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

In the Matter of the Accusation Against: Tri-Dung Gia Hoang, M.D. Physician's & Surgeon's Certificate No A 79685 Respondent	Case No. 800-2016-027692

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 March 2, 2022.

IT IS SO ORDERED: January 31, 2022.

MEDICAL BOARD OF CALIFORNIA

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

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In the Matter of the Accusation Against:

TRI-DUNG GIA HOANG, M.D., Respondent

Agency Case No. 800-2016-027692

OAH No. 2020021203

PROPOSED DECISION

Tiffany L. King, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on June 28 through July 1, and August 16, 2021, from Sacramento, California.

Megan R. O'Carroll, Deputy Attorney General, represented William Prasifka (complainant), Executive Director, Medical Board of California (Board).

Lawrence S. Giardina, Attorney at Law, represented Tri-Dung Gia Hoang, M.D. (respondent), who was also present.

Oral and documentary evidence was received at hearing. The record was held open for written closing briefs. Complainant's closing brief (marked as Exhibit 19) was received on October 1, 2021; respondent's closing brief (marked as Exhibit S) was received on October 14, 2021; and, complainant's reply brief (marked as Exhibit 20)

was received on October 22, 2021. The record closed, and the matter was submitted for decision on October 22, 2021.

FACTUAL FINDINGS

1. On March 9, 1987, the Board issued Physician's and Surgeon's Certificate No. A79685 (license) to respondent. The license will expire on May 31, 2022, unless renewed or revoked.

2. On October 16, 2019, complainant, in his official capacity, made and served an Accusation seeking to discipline respondent's license alleging he committed gross negligence and repeated acts of negligence, and failed to maintain adequate and accurate records. The allegations arise from the care and treatment of Patient A[1] at Tri Hoang, M.D., Inc. on eight appointments between January and September 2016. Specifically, complainant alleges respondent failed to adequately follow up on Patient A's complaints of back pain, fatigue, and weight loss; failed to evaluate her anemia, abnormal liver function tests, elevated alkaline phosphatase and ferritin (blood protein containing iron) levels; and failed to maintain adequate and accurate records. Respondent timely filed a Notice of Defense.

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[1] To maintain her privacy, the confidential patient is referred to as Patient A.

Respondent's Practice

3. Respondent graduated from medical school in 1998. He was previously board-certified in internal medicine[2], but did not renew his certification thereafter. He explained, "if you practice good medicine, patients are happy with you . . . . patients [continue to] treat with you," and "board certification has nothing to do with how well you take care of patients."

4. At all times relevant, respondent worked in private practice, as Tri Hoang, M.D., Inc., with two other physicians, Hung-Anh Nguyen, M.D., and Hoang Wong, M.D. (respondent's father), and a nurse practitioner (NP), Richard Gno. The practice has two clinics, Sacramento and Rancho Cordova, and is open Monday through Saturday. Respondent sees an average of 30 patients a day. Respondent and Dr. Nguyen are internists, treating adult patients. Respondent's father is a family practitioner and treats both adult and pediatric patients. The four providers regularly rotate between both clinics.

Patient A

5. Patient A was 48 years old when she began treating at Tri Hoang, M.D., Inc. in approximately 2005; she continued to be seen there through September 2016. During that time, she saw different providers at the clinic, including respondent, Dr. Nguyen, and NP Ngo, for a variety of acute issues including obesity, diabetes, gastroesophageal reflux disease (GERD), hyperlipidemia, and allergic rhinitis. Patient A spoke very little English; her first language was Vietnamese. Respondent is fluent in Vietnamese and Vietnamese-speaking patients account for roughly 90 percent of his

[2] The effective dates of respondent's board-certification were not in the record.

practice. When he saw Patient A, he primarily communicated with her in Vietnamese. Dr. Nguyen was also partially fluent in Vietnamese and could communicate with patients in both English and Vietnamese.

6. Patient A stood five feet tall. In 2013 and 2014, her weight was roughly 145 pounds. Her body mass index (BMI) was considered elevated at 27 or 28 and meeting the criteria for obesity. Respondent and Dr. Nguyen recommended Patient A change her diet and increase her exercise. By November 2015, her weight had dropped to 136 pounds. Between January and September 2016, Patient A was seen eight times at Tri Hoang, M.D., Inc.: January 29, May 10, June 29, July 12 and 21, August 24, and September 6 and 30. Three visits were with Dr. Nguyen (January 29, June 29 and August 24) and five visits with respondent (May 10, July 12 and 21, and September 6 and 30).

7. On January 29, 2016, Patient A presented to Dr. Nguyen with a sore throat and cough for the last two days, as well as joint pain at her left second finger. She had no fever or rash. She weighed 130 pounds. Dr. Nguyen diagnosed her with an upper respiratory tract infection and prescribed amoxycillin and Phenergan. He also prescribed Tylenol for the joint pain. Finally, he recommended she continue to lose weight to address her diabetes. Dr. Nguyen's notes did not reflect any complaint of back pain during this visit. Dr. Nguyen speaks some Vietnamese, and may have communicated with Patient A in both English and Vietnamese.

8. On May 10, 2016, Patient A presented to respondent with abdominal pain, vomiting, and diarrhea for the last two to three days. This was the first time respondent had seen Patient A in nearly a year. He conducted and documented a physical examination, but did not document an abdominal examination. He diagnosed

her with acute gastroenteritis and prescribed Zofran[3] and Lomotil.[4] Patient A's weight was 124 pounds, but she made no complaint about the weight loss. Additionally, there was no documented complaint of back pain during this visit.

9. On June 29, 2016, Patient A presented to Dr. Nguyen with complaints of fatigue and weight loss. She weighed 121 pounds, a 23-pound loss over one year. Dr. Nguyen assessed her for diabetes, hyperlipidemia and weight loss. He then ordered a complete blood count (CBC), metabolic panel, lipid panel, thyroid tests and glycohemoglobin regarding the weight loss. There was no documented complaint of back pain during this visit.

10. On July 12, 2016, respondent saw Patient A to review the results of her laboratory tests. Patient A weighed 123 pounds at this visit. Respondent noted abnormalities in the test results showing microcytic anemia with a hemoglobin of 11.6 (normal range 11.7 to 15.5), an elevated white blood cell count of 11.1 (normal range 3.8 to 10.8), and an elevated alkaline phosphatase of 445, more than three times the normal range (33 to 130). Other liver results and thyroid stimulating hormone (TSH) results were normal. Hemoglobin A1c was 5.8. Suspecting leukemia, respondent ordered iron studies (including ferritin level) for the anemia and recommended Patient A get a mammogram screening.

