Then, 300 mg of cocaine on wire-tip applicators soaked in Afrin was used to cocainize the right and left nasal cavity. The wire-tip applicators were left in place for 4 to 5 minutes and then removed.

The operating microscope was brought in the surgical field. Visualization of the inferior turbinate on the left side was noted. Here, an incision was carried out along the longitudinal axis along the lateral border, along the anterior 1/3 and middle 2/3. Incision was carried down through the turbinate mucosa to the region of the concha bone. Elevation of turbinate mucosa from concha bone was carried out using Freer elevator. Straight-biting forceps was used to resect small portions of concha bone and anterior turbinate mucosa. Then, polypoid degenerative nasal mucosa on the left side was excised and vaporized because it was obstructing the nasal cavity on the left. The inferior turbinate on the right side was then infractionated laterally 2 to 3 mm and the procedure was terminated.

The patient was awakened and taken to the recovery room up to be discharged home and to follow up in one week.

(Exhibit 4, p. 89.)

8C. In a separate July 5, 2013 operative report, Respondent documented that he performed a laser excision of the left middle turbinate. In a section of that report describing the "Procedure in Detail," Respondent did not repeat the documentation of patient prep and anesthesia administration as noted in the main July 5, 2013 operative report. Instead, Respondent merely documented:

> A fiberoptic cord attached to the KTP laser was inserted into the left middle turbinate mucosa down to the region of bone. Energy was emitted at 4 continuous watts along the longitudinal axis of the middle turbinate along the inferior and lateral borders.

(Exhibit 4, p. 91.)

8D. Respondent sent a specimen (left inferior turbinate) for pathology analysis. The surgical pathology report indicated no significant tissue abnormality.

9. On July 12, 2013, Patient 1 was treated by Respondent during a post-surgical follow-up appointment. Respondent documented "septum deviated right." (Exhibit 4, p. 94.) Respondent diagnosed Patient 1 with a deviated nasal septum.

10A. On July 23, 2013, a CT scan was performed by a different healthcare provider. The scan showed a mild right-sided nasal septal deflection, with "clear" paranasal sinuses. (Exhibit 4, p. 100.)

10B. On July 23, 2013, Patient 1 was seen by Respondent during a follow-up appointment. Respondent performed a nasal endoscopy. During that July 23, 2013 endoscopy, Respondent found "the inferior and middle turbinates were enlarged on the right," and he noted "the ostium of Ethmoid and Maxillary sinus had pur[u]lent

deb[r]is extruding in the middle meatus." (Exhibit 4, p. 105.) The July 23, 2013 endoscopy report had identical typographical errors as the June 6, 2013 endoscopy report (e.g., "purlent debis"). Respondent did not obtain a culture of the purulent debris.

10C. During the July 23, 2013 endoscopy, Respondent noted the patient's septum was deviated 90 percent to the right. Respondent documented in a separate portion of the treatment record for that day that Patient 1 had a midline septum. During this visit, Respondent did not diagnose Patient 1 with a deviated septum.

10D. On that date, Respondent discussed surgery with Patient 1, and he documented the plan for the following procedures: "30140 submucous resection turbinate partial," "31255 nasal/sinus endoscopy, surgical; with ethmo," and "31267 nasal/sinus endoscopy, surgical; with maxil." (Exhibit 4, p. 104.)

10E. On July 23, 2013, Patient 1 signed a consent form for the following listed procedures: "Nasal Bilateral Endoscopy, Submucous Resection of Inferior Turbinate via KTP laser, Fractionate Inferior Turbinate, Excision Degenerative Nasal Mucosa, Excision of Middle Turbinate." (Exhibit 4, pp. 116-117.) This consent form listed procedures identical to the procedures for which the patient consented on June 28, 2013, for her July 5, 2013 surgery.

11A. On July 29, 2013, Respondent performed bilateral functional endoscopic sinus surgery on Patient 1, including a total ethmoidectomy, septal reconstruction, and submucous resection of the right inferior turbinate. Respondent documented that the ethmoid sinuses were open bilaterally, but he did not document any issue with the maxillary sinuses.

11B. In a July 29, 2013 operative report, Respondent set forth the indications for surgery as follows:

> This is a 45-year-old female, who notes a history of nasal obstruction rhinorrhea, postnasal drip, facial pressure pain and headaches. The patient notes significant septal deviation on the right. The patient has also had persistent problems over the last 4-5 years getting progressively worse. The patient has been treated with numerous antibiotics, decongestants topical steroid sprays. In light of all the above patient's problems are persistent and ongoing. The patient is taken to the operating room for the above procedure.

(Exhibit 4, p. 121.)

11C. Respondent documented taking "specimens of right and left ethmoid, septal cartilage, right inferior turbinate." (Exhibit 4, p. 122.) However, there was no corresponding surgical pathology report contained in Patient 1's records.

12. On August 5, 2013, Patient 1 was seen by Respondent for a follow-up appointment. Respondent documented the patient's "septum midline bilaterally, silastic splints in place" (Exhibit 4, p. 135), but he also diagnosed Patient No. 1 with a deviated nasal septum.

13. On August 14, 2013, Patient 1 was again seen by Respondent, and he performed a nasal endoscopy. During that August 14, 2013 endoscopy, Respondent found "the inferior turbinates were enlarged on the left," and he noted "the ostium of Ethmoid and Frontal sinus had pur[u]lent deb[r]is extruding in the middle meatus."

(Exhibit 4, p. 141.) The August 14, 2013 endoscopy report contained identical typographical errors as the June 6, 2013 and July 23, 2013 endoscopy reports for Patient 1 (e.g., "purlent debis"). Respondent did not obtain a culture of the observed purulent debris. Respondent documented his plan to prescribe Medrol and Ceftin. However, another part of the medical chart indicates Medrol and Augmentin were prescribed on August 14, 2013.

14. On August 15, Respondent provided a certification for Patient 1's employer regarding her need for medical leave from July 29, 2013, until October 7, 2013. The form also noted the patient had "sinus surgery scheduled 9/23/13." (Exhibit 4, p. 126.)

15. On September 19, 2013, Patient 1 was seen by Respondent during a pre-operative examination. On physical examination, Respondent documented a midline septum, but diagnosed Patient 1 with a deviated nasal septum.

16. On September 19, 2013, Patient 1 signed a consent form for the following listed procedures: "Nasal Bilateral Endoscopy, Submucous Resection of Inferior Turbinate via KTP laser, Fractionate Inferior Turbinate, Excision Degenerative Nasal Mucosa, Excision of Middle Turbinate." (Exhibit 4, pp. 160-161.) This consent form listed identical procedures for which the patient consented on June 28, 2013 (for her July 5, 2013 surgery), and for which the patient consented on July 23, 2013 (for her July 29, 2013 surgery).

17. On September 26, 2013, Respondent performed the following surgical procedures on Patient 1: bilateral frontal sinus surgery, ethmoidectomy, submucous maxillary sinusotomies, submucosal resection of the left inferior turbinate. Respondent documented that scar and granulation tissue "had closed down to the opening on the

ethmoid sinuses," and "the opening into the frontal sinus had had closed down secondary to granulation tissue." (Exhibit 4, p. 167.) Respondent reopened the blocked sinuses. Respondent sent a specimen (i.e., left ethmoid sinus) to pathology, and the pathology report indicated benign nasal and sinus tissue.

18. On October 7, 2013, Patient 1 was seen by Respondent for a follow-up appointment. On physical examination, Respondent documented a midline septum, but he diagnosed Patient 1 with a deviated septum.

19. Respondent's medical chart for Patient 1 contained numerous discrepancies in the documentation of the status of her nasal septum. During the course of treatment, Respondent documented both a midline septum (seven times) and a deviated septum to the right (eight times). (Factual Findings 3, 4, 5, 6, 7, 10C, 12, 15, and 18.)

Treatment of Patient 2

20. On November 22, 2013, Patient 2 sought treatment with Respondent for snoring and headaches. She also complained of nasal congestion, post-nasal drip, and facial pressure for 20 years. Respondent performed a physical examination and documented the patient's nasal mucosa as "degenerative, polypoid and thick," and bilateral turbinates as "boggy," with "edema" and "erythema" (i.e., swollen with redness). (Exhibit 5, p. 196.) Respondent documented no abnormal findings regarding Patient 2's tonsils. The patient reported she was allergic to penicillin. Respondent diagnosed Patient 2 with chronic ethmoidal sinusitis, chronic frontal sinusitis, turbinate hypertrophy, allergic rhinitis, obstructive sleep apnea, and hypersomnia (i.e., excessive daytime sleepiness). Respondent prescribed regular nasal washes, Ceftin, and Flonase.

He also ordered allergy testing, a CT scan of the sinuses, tympanometry, and rhinomanometry.

21. On December 3, 2013, another provider performed a CT scan of Patient 2's sinuses. The CT scan showed "chronic sinusitis of the left with a mucous retention cyst" measuring 17 by 14 millimeters. (Exhibit 5, p. 201.) The remaining sinuses appeared clear.

22. On December 3, 2013, Respondent saw Patient 2 for a follow-up appointment. Respondent documented Patient 2's persistent sinus infection for which she was previously prescribed multiple antibiotics and decongestants for more than six weeks without improvement. Respondent did not document the specific antibiotic previously prescribed, the identity of the prescriber, or the dates of use. Respondent conducted a physical examination which again showed boggy turbinates. Respondent diagnosed Patient 2 with chronic ethmoidal sinusitis, chronic maxillary sinusitis, turbinate hypertrophy, and allergic rhinitis. Respondent performed a Kenalog (steroid) injection into the turbinates. He also prescribed Augmentin and Medrol. Respondent failed to document his rationale for changing antibiotic medication (particularly to penicillin-class Augmentin in light of the patient's penicillin allergy) and for adding Medrol.

23. On December 8, 2013, a sleep study was performed and found no apnea or sleep-related breathing disorder.

24A. On December 24, 2013, Respondent again saw Patient 2. On that date, Respondent discussed surgery with Patient 2, and he documented the plan for the following procedures: "30140 submucous resection turbinate partial," "30130 excision

turbinate partial/complete," "30117 excision/destruction paranasal lesion," and "30930 fx nasal turbinates, therapeutic." (Exhibit 5, p. 214.)

24B. On December 24, 2013, Patient 2 signed a consent form for the following listed procedures: "Nasal Bilateral Endoscopy, Submucous Resection of Inferior Turbinate via KTP laser, Fractionate Inferior Turbinate, Excision Degenerative Nasal Mucosa, Excision of Middle Turbinate." (Exhibit 5, pp. 223.) This consent form for Patient 2 listed identical procedures as the consents for the variety of procedures for which the Patient 1 consented on June 28, 2013 (for her July 5, 2013 surgery), on July 23, 2013 (for her July 29, 2013 surgery), and on September 19, 2013 (for her September 26, 2013 procedure).

25A. On December 28, 2013, Respondent performed several surgical procedures on Patient 2. In a December 28, 2013 operative report, Respondent documented that he performed submucosal resection of the left inferior turbinate, excision of polypoid degenerative nasal mucosa on the left, and fractionating of the right inferior turbinate. In a section of the operative report describing the procedure, Respondent documented:

> The patient was placed on the table supine, prepped and draped in standard fashion, [and] placed under general anesthesia. After which time, 300 mg of cocaine and wide tip applicator soaked in Afrin were used to cocainize the right and left nasal cavity. The wide tip applicator was left in place for four to five minutes and then removed. After which time period, zero degree nasal endoscope was brought into the surgical field. After which time period, operative microscope was brought into surgical field. [A]n

> incision was carried out along the longitudinal axis of the inferior turbinate, along the lateral border, along the anterior one third, and middle two thirds. Incision was carried down through turbinate mucosa to the region of the concha bone. Elevation of the turbinate mucosa from conchal bone was carried out using freer elevator. Straight biting forceps were used to resect small portions of concha bone and anterior turbinate mucosa on the left. Polypoid degenerative nasal mucosa was excised and vaporized using KTP laser at 4 continuous watts because it was obstructing the nasal cavity on the left. The inferior turbinate on the right was then fractionated laterally and the procedure was terminated. Needle and sponge count was correct. The patient was awakened and taken to the recovery room to be discharged home. Follow up in one week.

(Exhibit 5, p. 230.)

25B. In a separate December 28, 2013 operative report, Respondent documented that he performed excision of the left middle turbinate. In a section of that report describing the procedure, Respondent did not repeat the documentation of patient prep and anesthesia administration as noted in the main December 28, 2013 operative report. Instead, Respondent merely documented:

> A fiber optical was attached. KTP laser was inserted into the left middle turbinate-mucosa down to the region of bone. Energy was admitted [*sic*] at 4 continuous watts along the

longitudinal axis of the middle turbinate, along the inferior and lateral borders.

(Exhibit 5, p. 231.)

25C. Respondent sent a specimen (i.e., left inferior turbinate) to pathology for analysis. The surgical pathology report indicated chronic inflammation.

