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

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|---|---|
| In the Matter of the Accusation Against:<br><br>Philip A. Edington, M.D.<br><br>Physician's and Surgeon's Certificate No. G 58380<br><br>Respondent. | Case No.: 800-2018-043721 |

## DECISION

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

This Decision shall become effective at 5:00 p.m. on February 25, 2022.

IT IS SO ORDERED: January 27, 2022.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
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Supervising Deputy Attorney General
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*Attorneys for Complainant*

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

| In the Matter of the Accusation Against:<br><br>**PHILIP A. EDINGTON, M.D.**<br>**1899 W. March Lane**<br>**Stockton, CA 95207-6402**<br><br>**Physician's and Surgeon's Certificate No. G 58380**<br><br>Respondent. | Case No. 800-2018-043721<br><br>OAH No. 2021061033<br><br>**STIPULATED SETTLEMENT AND DISCIPLINARY ORDER** |
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IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

**PARTIES**

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Ryan J. Yates, Deputy Attorney General.

2. Respondent Philip A. Edington, M.D. (Respondent) is represented in this proceeding by attorney David A. Depolo, Esq., whose address is: 201 North Civic Drive, Suite 239

Walnut Creek, CA 94596. On or about August 25, 1986, the Board issued Physician's and Surgeon's Certificate No. G 58380 to Philip A. Edington, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2018-043721, and will expire on November 30, 2021, unless renewed.

## JURISDICTION

3. Accusation No. 800-2018-043721 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on April 21, 2021. Respondent timely filed his Notice of Defense contesting the Accusation.

4. A copy of Accusation No. 800-2018-043721 is attached as exhibit A and incorporated herein by reference.

## ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2018-043721. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

## CULPABILITY

8. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2018-043721, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. Respondent agrees that, at a hearing, Complainant could establish a prima facie case or factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

10. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2018-043721, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. G 58380 to disciplinary action.

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

## CONTINGENCY

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

13. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against her before the Board, all of the charges and allegations contained in Accusation No. 800-2018-043721 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

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

**DISCIPLINARY ORDER**

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 58380 issued to Respondent Philip A. Edington, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

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

Medical Education (CME) requirements for renewal of licensure.

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

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

3. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the

scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

4. MONITORING - PRACTICE/BILLING. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

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

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

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

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and

education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

5. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

6. PROHIBITED PRACTICE: STRABISMUS SURGERIES. During probation, respondent is prohibited from performing strabismus surgeries. After the effective date of this Decision, all patients being treated by the respondent shall be notified that the respondent is prohibited from performing strabismus surgeries. Any new patients must be provided this notification at the time of their initial appointment. Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the

notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

7. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

8. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

9. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

10. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

12. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If

Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

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

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

14. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

15. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation,

or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

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

17. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

18. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2018-043721 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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## ACCEPTANCE

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

DATED: 1/5/22

PHILIP A. EDINGTON, M.D.
*Respondent*

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

DATED: 1/10/22

DAVID A. DEPOLO, ESQ.
*Attorney for Respondent*

## ENDORSEMENT

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

DATED: 1/11/21

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

Ryan J. Yates

RYAN J. YATES
Deputy Attorney General
*Attorneys for Complainant*

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stipulated settlement 12-20-21.docx

# Exhibit A

**Accusation No. 800-2018-043721**

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*Attorneys for Complainant*

**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
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| In the Matter of the Accusation Against: | Case No. 800-2018-043721 |
|---|---|
| **Philip A. Edington, M.D.**<br>**1899 W. March Lane**<br>**Stockton, CA 95207-6402**<br><br>**Physician's and Surgeon's Certificate No. G 58380,**<br><br>Respondent. | **A C C U S A T I O N** |

## PARTIES

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

2. On or about August 25, 1986, the Medical Board issued Physician's and Surgeon's Certificate Number G 58380 to Philip A. Edington, 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 November 30, 2021, unless renewed.

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## JURISDICTION

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

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

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

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

"..."

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6. 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."

**FIRST CAUSE FOR DISCIPLINE**

**(Gross Negligence)**

7. Respondent's Physician's and Surgeon's Certificate No. G 58380 is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in his care and treatment of Patient B[1], Patient C, and Patient D, as more particularly alleged hereinafter:

8. Respondent is a general ophthalmologist, who practices medicine at the Center for Sight clinics, where he has an ownership interest. The clinics are located in Stockton (two locations), Manteca, Tracy, and Modesto. Respondent also practices at several hospitals in the Central Valley area. The case came to the attention of the Board through an online complaint, filed by Respondent's former employee. The complaint alleges that Respondent had performed several unnecessary and improper strabismus surgeries during her time as his employee. It further alleged that many of the patients are children who otherwise should have been prescribed glasses for ocular alignment, but because they had initial strabismus surgery, had to have multiple subsequent surgeries to correct the initial one. This resulted in the amblyopia[2] being left untreated and some of the patients were left legally blind from the amblyopia. The complaint further alleged that a reason for the poor outcomes is because Respondent moves the eye muscle the same amount in each surgery, regardless of the pre-operative measurement.