11. On July 21, 2016, Patient A presented to respondent with complaints of gingivitis and painful gums. Her weight was 124 pounds. There is no documented

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[3] Zofran is the brand name for ondansetron, an antiemetic taken to prevent nausea and vomiting.

[4] Lomotil is the brand name for diphenoxylate/atropine used to treat diarrhea.

complaint of joint or back pain. The patient had not yet completed the iron studies as requested by respondent at her previous appointment. She had a mammogram on the week prior, which came back negative. Respondent prescribed ampicillin for the gingivitis and referred her to her dentist. He again requested she complete the iron studies he had ordered.

12. On August 24, 2016, Patient A met with Dr. Nguyen for a follow up and to review the results of her iron studies, which she had completed on August 11, 2016. Patient A complained of fatigue, but there is no notation she complained of back pain during this visit. The iron studies showed low serum iron at 30 (normal range 45 to 160), iron-binding capacity of 266 (normal range 250 to 450), percent saturation of 11 (normal range 11 to 50), and extremely elevated ferritin level at 1,438 (normal range 10 to 232). Dr. Nguyen diagnosed her with anemia and prescribed iron (ferrous sulfate 325 mg daily). He did not order any tests or make any referrals on this date.

13. On September 6, 2016, Patient A presented to respondent with a complaint of left scapula (back) pain for the last three days, which was partially relieved by Tylenol. She also complained of bilateral knee, shoulder, buttock, and ankle pain. Her weight was 123 pounds. This was the first notation of a back pain complaint in the medical record. Respondent conducted a physical examination of the patient. She was well-developed and well-nourished and had no acute distress. Her head, eyes, ears, nose and throat were normal, and her eye movement was intact. Her neck was supple and had normal range of motion. Upon musculoskeletal exam, she had normal range of motion in all joints.

Respondent ordered a repeat complete blood count and asked Patient A to return in two weeks for a follow up visit. He made the following assessment and plan: (1) left scapula pain/arthritis increase Tylenol; (2) gastritis, Maalox Plus and Protonix;

(3) continue present medications; (4) return to clinic if not better; and, (5) increased white blood cell count, retest.

14. On September 30, 2016, Patient A again met with respondent for a follow up visit. Her weight was 123 pounds. Respondent conducted a physical examination, but did not include a musculoskeletal examination. Lab results from the prior visit showed persistence of leukocytosis, with a white blood cell count of 12.1, and microcytic anemia with hemoglobin of 11.2. Respondent referred Patient A to Colin Spears, M.D., a hematologist and oncologist for diagnosis. A Post-It note dated November 1, 2016 and attached to the medical record read, "Pt will come on Monday 11/7/16 (walk in)."

15. On October 19, 2016, Patient A was admitted to the emergency department (ED) at Dignity Methodist Hospital (Dignity or Dignity Hospital) of Sacramento around 7:00 a.m. During intake, she complained of "lower back pain for the past 2 weeks, worsening today." During a physical performed roughly four hours later, Patient A reported that "she has had back pain for the last 6 months but has been worsening over the last couple of weeks." She also noted she experienced a 30-pound weight loss. After computed tomography (CT) scans were taken, she was diagnosed with suspected metastatic lung cancer with unknown primary, and metastases to her ribs, lumbar spine, and brain. On October 24, 2016, she was discharged on morphine and hydrocodone for breakthrough pain. On May 30, 2017, Patient A passed away.

Board Investigation

16. On or about November 8, 2016, Ms. Tran helped her mother prepare an online consumer complaint and file it with the Board. In the complaint, Patient A

alleged she had been complaining of back pain to respondent since "the beginning of 2016," and that respondent "noted and simply replied that back pain is normal in old people." Patient A also alleged she had "requested numerous times to have a CT scan and x-ray done as the back pain progressed but he denied [them], deeming that it was [not] necessary." Instead, respondent referred her to "have blood tests and glucose testing done, which seemed irrelevant to the current back pain."

17. On August 9, 2017, Senior Board Investigator Robert Moya was assigned to investigate the allegations in Patient A's complaint. He obtained documentation, including Patient A's 2016 medical records from respondent's clinic, an October 28, 2017 written statement by respondent, and a certified copy of Patient A's medical records from Dignity Hospital. He also interviewed respondent, as well as Patient A's three daughters, Vicki Lam (Vicki), Lisa Tran, and Danh Lam (Danh). Investigator Moya prepared a report, dated February 26, 2019, summarizing his initial findings. On July 21, 2019, Investigator Moya prepared a first supplemental report after obtaining a copy of Patient A's death certificate. On September 19, 2019, Investigator Moya prepared a second supplemental investigation report, summarizing the daughters' interview statements.

18. On December 20, 2017, Investigator Moya interviewed respondent. Respondent explained that both he and Dr. Nguyen treated Patient A during the relevant time period, and that the patient never complained of back pain. Respondent further stated Patient A did not comply with physician instructions provided to her, such as getting a colonoscopy and blood tests. Finally, respondent acknowledged seeing the elevated alkaline phosphatase, but did not evaluate it at that visit.

19. In August 2019, Investigator Moya interviewed Patient A's three daughters. Vicki stated she took her mother to see respondent on several occasions

for back pain, which Patient A had been complaining about for a couple of months. Vicki dropped her mother off at the clinic and picked her up after her visits; she did not accompany Patient A into any of her visits. Her mother complained to Vicki that respondent would ignore her back pain and state words to the effect of, "that is what happens when you get old." In August 2016, Vicki dropped her mother off for a visit because of itchy hands. Vicki told her mother that something was wrong, noting her excessive weight loss. Danh said she never took her mother to respondent's clinic. However, she was "very aware" of her mother's back pain; that Patient A had seen respondent several times for back pain; and that respondent was dismissive of her complaints saying it was related to getting old.

20. Ms. Tran told Investigator Moya she accompanied her mother to three or four visits at respondent's clinic for complaints of back pain. Respondent ordered blood work to check for diabetes. She recalled respondent attributing Patient A's back pain to getting old and that it was normal for old people.

21. Ms. Tran was the only one of Patient A's daughters who testified at hearing. She testified that she accompanied her mother to her "last four or five" visits, all with respondent, before she was hospitalized. Patient A would schedule her appointments in the afternoon, so Ms. Tran could drive her after she was done with school for the day. During the appointments, respondent spoke to Patient A in Vietnamese and to Ms. Tran in English.

Ms. Tran was resolute that respondent was the only physician at the clinic who treated Patient A when she accompanied her on visits between June and September 2016. Ms. Tran was familiar with respondent because he had been their family physician for her, her sisters, and her parents alike, for "more than 20 years." The other

physicians in the office were respondent's father, who was much older, and a female physician "with a bob haircut."