26. On January 8, 2014, Respondent saw Patient 2 during a follow-up visit. Respondent performed a nasal sinus debridement. He prescribed Ceclor (an antibiotic) and Flonase.

27A. On February 3, 2014, Respondent saw Patient 2 in a follow-up visit. Respondent documented that Patient 2 complained of right nasal congestion, problems sleeping since the surgery, and no improvement despite medications. On physical examination, Respondent noted "right nasal mucosa degenerative, polypoid and thick," and right turbinates "boggy, edema, erythema." (Exhibit 5, p. 243.)

27B. On that date, Respondent discussed surgery with Patient 2, and he documented the plan for the following procedures: "30140 submucous resection turbinate partial," "31255 nasal/sinus endoscopy, surgical; with ethmo," and "31267 nasal/sinus endoscopy, surgical; with maxil," and "31276 nasal/sinus endoscopy, surgical; with fronta." (Exhibit 5, p. 244.)

27C. On February 3, 2014, Patient 2 signed a consent form for the following listed procedures: "Nasal Bilateral Endoscopy, Submucous Resection of Inferior Turbinate via KTP laser, Fractionate Inferior Turbinate, Excision Degenerative Nasal Mucosa, Excision of Middle Turbinate." (Exhibit 5, pp. 223.) This consent form for Patient 2 listed identical procedures as the consents for the variety of procedures for

which the Patient 1 consented on June 28, 2013 (for her July 5, 2013 surgery), on July 23, 2013 (for her July 29, 2013 surgery), and on September 19, 2013 (for her September 26, 2013 procedure), and was also identical to Patient 2's consent signed on December 24, 2013 (for her December 28, 2013 procedure).

27D. During that visit, Respondent also performed a nasal endoscopy. During that February 3, 2014 endoscopy, Respondent found "the inferior and middle turbinates were enlarged on the right," and he noted "the ostium of Ethmoid and Frontal sinus had pur[u]lent deb[r]is extruding left > right in the middle meatus." (Exhibit 5, p. 246.) Patient 2's February 3, 2014 endoscopy report had identical typographical errors as Patient 1's the June 6, 2013 and July 23, 2013 endoscopy reports (e.g., "purlent debis"). Respondent did not obtain a culture of the purulent debris. Respondent prescribed Zithromax (an antibiotic).

28. On February 6, 2014, Respondent again performed surgery on Patient 2. In his operative report, he listed the procedures he performed to include: "maxillary sinusotomy with polyp removal," "ethmoidectomy total," and "submucosal resection of the inferior turbinate on the right." (Exhibit 5, p. 256.) Respondent noted the following specimens removed during the procedure: "right and left ethmoid, right and maxillary, and right inferior turbinate." (*Ibid.*) In the body of his operative report, Respondent documented removing "polypoid material" from the maxillary sinus. (*Id.* at p. 257.) He also noted, "There is a significant amount of purulent material was noted [*sic*] in the middle meatus on the left opening into the ethmoid sinuses[.] [N]oted polypoid material and purulent material was extracted. . . ." (*Ibid.*) Respondent took no cultures of the documented purulent material. There was no surgical pathology report contained in Patient 2's records regarding the specimens removed during the February 6, 2014 procedure.

29. On February 14, 2014, Respondent saw Patient 2 for a follow-up visit. Respondent performed a bilateral sinus debridement. Respondent prescribed Ceftin and Pulmicort.

30. On June 2, 2014, Patient 2 presented with complaints of sore throat beginning four days prior. Patient 2 reported suffering recurrent sore throats, approximately two to three times per year. On physical examination, Respondent noted Patient 2's tonsils were enlarged, tender to palpation, red, swollen, and covered in a white coating. Respondent's diagnoses included chronic tonsillitis. Respondent prescribed Norco (an opioid analgesic), Cipro (an antibiotic), and Medrol.

31. On June 30, 2014, Patient 2 presented with continuing complaints of a sore throat. Respondent documented that Patient 2 had a recurrent sore throat, about four to five times a year, with the most recent episode beginning about one week prior. Patient 2 signed a consent for a tonsillectomy.

32. On July 8, 2014, Respondent performed a bilateral tonsillectomy on Patient No. 2.

33. On July 14, 2014, Respondent saw Patient 2 during a one-week post-surgery follow-up visit. Respondent documented that Patient 2 had a white coating on her throat, consistent for post tonsillectomy patients.

34. On July 21, 2014, Patient 2 was seen by Respondent for a follow-up visit. The patient complained of sore throat and intermittent headaches along the malar region. Respondent documented bilateral boggy turbinates and nasal mucosa, as well as swollen, red tonsils with a white coating. Respondent prescribed Ceftin.

35. On August 11, 2014, Respondent saw Patient 2 during a one-month post-operative visit. Patient 2 reported a persistent sore throat since surgery. She also complained of intermittent headaches and nasal congestion. Respondent again documented bilateral boggy turbinates and nasal mucosa, as well as swollen, red tonsils with a white coating. Respondent took no culture of the observed white coating. Respondent also noted tonsil "remnants." (Exhibit 5, p. 300.) Respondent prescribed Ceclor and Medrol. Respondent also ordered a sinus CT scan.

36. On October 3, 2014, Patient 2 presented with a chief complaint of a "knot" in the side of her neck for two days. Respondent performed a physical exam and documented bilateral boggy turbinates and nasal mucosa, as well as swollen, red tonsils with a white coating. Respondent took no culture of the observed white coating. Respondent prescribed Cipro and Norco. Respondent again noted the plan to obtain a sinus CT scan.

37. On October 24, 2014, Patient 2 underwent a CT scan. The October 24, 2014 CT scan report noted a "1.2 cm polyp versus mucous retention in the left maxillary sinus." (Exhibit 5, p. 318.) The CT scan results were otherwise clear.

38. On October 31, 2014, Patient 2 returned to Respondent with the same continuing complaints. Patient 2 signed a consent for a tonsillectomy. She also signed a consent form for the following listed procedures: "Nasal Bilateral Endoscopy, Submucous Resection of Inferior Turbinate via KTP laser, Fractionate Inferior Turbinate, Excision Degenerative Nasal Mucosa, Excision of Middle Turbinate." (Exhibit 5, pp. 331-332.) This consent form listed procedures identical to the consents for the variety of procedures for which the Patient 1 consented on June 28, 2013 (for her July 5, 2013 surgery), on July 23, 2013 (for her July 29, 2013 surgery), and on September 19, 2013 (for her September 26, 2013 surgery), and for which Patient 2 consented on December

24, 2013 (for her December 28, 2013 surgery), and on February 3, 2014 (for her February 6, 2014 surgery).

39. On November 11, 2014, Respondent again performed surgery on Patient 2. In his operative report, he listed the procedures he performed to include: "bilateral functional endoscopic sinus surgery, maxillary . . . sinusotomy with polyp removal, submucosal resection of the inferior turbinate on the left, and tonsillectomy" which involved removal of right and left tonsil remnants. (Exhibit 5, p. 340.) Respondent also documented the removal of "granulation tissue and polypoid material" that blocked Patient 2's maxillary sinus. (*Id.* at p. 341.) Respondent also removed small portions of conchal bone during the submucosal resection. Respondent noted the following specimens removed during the procedure: "right and left tonsils, right and left maxillary sinus, and inferior turbinate on the left." (*Id.* at p. 340.) In Patient 2's medical records, there was no surgical pathology report regarding the specimens removed during the November 11, 2014 procedure.

Respondent's Typical Practices

STAGING PROCEDURES

40. The Board subsequently interviewed Respondent in September 2018.

41A. During the 2018 Board interview, Respondent revealed it is his regular practice to "stage" turbinate procedures to be performed first on one side of the patient's nose, with a later-scheduled surgery on the opposite side. Specifically, when discussing Patient 1's May 30, 2013 visit, Respondent stated:

> And I looked at her testing, and at this time period I planned that we were going to go in and shrink the

> turbinates. We were going to do turbinate on one side. I usually stage it out. I do one side, then I come back and I do the other side. I do the worse side of her turbinates first. And that is usually the worst side that the patient complains of. . . . So that is the side we planned to do at that time period.

(Exhibit 7, p. 414, lines 1-11, emphasis added.)

41B. Given Respondent's use of the word "usually," it is apparent that his usual practice is to stage out his procedures. Additionally, Respondent's explanation for staging procedures confirmed his global use of the practice rather than just for Patient 1. Respondent acknowledged that staging turbinate procedures is not a common approach, but it is a practice he has followed for 20 years. Specifically:

> [Q:] Is there a reason why you don't do both at the same time?
>
> [A:] Yes. A very good reason. When I was trained to do this 20 years ago, the only thing we had to reduce was turbinates. . . and . . . the only thing we had at that time period was . . . the laser procedure. . . . When I first started doing it, I was doing both sides. And the guy, the who told . . . me about this said, nah, don't do both sides. They're going to complain. The patient's going to be just a pain in the ass afterwards. . . . They were just miserable. . . . With the laser, that tissue sloughs and it totally obstructs the nose and it stays that way for about six to seven days. . . .

> So I said, he says, just do one side at a time. They do much better, they get back to work, they won't be complaining. You've always got one side open. They get back to work. They'll always – you'll always – have one side open. So once I started doing one side, I've always stayed with one side. And patients really really appreciate you for doing it. . . . When you do one side, you always have one side open. And you have a much more happy, compliant patient.

(Exhibit 7, p. 415, lines 5-12, 23-25, p. 416, lines 1-25; p. 417, line 1, emphasis added.)

41C. Respondent also confirmed his practice of staging has remained same, as follows:

> [Q:] And medically has anything changed as far as the best strategy to do these types of surgeries? Whether it is better to do one at a time, or to do both of them at the same time?
>
> [A:] Medically, no.

(Exhibit 7, p. 417, lines 9-14.)

41D. When asked later about his practice of performing turbinate procedures on one side first and the other side later, Respondent again confirmed it is his standard practice despite his initial training to the contrary. Specifically, he stated:

> So everybody's trained to do all of that at once. . . . I was trained to do all of it at once. . . . But then once the – the doctor showed me why I should do this, I've seen over the

last 20 years patients just do well when you can do one side at a time.

[Q:] Your personal preference --?

[A:] Is one side at a time. . . . And I've always done it that way.

(Exhibit 7, p. 466, line 11-24, p. 467, lines 8-12.)

41E. At the hearing, Respondent denied it is his practice to perform staged nasal surgeries for all his patients. Respondent insisted that, when he explained his reasoning during the Board interview (set forth in Factual Finding 41A-41D), he was referring only to Patient 1, not his general practice. This assertion is not credible. As noted in Factual Finding 41B, Respondent's use of the word "usually" indicates his usual practice of staging his procedures. Additionally, Respondent's explanation indicated his global use of the practice rather than just for Patient 1.

41F. Although not mentioned during his Board interview, at hearing Respondent testified he only staged Patient 1's and Patient 2's procedures due to their employment issues and anxiety. Respondent's assertions were unsupported by the medical records and are not credible, as set forth below.

(1) Respondent testified he spoke to Patient 1 about her issues regarding her job and anxiety, and she "gave [him] a good reason why" he should stage her surgery. Respondent testified that Patient 1's procedures were staged due to the physical demands of her job as a FedEx worker, and she was anxious about having her nose obstructed. Despite his current assertion that Patient 1 was anxious about having both sides completed at once, Respondent did not document the patient's

anxiety or any other reason for the staged procedures in her medical record. Although Respondent asserted Patient 1's return to job duties were a factor in the staging, he admitted he placed her on leave after the July 5, 2013 surgery and after her additional surgeries. Consequently, Patient 1 was not required to return to work immediately after her surgeries, removing one of the purported reasons Respondent staged the procedures. Additionally, Patient 1 could have incurred less time away from work with only one (non-staged) procedure. Respondent also explained he chose not to prescribe anti-anxiety medication in order to complete the procedures in just one surgery because he did not feel she should stay on anti-anxiety medication for up to two weeks. This explanation was unclear and inadequate.

(2) Respondent testified Patient 2 "decided she wanted to stage the surgery" due to her desire to return to work as a FedEx worker. Respondent did not document this reason for the staged procedures in Patient 2's medical record. There was also no documented discussion about any patient anxiety regarding nasal obstruction after surgery.

41G. (1) In a document dated July 7, 2021, in response to the Accusation, Respondent set forth his opinions regarding the issues in this matter. Respondent documented for the first time:

> [Patient 1] was staged for two parts . . . because she didn't want sinus surgery at the time, she was a fedex worker and wanted to return to work immediately. She was anxious about having both side of her nose done at once. Wanting to do the worse side first, which is why she was staged in two parts. Also she was an extremely healthy individual so her anesthetic risk was very low. [Patient 2] had some

> anxiety about her being obstructed bilaterally after surgery so she was also staged to have her surgery in 2 parts within 60 days. . . . I disagree with that I have deviated with the standard of care because each of these patients had reasons for staging their surgery; either medically, psychologically or economically.