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[1] Identifying information has been removed to protect the confidentiality of the minor patients. Patients A, B, C, D, and E will be fully identified in discovery to the Respondent.

[2] Amblyopia is a disorder of sight in which the brain fails to process inputs from one eye and over time favors the other eye. It results in decreased vision in an eye that otherwise typically appears normal. Amblyopia occurs in early childhood. When nerve pathways between the brain and an eye aren't properly stimulated, the brain favors the other eye. Symptoms include a wandering eye, eyes that may not appear to work together, or poor depth perception. Both eyes may be affected. Treatment includes eye patches, drops, glasses or contact lenses, and sometimes surgery.

**Patient A**:

9. Patient A is a minor patient, who underwent two strabismus surgeries with Respondent. Prior to the surgeries, Respondent failed to consider prescribing corrective lenses as a non-surgical alternative. The first surgery (a bilateral medial rectus recession[3] of 4 mm for esotropia[4]) occurred on December 23, 2008. At that time, the patient was one year, two months of age. Following the surgery, Patient A developed consecutive exotropia[5]. The second surgery was on July 12, 2009, and was a right lateral rectus recession of 4 mm for exotropia. He was 1 year 9 months of age. Due to a lack of medical records in the file, prior to these surgeries, it is unknown whether Respondent used a nomogram.

10. On October 23, 2012, Patient A had a visit with an optometrist. The optometrist recorded a refraction[6] of +1.25[7] in both eyes with a corrected visual acuity of "20/20[8]" in the right eye and "20/20" in the left eye. He noted "RET" for right esotropia. There was no associated measurement of deviation recorded. The optometrist prescribed glasses and a 6 month follow-up, noting "may need surgery [right eye]."

11. The next office visit was on September 4, 2013, with Dr. L, M.D., a physician with the Center for Sight in Stockton. Patient A's vision was recorded to be less than 20/200 in the right eye. He was diagnosed with dense amblyopia of the right eye. A right esotropia of 30-35 diopters[9] was measured. He was also noted to have right inferior oblique overaction.[10] Dr. L

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[3] A surgical technique designed to modify the rectus (eye) muscle to correct strabiscus.

[4] Esotropia is a form of strabismus characterized by an inwards turn of one or both eyes.

[5] Exotropia is a form of strabismus where the eyes are deviated outward.

[6] A refraction test is usually given as part of a routine eye examination. It may also be called a vision test. This test tells your eye doctor exactly what prescription is necessary for corrective lenses.

[7] A 1.25 eye prescription refers to the power of the lens used to correct the problem. A diagnosis of 1.25 power lens correction is relatively mild.

[8] 20/20 vision is a term used to express normal visual acuity (the clarity or sharpness of vision) measured at a distance of 20 feet. If you have 20/20 vision, you can see clearly at 20 feet what should normally be seen at that distance. 20/20 vision only indicates the sharpness or clarity of vision at a distance.

[9] Diopters are a unit of measurement of the refractive power of a lens equal to the reciprocal of the focal length in meters.

[10] Inferior oblique muscle overaction (IOOA) manifests by overelevation of the eye in adduction and is frequently associated with horizontal deviations. It is reported in 70% of patients with esotropia and 30% of patients with exotropia.

prescribed patching of the left eye 4-6 hours per day and referred the patient to a pediatric specialist.

12. The next visit was one month later, on October 13, 2013, with Dr. H treating Patient A. The child's vision measurement was between 20/40 and 20/100 in the right eye and 20/20 in the left eye.

13. Refraction was performed and measured +0.75 in the right eye and +0.25 in the left eye. A right esotropia was measured to be 16 diopters. Dr. H recommended further patching therapy to treat amblyopia before considering further strabismus surgery. The child was 6 years old at that time.

14. The next office visit was one year later, on October 23, 2014, with Dr. H. The vision was recorded to be 20/100 in the right eye and 20/20 in the left eye. Refraction was performed and again found to be emmetropic (without defects) (+0.50 in both eyes). A right esotropia of 12 diopters was measured. The child was prescribed continued patching therapy with a plan for re-operation. The child was 7 years old. On follow-up with Dr. H, on January 12, 2015, the vision in the right eye had improved to 20/60, and the left eye vision was stable at 20/20. The right esotropia measured 14 diopters. Dr. H planned to explore and advance the right lateral rectus for consecutive esotropia. Patching therapy was increased. At the pre-operative appointment with Dr. H on February 4, 2015, visual acuity was measured to be between 20/70 and 20/100 and the right esotropia measurement was consistent with prior measurements at 16 diopters.

15. On February 19, 2015, Patient A underwent his third strabismus surgery, which was performed by Dr. H. Exploration found the right lateral rectus at 11 mm, consistent with the 4 mm recession performed by Respondent in 2009. Respondent's surgery was corrected by Dr. H, by advancing the recession 4 mm to the original insertion. On post-op day 1, the eyes were noted to be aligned. On follow-up 6 weeks later, a right esotropia was noted to have recurred, measuring 8 diopters at distance and 18 diopters at near. Patching therapy was continued and it was noted that further strabismus surgery may be needed.