According to Ms. Tran, Patient A complained of back pain to respondent on multiple visits. Ms. Tran explained to respondent that when her mother's back hurt, the pain traveled down her leg and was overwhelming. Respondent was dismissive, stating "that's what happens when people get old." Instead of ordering tests to explore the cause of the back pain, respondent only ordered blood tests. Ms. Tran requested more than once that respondent order CT scans and x-rays, but respondent never did.

Expert Witnesses

WILLIAM MORA, M.D.

22. Dr. Mora testified as an expert on behalf of complainant. He graduated from the University of California, Davis, School of Medicine in 1985. After medical school, Dr. Mora completed a three-year residency in family practice at Valley Medical Center of Fresno, followed by a one-year fellowship in emergency medicine at the same facility. Dr. Mora has been licensed to practice medicine in California since 1986. He is board-certified in family medicine (1988) and a diplomate of the National Board of Medical Examiners (1986). Additionally, he has served as an expert medical reviewer for the Board since 1996.

From 1989 to 1990, Dr. Mora was part of an international rescue committee providing medical care to refugees in Malawi. He then practiced emergency medicine for approximately three years in the Sacramento area before transitioning to family practice. He practiced family medicine in the greater Sacramento area with Sutter Medical Group for roughly seven years before going into private practice in 2000. For the last 20 years, he has maintained a private practice in general medicine, treating

primarily adult patients for a variety of issues including acute and chronic conditions. He sees an average of 10 patients per day.

23. Dr. Mora reviewed the consumer complaint filed with the Board, Patient A's medical records from respondent's clinic, the Board investigation report, respondent's response to the issues identified, and the transcript of respondent's Board interview. Dr. Mora prepared a written report of his findings dated January 14, 2019. He prepared a supplemental report, dated September 9, 2019, after reviewing Patient A's medical records from Dignity Hospital and additional information from the Board. In sum, Dr. Mora identified six areas for discussion: complaints of back pain; elevated alkaline phosphatase; unintentional weight loss; evaluation of microcytic anemia; evaluation of elevated ferritin level; and medical record-keeping. Ultimately, Dr. Mora found respondent made no departure from the standard of care about Patient A's ferritin level; two simple departures as to Patient A's weight loss and anemia; and two extreme departures regarding Patient A's back pain and alkaline phosphatase. He testified at hearing consistent with his reports.

Complaints of Back Pain

24. When a patient presents with back, scapula or joint pain, Dr. Mora noted the standard of care requires the physician to "take a thorough history, perform an appropriate physical examination, and then entertain a differential diagnosis before performing a diagnostic workup of ... [the] pain." Based on the daughters' interviews, Patient A's consumer complaint, and Patient A's statements in the Dignity records, Dr. Mora determined Patient A complained of back pain to respondent for several months in 2016, and respondent ignored her complaints, constituting unprofessional conduct and an extreme departure from the standard of care. However, Dr. Mora clarified that if Patient A only complained of back pain on September 6, 2016, then respondent's

failure to properly examine (i.e., respondent did not conduct, or did not document, a musculoskeletal examination on that date) and evaluate the scapula pain was a simple departure from the standard of care.

25. On cross-examination, Dr. Mora acknowledged that the slash mark just below the box for musculoskeletal exam on the progress note could be interpreted to mean respondent conducted said exam. The box for "skin," located directly below the box for musculoskeletal has two slashes, one near the top of the box, and one near the bottom. Dr. Mora conceded it was plausible that respondent intended to check the musculoskeletal box, but missed, and checked the skin box twice instead.

Elevated Alkaline Phosphatase

26. Dr. Mora explained the significance of elevated alkaline phosphatase:

> Elevated alkaline phosphatase has many possible causes. Serum alkaline phosphatase originates mostly from liver and bone. [Patient A] had normal liver transaminases. She had microcytic anemia and leukocytosis. Her ferritin level was extremely elevated. She had significant weight loss. She had fatigue. She had back pain, joint pain and left scapular pain. These findings suggest a bone origin of the alkaline phosphatase. [Respondent] ignored the markedly elevated alkaline phosphatase.

27. At hearing, Dr. Mora explained that, at a minimum, respondent should have repeated the alkaline phosphatase test to ensure it was accurate and not a laboratory error. If the result was confirmed on retest, then respondent could have asked the laboratory to break down the alkaline phosphatase to determine its origin,

(e.g., whether it is coming from the bone, liver, etc.) This is especially important in light of Patient A's other conditions, including weight loss, fatigue, back pain, and elevated ferritin level. Instead, respondent did nothing to further evaluate the elevated alkaline phosphatase. Respondent's failure to order a retest of the alkaline phosphatase to confirm it was "markedly elevated" constituted an extreme departure from the standard of care.

28. On cross-examination, Dr. Mora conceded that it was not improper for respondent to pursue a different diagnostic pathway. Leukemia would explain her elevated alkaline phosphatase when combined with an elevated white blood cell count, elevated ferritin level, weight loss and fatigue. However, Dr. Mora maintained that taking "rapid action" with respect to the elevated alkaline phosphatase, by ordering a repeat test, was paramount to any differential diagnosis.

Unintentional Weight Loss

29. The standard of care for the evaluation and treatment of a patient complaining of significant weight loss includes: 1) obtaining an appropriate history, 2) performing a physical examination, 3) ordering additional laboratory testing if appropriate, and 4) formulating a differential diagnosis. Dr. Mora asserted the standard of care for evaluating unintentional weight loss in older adults requires the physician to order tests to rule out underlying causes such as malignancy, nonmalignant gastrointestinal disease, and endocrine causes. These tests include CBC, basic metabolic panel, liver function tests, C-reactive protein (CRP), erythrocyte sedimentation rate (ESR), lactate dehydrogenase (LDH), urinalysis, chest radiography and fecal occult blood test to see if she was bleeding in her colon. While respondent ordered iron studies, he did not order CRP, ESR, LDH, urinalysis, chest x-ray or fecal

blood occult test.[5] Dr. Mora opined this failure was a simple departure from the standard of care.

30. On cross-examination, Dr. Mora conceded that a high level of ferritin (greater than 100 nanograms per milliliter (ng/ml)) generally rules out an iron deficiency. Still, he noted that Patient A's serum iron was very low, indicating iron deficiency anemia, and thus the high ferritin level likely indicated something different.