(Exhibit A, Respondent July 7, 2021 opinion, p. 3.)

(2) Respondent's new assertions dovetail with his expert witness' report, also dated July 7, 2021, which alludes to both patients' anxiety as purportedly detailed in "supplemental documentation" which was not submitted in evidence. Based on Respondent's new factual assertions of patient anxiety, his expert opined, "Although uncommon to stage such sinonasal procedures, if this was done at the behest of the patient due to anxiety issues as indicated in the supplemental documentation, then this approach would be a reasonable solution to accommodate the patient's preferences." (Exhibit A, Dr. Lee Report, pp. 11-12.)

(3) Respondent's new assertions of patient anxiety are apparently noted to bring Respondent's staging of Patient 1's and Patient 2's procedures within the standard of care. Given the apparent self-serving character of the new factual assertions, Respondent's testimony regarding Patient 1's and 2's selection of staged procedures due to anxiety is not credible.

41H. The evidence established it was Respondent's custom and practice to stage his procedures to be performed first on one side of the patient's nose, with a later-scheduled surgery on the opposite side.

OBTAINING CULTURES

42A. At hearing, Complainant sought, but failed, to establish that during the Board interview, Respondent admitted he never took cultures.

42B. During the Board interview while discussing Patient 1's nasal endoscopy findings, Respondent was asked about taking cultures. However, the question posed was ambiguous and compound, and it was unclear whether Respondent was being asked about taking cultures with just Patient 1 or as routine practice. Consequently, it was similarly unclear whether Respondent's answer pertained just to Patient 1, to his regular practice, or both. Specifically, the discourse unfolded as follows:

> [Q:] Was a culture done? Routinely usually? During either the endoscopy or surgery?
>
> [A:] No. I don't do cultures. Not – not – I didn't do a culture. . . . During that time period when I did this. I didn't do cultures then, no.

(Exhibit 7, p. 434, lines 15-19.)

42C. However, Respondent expounded on his answer, and it appeared he did take cultures in some cases. Specifically, Respondent explained:

> I usually do – in general practice – when I open into the sinus . . . If I get – If I think I need to take cultures and I need to do something, I'll do them at that time period. Because classically, I'm still going to treat the same. . . Not unless I really have a problem. . . . and I can't control the

> patient. . . . I keep putting them on antibiotics and they – it's not getting better.

(Exhibit 7, p. 434, line 25, p. 435, lines 1-14.)

42D. However, when later discussing finding purulent debris on endoscopy for Patient 1 two weeks post-surgery, Respondent's answer was confusing. Respondent was asked "Well, why didn't you do a culture at this time?" Respondent stated, "I know, we just don't . . . we don't culture." (Exhibit 7, p. 449, lines 15-18.) Nevertheless, Respondent again explained about attempting antibiotic treatment to address the detected purulence.

42E. (1) At hearing, Respondent confirmed he occasionally took cultures in 2013. He testified it is within his discretion to take cultures, and he takes cultures when he feels the need to do so. However, he did not feel it was necessary to obtain cultures in Patient 1's or Patient 2's cases. He explained he only takes cultures if he believes it will change his direction in treating a patient medically or surgically. Respondent noted sinus issues are "typically a problem of obstruction and inflammation," with secondary infection. In such cases, he does not typically rely on cultures because he will first prescribe antibiotics to address the infection. Respondent denied needing a culture to prescribe the correct antibiotics. He follows a regimen of antibiotics he was trained to use, starting with one class of antibiotics and, if that is not effective, moving onto the next class. However, he noted that the sinus issue remains "an inflammatory obstructive problem," and he ultimately must address the obstruction.

(2) Respondent also noted that pathology on cultures will determine what organisms are growing, but that there is a lot of "cross-contamination in terms of what organisms are growing in the nasal cavity," resulting in some inaccurate results.

Consequently, there is "some controversy" regarding interpretation of cultures from the nasal cavity.

42F. The evidence failed to establish that Respondent never obtained cultures. However, Respondent did not often culture purulent material, and it was his typical practice to first address purulence via antibiotics, nasal rinses, and steroid medication.

DOCUMENTING DISAGREEMENT WITH RADIOLOGIST FINDINGS

43. In his Board interview, Respondent noted that when obtaining a CT scan, he reads the CT scan itself, in addition to the radiologist's report of findings. (Exhibit 7, p. 437, lines 21-24.) Respondent acknowledged he disagreed with the radiologist regarding the results of Patient 1's first CT scan, but he did not document his contrary findings. (*Id.* at p. 438, lines 1-8.) Respondent admitted he has since changed his practice and now documents his contrary findings. (*Id.* at p. 438, lines 13-14, 21-25.)

GENERALIZED BOILERPLATE CONSENTS

44. As noted above (in Factual Findings 7B, 10E, 16, 24B, 27C, and 38), Respondent used the same boilerplate descriptions in the consent forms for the procedures he performed. Respondent acknowledged the consent forms do not specify on what side the procedures will be performed, nor do they indicate the procedures will be staged. He explained that this inclusive language on the consent form allows him, intraoperatively, to select the side on which he will work and the option to work on both. Respondent testified that, although he will plan with the patient to work on the "worst" side first, he makes the final decision "once [he] get[s] in there to do the surgery."

MIDDLE TURBINATE PROCEDURES

45. During the Board interview, while discussing 20 years of staging of his procedures, Respondent tangentially mentioned performing middle turbinate procedures with the added benefit of headache reduction. Specifically, Respondent stated, "I do the middle turbinate and the inferior turbinate. Now, some of us will argue about that middle turbinate, but I do both. I do both because that middle turbinate, patients coming in, especially females, complain of headaches. You get rid of the headaches. Just doing the middle turbinate." (Exhibit 7, p. 69, lines 17-22.) Respondent never stated that headache reduction was the sole reason for performing middle turbinate procedures on either Patient 1 or Patient 2.

The Experts

46A. Complainant offered the testimony of Michael Joseph Kearns, M.D., F.A.C.S., to establish the standard of care for the treatment of the patients in this case. Dr. Kearns obtained his medical degree from the University of California (UC), Irvine, and completed a residency in otolaryngology at UC San Diego. He is licensed to practice medicine in California, and he received certification from the American Board of Otolaryngology – Head and Neck Surgery. Since 2003, Dr. Kearns has operated a private practice as an otolaryngologist (ENT), and since 2013, he has been employed as a Clinical Professor of Medicine at California Northstate University College of Medicine.

46B. Respondent offered the testimony of Jivianne T. Lee, M.D., to establish the standard of care for the treatment of the patients in this case. Dr. Lee obtained her medical degree from UCLA, and she completed a residency there in Otolaryngology – Head and Neck Surgery. She also completed a fellowship in Rhinology and Skull Base

Surgery at the University of Pennsylvania, and another fellowship in Medical Education at UCLA. Dr. Lee is licensed to practice medicine in California, and she is board-certified in Otolaryngology – Head and Neck Surgery (originally in 2005, and re-certified in 2015). Dr. Lee is employed at UCLA David Geffen School of Medicine, Department of Head and Neck Surgery, as an Associate Professor of Rhinology and Skull Base Surgery and as the Co-Director of the Fellowship in Rhinology and Endoscopic Skull Base Surgery. She has authored numerous publications in her field, and she has conducted a great number of presentations and lectures at various local, national, and international medical association meetings. She also serves on the editorial board of several medical journals including the American Journal of Rhinology and Allergy and the Otolaryngology-Head and Neck Journal.

46C. Drs. Kearns and Lee were both qualified to testify as experts regarding the standard of care in this case. Any additional weight given to one expert's testimony over the other's was based on the content of their testimony and bases for their opinions, as set forth more fully below.

Standard of Care

47. Dr. Kearns provided an October 24, 2018 expert report, and Dr. Lee provided a July 7, 2021 expert report, setting forth their opinions regarding Respondent's care and treatment of Patients 1 and 2. Those reports were admitted into evidence at the hearing, and Drs. Kearns and Lee testified in conformity with their reports.

DOCUMENTATION

48. According to Dr. Kearns, the standard of care for medical documentation requires the physician "to accurately document what was seen and done in an

encounter with the patient. The documentation should accurately reflect the interaction between the physician and the patient, so it is clear to others what exactly was done and why it was done." (Exhibit 10, p. 591.) Dr. Lee concurred with this statement of the standard of care for documentation.

49A. Dr. Kearns leveled several criticisms of Respondent's medical documentation. First, he noted Respondent documented middle turbinate procedures in separate operative reports from the main operative reports for procedures performed during the same operation. (See Factual Findings 8 and 25, above.) Dr. Kearns opined that the separate operative reports "suggest that this was a completely separate procedure from the lower turbinate procedure and does not accurately reflect the operation that was done." (Exhibit 10, p. 591.) According to Dr. Kearns, "the correct and more efficient way" to dictate the middle turbinate procedure is to include it as part of the overall internal nasal procedure.

49B. Dr. Lee disagreed with Dr. Kearns' criticism, and she found no deficiencies in Respondent's documentation noting that it "described the procedures that were performed. Although it may be more 'efficient' to combine the procedure dictations, that would come down to personal preference and I do not concur that there was any violation of the standard of care." (Exhibit A, Dr. Lee Report, p. 7.[3]) At the hearing, Dr. Lee testified she saw no issue with the separate documentation since "it is a separate procedure done in a different anatomical structure in the sino-nasal cavity." She saw

[3] Respondent's exhibits were not Bates stamped, so the page number reflects the internal pagination of Dr. Lee's report.

the separate reports as physician "preference," and not a violation of the standard of care.

49C. Regarding Respondent's separate documentation of contemporaneous procedures, the opinions of Dr. Lee were more persuasive than those of Dr. Kearns. The separate operative reports did not repeat the patient prep and anesthesia information, so there was no confusion over there being two separate operations with separate administrations of anesthesia for the two procedures. The separate operative reports merely added information about another procedure contemporaneously performed. Complainant did not establish by clear and convincing evidence that Respondent violated the standard of care by dictating separate operative reports.

50A. Dr. Kearns next opined Respondent violated the standard of care in his documentation of endoscopy findings. Dr. Kearns noted:

> [Respondent] had on several occasions indicated that endoscopy could visualize into the ethmoid and maxillary sinuses in patients that had never had sinus surgery.
>
> On [Patient 2], as discussed in [Respondent's] interview, page 144, prior to the 02/06/2014 surgery, [Respondent] reports seeing disease and polyps on endoscopy in the maxillary and ethmoid sinuses. This is his verbal reflection, this is not documented in the records preoperatively.
>
> Also by endoscopy, a physician cannot directly see into the maxillary and ethmoid sinuses unless prior surgery had been done. This is not the case in [Patient 2's] care as of 02/06/2014.

(Exhibit 10, p. 591.)

50B. Dr. Kearns' understanding of the facts is not borne out by the evidence. Contrary to Dr. Kearns' assertion, in Respondent's interview (transcript at page 144), he does not report seeing disease and polyps in the maxillary and ethmoid sinuses during the February 3, 2014 endoscopy. Instead, Respondent stated, "on my endoscopy, I saw that there were some issues in the maxillary and ethmoid sinuses." (Exhibit 7, p. 492 (transcript, p. 144), lines 2-4.) Respondent also later explained he removed polypoid material, but "that's not polyps. . . . Because I'll say polyps if it's polyps." (*Id.* at p. 492, line 25, p. 493, lines 1-6.) Additionally, Respondent's February 3, 2014 endoscopy report does not state that Respondent looked directly into the maxillary and ethmoid sinuses. Rather, Respondent's endoscopy report merely states, "the ostium of Ethmoid and Frontal sinus had pur[u]lent deb[r]is extruding left > right in the middle meatus." (See Factual Finding 27D.) Respondent confirmed at hearing that he was not stating he could see into ethmoid and maxillary sinuses. Rather, he was documenting what he saw looking at middle meatus and ostium (i.e., opening) to the sinuses.

50C. Dr. Lee agreed "it would be challenging to visualize the interior of the maxillary sinus or ethmoid sinus with nasal endoscopy without prior surgery." (Exhibit A, Dr. Lee Report, p. 7.) However, Dr. Lee also pointed out that was not documented in Respondent's endoscopy report, and she noted the report instead stated "the ostium of ethmoid and maxillary sinus has pur[u]lent deb[r]is extruding left>right in the middle meatus." Dr. Lee credibly opined:

> Polyps, edema, and mucopurulent debris can be visualized within the middle meatus, overlying the ethmoid bulla in the ethmoid cavity, ostiomeatal complex, and obstructing the maxillary sinus ostia. Consequently, I do not see any

> issues with the findings that were reported, as it was not documented that he was looking into the interior of the maxillary and ethmoid sinuses themselves.

(Exhibit A, Dr. Lee Report, p. 7.)