16. The next chronologic record is an operative report from the fourth strabismus surgery on September 7, 2016, performed by a different physician, for recurrent esotropia and right

hypertropia. The medial recti were found at 10 mm posterior to the limbus, consistent with the operation performed in 2008. A right inferior oblique myectomy was performed for right inferior oblique overaction. The left lateral rectus was resected 5 mm.

17. On or about September 22, 2020, Respondent was interviewed by a Board investigator via teleconference. During the interview, Respondent was asked to comment on the diagnosis that preceded the decision for the first surgery performed in 2008. Respondent stated he did not have the records preceding the surgery. When asked about what his usual practice was at the time, Respondent stated that he would perform a complete exam, including a dilated fundus exam,[11] a refraction, would give glasses "if the child were in a position that they could wear glasses" "to see how much of the crossing was accommodative," and would operate for non-accommodative esotropia. He also stated that he uses a nomogram to decide how much to move the muscle. However, Respondent's statements regarding the initial surgeries cannot be verified, due to a lack of pre-operative and post-operative medical records.

18. Respondent was questioned about when a child can wear glasses. He stated words to the effect of, "We can give [glasses] to them when they're children... they don't often wear them...you see three-year-olds with their glasses on, but they're not going to keep them on. So it's not too often we give [glasses] to a two-year-olds." However, the child's age alone, should not have precluded the prescription of medically necessary glasses.

19. Respondent was also asked to speak on the child's development of amblyopia between October 23, 2012 and September 4, 2013. He incorrectly concluded that the vision must have started to decrease between that time because at the visit on October 23, 2012, the vision was 20/20 in each eye. Respondent failed to consider the greater likelihood that Patient A used the assistance of his left eye to improperly reach a 20/20 visual diagnosis, during the October 23, 2012 examination.

20. Respondent additionally mentioned that the eyes started to cross again after the Dr. H's February 19, 2015 surgery on Patient A. He explained that it is common to need more than

[11] A dilated fundus examination is a diagnostic procedure that employs the use of mydriatic eye drops (such as tropicamide) to dilate or enlarge the pupil in order to obtain a better view of the back portion of the eye.

one surgery. He stated that the child saw two specialists after his surgeries, that "the first specialist couldn't [straighten the eyes] and they went to another specialist."

**Patient B:**

21. Patient B, was first seen on April 26, 2006, by an ophthalmologist at Center for Sight, for tearing in the left eye. She was diagnosed with a tear duct obstruction and prescribed lacrimal massage and a topical antibiotic. On follow-up one month later, there was no improvement in her tearing. Patient B was referred to Respondent for a nasolacrimal probing procedure.[12] The probing was performed on October 5, 2006. At the one week post-op visit with Dr. C (a Center for Sight physician), the tearing was noted to have resolved. It was recommended for the child to return for routine complete eye exam in 3 months.

22. On January 17, 2007, Patient B was seen by Dr. S (a Center for Sight physician) and found to have esotropia and hyperopia of +3.00 +1.00 x 090 in the right eye and +4.00 + 0.75 x 090 in the left eye. The child was one year and eight months old. She was prescribed glasses for presumed accommodative esotropia.

23. At the three month follow-up with Dr. C, the child was not compliant with spectacle wear and was found to have persistent esotropia. Dr. C recommended observation and six months follow-up. On or about December 27, 2007, Patient B was re-evaluated by Dr. C and found to have a similar amount of hyperopia on repeat cycloplegic[13] refraction, was still not wearing the glasses, and had persistent esotropia. Dr. C re-prescribed the glasses for full-time wear. At that point, the child was two years old.

24. The next visit took place two years later on April 5, 2010, with Dr. S. Patient B was almost five years old. She was found to have persistent esotropia of 30 diopters, persistent hyperopia[14], was not wearing glasses, and the vision was recorded to be 20/50 in the right eye and 20/200 in the left eye. She was diagnosed with esotropia and amblyopia of the left eye and

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[12] Probing of the nasolacrimal duct is done to open the valve between the nasolacrimal duct and the nose.

[13] Cycloplegia is paralysis of the ciliary muscle of the eye, resulting in a loss of accommodation. Because of the paralysis of the ciliary muscle, the curvature of the lens can no longer be adjusted to focus on nearby objects.

[14] Farsightedness.

prescribed glasses and patching of the right eye 4-6 hours daily. Dr. S noted that strabismus surgery may be needed after amblyopia improves.