Evaluation of Microcytic Anemia

31. Dr. Mora explained the standard of care for evaluating the underlying cause of microcytic anemia is to take an adequate history, perform an appropriate physical examination, outline a differential diagnosis, and order appropriate tests. He further noted the most common cause of mild microcytic anemia is iron deficiency, while other causes include thalassemia and anemia of chronic disease. Finally, he noted that iron deficiency anemia in adults is commonly caused by blood loss, often caused by bleeding in the gastrointestinal tract.

32. Respondent evaluated the cause for Patient A's microcytic anemia by ordering iron studies in July 2016. On August 24, 2016, presuming she had iron deficiency anemia, Dr. Nguyen prescribed iron. He also refilled her Protonix prescription, likely for gastritis. On September 6, 2016, respondent diagnosed Patient A with gastritis for which she was taking Maalox Plus and Protonix. Dr. Mora noted

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[5] In his written reports, Dr. Mora also criticized respondent for not ordering a thyroid test; but he withdrew that criticism at the hearing. However, he confirmed this did not change his ultimate opinion that respondent's response to Patient A's weight loss and fatigue constituted a simple departure from the standard of care.

that respondent did not perform an abdominal examination, test for stool occult blood, or recommend gastroscopy or colonoscopy. Dr. Mora opined that respondent's failure to take these steps was a simple departure from the standard of care.

Evaluation of Elevated Ferritin Level

33. In his reports, Dr. Mora noted that the standard of care requires a physician presented with an unexplained ferritin level greater than 1,000 to make a referral for further investigation. He explained that "extremely elevated ferritin, without iron overload, has many causes, but the most common is malignancy." Here, Patient A's ferritin level was "extremely high" at 1,438, more than six times higher than the normal range. While respondent ordered a repeat CBC due to leukocytosis, he did not order a retest of the ferritin level "to see if it was a spurious result." Furthermore, although respondent referred Patient A to a hematologist for evaluation of the leukocytosis, he did not do so because of her elevated ferritin. Finally, respondent made no assessment or comments of the elevated ferritin level in Patient A's medical record. However, respondent ordered a retest of the ferritin level when he made the hematology referral. Based thereon, Dr. Mora found no departure.

Medical Record Keeping

34. Dr. Mora's written reports did not specifically address the adequacy or accuracy of respondent's medical record keeping with respect to Patient A. At hearing, however, he noted that respondent's handwritten entries were "moderately illegible," and there were instances where respondent failed to document an exam or action which he claimed to have done. Dr. Mora conceded a single error in the medical record does not constitute a departure from the standard of care, but noted there were multiple instances in this case, resulting in another simple departure.

GARY STEINKE, M.D.

35. Dr. Steinke testified as an expert on behalf of respondent. He is licensed to practice medicine in California, specializing in internal medicine and geriatric care. Dr. Steinke earned his medical degree from Temple School of Medicine in 1972. He has been board-certified in internal medicine since 1974, and obtained a certificate of added competence in geriatric medicine in 1988. Currently, Dr. Steinke works as a contract physician in the primary care division/geriatrics medicine section, Department of Medicine, Santa Clara Valley Medical Center in San Jose. Previously, he was a clinical professor in the Department of Medicine at Stanford University School of Medicine between 1996 and 2012.

36. Dr. Steinke reviewed Patient A's medical records from respondent's clinic from 2005 to 2016, the Accusation and investigation reports, respondent's response to the issues identified, Dr. Mora's expert reports, and the transcript of respondent's Board interview. Dr. Steinke prepared a written report of his findings, dated November 2, 2020, and testified at hearing consistent with that report.

37. Based on his training and experience, Dr. Steinke is familiar with the standard of care regarding the care and management of adult outpatients, including the evaluation, diagnosis and treatment of weight loss, abnormal liver function tests including elevated alkaline phosphatase and ferritin levels, and musculoskeletal complaints. He is also familiar with the standard of care for outpatient medical record keeping, coordinating with other specialists, and following up on laboratory tests. Dr. Steinke opined that respondent's medical treatment of Patient A in 2016 was within the standard of care. He explained that Patient A's weight loss was understandable given Dr. Nguyen's recommendation she lose weight to address her elevated BMI.

Complaints of Back Pain

38. Dr. Steinke explained that, generally, the patient's chief complaint directs the evaluation, i.e., generates a historical analysis, possible review of systems and physical examination, and a treatment plan. Thus, there is no departure from the standard of care when a physician does not evaluate something, e.g., back pain, if the patient does not raise that complaint.

39. In this case, Dr. Steinke noted that, despite multiple visits with Dr. Nguyen and respondent between January and September 2016, there was no documentation of back pain complaints by Patient A, even though there is a specific box on the chart note form to check for back pain. The chart notes documented the patient's reported joint pain as well as a plethora of other symptoms such as nausea, vomiting, diarrhea, fatigue, weight loss, gingivitis, shortness of breath, cough, and chest pain. The first notation of back pain complaint is in the chart note for the September 6, 2016 visit, where Patient A complained of scapula pain. The only evidence of previous back pain complaints to either respondent or Dr. Nguyen are the statement and testimony by Patient A's daughter, Ms. Tran.

40. Based on the totality of records reviewed, Dr. Steinke concluded respondent was not aware of Patient A's back pain prior to her September 6, 2016 visit. Thus, he opined, respondent did not depart from the standard of care when he did not previously evaluate Patient A for back pain.

Elevated Alkaline Phosphatase

41. Dr. Steinke noted that, when a physician is presented with one or more abnormal values, the patient's presentation still dictates, in part, the physician's evaluation and diagnostic pathway of the issue. He continued:

> If the [presenting] complaint is something that makes the physician suspect it needs to be evaluated, they'll do some initial comprehensive screening tests to determine whether or not there is any indication pointing to a focus that they would not have in further evaluating.

42. Dr. Steinke explained that an elevated alkaline phosphatase can indicate that "something could be going on with the gastrointestinal system, such as intestines or gallbladder." It can also indicate "there is something going on with the bone" or something is obstructing the liver. Here, Dr. Nguyen ordered the initial CBC on June 29, 2016. Respondent reviewed the results during the July 12, 2016 visit, where he noted both microcytic anemia and an elevated alkaline phosphatase, as well as low hemoglobin and elevated white blood cell count. At that point, he chose to pursue a diagnostic pathway of microcytic anemia and leukemia, and ordered the iron studies and a ferritin test accordingly.

43. Dr. Steinke opined that respondent acted "well within the standard of care" when he opted to verify the microcytic anemia before subjecting the patient to other studies, including a retest of the alkaline phosphatase level. Finally, because the iron studies and ferritin test were not performed until August 2016, respondent did not get an opportunity to work up the alkaline phosphatase elevation, or proceed with a referral to a hematologist, until he saw Patient A again in September.