50D. Given that the factual bases for Dr. Kearns' opinions were not established by the evidence, his opinion that Respondent violated the standard of care through his endoscopy documentation is given no weight.[4]

51A. Although not alleged in the Accusation, Complainant sought to establish purported coding errors made by Respondent in his medical billing. Respondent objected to admission of evidence regarding coding errors since the coding allegations were not contained in the Accusation.[5] However, evidence of alleged coding errors was allowed only insofar as the purported errors overlapped with allegations of inaccurate documentation set forth in the Accusation. Specifically, the only overlap of allegations involved the separate documentation and coding for the

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[4] The expert's opinion is no better than the facts on which it is based and, "where the facts underlying the expert's opinion are proved to be false or nonexistent, not only is the expert's opinion destroyed but the falsity permeates his entire testimony; it tends to prove his untruthfulness as a witness." (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923-924.)

[5] The Accusation must set forth "the acts or omissions with which the respondent is charged, to the end that the respondent will be able to prepare his or her defense." (Govt. Code, § 11503, subd. (a).)

middle turbinate procedures from other procedures performed during the same operation. (See Factual Findings 8 and 25.)

51B. Similar to his testimony regarding the separate operative reports (see Factual Finding 49A, above), Dr. Kearns opined Respondent engaged in deficient coding in that Respondent used a billing code (30130) for the middle turbinate procedure separately from the billing code (30117) for the remainder of the procedures performed the same day. Dr. Kearns noted, "it appears that the codes 30130 and 30117 reflect doing the same procedure: that is laser ablation of presumed degenerated or polypoid tissue." (Exhibit 10, p. 591.) Dr. Kearns opined that, despite performing one procedure on the same day, Respondent incorrectly dictated two operative notes and used two billing codes.

51C. Respondent testified that his operative reports and billing for the middle turbinate procedure were separated from the remainder of the procedures because it is a separate procedure on a different anatomical structure. Respondent believed his coding was correct because he had been instructed that 30130 was the code used for work on the middle turbinate. He was not paid separately for using the separate code 30130.

51D. Similar to Factual Finding 49 above, Complainant did not establish by clear and convincing evidence that Respondent violated the standard of care or failed to keep accurate records by using the separate billing code 30130 for the middle turbinate procedure.

52A. As Dr. Kearns correctly points out, Respondent's records fluctuate as to whether Patient 1's septum was midline or deviated. In Patient 1's records, on at least seven occasions Respondent documented Patient 1's septum as midline, and on at

least eight occasions, he documented the septum as deviated to the right. Dr. Kearns opined this was a simple departure from the standard of care.

52B. Dr. Lee does not address this deviation in her report, but merely concludes, "No issues in terms of documentation with respect to standard of care were identified." (Exhibit A, Dr. Lee Report, p. 7.) At hearing, Dr. Lee agreed that Respondent's describing Patient 1's septum as both midline and deviated is not internally consistent.

52C. Given the multiple instances of inaccuracies in Patient 1's records regarding whether Patient 1's septum was midline or deviated, Complainant established by clear and convincing evidence that Respondent failed to keep accurate records and that he committed a simple departure from the standard of care by his inaccurate documentation.

53A. Although not specifically addressed in the Accusation or the experts' reports, Dr. Kearns also pointed out documentation concerns regarding the patients' surgery consents. Respondent did not object to this testimony, and he provided responsive opinions via Dr. Lee's testimony.

53B. Dr. Kearns credibly testified it is the standard of care to specify in the consent form on what side surgery will be performed, and consents cannot be made in general terms. Dr. Kearns noted that Respondent's practice for 20 years has been to perform procedures one side at a time, but the patients' consents all noted the same bilateral procedures without indicating the side on which the procedures were to be performed. Consequently, the consent forms and medical records were unclear regarding the specific side for surgery to which the patients were consenting.

53C. When asked whether Patient 1's consent forms failed to specifically list the actual surgeries performed, Dr. Lee testified she "did not recall inconsistencies" in comparing the consent form and the procedures performed. She agreed that "ideally," the consent form should accurately reflect the actual surgery to be performed. However, she did not concede that, to properly consent a patient for staged surgery, the consent form should specify the side to be operated on. Dr. Lee asserted the wording of the consent form depends on the discussion with the patient and the plans for surgery. If the surgeon wants "flexibility," the consent will say "endoscopic sinus surgery," and they will "leave it universal" to encompass one or both sides. Dr. Lee noted that, if a patient has disease on only one side, like a tumor, then laterality should be addressed. However, with inflammatory cases where the surgeon plans to work on one side with the possibility of also working on the opposite side, the general terminology "endoscopic sinus surgery" will encompass both sides. For example, the consent will often say, "inferior turbinate reduction," but not "bilateral inferior turbinate reduction." Dr. Lee conceded that, if the patient and surgeon pre-operatively agreed to surgery on only one specific side, that should be in the consent.

53D. Regarding the inaccuracy or inadequacy of the consent forms, the opinions of Dr. Kearns were more persuasive than those of Dr. Lee. Despite the variety of procedures performed on Patient 1 and Patient 2, all six consent forms use the same boilerplate description of the consented procedures. (See Factual Findings 7B, 10E, 16, 24B, 27C, and 38.) This boilerplate language resulted in consent forms that were vague and generalized and did not reflect the agreed plans for surgery. Consequently, Complainant established by clear and convincing evidence that Respondent failed to keep adequate and accurate records and committed a simple departure from the standard of care by his deficient consent documentation.

53E. Nevertheless, since this specific allegation of deficient documentation was not alleged in the Accusation, which was not amended to conform to proof at hearing, this specific violation cannot form a basis for discipline. (See fn. 5.)

EXCESSIVE TREATMENT (UNINDICATED SURGERIES)

54A. In his report, Dr. Kearns opined, "The standard of care in California is for a surgeon, when considering surgery for a patient, to have clear and adequate indication. The indication for sinus surgery is based on patent history, physical examination, results of ancillary testing such as allergy testing, radiographic imaging and the patient prior response to therapy." (Exhibit 10, p. 591.) In his testimony, Dr. Kearns expounded on the standard of care to include that the surgeon must employ conservative, non-surgical treatment of the patient's condition, and for those patients who are either intolerant or unresponsive to conservative measures, the correct operation should be proposed.

54B. In her report, Dr. Lee noted the following standard of care for the treatment of allergic rhinitis and chronic rhinosinusitis: "In the [2018] International Consensus Statement on Allergy and Rhinology: Allergic Rhinitis, a strong recommendation was made for the use of oral H1 antihistamines, nasal saline, and/or intranasal corticosteroids in the medical treatment of allergic rhinitis [citation omitted]. Likewise, based on the [2016] International Consensus Statement on Allergy and Rhinology: Rhinosinusitis, nasal saline irrigations, certain antibiotics, and/or intranasal corticosteroids are recommended in the medical treatment of chronic rhinosinusitis [citation omitted]. Surgical intervention including endoscopic sinus surgery, septoplasty and inferior turbinate submucous resection are typically only indicated in patients with persistent symptoms following a trial of appropriate medical therapy

which would include saline irrigation and a nasal steroid spray of at least 4 weeks." (Exhibit A, Dr. Lee Report, p. 8.)

54C. (1) Complainant sought to discredit Dr. Lee's statement of the standard of care by pointing out her citation to the International Consensus Statements on Allergic Rhinitis and on Rhinosinusitis (see Factual Finding 54B) and her citation to the Clinical Practice Guideline: Adult Sinusitis, published by the American Academy of Otolaryngology – Head and Neck Surgery Foundation (AAO Guideline).

(2) The AAO Guideline was published in 2007 and revised in 2015. In arguing that Dr. Lee misconstrued the standard of care by relying on the AAO Guideline, Complainant pointed to a Disclaimer within the AAO Guideline which states, in part:

> The clinical practice guideline is provided for information and educational purposes only. It is not intended as a sole source of guidance in managing adults with rhinosinusitis. Rather, it is designed to assist clinicians by providing an evidence-based framework for decision-making strategies. . . . <u>Guidelines are not mandates; these do not and should not purport to be a legal standard of care.</u> The responsible physician, in light of all circumstances presented by the individual patient, must determine the appropriate treatment. . . .

(Exhibit 11, p. S31, emphasis added.)

(3) While Dr. Lee did cite the International Consensus Statements on Allergic Rhinitis and on Rhinosinusitis in her statement of the standard of care for

treatment and surgical intervention, she did not specifically cite the AAO Guideline for that purpose. Rather, in summarizing the patient's medical records and Respondent's diagnoses, she cited to the AAO Guideline in finding that Respondent made the proper diagnoses of chronic rhinosinusitis in Patients 1 and 2. Specifically, Dr. Lee noted:

> According to the 2015 [AAO Guideline], a patient meets the diagnostic criteria for chronic rhinosinusitis if the patient has 12 weeks or more of at least 2 of the following signs and symptoms (1) nasal construction/congestion, (2) nasal discharge, (3) facial pain/pressure/fullness, (4) decreased sense of smell; AND inflammation is documented by one or more of the following findings: (1) purulent (not clear) mucus or edema in the middle meatus or anterior ethmoid region, (2) polyps in nasal cavity or the middle meatus, and/or (3) radiographic imaging showing inflammation of the paranasal sinuses.

(Exhibit A, Dr. Lee report, pp. 1 and 5.)

(4) Since the Accusation contains no allegation of improper diagnosis, Dr. Lee's citation to the AAO's list of diagnostic criteria for chronic rhinosinusitis as a basis for finding Respondent's proper diagnoses is a tangential issue (i.e., whether the AAO's list of diagnostic criteria mirrors the diagnostic criteria required to meet the standard of care). Thus, the citation regarding diagnostic criteria does not discredit Dr. Lee's statement regarding the standard of care for proper treatment of chronic rhinosinusitis.

(5) Complainant pointed out that, similar to the AAO Guideline, the International Consensus Statement on Allergic Rhinitis noted: "The recommendations in this document are evidence-based. They do not define the standard of care or medical necessity." (Exhibit 11, p. 114.) Despite that statement, Dr. Lee testified credibly that it is appropriate to incorporate the information from the International Consensus Statements into her determination of the standard of care in managing adult rhinosinusitis because they are "general consensus statements" whose purpose is to provide evidence-based recommendations for ENTs to guide in the treatment of patients. Dr. Lee never asserted the consensus statements were the sole statement of the standard of care. Moreover, the consensus statements apparently recommend the best practices at the time of publication, rather than practices below the standard of care. Consequently, Dr. Lee's consultation of the consensus statements in rendering her statement of the standard of care is not unreasonable and may result in her holding Respondent to a higher, best practices standard.

54D. Drs. Kearns and Lee apparently agree that surgical intervention is warranted only after persistence of symptoms following a trial of appropriate non-surgical treatment. According to Dr. Lee, and undisputed by Dr. Kearns, the trial period of conservative treatment should be at least four weeks.

55A. (1) In his report, Dr. Kearns opined there was "no CT support" for the July 29, 2013 surgery on Patient 1 and the February 6, 2014 surgery on Patient 2. (Exhibit 10, p. 592.) Dr. Kearns further opined, "In circumstances where the radiographs are interpreted as clear by the radiologist and abnormal by the operating physician there needs to be clear demonstration of the thought process behind the surgery as well as the adequate medical therapies that have been pursued." (*Ibid.*) Regarding Patient 1, Dr. Kearns asserted there was "insufficient radiographic evidence for surgical

indication, an inadequate documentation of the complete medical therapy that has been tried appropriately and failed." (*Ibid.*) Dr. Kearns opined that these deficiencies constituted "a simple departure from the standard of care." (*Ibid.*) Dr. Kearns' criticisms appear to be assertions only of Respondent's insufficient documentation of the indications for surgery.

(2) At hearing, Dr. Kearns acknowledged that, upon review of Patient 2's medical records, he "can infer the clinical reason" for the procedures performed by looking at the chief complaint and the symptoms.

55B. Dr. Lee opined that the indications for surgery for both patients were within the standard of care.

(1) Regarding Patient 1, Dr. Lee testified in conformity with her report which noted:

> In this case, it was documented several times in the operative notes from 7-5-2013, 7-26-2013, and 9-29-2013, that the patient is a "45-year-old female, who notes nasal obstruction, rhinorrhea, postnasal drip, facial pressure, pain, headaches, medial canthal pain, and malar eminence pain. The patient has noted problem ongoing over the last four to five years, getting progressively worse. The patient has been treated with numerous antibiotics, decongestants, topical nasal steroid sprays. In light of all the...patient's problems are persistent and ongoing... patient is taken to the operating room for the above procedure." As it was documented that the patient had ongoing symptoms

> despite appropriate medical therapy with several courses of antibiotics, nasal saline irrigations, etc. and had objective findings consistent with chronic rhinosinusitis, the surgical procedures performed (i.e., endoscopic sinus surgery, septoplasty, submucous resection of inferior turbinates) would be considered medically necessary and within the standard of care.

(Exhibit A, Dr. Lee Report, p. 9.)