25. On or about May 21, 2010, Patient B was seen by Respondent. At that point she was wearing the glasses full-time but was not compliant with patching. Vision was improved in both eyes, to 20/30 in the right eye and 20/60 in the left eye in the glasses. Esotropia was measured to be 30 diopters. Although the patient was improving through corrective lenses and patch therapies, Respondent recommended strabismus surgery. At this point, Respondent had not considered continued patching therapy or alternatives to patching such as pharmacologic and/or optical alternatives. Additionally, Patient B appeared to have accommodative esotropia and not partially accommodative or non-accommodative esotropias—which would have been indicative for surgery. At the pre-operation stage, on or about August 13, 2010, Patient B was no longer compliant with glasses. Vision was measured without glasses and was 20/40 in the right eye, and worse than 20/200 in the left eye. Esotropia was measured to be 30 diopters. Respondent prescribed patching and pharmacologic therapy to treat strabismic amblyopia, but failed to diagnose and treat refractive amblyopia. Respondent additionally recommended proceeding with surgery, rather than corrective lenses and patch therapy.

26. On August 20, 2010, Respondent performed strabismus surgery on Patient B. During surgery, Respondent made a 6 mm recession of both medial recti muscles. However, the 6 mm recession was not consistent with either the nomogram that Respondent referenced, or with other widely used published nomograms. Based on the nomogram reference by Respondent, a bilateral rectus recession of 4.5 mm should have been performed to correct the 30 diopters of esotropia. Respondent's incorrect 6 mm recession likely resulted in an iatrogenic[15]overcorrection, which would require subsequent surgeries to correct. None of the aforementioned complications were noted by Respondent in Patient B's medical records.

27. On September 10, 2010, Patient B had a three week post-operative visit with Respondent. Vision was unchanged. Alignment was noted to be 5 diopters of consecutive

[15] Iatrogenesis is the causation of a disease, a harmful complication, or other ill effect by any medical activity.

exotropia. Patching was prescribed. Six weeks later, during follow-up, Respondent found persistent amblyopia and a larger exotropia of 10 diopters. Patching and pharmacologic therapy were prescribed and it was noted that the patient "may need a touch-up." On November 5, 2010, during a post-op visit, Respondent found Patient B to have worsening exotropia, now 15 diopters. He prescribed another strabismus surgery for the consecutive exotropia and planned for a left lateral rectus recession.

28. The second strabismus surgery took place on January 14, 2011. Respondent recessed the left lateral rectus by 4 mm.

29. On January 21, 2011, Patient B was seen by Dr. S for her 1 week post-op visit. She was found to have persistent consecutive exotropia, which measured 30 diopters. Amblyopia persisted with vision at 20/30 in the right eye and 20/200 in the left eye. She referred the patient back to Respondent. On February 15, 2011, 1 month post-op, Patient B was seen by Respondent and found to have a persistent consecutive exotropia of 15 diopters. Respondent failed to perform a cycloplegic refraction, correct any refractive error and continue patching therapy. Instead, Respondent recommended observation at subsequent visits.

30. On or about May 10, 2011, at 4 months post-op, amblyopia and exotropia persisted. Respondent recommended observation.

31. On July 26, 2011, the patient was seen by Respondent. At that point, Patient B was six years old. Amblyopia had worsened, with vision now at count fingers[16] in the left eye. Left exotropia of 15 diopters persisted. Refraction showed persistent hyperopia. He prescribed glasses and 3 month follow-up.

32. On follow-up with Respondent on January 27, 2012, dense amblyopia persisted with the corrected vision at 20/400 in the left eye. Left exotropia had increased to 20 diopters. Respondent then referred the patient to Dr. H.

33. Three months later, on April 3, 2012, the patient saw Respondent. The exam was unchanged. He recommended further strabismus surgery and planned for "left recess/resect." At

[16] Counting fingers (CF) is a method of recording vision in patients who are unable to identify any optotype on an acuity chart. If a patient correctly counts the numbers of the examiner's fingers shown, this is recorded with the distance at which it is performed.

pre-op on July 12, 2012, 20 diopters of left exotropia was noted and the plan read "Surgery to [left eye] (2 muscles) as planned." On July 13, 2012, Respondent performed a third strabiscus surgery on Patient B. Respondent performed a bilateral medial rectus resection of 3 mm.

34. At the three week post-op visit, on August 7, 2012, a left exotropia of 20 diopters and dense left amblyopia remained. Respondent recommended performing a complete examination after a month. On or about September 25, 2012, the patient was seen; however, the assessment and plan sections of Respondent's notes are not legible. Respondent's next visit with Patient B was on January 30, 2014. Her exam was unchanged with dense amblyopia and exotropia of the left eye.

35. Glasses were prescribed with six months follow-up. At the six months follow-up exam, Patient B's symptoms remained unchanged and Respondent referred Patient B to Dr. H.

36. On October 23, 2014, Patient B was seen by Dr. H. The vision was 20/25 in the right eye and between 20/100 and 20/200 in the left eye. There was 65 diopters of left exotropia. The cycloplegic refraction was +3.00 +1.00 x 095 in the right eye and +4.00 +2.00 x 095 in the left eye. Due to consecutive exotropia, glasses were prescribed in an over-minus fashion. The minimum amount of hyperopic correction required to treat refractive amblyopia was given in order to avoid relaxing accommodative effort to the extent possible to minimize worsening the consecutive exotropia. Dr. H also prescribed patching and planned for future strabismus surgery. At pre-op, the left exotropia measured 65 diopters. On January 27, 2015, Dr. H performed exploration and advanced the right medial rectus from 12 mm to 5 mm posterior to the limbus and the left medial rectus from 14 mm to 5 mm posterior to the limbus.