Unintentional Weight Loss

44. Dr. Steinke noted that Patient A was previously advised, in 2014 and 2015, to lose weight to address obesity and diabetes. By the time she saw Dr. Nguyen on January 26, 2016, she had lost 14 pounds. This weight loss was intentional because

it was according to medical instruction. By May 10, 2016, she had lost another six pounds which was consistent with and reasonably related to her acute presentation of gastroenteritis, vomiting and diarrhea. Respondent's actions in conducting a physical examination and prescribing medication to address the patient's vomiting and diarrhea were "well within the standard of care."

45. When Patient A complained of further weight loss on June 29, 2016, Dr. Nguyen's evaluation was appropriate, and the tests he ordered (CBC, metabolic panel, lipid panel, thyroid tests and glycohemoglobin) were a "very comprehensive first start." Respondent saw Patient A two weeks later, on July 12, 2016, reviewed the test results and ordered iron studies and a ferritin test. Responding to Dr. Mora's criticism that more tests were not ordered, Dr. Steinke opined:

> A different physician might have ordered additional studies, but I don't see that there was any violation of the [standard of] care by not ordering those other comprehensive studies. You know, there was no good indication for some of those. A urinalysis, the patient had no complaint. The LDH is part of the comprehensive metabolic panel. The CRP that's ordered there was – it's an inflammatory index. ... We don't normally order that just as a screening tool.

Dr. Steinke again noted respondent decided to confirm Patient A had iron deficiency anemia before subjecting the patient to further tests, explaining "physicians will order different tests depending on what their differential diagnosis is for this patient." He concluded that respondent's assessment of Patient A's weight loss and fatigue, and the tests ordered, did not depart from the standard of care.

Evaluation of Microcytic Anemia

46. Dr. Steinke noted that respondent properly ordered iron studies and ferritin level test after becoming aware of Patient A's potential microcytic anemia on July 12, 2016, and that the standard of care did not require any other testing be done at that time. When Patient A returned on July 21, 2016, she had not yet completed the lab tests requested by respondent. Patient A did not see respondent again until September 6, 2016, at which time respondent ordered a repeat set of laboratory tests and ferritin test, which was within the standard of care. Alternatively, respondent could have referred Patient A to a specialist, which he did at her next visit on September 30, 2016.

47. Respondent evaluated the cause for Patient A's microcytic anemia by ordering iron studies in August 2016. On August 24, 2016, presuming she had iron deficiency anemia, respondent prescribed iron. He also refilled her Protonix prescription, likely for gastritis. On September 6, 2016, respondent diagnosed Patient A with gastritis for which she was taking Maalox Plus and Protonix. Dr. Steinke determined respondent acted within the standard of care in his evaluation of Patient A's microcytic anemia.

Evaluation of Elevated Ferritin Level

48. For the reasons explained in Dr. Steinke's opinions regarding the elevated alkaline phosphatase and microcytic anemia, Dr. Steinke opined that respondent's evaluation of Patient A's elevated ferritin level was within the standard of care.

Medical Record Keeping

49. Dr. Steinke opined that both respondent and Dr. Nguyen had "appropriate documentation for each visit, description of symptoms, vital signs and physical examination findings as well as assessments and plans with listing of medications, tests ordered, timing of follow-up visits." He concluded that the medical records were within the standard of care and found no departure of any kind.

Respondent's Testimony

50. At hearing, respondent could not specifically recall his care and treatment of Patient A during the relevant time period. He therefore testified based on his review of the medical records and his custom and practice.

51. At all relevant times, medical providers at respondent's clinic used a preprinted form to chart their progress notes. The top of the form had spaces to list the patient identification information and date of visit. Next was a single line entitled "CC/HPI," which stood for chief complaint / history of present illness. Underneath that were a list of symptoms with blank boxes next to each one. The bottom of the form included a review of systems, again with blank boxes next to each one. There was also open space where the provider could add or supplement their notes.

52. At the beginning of a patient visit, it was respondent's custom and practice to ask why they were there and the patient would state their chief complaint. Respondent then asked questions to see if the condition was chronic or acute, note their general appearance, and physically examined them to "get [the] whole picture and conclude with [a] vast diagnosis." In the progress note, respondent checked the box next to the areas evaluated. If the box was unchecked he did not evaluate that

area during that particular visit. If the box was unchecked but the name of the area was lined out, that meant respondent evaluated the area and the result was negative.

53. Respondent contended that Patient A did not complain of back pain at any of her 2016 visits with him until September 6, 2016, noting he would have documented any such complaint as he did her various other complaints. Respondent did not recall Ms. Tran's presence at any of her mother's visits with him, and believed Ms. Tran was mistakenly referring to Patient A's visits with Dr. Nguyen. Respondent explained that, as owner of the clinic, his name is on the door, on the patient's insurance card, and on the appointment card the receptionist gives the patient. However, when the patient arrives for their appointment, they are seen by the provider who is available, regardless of whose name is on the appointment card.

Respondent also denied making the statement that it was normal for old people to have back pain. He noted this was inconsistent with his own philosophy, as well as common sense and accepted medical practice.

54. On May 10, 2016, respondent saw Patient A for the first time that year. He noted her weight loss, but believed this was explained by her reported vomiting and diarrhea, which both involve significant water loss. Patient A also presented with abdominal pain for two or three days. No abdominal examination was documented in the progress note. Respondent explained it was his custom and practice to conduct an abdominal examination if the patient reported pain in that area, and therefore, he believed he conducted said exam in this instance. He admitted it was an "oversight" to have failed to document that Patient A's abdomen was normal.

55. Respondent next saw Patient A on July 12, 2016, when she presented with complaints of weight loss and fatigue. Respondent had reviewed the lab test

results ordered by Dr. Nguyen on June 29, 2016, and reviewed them with Patient A. Respondent noted the elevated alkaline phosphatase and suspected a possible malignancy; considering the white blood cell count was also high, he suspected possible leukemia. At hearing, he explained that when the white blood cell count is high, they are out of control and do not function properly, crowding the bone marrow which can cause anemia. In medical school, respondent was taught to evaluate the totality of the symptoms presented, rather than each symptom individually. Respondent ordered a CBC to determine the ferritin level and confirm his suspected diagnosis. He referred the patient for a mammogram to rule out breast cancer. However, he did not order a retest of the alkaline phosphatase, explaining:

> A repeat alkaline phosphatase, if it was in by itself, may have to be – may – can be repeated to confirm whether it is, indeed, high. But given the clinical circumstances – which a patient has fatigue, weight loss, increased white blood cell count, anemia, as I explained before – all these conditions in a setting of increased alkaline phosphatase, any increase would have cost more time and would also be elevated. So what I'm trying to get is, when you have consistent lab tests that fit with your suspicion and clinical presentation, you do not need to repeat the alkaline phosphatase.