(2) Regarding Patient 2, Dr. Lee testified in conformity with her report which noted:

> With respect to Patient [2], as it was documented that the patient had ongoing symptoms despite appropriate medical therapy with several courses of antibiotics, nasal saline irrigations, nasal steroid sprays etc. and had objective findings consistent with chronic rhinosinusitis, the surgical procedures performed (i.e. left middle turbinate excision, endoscopic sinus surgery, submucous resection of inferior turbinates) would be considered medically necessary. In terms of the second sinus surgery performed on 11-11-2014 (Bilateral functional endoscopic sinus surgery, maxillary sinus with sinusotomy with polyp removal, submucosal resection of the inferior turbinate on the left), it was noted that "patient [was] having recurrent episodes of sinusitis, nasal obstruction, rhinorrhea, and postnasal drip" despite being "treated with antibiotics, decongestants, and

> steroids." The clinic visits prior to the surgery also documented the patient's ongoing symptoms despite multiple courses of medical therapy. The CT sinus showed a "1.2 cm polyp versus retention cyst in the left maxillary sinus." Intraoperatively, it was documented that the "opening into the right maxillary sinus had closed down. Antrum punch was used to make an opening...left side... granulation and scar tissue...taken down using antrum punch and microdebrider...polypoid material was extracted...incision was carried along left inferior turbinate." Therefore, the surgery performed on 11-11-2014 would also be considered medically necessary.

(Exhibit A, Dr. Lee report, p. 9.)

55C. (1) Although not specifically alleged in the Accusation or noted in Dr. Kearns' expert report, at hearing, Dr. Kearns also criticized the September 26, 2013 surgery Respondent performed on Patient 1 (bilateral frontal sinus surgery, ethmoidectomy, submucous maxillary sinusotomies, submucosal resection of the left inferior turbinate), noting it was based on failed medication management, and "that is not a deviation from the standard of care, per se." However, Dr. Kearns questioned why the September 26, 2013 surgery was already scheduled as of August 15, 2013, when there was no indication radiographically that surgery was indicated only 17 days after the prior major operation. Dr. Kearns opined there was no documented reason for having to perform a major revision surgery this soon after the first major operation, particularly without the benefit of an updated CT scan to provide the current level of anatomy. Although Respondent explained in his Board interview that the surgery was

based on a lack of clinical progression in Patient 1's symptoms, Dr. Kearns found that rationale insufficient to justify the September 26, 2013 surgery based on his review of the medical records.

(2) This specific allegation was not included in the Accusation, and it should not be considered as a factual basis for discipline. (See fn. 5.) Nevertheless, Dr. Lee credibly testified that all surgeries Respondent performed on Patient 1 were medically indicated. (See Factual Finding 55B, above.)

55D. (1) Although not specifically alleged in the Accusation or noted in Dr. Kearns' expert report, at hearing, Dr. Kearns testified he had a "question" about Patient 2's bilateral revision tonsillectomy when preoperative records indicated only a problem on the right. Dr. Kearns opined that, while Respondent may have seen something intraoperatively, absent a diagnosis and symptoms, there was no indication for the bilateral revision tonsillectomy.

(2) This specific allegation was not included in the Accusation, and it should not be considered as a factual basis for discipline. (See fn. 5.) Nevertheless, Dr. Lee credibly testified that all surgeries Respondent performed on Patient 1 were medically indicated. Specifically, regarding Patient 2's bilateral revision tonsillectomy, Dr. Lee testified in conformity with her report which noted:

> With respect to the tonsillectomy that was performed on 7-8-2014, it was documented that the patient was a "40-year-old female who notes repeated episodes of greater than 5 times per year of tonsillitis. She has been treated with numerous antibiotics." In terms of the revision tonsillectomy on 11-11-2014, it was noted that the patient was a "40-

> year-old female who notes persistent right sided tonsillitis...patient has had recurrent episodes at least three to four episodes over the last four months of right sided tonsillitis...the patient has a remnant of her tonsil of which the patient had previous tonsillectomy about six months ago since that time period... because of the remnant on the right side of the tonsil, the patient has been having recurrent episodes of tonsillitis." . . . [C]hronic infection is still the most common indication reported for adult tonsillectomy [citation omitted]. It has been recommended that tonsillectomy be performed in patients with recurrent acute pharyngitis whose quality of life is adversely affected. Consequently, if the patient had recurrent episodes of tonsillitis as documented that impacted her quality of life, then the tonsillectomy performed would be considered within the standard of care. In terms of the revision tonsillectomy, while unusual, if the patient had residual remnants that were associated with recurrent tonsillitis adversely impacting her quality of life, then the revision tonsillectomy would be considered within the standard of care.

(Exhibit A, Dr. Lee report, pp. 9-10.)

55E. Regarding the indications for surgery on both patients, the opinions of Dr. Lee were more persuasive than those of Dr. Kearns. Complainant did not establish

by clear and convincing evidence that Respondent violated the standard of care by performing surgery on Patient 1 or Patient 2.

56. In his report, Dr. Kearns also noted Respondent's statement in his Board interview regarding middle turbinate resection as effective treatment for headaches. Dr. Kearns opined, "There is no medical evidence that laser reduction of potentially hypertrophic mucosa over a middle turbinate is appropriate therapy for headaches." (Exhibit 10, p. 592.) Since it was not established that headache reduction was the reason for any of the middle turbinate procedures on Patient 1 or Patient 2, this criticism of Respondent's offhand comment will not be considered as a basis for discipline.

REPEATED NEGLIGENT ACTS

57. Complainant alleged Respondent is subject to disciplinary action for the commission of repeated negligent acts and omissions in the care and treatment of Patients 1 and 2. Complainant established by clear and convincing evidence that Respondent deviated from the standard of care in his care and treatment of Patients 1 and 2 as noted above (Factual Finding 52C regarding documentation.) Additional deviations from the standard of care are set forth below (Factual Findings 61C and 62D).

Pathology Follow-Up

58A. Dr. Kearns testified it is important to send diseased tissue to pathology to confirm diagnoses because "sometimes medical conditions can appear to be benign nasal polyps when in fact it can be more aggressive pathology such as . . . pre cancer or cancer." In his report, Dr. Kearns articulated, "The standard of care in California is for a surgeon who is removing potentially pathologic tissue to ensure that the specimen is

sent to Pathology for microscopic analysis." (Exhibit 10, p. 592.) Dr. Kearns opined that Respondent committed "a simple departure from the standard of care when, on three occasions (on July 29, 2013, for Patient 1; and February 6, and November 11, 2014, for Patient 2), Respondent noted specimens intraoperatively, but "failed to ensure that the pathology specimen was appropriately forward to Pathology for analysis." (*Ibid.*) Dr. Kearns further opined, "It is incumbent upon the physician to follow up to make sure that the specimens are adequately analyzed for appropriate care and treatment of the patient." *(Ibid.)*

58B. Dr. Lee noted, the decision whether to send tissue for pathologic analysis is "at the discretion of the surgeon." (Exhibit A, Dr. Lee report, p. 7.) Dr. Lee concurred "that it is the standard of care for surgical specimens that the surgeon would like to undergo pathologic analysis be sent to pathology." (*Ibid.*) However, she "disagree[d] that delivery of the actual specimen to pathology is incumbent on the surgeon. Specimen delivery to pathology is typically under the auspices of the surgery center or hospital where the surgery is taking place." (*Ibid.*) For the instances where no pathology reports were found in the two patients' records, Dr. Lee noted, "It is unclear if the tissue did undergo pathologic analysis and no pathology report was included in discovery or whether the tissue was never delivered. If the latter, then that would be a systems issue with the hospital and surgery center which would need to be investigated to determine where the lapse occurred." (Exhibit A, Dr. Lee report, p. 8.) Dr. Lee concluded Respondent did not violate the standard of care in not ensuring the pathology specimens were actually sent to and analyzed at the pathology lab.

58C. Regarding the duty to ensure that pathology specimens are appropriately forwarded to the lab for analysis, the opinions of Dr. Lee were marginally more persuasive than those of Dr. Kearns. Complainant did not establish by clear and

convincing evidence that Respondent violated the standard of care by failing to ensure that intraoperative pathology specimens had been forwarded to the lab for analysis.

Use of Cultures

59A. (1) Dr. Kearns stated, "The standard of care in California is for a physician to when possible direct antibiotic therapy to a specific identified pathogen. The use of culture on identified purulent material is an effective means to limit the type and duration of antibiotic therapy." (Exhibit 10, p. 593.)

(2) Dr. Kearns asserted Respondent "in his interview indicates that he does not do culture[s]." (*Ibid.*) However, contrary to Dr. Kearns' assertion, as noted above (Factual Finding 42F), the evidence did not establish that Respondent never obtained cultures. Instead, the evidence established Respondent did not often culture purulent material, and it was his typical practice to first address purulence via antibiotics, nasal rinses, and steroid medication.

(3) Dr. Kearns noted several instances in Patient 1's and Patient 2's care where he believed "culture could be considered effective and standard of care in directing medical therapy." (Exhibit 10, p. 593.) For Patient 1, Respondent identified purulent material during the July 23 and August 14, 2013 endoscopies, and the purulent material was not cultured. Specifically, Dr. Kearns noted, on August 14, 2013, "antibiotics were empirically changed from Augmentin to Ceftin. There appears to be no justification for that antibiotic change especially when a culture could be done to specifically direct antibiotic therapy prior to consideration for surgery." (*Ibid.*) For Patient 2, Respondent identified purulent material intraoperatively on February 6, 2014, and the material was not cultured. Additionally, for Patient 2, Respondent noted a "white coating on tonsil tissue five weeks postoperatively that was treated [at the

August 11, 2014 visit], but no culture was done." (*Ibid.*) Dr. Kearns opined Respondent committed a simple departure from the standard of care in these instances of failing to take cultures.

59B. Explaining his reasons for not obtaining cultures for Patient 1 or Patient 2, Respondent testified that culturing may not necessarily help in the treatment of a patient because there "is a huge discrepancy" in the resulting findings. With obstructive, inflammatory problems, he believes it is in his discretion to prescribe antibiotics, and some diseases respond better to certain antibiotics. In his experience as an ENT treating chronic sinus diseases, he has learned what organisms are typically involved and what antibiotics will help. He noted that sinus obstruction and inflammatory problems result in secondary bacterial infection, and he disagreed that attempting to identify the bacteria through a culture would assist in determining the correct antibiotic treatment.

59C. Dr. Lee disagreed with Dr. Kearns' statement of the standard of care, instead opining that not obtaining a culture does not fall below standard of care because the field of otolaryngology is still trying to define what the standard of care should be. Dr. Lee testified in conformity with her report which noted:

> The role of cultures in sinonasal disease is still the subject of ongoing debate. . . . At this time, cultures may be helpful but given the advent of culture-independent techniques and the questionable sensitivity of cultures, their role and result interpretation is still being studied and standard of care yet to be defined.

> [W]hile the medical board expert indicated that there were several occasions where a culture would have been the standard of care, it is still up to the discretion of the clinician. Not performing a culture is not a violation of the standard of care, as the role of cultures is controversial and the standard of care yet to be defined.

(Exhibit A, Dr. Lee report, p. 10.)

59D. Regarding the standard of care for obtaining cultures, the opinions of Dr. Lee were equally as persuasive as those of Dr. Kearns. Consequently, Complainant did not establish by clear and convincing evidence that Respondent violated the standard of care by not obtaining cultures for Patient 1 or Patient 2.

Clinical and Pathological Interpretation Discrepancies

60A. (1) Dr. Kearns stated the standard of care requires "that if the clinician makes a clinical diagnosis (whether it be on physical examination, endoscopy or intraoperatively) and that diagnosis is profoundly different after review by Pathology, that there either be a discussion between the clinician and the pathologist as to the potential findings, or accurate description in the medical record outlining the rationale for that discrepancy." (Exhibit 10, p. 593.)

(2) Dr. Kearns noted two instances in Patient 1's medical records where he believed "the histopathologic report differs considerably from the intraoperative observation." First, Dr. Kearns pointed out the July 5, 2013 surgical pathology report indicates the specimen (left inferior turbinate) had "no significant histopathologic abnormality." (Exhibit 10, p. 593; Exhibit 4, p. 93.) According to Dr. Kearns, "This differs considerably from [Respondent's] intraoperative observation of

polypoid degenerative nasal mucosa obstructing the nasal cavity." (Exhibit 10, p. 593.) However, the evidence did not establish that the specimen (left inferior turbinate) was part of the observed polypoid degenerative nasal mucosa that Respondent excised and vaporized. (See Factual Finding 8.) Additionally, even if the turbinate specimen contained polypoid degenerative nasal mucosa, the evidence did not establish that pathological findings from that specimen would necessarily indicate a significant histopathologic abnormality such that the lack of such pathological finding would be considered as "differ[ing] considerably" from Respondent's intraoperative observation.