37. At post-op follow-up on January 29, 2015 with Dr. H, the left exotropia was reduced to 16 diopters. She prescribed continued patching therapy for dense left amblyopia. At the six weeks post-op visit with Dr. H, the left exotropia had recurred to 45 diopters. She prescribed continued patching therapy and follow-up in 2 months.

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38. The next visit was on May 20, 2016 with Dr. M, O.D. Patient B, who was then eleven years old, had dense left amblyopia and "strabismus" of the left eye. It was noted the family was not interested in further surgery.

39. During Respondent's taped interview, he stated that glasses and patching were tried for several years and that the child had a large angle esotropia that did not respond to glasses or patching. He further stated he believed the case was one that would require multiple surgeries to correct. He stated that the rate of re-operation in strabismus surgery is, "under any circumstances," much higher compared to other eye surgeries like cataract surgery, and that he believed this to be standard of care and that this was a difficult case requiring multiple surgeries.

**Patient C**:

40. Patient C was first seen by Respondent on January 2, 2014. Patient C was then three years and six months old and was referred for esotropia. On exam, Patient C was noted to have 10 diopters of esotropia and high hyperopia in both eyes (+4.75 +1.00 x 090 in the right eye and +3.50 +1.00 x 090 in the left eye). Glasses were prescribed and it was noted that "surgery may have to be done in the future." At follow-up on March 6, 2014, Patient C's mother stated that he does not wear the glasses. On exam, there was 20 diopters of esotropia without the glasses and 10 diopters of esotropia with the glasses.

41. On May 8, 2014, the preoperative examination showed Patient C's diagnosis was unchanged and Patient C continued to fail to wear glasses. Although the corrective lenses were demonstrated to be correcting Patient C's vision, Respondent should have restarted the glasses full-time or performed an atropine refraction to evaluate for latent hyperopia. Additionally, when Patient C was refusing to wear the glasses, Respondent should have examined the fit of the frame, provided counseling on spectacle wear, and/or prescribe atropine to facilitate spectacle acceptance. Furthermore, prior to surgery, Respondent should have started patching therapy for amblyopia. Instead of attempting the aforementioned less invasive therapies, Respondent recommended strabismus surgery at this visit and planned to perform a 3 mm bilateral medial rectus recession.

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42. On May 23, 2014, Respondent performed a bilateral medial rectus recession of 4 mm. However, the recession was not consistent with the nomogram referenced by Respondent, or with other widely used published nomograms. On June 2, 2014, ten days after surgery, Respondent noted an esotropia of 5 diopters. Two months after surgery, an exotropia of 5 diopters was noted. Respondent prescribed a steroid eye drop ("PF 0.5 BID") with one month follow-up. By September 25, 2014, the exotropia measured 10 diopters. At this visit, visual acuity was measured to be 20/80 in the right eye and 20/400 in the left eye. The pinhole visual acuity was 20/30 in the right eye and 20/50 in the left eye, indicating a refractive error. The chart notes "PF 1% BID OS". Respondent left the refractive error uncorrected and failed to treat the amblyopia. Respondent failed to indicate in Patient C's chart whether glasses were continued between March 6, 2014 and September 25, 2014. Additionally, Respondent discontinued the eye drops and referred the patient to Dr. H.

43. On October 24, 2014, Patient C was evaluated by Dr. H. He had a left exotropia of 35 diopters. He additionally had amblyopia of the left eye and uncorrected high hyperopia greater than what was measured by Respondent, on January 2, 2014. The refraction was +5.00 +1.50 x 090 in the right eye and +5.00 +2.25 x 095 in the left eye. Dr. H prescribed over-minus glasses, patching therapy, and scheduled a 3 month follow-up. The prescribed glasses were +2.00 +1.50 x 090 for the right eye and +2.00 +2.25 x 095 for the left eye.

44. On January 22, 2015, the exotropia had increased to 60 diopters with correction. Patient C was now noted to be wearing his glasses and compliant with patching. Dr. H recommended advancing the recessed medial recti and continued glasses and patching. On February 4, 2015, during Patient C's preoperative examination, measurements were noted as stable.

45. On February 10, 2015, Dr. H performed exploration and advancement of the medial recti to the original insertion, in order to correct the first surgery performed by Respondent. On post-operative day 1, the child was noted to be doing well. On post-operative day 2, Patient C was noted to have right orbital cellulitis and was admitted for intravenous antibiotics. On post-operative day 6, the cellulitis had resolved and residual exotropia was noted. At post-operative

week 6, recurrent left exotropia measured 45-50 diopters and the corrected visual acuity was 20/40 in the right eye and 20/50 in the left eye. Dr. H recommended bilateral lateral rectus recession.