Regarding Patient A's complaints of weight loss and fatigue, respondent explained he did not order tests for CRP, ESR, or LDH because they were nondiagnostic and unrelated to the differential diagnosis of leukemia he was exploring. Similarly, respondent did not believe a urinalysis or chest x-ray would add anything beneficial. As was his custom and practice, respondent discussed his suspected diagnosis with

Patient A and explained that additional laboratory tests were necessary. When Patient A returned nine days later, on July 21, 2016, she had not yet had the CBC performed.

56. Respondent next saw Patient A on September 6, 2016, when she presented with scapula pain for last two to three days. This was the first time Patient A had reported any sort of back pain to respondent. Still, he did not check the "back pain" box on the preprinted progress note because he considered "back" to refer to the mid-back area, whereas the scapula is the shoulder area. Instead, he handwrote "scapula pain" in the open note area on the form and conducted a musculoskeletal exam. Patient A was already taking Tylenol for her joint pain and reported it provided some relief. Thus, respondent increased the dosage of Tylenol to also address the scapula pain.

Respondent reviewed the CBC results, noting the elevated ferritin level. The results confirmed Patient A had microcytic anemia. However, the elevated ferritin level ruled out an iron deficiency as the cause of the anemia; and, without an iron deficiency, there was no need to look for bleeding in the gastrointestinal tract. For that reason, he determined it was unnecessary to order a colonoscopy, endoscopy, or occult stool blood testing.

Instead, respondent ordered another white blood cell count test to confirm the leukemia diagnosis. Because the ferritin was so elevated, he also had to consider differential diagnoses of hemochromatosis and liver cirrhosis. Hemochromatosis is a rare genetic disorder where excessive iron is deposited into different organs of the body. Respondent explained the finger joint is known as the "hallmark" of the disorder, and noted Patient A's complaint of joint pain to Dr. Nguyen on January 29, 2016.

57. Patient A next saw respondent on September 30, 2016. Her white blood cell count remained elevated, confirming the leukemia diagnosis. Respondent therefore referred her to hematology. He later learned that Patient A did not go to the hematology consultation scheduled for October 26, 2016.

Analysis

58. It is well settled that the standard of care for physicians is the reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of the medical profession under similar circumstances." (*Avivi v. Centro Medico Urgente Medical Center* (2008) 159 Cal.App.4th 463, 470; *Brown v. Colm* (1974) 11 Cal.3d 639, 643.) Importantly, a medical professional is held to the standard of care in his or her own "school" or specialty. Specialists are held to that standard of learning and skill normally possessed by such specialists in the same or similar locality under the same or similar circumstances. (*Quintal v. Laurel Grove Hospital* (1964) 62 Cal.2d 154, 159.) Proof of this standard is ordinarily provided by another physician. (*Brown v. Colm, supra*, 11 Cal.3d at p. 643.)

59. In this case, the experts disagree on all issues but one: Dr. Mora found respondent departed from the standard of care regarding Patient A's complaints of back pain; elevated alkaline phosphatase; unintentional weight loss; evaluation of microcytic anemia; and medical record-keeping. Conversely, Dr. Steinke found respondent made no departures from the standard of care when treating Patient A. Differences between experts' opinions go to the weight of the evidence. (*In re Marriage of Duncan* (2001) 90 Cal.App.4th 617, 632.) In doing so, consideration must be given to the qualifications and persuasiveness of each witness, the reasons for each opinion, and the factual basis of their opinions. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon

which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

60. The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.*, at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) A fact finder may disbelieve any or all testimony of an impeached witness. (*Wallace v. Pacific Electric Ry. Co.* (1930) 105 Cal.App. 664, 671.)

FAILURE TO EVALUATE PATIENT A'S MULTIPLE BACK COMPLAINTS

61. Complainant did not establish, by clear and convincing evidence, that Patient A made multiple complaints of back pain to respondent over the course of several months in 2016. First, there is no complaint of back pain in the medical record until September 6, 2016, when respondent noted she had scapula pain. Respondent's prior progress notes evidence that he routinely documented the specific complaint areas she reported, and there is no reason to assume he would not have likewise documented back pain had Patient A reported it. Moreover, there is no complaint of back pain in the record for those dates Patient A saw Dr. Nguyen, and Dr. Nguyen

confirmed in his testimony that he would have recorded such a complaint had Patient A made it.

62. Complainant primarily relied on Ms. Tran's testimony as supporting his contention Patient A had complained of back pain to respondent on numerous occasions previously. However, Ms. Tran's testimony was not credible. First, Ms. Tran was steadfast that her mother met with respondent for the last four or five appointments prior to being admitted to Dignity, which would have been June through September 2016. However, it was undisputed, and the medical record conclusively established, that Dr. Nguyen was the treating physician for two of Patient A's last five visits.

Second, Ms. Tran asserted respondent had been her and her sisters' physician since they were small children. However, at all relevant times, respondent was an internist and did not treat pediatric patients. As respondent's name was on the clinic door, as well as the patient's insurance card and appointment card, it is more probable than not that Ms. Tran mistakenly believed she took her mother to see respondent at each visit and she herself had been treated by him previously.

63. Complainant also proffered Vicki and Danh's statements to the Board investigator, as well as Patient A's statements in her consumer complaint and as recorded in the Dignity records as further evidence she had been complaining of back pain to respondent "since the beginning of 2016." However, Vicki and Danh's statements to Investigator Moya are hearsay and inadmissible as they did not testify at hearing. Furthermore, neither of them accompanied Patient A to any of her appointments at the clinic, and thus they had no personal knowledge of what Patient A reported, or what respondent said, during those visits. Similarly, Patient A's statements in the consumer complaint and Dignity records are hearsay and unreliable.

64. When the evidence is considered as a whole, complainant did not establish by clear and convincing evidence that Patient A repeatedly complained of back pain to respondent prior to September 6, 2016. Because Dr. Mora assumed Patient A had in fact made multiple complaints, his opinion that respondent's failure to address said complaints was an extreme departure from the standard of care must be rejected.

65. Dr. Mora's opinion that respondent failed to evaluate Patient A's complaint of scapula pain on September 6, 2016 is also rejected. Respondent credibly testified it was his custom and practice to perform a musculoskeletal exam upon a complaint of back or shoulder pain. The progress note has two check marks in the skin box located directly below the musculoskeletal box. Dr. Mora conceded it was reasonable to infer respondent intended to mark the musculoskeletal box but marked the skin box twice instead. Further, respondent did not fail to address the scapula pain. He increased Patient A's dosage of Tylenol, as that medication had provided some relief up to that point. When all is considered, complainant did not establish, by clear and convincing evidence, that respondent failed to address Patient A's complaint of scapula pain or that his care and treatment of her scapula pain was a departure from the standard of care.