(3) Secondly, Dr. Kearns pointed out that Patient 1's September 26, 2013 pathology report indicates the specimen (left ethmoid sinus) was "a portion of benign nasal sinus tissue." (Exhibit 10, p. 593; Exhibit 4, p. 165.) According to Dr. Kearns, based on Respondent's September 26, 2013 operative report, "there should have been a considerable inflamed granulation tissue" in the specimen. (Exhibit 10, p. 593.) However, the September 26, 2013 operative report documented "scar and granulation tissue" that "closed down to the opening on the ethmoid sinuses" (Factual Finding 17), and it was not established that the specimen (left ethmoid sinus) contained "considerable inflamed granulation tissue" as Dr. Kearns asserts. Additionally, the evidence did not establish that pathological findings from scar and granulation tissue would necessarily return any significant histopathologic abnormality or a finding other than a benign (non-malignant) nasal sinus tissue.

(4) Based on the two purported considerable differences between intraoperative observations and pathology report findings, Dr. Kearns opined Respondent committed a simple departure from the standard of care by his failure to document any conversation with the pathologist or any explanation "why that discrepancy exists." (Exhibit 10, p. 593.)

60B. Dr. Lee opined Respondent did not violate the standard of care based on failure to confer with the pathologist or document any discrepancies between intraoperative observations and pathology findings. Dr. Lee noted that the "instances where the pathology report was benign or showed no abnormality," was "not uncommon as it ultimately comes down to tissue sampling, which tissue was sent, and what was actually examined by pathology." (Exhibit A, Dr. Lee report, p. 10.) She also noted the two surgeries "were for inflammatory disease," and "there was no suspicion for malignancy so the actual pathology is not as critical in terms of guiding management that would mandate discussion with the patient." (*Ibid.*)

60C. Given that the factual bases for Dr. Kearns' opinions were not clearly and convincingly established by the evidence (i.e., that there were considerable differences between intraoperative observations and pathology report findings), Dr. Kearns' opinion that Respondent violated the standard of care through failure to confer with the pathologist or document any discrepancy is given little weight. Thus, Dr. Lee's opinion that Respondent did not violate the standard of care was more persuasive than that of Dr. Kearns. Consequently, Complainant did not establish by clear and convincing evidence that Respondent violated the standard of care by failing to confer with the pathologist or to document any discrepancies between intraoperative observations and pathology findings.

Clinical and Radiological Interpretation Discrepancies

61A. (1) Dr. Kearns stated the standard of care required that, if there is a significant discrepancy in a radiologist report and the clinician's observation of the radiograph that there would be a discussion between the clinician and radiologist or at least a documentation that the clinician points out the specific difference in opinion

and observation between the radiologist interpretation and the clinician's review." (Exhibit 10, pp. 593-594.)

(2) Dr. Kearns noted two instances in Patient 1's medical records and one instance in Patient 2's medical records where he believed "the radiologist interpretation is substantially less severe than [Respondent's] apparent interpretation based on subsequent treatment." (Exhibit 10, p. 594.) First, for Patient 1's July 23, 2013 CT scan, the radiologist report indicates "clear paranasal sinuses and mild septal deflection. [Respondent] subsequently documented a 90% septal deflection. The images provided on that CT scan do not support a 90% septal deflection, and there is no discussion in the medical record to explain that discrepancy." (*Ibid.*)

(3) Second, for Patient 1's July 23, 2013 nasal endoscopy, Respondent notes "purulent debris in the middle meatus with a deviated septum 90% to the right side. That is the same day that a CT scan of the paranasal sinuses showed that the sinuses are clear. Again, there is no review as to either a discussion between the radiologist and the clinician nor any discussion as to the clinician's opinion [regarding] why there is that discrepancy." (Exhibit 10, p. 594.)

(4) Third, for Patient 2's October 24, 2014 CT scan, "other than a 1.2 cm mucous retention cyst at the inferior aspect of the left maxillary sinus, the paranasal sinuses are clear. [Respondent] within two weeks had begun [the] authorization process for bilateral sinus surgery. There is no documentation as to any discussion between the clinician and the radiologist nor any documentation by the clinician indicating his interpretation in findings of CT abnormalities that would warrant additional sinus surgery." (Exhibit 10, p. 594.) Dr. Kearns acknowledged that Respondent's performing surgery on the patient despite the clear CT scan "in and of itself is not necessarily substandard." (Dr. Kearns' testimony.) However, Respondent

was required to document why he was "seeing things differently," and that did not occur.

(5) Dr. Kearns opined Respondent committed a simple departure from the standard of care in failing to document his differences of opinion from the radiologists' interpretations of CT scans.

61B. (1) Dr. Lee found Respondent did not violate the standard of care, which she opined was the "to communicate imaging results to the patient and to discuss the findings as well as the clinician's interpretation." (Exhibit A, Dr. Lee report, p. 11.) However, in her report, Dr. Lee did not address whether a physician must document and explain discrepancies between the radiologist's and physician's findings. Instead, Dr. Lee noted:

> [D]iscordance between imaging and endoscopic findings are not uncommon, as they are meant to compl[e]ment each other. All the diagnostic studies must be taken into consideration collectively when determining diagnosis and indications for surgery. According to the 2015 [AAO Guideline on Adult Sinusitis], a patient meets the diagnostic criteria for chronic rhinosinusitis if the patient has 12 weeks or more of at least 2 of the following signs and symptoms (1) nasal construction/congestion, (2) nasal discharge, (3) facial pain/pressure/fullness, (4) decreased sense of smell; AND inflammation is documented by **one** or more of the following findings: (1) purulent (not clear) mucus or edema in the middle meatus or anterior ethmoid region, (2) polyps in nasal cavity or the middle meatus, **and/or** (3)

> radiographic imaging showing inflammation of the paranasal sinuses. [Citation.] Consequently, nasal endoscopic and CT findings are not mutually exclusive and that is why only 1 is needed to meet objective criteria for chronic sinusitis.

(Ibid.)

(2) Dr. Lee's citation to the AAO Guideline regarding radiographic imaging as an alternative diagnostic criterion for chronic rhinosinusitis credibly informs her belief that CT scans are less significant as they are only one piece of the complementary information in diagnosing chronic rhinosinusitis. However, this citation does not address the standard of care for whether to document any discrepancy in radiologic findings by the clinician and the radiologist. Additionally, on cross examination, Dr. Lee admitted that, while she would not comment on any disagreement with the radiologist's interpretation of imaging, she would document her own interpretation of the imaging. Respondent did not include such an interpretation of the CT scans in the patients' medical records.

61C. Regarding the documentation of differences in interpretation of radiological imagining, Dr. Kearns' opinions are more persuasive than those of Dr. Lee. Consequently, Complainant established by clear and convincing evidence that Respondent violated the standard of care by failing to document his differing interpretations from the radiologist's interpretations of CT scans.

Staging of Surgery

62A. As set forth in Factual Finding 41, during the time frame at issue, it was Respondent's custom and practice to stage his procedures to be performed first on one side of the patient's nose, with a later-scheduled surgery on the opposite side.

62B. (1) Dr. Kearns opined it is the standard of care for a physician to "efficiently and safely operate on patients for indicated medical reasons. If the condition is bilateral and the disease can be safely approached, then the bilateral condition should be addressed during one operation." (Exhibit 10, p. 594.) Dr. Kearns noted Respondent would routinely stage turbinate surgery, performing surgery on one side and returning several weeks later to operate on the opposite side. According to Dr. Kearns:

> There may be occasions where a patient could be approached [with] unilateral treatment. Such examples would be if an issue or complication developed intraoperatively that only one side could be done at one sitting, if there was absence of disease on the contralateral side or in nasal procedures if the patient had significant sleep apnea and the clinician wanted to preserve some degree of nasal airway. None of these situations seem to apply in these two patients.
>
> There is no strong medical reason to stage things this way and the standard of care in California . . . is for the clinician to try to minimize the number of general anesthetics when

possible and operate on the bilateral pathology at one sitting.

(Ibid.)

(2) Dr. Kearns further noted there was no medical justification documented in the patients' records for staging of their surgeries and exposing them to multiple operations. While it is only potential harm, there remains a risk of having two operations which involves undergoing anesthesia twice and having two recovery periods. Dr. Kearns opined credibly that Respondent committed a simple departure from the standard of care in staging surgeries.

62C. (1) Dr. Lee opined the standard of care provides, "Whether to stage a procedure is ultimately up to the patient and the clinician depending on the particular context and situation." (Exhibit A, Dr. Lee report, p. 11.)

(2) Dr. Lee noted:

> With respect to Patient [1], in terms of the staged sinonasal procedures, it was documented that "I explained to her we could plan a staged procedure if she had some anxiety about her being obstructed when I discussed the turbinate procedure...she was staged for a two-part nasal surgery or procedure to be completed within 30-60 days...doing the worse side first, of her nasal obstruction, which was the left side...with this technique it allows the patient to always have one side of the nose open. Thus, not being totally obstructed post-op bilaterally. . . .

> With respect to Patient [2], in terms of the staged sinonasal procedures, it was documented that "at this time she was staged for a two part nasal surgery or procedure to be completed within 30-60 day. Doing the worse side first, of her nasal obstruction, which was the left side, (turbinate only). She didn't want sinus work at the time. She was a Fed Ex employee and wanted to return to work immediately. She was also very anxious about having both sides of her nose obstructed. Which is why she was staged in two parts. With this technique it allows the patient to always have one side of the nose open. Thus, not being totally obstructed post-op bilaterally.

(Exhibit A, Dr. Lee report, p. 11.)

(3) For both patients, Dr. Lee opined: "Although uncommon to stage such sinonasal procedures, if this was done at the behest of the patient due to anxiety issues as indicated in the supplemental documentation, then this approach would be a reasonable solution to accommodate the patient's preferences." (Exhibit A, Dr. Lee report, p. 11.) Dr. Lee concluded, "If the staged procedures were performed to accommodate the patients' preferences, no violation of the standard of care was identified."

(4) However, Dr. Lee's factual assertions are not borne out by the evidence, and she relies on "supplemental documentation" which was not part of the patients' medical records. Respondent's new assertions of accommodating the patients' anxiety and return-to-work preferences were found not credible and

apparently noted solely to bring Respondent's staging of Patient 1 and Patient 2's procedures within the standard of care. (See Factual Finding 41.)

62D. Given that the factual bases for Dr. Lee' opinions were not established by the evidence, her opinions on this issue were given little weight. Thus, the opinions of Dr. Kearns regarding Respondent's staging of surgeries were more persuasive than those of Dr. Lee. Complainant established by clear and convincing evidence that Respondent violated the standard of care by staging his surgeries rather than basing the staging on accommodation of the patients' documented preferences.

Disciplinary Considerations

63. To determine the degree of discipline, if any, to be imposed on Respondent, the following prior disciplinary history is considered:

A. Effective July 7, 2011, in Case Number 11-2007-187023, the Board issued Respondent a public reprimand for committing repeated negligent acts in violation of Business and Professions Code section 2234, subdivision (c), and failing to maintain adequate and accurate records, in violation of Business and Professions Code section 2266. Respondent was ordered to complete a medical record keeping course and a sinus surgery course. The public reprimand stated:

> On September 2, 2010, the [Board] filed an accusation against your license to practice medicine. The accusation was based on your care and treatment of a patient in 2005, during which you failed to properly manage P.M.'s medical condition, and failed to maintain adequate and accurate medical records (including when you used electronic notes from the first patient visit as a template, and failed to

> update the clinical information in such electronic records), in violation of Business and Professions Code sections 2266 and 2234, subdivision (c). Practicing within the standard of care is necessary for protection of the public, and maintaining appropriate records of patient care is absolutely necessary not only to ensure proper treatment by you, but also by subsequent treating physicians.

(Exhibit 9.)

B. Effective May 5, 2000, in an action entitled In the Matter of the Accusation Against Terry Wesley Scott, MD., Case Number 02-2000-105504 (Probation Order), the Board placed Respondent's license on three years of probation with terms and conditions for committing repeated dishonest acts, in violation of Business and Professions Code section 2234, subdivision (e), and for sustaining a conviction of an offense that is substantially related to the practice of medicine, in violation of Business and Professions Code section 2236, subdivision (a). The Probation Order included a suspension of Respondent's license while he was incarcerated in the United States Bureau of Prisons for being convicted of one count of violating 26 U.S.C. 14 § 7206(1), false statements in a tax return.

Respondent's Rehabilitation and Character Evidence

64. Respondent has been in private practice as an ENT since 1988, and he keeps up to date on his continuing medical education. He holds clinical privileges at West Covina Medical Center.

65. Respondent has not been subject to adverse actions or medical malpractice actions in the past five years.

66A. Respondent acknowledged the discrepancies in Patient 1's medical records regarding the midline/deviated septum. He explained that, in 2013, he was using an electronic medical record (EMR) system called Altra Point which automatically noted a physical finding of midline septum, and he could not make amendments of mistakes to the EMR once he closed out the note. Respondent testified he changed EMR systems six to seven years ago, and he now uses a "much better system" called Prognosis which allows him to amend mistakes in the EMR.