46. At pre-op, it was noted the child was not compliant with wearing the glasses. The visual acuity without glasses was the same as the previous visit. Exotropia was 25 diopters. On May 7, 2015, Dr. H performed a bilateral lateral rectus recession of 7.0 mm. At post-operative week 1, Patient C's alignment was straight and glasses were reissued. At post-operative week 8 (06/24/2015), Patient C's alignment remained straight, and he was compliant with spectacle wear. His corrected vision was 20/40 in the right eye and 20/60 in the left eye. Dr. H additionally prescribed patching therapy for the right eye two hours a day.

47. On September 1, 2015, Patient C was seen by Respondent for allergic conjunctivitis. The corrected visual acuity at this visit was 20/30 in the right eye and 20/20 in the left eye. On December 1, 2015, Patient C was seen by Respondent for follow-up of allergic conjunctivitis. Patient C was noted to be doing well without eye drops, was wearing his glasses and patching the right eye. The corrected visual acuity was 20/40 in the right eye and 20/20 in the left eye. Respondent prescribed continued patching three times per week.

48. On February 28, 2016, Patient C was seen by Respondent for allergic conjunctivitis. The visual acuity was unchanged from the prior visit; however, Patient C's eyes were injected by Respondent. He prescribed a steroid eye drop (Pred Forte[17]) and an antibiotic eye drop (Ocuflox). He noted exotropia in his assessment. Respondent failed to note if a sensorimotor examination was performed. Additionally, no plan was specified for exotropia. One month follow-up was recommended. On April 28, 2016, Patient C presented again for eye redness. He was using an allergy eye drop (ketorolac) and a steroid and antibiotic combination eye drop (maxitrol[18]). Corrected visual acuity was 20/60 in both eyes. Respondent prescribed maxitrol in both eyes for 1-2 weeks and recommended a follow-up in 1-2 months.

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[17] Prednisolone acetate ophthalmic suspension is indicated for the treatment of steroid-responsive inflammation of the palpebral and bulbar conjunctiva, cornea, and anterior segment of the globe.

[18] Neomycin, Polymyxin B and Dexamethasone Ophthalmic medication is used to treat conditions involving swelling of the eyes and to treat or prevent bacterial eye infections.

49. On June 8, 2016, Patient C was seen by Dr. R at the Center for Sight. He no longer had symptoms of redness. His corrected visual acuity was 20/50 in the right eye and 20/60 in the left eye. Dr. R recommended lid hygiene.

50. On December 1, 2016, Patient C was seen by Respondent for allergic conjunctivitis. He had been wearing his glasses and his father was administering maxitrol on Patient C's eyes for occasional redness. The corrected visual acuity was 20/30 in the right eye and 20/40 in the left eye. Respondent prescribed maxitrol as needed. He noted amblyopia of the left eye and recommended observation with follow-up in 6 months. Although amblyopia was noted in the assessment, patching was not prescribed and refraction was not performed to address the issue.

51. On June 1, 2017, Patient C was seen by Respondent. The corrected visual acuity was 20/40 in the right eye and 20/50 in the left eye. Respondent diagnosed amblyopia of the left eye. However, he improperly concluded "no treatment is required at this time," and continued prescribing Patient C's glasses, of which the same prescription lenses had been in effect since October 24, 2014.

52. On November 30, 2017, Patient C was seen by Respondent for amblyopia follow-up. The corrected visual acuity was 20/30 in the right eye and 20/50 in the left eye. Respondent diagnosed amblyopia of the left eye and recommended to "continue with current specs."

53. During his taped interview, Respondent addressed his management of Patient C's condition between the first visit on January 2, 2014, and follow-up on March 6, 2014. Respondent stated that he "tried glasses with no success." When asked if he was able to assess the visual acuity after the surgery, Respondent stated that the child was three years old and therefore the child was able to fix and follow.

54. When asked to comment on the evolution of amblyopia by January 22, 2015, at the visit with Dr. H and why it occurred, he stated that visual acuities are "uncertain in small children," and that you often don't get a visual acuity in a 4 year old. Respondent stated that on September 25, 2014, Patient C's visual acuity was 20/80 on the right and 20/400 on the left, with the vision improved to 20/50 and 20/30. However, Respondent failed to address other methods of determining visual acuity in small children, such as matching and/or the fix and follow method.

55. In reference to Patient C's visit with Dr. H, on January 12, 2015, Respondent stated that Dr. H felt Patient C did not see as well with the left eye and started patching and glasses. He went on to state that Patient C's eyes were starting to drift but were almost straight at the post-operative visits with him.

56. In reference to Patient C's visit with Dr. H on October 24, 2014 and January 12, 2015, Respondent stated: "[Dr. H] determined that the eyes had drifted out more by the time she saw him...did patching, patching did not make any significant difference in the vision and she performed additional strabismus surgery in February 2015...and a third surgery in May 2015...it took three surgeries."

57. When asked if intervention of amblyopia would have made a difference, Respondent stated he "didn't have a good determination of the amblyopia," at the time, and if he knew there was amblyopia, he would prescribe patching. However, he stated, "patching doesn't always work." He added that patching was tried by Dr. H before her surgery and Patient C still required another surgery. He stated that this is "not unusual."