FAILURE TO EVALUATE ELEVATED ALKALINE PHOSPHATASE

66. Dr. Mora opined that respondent should have ordered a retest of Patient A's alkaline phosphatase immediately after seeing it was three times the normal level, especially in light of her elevated white blood cell count, elevated ferritin level, weight loss, fatigue, and complaints of back, joint and scapula pain. However, Patient A's ferritin level was not known until more than a month later, on August 24, 2016.

67. Here, respondent credibly testified that he was pursuing a differential diagnosis of leukemia. He re-ordered a CBC to confirm the white blood cell count and determine Patient A's ferritin level before addressing the elevated alkaline phosphatase, which Dr. Steinke opined was within the standard of care. Dr. Mora acknowledged it was reasonable for respondent to pursue an alternate diagnostic pathway, but maintained he should have retested the alkaline phosphatase immediately. When all the evidence is considered under the clear and convincing standard, it was not established that respondent failed to evaluate the alkaline phosphatase or that his actions or inaction constituted a departure from the standard of care.

FAILURE TO EVALUATE WEIGHT LOSS

68. The evidence established that Patient A was diabetic and clinically obese. As recently as 2014, Patient A had been advised to diet and exercise to address these issues. Patient A subsequently lost 14 pounds between 2014 and January 2016. Nothing in the record indicated this weight loss was unintentional or due to any cause other than following medical instruction. Between January 29 and May 10, 2016, she lost another six pounds. Respondent credibly explained he attributed this to the patient's acute complaints of vomiting and diarrhea. On June 29, 2016, she presented to Dr. Nguyen with complaints of weight loss and fatigue. Dr. Nguyen ordered a battery of tests, the results of which respondent reviewed on July 12, 2016.

69. As noted above, respondent credibly testified that he opted to pursue a differential diagnosis of leukemia and took appropriate steps accordingly. He explained his reasoning for not ordering the other tests listed by Dr. Mora, noting they were not conducive to an analysis for leukemia. Dr. Steinke persuasively opined that the tests respondent ordered (CBC, metabolic panel, lipid panel, thyroid tests and

glycohemoglobin) were a "very comprehensive first start" and within the standard of care. Ultimately, the ferritin test ruled out iron deficiency anemia, rendering it unnecessary to test for blood in the colon.

70. When all the evidence is considered, under the clear and convincing standard, complainant did not establish that respondent's evaluation of Patient A's weight loss constituted a departure from the standard of care.

FAILURE TO EVALUATE MICROCYTIC ANEMIA

71. Respondent began pursuing the differential diagnosis of leukemia on July 12, 2016, when he ordered iron studies including ferritin level. Patient A did not get the tests done, and was reminded to do so again on July 21, 2016. Dr. Nguyen reviewed the test results with Patient A on August 24, 2016, and prescribed iron. Respondent then met with Patient A on September 6, 2016 and, seeing the elevated ferritin level, ruled out the possibility that Patient A's anemia was caused by an iron deficiency. Respondent credibly explained, and Dr. Steinke concurred, that there was therefore no purpose in ordering a colonoscopy, endoscopy or stool occult blood test because there was no bleeding in the colon. Instead, respondent ordered a new CBC and a ferritin retest to confirm the elevated level and diagnosis.

72. When all the evidence is considered, using the clear and convincing standard, complainant did not establish that respondent's evaluation of Patient A's microcytic anemia constituted a departure from the standard of care.

FAILURE TO RETEST OR DOCUMENT ELEVATED FERRITIN LEVEL

73. The experts agreed, respondent made no departure from the standard of care regarding Patient A's ferritin levels.

MEDICAL RECORD KEEPING

74. A physician is required to maintain adequate and accurate medical records for his patients. The purpose is to ensure: (1) the doctor has an accurate account of the patient's complaints and the physician's objective findings, assessment, and plan, and (2) that another physician can interpret the records accurately and guarantee a continuity of care. Dr. Mora opined that several of respondent's records were "moderately illegible." Dr. Steinke opined the records appropriately documented what had occurred during the visit, and found no departure from the standard of care. However, respondent admitted his failure to document the abdominal exam when Patient A presented with abdominal pain, calling it an oversight; and further conceded he failed to check the appropriate box for the musculoskeletal exam, double-checking the box immediately below instead. As noted by Dr. Mora, respondent's handwriting was often illegible. Plus, respondent's aversion to using an electronic medical record system does not relieve him of his duty to ensure his record entries are decipherable to others. Additionally, much of the confusion and uncertainty in this case could have been avoided had respondent better documented his assessment and plan, explaining his thought processes and diagnostic pathways.

75. When the evidence is considered as a whole, complainant established that respondent failed to maintain adequate and accurate medical records for Patient A during the relevant time period, and that this failure constituted a simple departure from the standard of care.

Discipline

76. The Board has adopted a Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th ed., 2016) (Guidelines) to determine the appropriate level of discipline. The Guidelines recommend, at a minimum, stayed revocation and five

years' probation for unprofessional conduct, including gross negligence, repeated negligent acts, and failure to maintain adequate records. The maximum discipline for each of these violations is license revocation. The Guidelines further note that a public reprimand may be appropriate in cases charging repeated negligent acts regarding a single patient.

77. In exercising its disciplinary functions, protection of the public is the highest priority of the Board. (Bus. & Prof. Code, § 2229, subd. (a).) To the extent it is not inconsistent with public protection, disciplinary action taken against a physician should be calculated to aid in his or her rehabilitation. (Bus. & Prof. Code, § 2229, subd. (b).) Here, the evidence established respondent committed a simple departure from the standard of care by failing to maintain accurate medical records. The more substantive allegations of gross negligence and repeated negligent acts regarding the care and treatment of Patient A were not proven.

78. The imposition of a public reprimand does not fall within the Guidelines' recommended discipline. However, respondent did not intentionally violate the Medical Practice Act. Although Patient A's cancer diagnosis and passing were tragic, there was no evidence that respondent departed from the standard of care in his care and treatment of her prior to her admission to Dignity Hospital. Considering the facts in this case as a whole, on balance with the violations proven, imposition of probation is unnecessary to protect the public. Rather, the issuance of a public reprimand and order to complete a medical record keeping course will be a sufficient measure for public protection.