66B. Respondent did not explain why, in 2013, he continued to use a template-based EMR with boilerplate language, despite being ordered in 2011 to complete a medical recordkeeping course for failure to maintain adequate and accurate medical records (based, in part, on his using electronic template notes and failing to update clinical information in the EMR).

67. As noted in Factual Finding 43, Respondent admitted during his Board interview that he has since changed his practice and now documents his contrary radiological findings if they differ from the radiologist's. However, at hearing, Respondent opined he should not need to document his disagreement with the radiological interpretation.

68. Respondent provided three patients' complimentary writings (an online rating, a card, and a letter) in which the patients praised his treatment of them. Respondent also has the support of patient, Charloletta Ransom, who testified on his behalf and confirmed she has been happy with his care.

LEGAL CONCLUSIONS

1. The standard of proof which must be met to establish the charging allegations is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This means the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

2. The Board has the authority to revoke or suspend a physician's license for engaging in unprofessional conduct. (Bus. & Prof. Code, §§ 2004, 2234.) Unprofessional conduct includes repeated negligent acts. (Bus. & Prof. Code, § 2234, subd. (c).)

3. Business and Professions Code section 725, subdivision (a), provides, in pertinent part:

> Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon. . . .

4. Business and Professions Code section 2266 provides, "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."

5. Cause does not exist to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 725, in that Complainant did not establish by clear and convincing evidence that Respondent engaged in acts of clearly excessive treatment by performing unindicated surgeries on Patient 1 or 2, as set forth in Factual Findings 3 through 62.

6. Cause exists to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2266, in that Respondent failed to maintain adequate and accurate records in his care of and treatment of Patients 1 and 2, as set forth in Factual Findings 3 through 62.

7A. Cause exists to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), in that Respondent committed repeated acts of negligence in his care and treatment of Patients 1 and 2, as set forth in Factual Findings 3 through 57, and 61 through 62.

7B. Cause does not exist to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), for acts of negligence which were not established by clear and convincing evidence, as set forth in Factual Findings 58, 59, and 60.

8A. Complainant established that Respondent engaged in a failure to maintain adequate and accurate records and in repeated acts of negligence in his treatment of two patients. The remaining question is the nature of the discipline to be imposed against Respondent's certificate for his violations.

8B. Business and Professions Code section 2229 provides, in pertinent part:

(a) Protection of the public shall be the highest priority for the Division of Medical Quality . . . 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 . . . 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.

8C. Business and Professions Code section 2227, subdivision (a), provides:

(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, . . . and who is found guilty, or who has entered into a stipulation for disciplinary action with the division, may, in accordance with the provisions of this chapter:

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

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

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

(4) Be publicly reprimanded by the division.

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

8D. Respondent's violations generally stem from his inadequate documentation (i.e., varying descriptions of a patient's midline/deviated septum; failure to document differing interpretations of CT scans; and failure to confirm and document patients' preferences to stage surgery). It is troubling that, in 2011, Respondent was publicly reprimanded and ordered to complete a medical recordkeeping course, but thereafter committed similar documentation violations in this case. Consequently, a public reprimand would provide insufficient rehabilitative effect. Conversely, revocation is not warranted, despite the ineffectiveness of the prior medical recordkeeping course. In weighing the goals of public protection and rehabilitation of the licensee, a period of probation with an updated medical recordkeeping course, educations courses, and a practice monitor will provide adequate public protection while working toward effective rehabilitation. Additionally, Respondent should be suspended from practice for 20 days to afford him the opportunity to implement new medical recordkeeping practices compliant with the standard of care and to establish a plan for future compliance with the laws and rules governing the practice of medicine.

ORDER

Physician's and Surgeon's Certificate Number G 54536, issued to Respondent, Terry Wesley Scott, M.D., is revoked. However, the revocation is stayed, and Respondent is placed on probation for three years upon the following terms and conditions.

1. 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.

2. 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.

3. 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.

4. General Probation Requirements

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 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.

5. 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.

6. Non-practice While on Probation

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

authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

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

Periods of non-practice for 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.

7. 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.

8. 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.

9. 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.

10. Actual Suspension

As part of probation, Respondent is suspended from the practice of medicine for 20 days beginning the sixteenth (16th) day after the effective date of this Decision.

11. 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 of the additional 40 hours of CME in satisfaction of this condition.

12. 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 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.

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

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

plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

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 and documenting appropriately. 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 five 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.

14. Completion of Probation

Respondent shall comply with all financial obligations (i.e., 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.

DATE: 09/03/2021

Julie Cabos-Owen
JULIE CABOS-OWEN
Administrative Law Judge
Office of Administrative Hearings

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Sept 19 20 19
BY D. Richards ANALYST

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

In the Matter of the Accusation Against:	Case No. 800-2016-028178
TERRY WESLEY SCOTT, M.D. **1111 S Grand Ave., # E** **Diamond Bar, CA 91765** **Physician's and Surgeon's Certificate No. G 54536,** Respondent.	**A C C U S A T I O N**

PARTIES

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

2. On or about April 8, 1985, the Medical Board issued Physician's and Surgeon's Certificate Number G 54536 to Terry Wesley Scott, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 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 2001.1 of the Code, states:

"Protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

5. 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."

6. 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."

7. Section 2228 of the Code states:

"The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

"(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

"(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

"(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(d) Providing the option of alternative community service in cases other than violations relating to quality of care."

STATUTORY PROVISIONS

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:

"...

"(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.

"..."

9. 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."

10. Section 725 of the Code states:

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

"..."

DEFINITIONS

11. Boggy Turbinates: The mucosa of the nasal turbinates may be swollen (boggy) and have a pale, bluish-gray color.

12. Ethmoidectomy: A surgical procedure that involves removing the partitions between the ethmoid sinuses in order to create larger sinus cavities.

13. Ethmoid Sinus: One of six sets of sinuses, located between the nose and eyes.

14. Granulation Tissue: New connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process.

15. Hypertrophy of Inferior Turbinates: An enlargement of the inferior turbinate that can cause nasal obstruction in one or both sides of the nose.

16. Inferior Turbinate: Structures located inside the nose, along the sides of the nasal cavities that help warm and moisten the air that flows through the nose. There are three pairs of turbinates, the inferior turbinates being the largest and located lowest in the nose.

17. Infracture: The removal of nasal bones medially (inward), to narrow a widened nose.

18. Maxillary Antrostomy: A surgical procedure to enlarge the opening (ostium) of the maxillary sinus.

19. Middle Meatus: A curved anteroposterior passage in each nasal cavity that is situated below the middle nasal concha and extends along the entire superior border of the inferior nasal concha.

20. Midline Nasal Septum: The equal spacing of the wall separating the left and right sides of the nose to allow passageways of equal size.

21. Nasal Endoscopy: A procedure that uses an endoscope to view the nasal and sinus passages.

22. Ostium: The opening from each of the paranasal sinuses that allows drainage into the nasal cavity.

23. Rhinomanometry: A test that measures air pressure and the rate of airflow in the nasal airway during respiration.

24. Submucous Resection of the Inferior Turbinates: A procedure wherein a surgeon makes a small incision in the lining of the inferior turbinates and lifts the lining off the thin bone that forms the structural support of the inferior turbinate.

25. Total ethmoidectomy: Surgical removal of infected tissue and bone in both the anterior and posterior ethmoid sinuses that blocks natural drainage.

26. Tympanometry: A test that measures the function of the middle ear by varying the pressure within the ear canal and measuring the movement of the eardrum.

FACTUAL ALLEGATIONS

PATIENT NO. 1

27. On May 24, 2013, Patient No. 1 sought treatment from Respondent for difficulty with breathing through her nose. Patient No. 1 reported that the problem persisted for 20 years. Patient No. 1 reported no prior nasal surgeries. Respondent performed a physical examination and noted Patient No. 1's septum was midline. Respondent diagnosed Patient No. 1 with chronic ethmoid sinusitis, chronic frontal sinusitis, hypertrophy of turbinates, allergic rhinitis, and

deviated septum (despite noting that Patient No. 1's septum was midline). Respondent prescribed Ceftin[1] and Flonase.[2] Respondent ordered allergy testing, a CT scan of the sinuses, tympanometry, and rhinomanometry.

28. On May 30, 2013, Patient No. 1 was treated by Respondent during a follow-up appointment. Respondent performed various nasal tests. Respondent documented a midline septum. During this appointment, Respondent did not diagnose Patient No. 1 with a deviated septum. The treatment plan included a future surgery.

29. On June 6, 2013, Patient No. 1 was treated by Respondent during a follow-up appointment. During this appointment, Respondent documented that Patient No. 1's septum was deviated 90% to the right. Respondent's diagnosis included deviated nasal septum. Respondent performed a nasal endoscopy during the visit. Respondent prescribed Medrol,[3] but failed to document his rationale for changing medications.

30. On June 13, 2013, Patient No. 1 was treated by Respondent during a follow-up appointment. During this appointment, Respondent noted that Patient No. 1's septum was deviated 90% to the right. Respondent's diagnosis included deviated nasal septum. Respondent performed a turbinate steroid injection.

31. On June 28, 2013, Patient No. 1 was treated by Respondent during a follow-up appointment. Respondent documented a midline septum. During this appointment, Respondent did not diagnose Patient No. 1 with a deviated septum. Respondent diagnosed Patient No. 1 with hypertrophy of the nasal turbinates, allergic rhinitis, and chronic maxillary sinusitis. The treatment plan included various nasal surgical procedures that were scheduled for July 5, 2013. Respondent prescribed Augmentin[4] and Flonase. Respondent failed to document his rationale for changing medications.

32. On July 5, 2013, Respondent documented that he performed the following surgical procedures: submucous resection of the left inferior turbinate, excision of degenerative nasal

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[1] An antibiotic.
[2] A steroidal medication.
[3] A steroidal medication.
[4] An antibiotic.

mucosa on the left, and infracturing of the right inferior turbinate. In a separate operative report, Respondent documented that he performed a laser excision of the left middle turbinate. The surgical pathology report indicated no significant tissue abnormality.

33. On July 12, 2013, Patient No. 1 was treated by Respondent during a post-surgical follow-up appointment. Respondent documented "septum deviated right." Respondent diagnosed Patient No. 1 with a deviated nasal septum.

34. On July 23, 2013, a CT scan was performed by a different healthcare provider. The scan showed a mild right-sided nasal septal deflection, with otherwise clear sinuses.

35. On July 23, 2013, Patient No. 1 was also treated by Respondent during a follow-up appointment. Respondent performed a nasal endoscopy and documented that the septum was deviated 90% to the right and the ethmoid and maxillary sinuses had purulent debris in the middle meatus. Respondent did not obtain a culture of the purulent debris. Respondent documented in a separate portion of the treatment record that Patient No. 1 had a midline septum. During this visit, Respondent did not diagnose Patient No. 1 with a deviated septum.

36. On July 29, 2013, Respondent performed additional surgical procedures on Patient No. 1. Respondent documented that he performed the following procedures: bilateral functional endoscopic sinus surgery including total ethmoidectomy, septal reconstruction, and submucous resection of the right inferior turbinate. Respondent documented that the ethmoid sinuses were open bilaterally, but did not document any issue with the maxillary sinuses.

37. On August 5, 2013, Patient was treated by Respondent during a follow-up appointment. Respondent documented a midline septum, yet diagnosed Patient No. 1 with a deviated septum.

38. On August 14, 2013, Patient No. 1 was treated by Respondent during a follow-up appointment. Respondent performed a nasal endoscopy and documented purulent debris in the middle meatus, and a midline septum. Respondent did not obtain a culture of the observed purulent debris. Respondent prescribed Medrol[5] and Ceftin.[6]

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[5] A steroidal medication.
[6] An antibiotic.

39. On September 19, 2013, Patient No. 1 was treated by Respondent during a pre-operation examination. Respondent documented a midline septum, but diagnosed Patient No. 1 with a deviated septum.

40. On September 26, 2013, Respondent performed additional surgical procedures on Patient No. 1. Respondent performed bilateral frontal sinus surgery, maxillary sinus antrostomies, ethmoidectomy, submucous resection of the left inferior turbinate. Respondent documented that scar and granulation tissue blocked the ethmoid and frontal sinuses. Respondent reopened the blocked sinuses with forceps and a microdebrider. The pathology report indicated benign nasal and sinus tissue. Postoperatively, Patient No. 1 complained of nasal congestion and was treated with saline irrigations.

41. On October 7, 2013, Patient No. 1 was treated by Respondent during a follow-up appointment. Respondent documented a midline septum, but diagnosed Patient No. 1 with a deviated septum.

42. Patient No. 1's medical charts contain numerous discrepancies in the documentation of the status of the nasal septum during the course of treatment. During the course of treatment, Respondent documented both a midline septum and a 90% deviated septum to the right.

PATIENT NO. 2

43. November 22, 2013, Patient No. 2 sought treatment with Respondent for snoring and headaches. Respondent performed a physical examination and documented boggy, swollen, and red turbinates. Respondent made no comment regarding Patient No. 2's tonsils. Respondent diagnosed Patient No. 2 with chronic ethmoid sinusitis, chronic frontal sinusitis, turbinate hypertrophy, allergic rhinitis, obstructive sleep apnea, and hypersomnia. The treatment plan included allergy testing, a CT scan of the sinus, rhinomanometry, and tympanometry. Respondent prescribed Ceftin and Flonase.