**Patient D**:

58. Patient D was first seen by Respondent on November 16, 2012. He was then two years and four months old and was referred for esotropia. During the examination, Respondent recorded 15 diopters of esotropia and low hyperopia (+0.75 D on the right, +1.00 on the left). He recommended strabismus surgery and planned to perform a 4 mm bilateral medial rectus recession. At the pre-operative visit on January 11, 2013, Respondent measured 15-20 diopters of esotropia. Respondent failed to take less invasive steps, such as prescribe the cycloplegic refraction, perform an atropine refraction to evaluate for latent hyperopia, and/or monitor the deviation and vision and to repeat the cycloplegic refraction at a following visit. Instead, Respondent incorrectly determined the only possible diagnosis was non-accommodative esotropia, and recommended to proceed with strabismus surgery.

59. Although there was little indication to do so, on January 25, 2013, Respondent performed a bilateral medial rectus recession of 4 mm on Patient D. However, that surgery was not consistent with the nomogram that Respondent referenced. It was also not consistent with

other widely used published nomograms. According to the referenced nomogram, a 4.0 mm recession would correct 25 diopters of esotropia.

60. On post-operative day 6, Patient D had a consecutive exotropia of 5 diopters. At the three week post-operative visit, the 5 diopter exotropia remained. At the two month post-operative visit, the exotropia measured 10 diopters. Rather than perform a repeat examination, Respondent recommended another strabismus surgery—a right lateral rectus recession, which was in order to correct the unnecessary, January 25, 2013, surgery. At preoperative examination on August 6, 2013, exotropia measured 15 diopters. Respondent decided to proceed with "surgery as planned." On August 15, 2013, Respondent performed a *right lateral* rectus recession of 4 mm. However, that surgery was not consistent with Respondent's referenced nomogram, or other widely published nomograms. According to the referenced nomogram, *a bilateral lateral* rectus recession of 4.0 mm would be required to correct 15 diopters of exotropia.

61. On post-operative day 8, exotropia measured 2 diopters. At approximately two months following the surgery, exotropia measured 10 diopters. Respondent recommended a complete eye exam in 3 months. At the next visit on April 18, 2014 with Respondent, exotropia was measured to be 5 diopters. Respondent unclearly noted if he was able to obtain a refraction, as the refraction was noted as +0.50 in both eyes as well as "unable." At that point, Patient D was three years, ten months old. Respondent then referred the patient to Dr. H.

62. On September 10, 2014, Dr. H performed a complete eye exam on Patient D, and found a left fixation preference, right exotropia of 18 diopters and high hyperopic astigmatism (+2.00 +4.00 x 110 in the right eye and +2.00 +4.00 x 080 in the left eye). She prescribed over-minus glasses due to consecutive exotropia and noted that strabismus surgery may be needed in the future. On December 1, 2014, Dr. H noted that exotropia had increased to 40 diopters. Dr. H planned strabismus surgery to advance the previously recessed medial rectus muscles, which was performed during Respondent's January 25, 2013, surgery on Patient D. On December 17, 2014, during Dr. H's preoperative examination on Patient D, the exotropia measured 20 diopters. On December 2, 2015, Dr. H performed a corrective surgery, in order to reverse the effects of

Respondent's previous surgery. She performed a 4 mm advancement of the medial recti bilaterally to the original insertion.

63. On post-operative day five, Patient D's eyes were straight. At five weeks post-op, the eyes were straight at distance and there was an intermittent exotropia of 6 diopters at near. Since Patient D had not been wearing his glasses, Dr. H prescribed spectacle wear. At the five month post-op visit, on June 18, 2015, Patient D's eyes remained straight at distance but the exotropia at near had increased to 12 diopters. Dr. H referred the child to a pediatric specialist.

64. On December 8, 2015, Patient D was seen by Dr. A, M.D., a physician who worked at the University of California, San Francisco. Corrected vision measured 20/60 in the right eye and 20/40 in the left eye. Refraction was similar to the wearing prescription. There was an exotropia at distance and near of 25 diopters. Glasses were prescribed for full-time wear and patching therapy was introduced. It was noted that strabismus surgery would be necessary if improvement was not made in the next ten weeks.

65. During his taped interview, Respondent was asked about the examination on November 16, 2012, that led to the first surgery. He stated he found mild hyperopia with significant crossing of the eyes and did not prescribe glasses because the hyperopia was minimal. However, 15 diopters is not considered minimal. Respondent stated that he felt there was no management option other than surgery.

**Patient E**:

66. Patient E was first seen by Respondent on January 17, 2008. She was three years and six months old at that time. She was referred for strabismus evaluation. Her past ocular history was significant for a traumatic left retinal detachment, status post repair, in 2006, as a result of shaken baby syndrome. On exam, she had 20 diopters of esotropia. Respondent's consult note stated poor visual potential and recommended observation with six months follow-up.