44. On December 3, 2013, another provider performed a CT scan of Patient No. 2's sinuses. The CT scan showed mild left maxillary sinus chronic disease with either a mucous retention cyst or polyp at the floor of the left maxillary sinus. The remaining sinuses appeared to be clear.

45. On December 3, 2013, Respondent also treated Patient No. 2 during a follow-up appointment. Respondent documented that Patient No. 2 was previously prescribed multiple antibiotics for a period greater than six weeks, had multiple sinus infections each month, and the condition did not improve with medication. Respondent failed to document the specific antibiotic previously prescribed, the identity of the prescriber, or the dates of use, and the type of antibiotic prescribed. The physical examination showed boggy turbinates. Respondent diagnosed Patient No. 2 with chronic ethmoid sinusitis, chronic maxillary sinusitis, hypertrophic turbinates, and allergic rhinitis. Respondent prescribed Augmentin and Medrol.

46. On December 8, 2013, a sleep study was performed. The result was interpreted as normal.

47. On December 24, 2013, Respondent treated Patient No. 2 during a pre-operation visit.

48. On December 28, 2013, Respondent performed various surgical procedures on Patient No. 2. Specifically, Respondent performed submucous resection of the left inferior turbinate, excision of degenerative nasal mucosa on the left, and fractionated right inferior turbinate. In a separate surgical report, Respondent documented that he performed an excision of the left middle turbinate and laser ablation of the left middle turbinate mucosa. The post-surgical pathology report indicated left inferior turbinate chronic inflammation consistent with turbinate.

A. During a subsequent interview with the Board, Respondent stated that he performs middle turbinate surgery as a treatment for headaches.

49. On January 8, 2014, Respondent treated Patient No. 2 during a follow up visit. Respondent performed a nasal sinus debridement. Respondent prescribed Ceclor[7] and Flonase.

50. On February 3, 2014, Respondent treated Patient No. 2 in a follow up visit. Respondent documented that Patient No. 2 complained of congestion, postnasal drainage, snoring, facial pain, and headaches. During the visit, Respondent performed a nasal endoscopy and a preoperative examination. Respondent documented purulent debris extruding from the left sinus. Respondent took no cultures of the purulent debris. Respondent prescribed Zithromax.[8]

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[7] An antibiotic.
[8] An antibiotic.

A. During a subsequent interview with the Board, Respondent stated he observed disease and polyps during the endoscopy in the maxillary and ethmoid sinuses. This observation is not documented in the preoperative records.

51. On February 6, 2014, Respondent performed a second set of surgical procedures on Patient No. 2. Specifically, Respondent performed bilateral ethmoid and maxillary sinus surgery and submucous resection of the right inferior turbinate. Respondent noted the presence of significant purulent material in the middle left meatus. Respondent took no cultures of the documented purulent material.

52. On February 14, 2014, Respondent treated Patient No. 2 during a follow-up visit. Respondent documented the presence of bloody clots and debris in Patient No. 2's sinuses. Respondent did not obtain a culture of the observed debris. Respondent performed a bilateral sinus debridement. Respondent prescribed Ceftin and Pulmicort.[9]

53. On June 2, 2014, Patient No. 2 presented with complaints of sore throat and nasal obstruction. Respondent documented that Patient No. 2 had recurrent sore throats, approximately two to three times per year. Respondent also documented bilateral hypertrophic turbinates. Respondent's physical examination revealed that Patient No. 2's tonsils were enlarged, tender to palpation, red, swollen, and covered in a white coating. Respondent's diagnoses included chronic tonsillitis. Respondent prescribed Norco, Cipro,[10] and Medrol.

54. On June 30, 2014, Patient No. 2 presented with complaints of tonsillitis and a sore throat. Respondent documented that Patient No. 2 had a recurrent sore throat, about four to five times a year.

55. On July 8, 2014, Respondent performed a tonsillectomy on Patient No. 2.

56. On July 14, 2014, Respondent treated Patient No. 2 during a post-surgery follow-up visit. Respondent documented that Patient No. 2 had a white coating on her throat, consistent with post tonsillectomy.

57. On July 21, 2014, Patient No. 2 was treated by Respondent during a follow-up visit.

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[9] A steroidal medication.
[10] An antibiotic.

Respondent documented hypertrophic turbinates, a midline septum, and erythema in the tonsils. Respondent prescribed Ceftin.

58. On August 11, 2014, Respondent treated Patient No. 2 during a follow-up visit. Patient No. 2 reported a persistent sore throat since surgery. Respondent again documented a white coating on Patient No. 2's throat. Respondent took no culture of the observed white coating. Respondent also documented tonsil remnants. Respondent prescribed Ceclor and Medrol.

59. On October 3, 2014, Patient No. 2 presented with a chief complaint of neck pain. Respondent performed a physical exam and documented turbinate hypertrophy and erythema of the tonsil with white coating. Respondent took no culture of the observed white coating. Respondent prescribed Cipro and Norco. Respondent also ordered a sinus CT scan.

60. The sinus CT scan report, dated October 24, 2014, reported a 1.2 cm mucous retention cyst at the inferior aspect of the left maxillary sinus. The CT scan results were otherwise clear, with normal turbinates, and no deviation of the septum.

61. On October 31, 2014, Respondent performed a pre-operative evaluation of Patient No. 2.

62. On November 11, 2014, Respondent performed another set of surgical procedures on Patient No. 2. Specifically, Respondent performed bilateral functional endoscopic sinus surgery with maxillary sinusotomy, polyp removal, submucous resection of the left inferior turbinate, and excision of the remnant tonsil tissue. Respondent documented the presence of granulation tissue that blocked Patient No. 2's sinuses. Respondent opened the blocked sinuses, removed the polypoid material, and removed small pieces of bone during the submucous resection. There is no pathology report for either the extracted tonsil or sinus tissue.

63. The Board subsequently interviewed Respondent. During the interview, Respondent stated several times that he purposely stages turbinate procedures. Respondent admitted that staging turbinate procedures is not a common approach, but is one he has developed and followed for 20 years.

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MEDICAL ISSUES IDENTIFIED

Documentation

64. The standard of care requires a physician to document their observations and the procedures performed during a patient encounter. The documentation should accurately reflect the interaction between the physician and the patient.

65. Respondent documented middle turbinate procedures separately from the co-occurring operative procedures. Documenting the procedures separately does not accurately reflect the operation performed.

66. Respondent documented that during endoscopy procedures, he observed the ethmoid and maxillary sinuses in Patients Nos. 1 and 2. However, neither patient had a prior sinus surgery. A physician is unable to see directly into the maxillary and ethmoid sinuses during an endoscopy unless the patient had prior sinus surgery.

67. Respondent inconsistently documented the status of Patient No. 2's septum. Respondent documented both a midline septum and a deviated septum.

Submission of Tissue to Pathology

68. The standard of care requires a surgeon who removes potentially pathologic tissue to ensure that a specimen is sent to pathology for microscopic analysis. The physician must follow-up to ensure that the specimens are adequately analyzed for appropriate care and treatment of the patient.

69. Respondent failed on multiple occasions with respect to Patient Nos. 1 and 2 to ensure that the specimens obtained from Patients Nos. 1 and 2 were appropriately forwarded to pathology for analysis.

Indications for Surgery

70. The standard of care requires that a surgeon have clear and adequate indication that surgery is appropriate. The indication for sinus surgery is based on the patient's history, physical examination, results of ancillary testing (e.g. allergy testing and radiographic imaging), and the patient's prior response to other forms of therapy. In circumstances where the radiographs are interpreted as clear by the radiologist and abnormal by the operating physician, there needs to be

clear demonstration of the surgeon's rationale as well as the results of prior medical therapies.

71. With respect to Patient No. 2's surgery dated July 29, 2013, Respondent's decision to perform surgery was not supported by the pre-operative CT scan. Similarly, with respect to Patient No. 1's surgery dated February 6, 2014, Respondent's decision to perform surgery was not supported by the pre-operative CT scan, nor was there adequate documentation of the prior unsuccessful medical therapies. Finally, Respondent's opinion that resection of the middle turbinate is an effective treatment for headaches is not supported by medical evidence.

Use of Culture in Medical Practice

72. The standard of care requires a physician, when possible, to direct antibiotic therapy to a specific identified pathogen. The use of culture on identified purulent material is an effective means to limit the type and duration of antibiotic therapy.

73. The medical charts for Patients Nos. 1 and 2 contain multiple instances in which Respondent failed to take cultures of identified purulent material. Additionally, on multiple occasions, Respondent abruptly changes antibiotics prescribed to Patients Nos. 1 and 2, without proper justification. A culture could have specifically directed the proper antibiotic therapy prior to consideration for surgery.

Clinical and Pathological Interpretation Discrepancies

74. When a physician's clinical diagnosis is profoundly different from the pathological interpretation, the standard of care requires a physician to discuss the findings with the pathologist. Alternatively, the standard of care requires the physician document the rationale for the discrepancy.

75. The records for Patients Nos. 1 and 2 contain numerous instances in which the histopathologic report differs considerably from Respondent's intraoperative observations. The records do not document that Respondent discussed the differences of interpretation with the pathologist, nor do the records document Respondent's analysis or opinion as to the discrepancies.

Radiology and Clinician Interpretation Discrepancy

76. When there is a significant discrepancy between a radiologist's report and the

clinician's observation of the radiograph, the standard of care requires that the physician discuss the difference with the radiologist. Alternatively, the standard of care, requires the physician to document the specific differences in opinion and observation between the radiologist's interpretation and the clinician's review.

77. As to Patients Nos. 1 and 2, the medical records document multiple occasions in which the radiologist interpretation is substantially less severe than Respondent's. The medical records contain no documentation as to the reasons for the discrepancy.

Staging of Surgery

78. The standard of care requires a physician to efficiently and safely operate on patients for indicated medical reasons. If focus of the surgery is a bilateral condition and the disease can be safely approached, then the bilateral condition should be addressed during one operation.

79. Respondent routinely staged turbinate surgeries without documenting a medical reason for staging.

FIRST CAUSE FOR DISCIPLINE

(Repeated Acts of Excessive Treatment)

80. Respondent Terry Wesley Scott, M.D. is subject to disciplinary action under section 725, subdivision (a), in that Respondent performed numerous unindicated surgeries on Patients Nos. 1 and 2. The circumstances are as follows:

81. The facts and circumstances alleged in Paragraphs 36 through 79 above are incorporated by reference as if set forth in full herein.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

82. Respondent Terry Wesley Scott, M.D. is subject to disciplinary action under section 2266 in that Respondent failed to maintain adequate and accurate medical records as to Patient Nos. 1 and 2. The circumstances are as follows:

83. The facts and circumstances alleged in Paragraphs 27 through 81 above, are incorporated by reference as if set forth in full herein.

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THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

84. Respondent Terry Wesley Scott, M.D. is subject to disciplinary action under section 2234, subdivision (c) in that Respondent's care and treatment of Patient Nos. 1 and 2 fell below the standard of care on multiple occasions. The circumstances are as follows:

85. The facts and circumstances alleged in Paragraphs 27 through 83 above are incorporated by reference as if set forth in full herein.

DISCIPLINARY CONSIDERATIONS

86. To determine the degree of discipline, if any, to be imposed on Respondent Terry Wesley Scott, M.D., Complainant alleges that on or about July 7, 2011, in a prior disciplinary action entitled *In the Matter of the Accusation Against Terry Wesley Scott, M.D. before the Medical Board of California*, in Case Number 11-2007-187023, Respondent was issued a Public Reprimand for committing repeated negligent acts in violation of section 2234, subdivision (c), and failing to maintain adequate and accurate records, in violation of section 2266. That decision is now final and is incorporated by reference as if fully set forth herein.

87. To determine the degree of discipline, if any, to be imposed on Respondent Terry Wesley Scott, M.D., Complainant alleges that on or about May 5, 2000, in a prior disciplinary action entitled *In the Matter of the Accusation Against Terry Wesley Scott, M.D. before the Medical Board of California*, in Case Number 02-2000-105504, Respondent's license was placed on three years of probation with terms and conditions for committing repeated dishonest acts, in violation of section 2234, subdivision (e), and sustaining a conviction of an offense that is substantially related to the practice of medicine, in violation of section 2236, subdivision (a). The probation terms and conditions of probation included a suspension of his license while he was incarcerated in the United States Bureau of Prisons for being convicted of one (1) count of violation of 26 U.S.C. 14 § 7206(1), false statements in tax return, in case number 98-330, *United States v. Scott*, in That decision is now final and is incorporated by reference as if fully set forth herein.

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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 G 54536, issued to Respondent;

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

3. Ordering Respondent, 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: September 19, 2019

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

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