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67. She was then seen by Dr. C at the Center for Sight, on December 10, 2008. During examination, she was noted to have an abduction deficit of the left eye. The physician's impression was left esotropia secondary to a history of subarachnoid hemorrhage.[19]

68. On February 3, 2009, Patient E was seen by Respondent. He measured 25 diopters of esotropia and recommended strabismus surgery.

69. On May 8, 2009, Respondent performed a bilateral medial rectus recession of 5 mm. Although the pre-operative deviation was measured to be 25 diopters of esotropia, Respondent performed a 5.0 mm bilateral medial rectus recession. This is not consistent with the nomogram referenced by Respondent, which shows a 5.0 mm recession to correct 35 diopters of esotropia.

70. At post-operative week one, Patient E had 5 diopters of exotropia. The medical record at the three month post-op visit is not clearly legible. It says "ortho" but also "XT." The next visit was on March 12, 2010 with Dr. S, at the Center for Sight. The deviation was noted to be a small angle left exotropia. Glasses were prescribed. A macular (retinal) scar and preretinal fibrosis [20] were noted. On May 14, 2012, Patient E was seen by Dr. M, M.D. at the Center for Sight, and patching was added. On April 12, 2013, the patient was seen by Dr. L at the Center for Sight. The exam was largely unchanged from prior.

71. On June 10, 2014, Patient E was seen by Dr. H. Exotropia was measured to be 45 diopters. The glasses were updated and patching prescribed again. Strabismus surgery of the left eye was recommended. On September 4, 2014, Dr. H performed exploration, left lateral rectus recession of 7.5 mm and advancement of the left medial rectus of 4.5 mm. On post-operative day 1, the eyes were straight for distance and had 6 diopters of esotropia for near.

72. On October 7, 2016, Patient E was seen by Dr. K, at the Center for Sight, for a conjunctival cyst of the left eye. Eye alignment is not noted in this record. The last recorded visual acuity measurement was 20/400 in the left eye.

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[19] Subarachnoid hemorrhage is a life-threatening type of stroke caused by bleeding into the space surrounding the brain.

[20] Pre-retinal fibrosis is an ocular condition that affects the retina, in which an extremely thin membrane of scar-like tissue covers the surface of the macula.

73. During his interview with the Board's investigator, Respondent stated that he attributes the consecutive exotropia to neurologic issues and a consequence of poor vision. He stated the indication for surgery was cosmetic.

74. During Respondent's care and treatment of Patient B, Patient C, and Patient D, Respondent committed the following grossly negligent acts:

a. Respondent failed to adequately manage Patient B's accommodative exotropia;

b. Respondent failed to adequately manage Patient B's amblyopia;

c. Respondent improperly recommended and performed strabismus surgery on Patient B, which was inconsistent with applicable nomograms;

d. Respondent failed to adequately diagnose and manage accommodative esotropia in Patient C;

e. Respondent failed to adequately diagnose and manage amblyopia in Patient C;

f. Respondent improperly recommended and performed strabismus surgery on Patient C, which was inconsistent with applicable nomograms;

g. Respondent failed to adequately evaluate and manage accommodative esotropia in Patient D; and

h. Respondent improperly recommended and performed strabismus surgery on Patient D, which was inconsistent with applicable nomograms.

## SECOND CAUSE FOR DISCIPLINE

**(Repeated Negligent Acts)**

75. Respondent's Physician's and Surgeon's Certificate No. G 58380 is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care and treatment of Patient A, Patient B, Patient C, Patient D, and Patient E, as more particularly alleged hereinafter:

76. Complainant re-alleges paragraphs 7 through 74, above, and those paragraphs are incorporated by reference as if fully set forth herein.

77. Respondent committed repeated negligent acts in his care and treatment of Patient A and Patient E, including, but not limited to, the following:

a. Respondent failed to prescribe glasses to Patient A;

b. Respondent failed to adequately conduct a pediatric eye evaluation for amblyopia on Patient A; and

c. Respondent improperly recommended and performed strabismus surgery on Patient E, which was inconsistent with applicable nomograms.

**THIRD CAUSE FOR DISCIPLINE**

**(Failure to Maintain Adequate and Accurate Medical Records)**

78. Respondent's Physician's and Surgeon's Certificate No. G 58380 is further subject to discipline under sections 2227 and 2334, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate medical records in the care and treatment of Patient A, Patient B, Patient C, Patient D, and Patient E. Paragraphs 7 through 77, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**PRAYER**

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

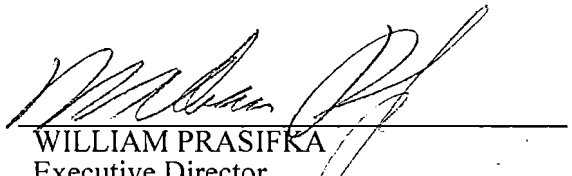
1. Revoking or suspending Physician's and Surgeon's Certificate Number G 58380, issued to Philip A. Edington, M.D.;

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

3. Ordering Philip A. Edington, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: APR 2 1 2021



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

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