LEGAL CONCLUSIONS

1. The Medical Practices Act (Bus. & Prof. Code, § 2000, et seq.) provides that "protection of the public shall be the highest priority for the Board 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."

2. Complainant has the burden of proving each of the grounds for discipline alleged in the Accusation, and must do so by clear and convincing evidence. (See, *Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This is a heavy burden and requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt, and must be sufficiently strong that it commands the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84 [citations omitted].)

Applicable Law

3. The Board is authorized to discipline a license where the licensee has violated the Medical Practices Act. (Bus. & Prof. Code, § 2227.) Said discipline may include revocation, suspension, placement on probation with terms and conditions the Board or an ALJ may deem proper, or issuance of a letter of reprimand. (*Ibid.*)

4. Business and Professions Code section 2234 requires the Board to "take action against any licensee who is charged with unprofessional conduct." "Unprofessional conduct" includes, but is not limited to gross negligence and repeated negligent acts. (Bus. & Prof. Code, § 2234, subds. (b) & (c).) "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." (Bus. & Prof. Code, § 2234, subd. (c).) The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Bd. of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care.

5. Unprofessional conduct also includes "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients." (Bus. & Prof. Code, § 2266.)

Causes for Discipline

6. As set forth in the Factual Findings as a whole, and in particular Factual Findings 61 through 67, it was not established that respondent committed an extreme departure from the standard of care regarding his care and treatment of Patient A's back pain or evaluation of her elevated alkaline phosphatase. Therefore, cause to discipline respondent's license for gross negligence does not exist under Business and Professions Code section 2234, subdivision (b).

7. As set forth in the Factual Findings as a whole, and in particular Factual Findings 68 through 73, it was not established that respondent committed a simple departure from the standard of care regarding his evaluation of Patient A's weight loss, microcytic anemia, or elevated ferritin level. Therefore, cause to discipline respondent's license for repeated negligent acts does not exist under Business and Professions Code section 2234, subdivision (c).

8. As set forth in the Factual Findings as a whole, and in particular Factual Findings 74 through 75, complainant established that respondent failed to maintain

accurate and adequate records concerning his care and treatment of Patient A. Accordingly, cause to discipline respondent's license exists pursuant to Business and Professions Code section 2234 and 2266.

Level of Discipline

9. As set forth in the Factual Findings as a whole, and particularly Factual Findings 76 through 78, placing respondent's license on probation is not necessary for public protection. Rather, a public letter of reprimand and order to complete a medical record keeping course is appropriate and sufficient to protect the public.

ORDER

1. The Physician and Surgeon License A79685 issued to Tri-Dung Gia Hoang, M.D is hereby PUBLICLY REPRIMANDED.

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 months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its

designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

DATE: December 22, 2021

TIFFANY L. KING
Administrative Law Judge
Office of Administrative Hearings

Attachment-Accusation 800-2016-027692

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Oct. 16 20 19
BY _____ ANALYST

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

In the Matter of the Accusation Against: **Tri-Dung Gia Hoang, M.D.** **6540 Stockton Blvd Ste 3A** **Sacramento, CA 95823-1635** **Physician's and Surgeon's Certificate No. A 79685,** Respondent.	Case No. 800-2016-027692 **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 July 1, 2002, the Medical Board issued Physician's and Surgeon's Certificate Number A 79685 to Tri-Dung Gia Hoang, 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 May 31, 2020, unless renewed.

JURISDICTION

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

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

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> (d) Incompetence.
>
> (e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct which would have warranted the denial of a certificate.
>
> (g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program

described in Section 2052.5.

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

6. Section 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 is subject to disciplinary action under section 2234, subdivision (b), in that he was grossly negligent in his care and treatment of a confidential patient (C.P.). The circumstances are as follows:

8. Respondent owns two medical clinics in Sacramento and Rancho Cordova. He practices internal medicine at these clinics with three other physicians and the physicians share patients between them. They see approximately 30 patients per day in their practice, both scheduled and walk-in patients.

9. Respondent has been C.P.'s primary care physician for many years, and at least since 2013. In 2016, C.P. was a 58-year-old woman with a history of type 2 diabetes, hyperlipidemia, GERD, depression and microcytic anemia. At the beginning of 2016, C.P. began reporting worsening back pain. On or about May 10, 2016, C.P. saw Respondent for an appointment. The notes of the appointment are almost completely illegible. There is a box to check for back pain, and there is mark on the page near that box, but it is not clear whether the mark was intended to check the box for back pain, or one of the other conditions near it. There is no musculoskeletal examination documented. Respondent noted that C.P. reported vomiting and he diagnosed acute gastritis. Respondent did not document an abdominal examination. At this appointment C.P. weighed 124 pounds. Throughout 2013-2015, C.P.'s weight had remained relatively stable at approximately 145 pounds.

10. On or about June 29, 2016, another physician in the practice had an appointment with C.P. This physician noted that C.P. complained of fatigue and weight loss. C.P. was now 121

pounds. The physician noted that C.P. had unintentionally lost 23 pounds over one year. This physician ordered laboratory tests and bloodwork.

11. In July of 2016, Respondent saw C.P. twice, on or about July 12, 2016, and on or about July 21, 2016. On or about July 12, 2016, Respondent reviewed the laboratory tests that showed C.P. had microcytic anemia, leukocytosis and an extremely elevated alkaline phosphatase. Respondent ordered further iron studies. These laboratory tests showed that C.P. had a ferritin level of 1438. Respondent repeated the complete blood count test due to the leukocytosis, but he did not repeat the serum ferritin to determine whether the 1438 result was a spurious result. Respondent did not make any assessment or comment about the extremely elevated ferritin level in C.P.'s record. Despite C.P.'s unintentional weight loss and fatigue, Respondent did not order thyroid function tests, c-reactive protein tests, erythrocyte sedimentation rate tests, lactate dehydrogenase tests, a urinalysis, a chest x-ray or fecal occult blood testing.

12. C.P. was seen by another physician in the practice on or about August 24, 2016. At this appointment, C.P. was known to have microcytic anemia. The physician who saw C.P. in August assumed C.P. was suffering from iron deficiency and prescribed iron.

13. C.P. saw Respondent on or about September 6, 2016, for left scapular pain and joint pain. Respondent did not perform a musculoskeletal examination. C.P.'s daughter accompanied her to several appointments with Respondent. C.P.'s daughter reported that C.P. complained of back pain to Respondent, but that Respondent did not address the back pain at the appointments, and told her that back pain is common as people age. C.P. returned for an appointment with Respondent on or about September 30, 2016. Respondent did not document C.P.'s history. Respondent performed a brief physical examination, but did not include a musculoskeletal examination. The repeated complete blood count test from September 8, 2016, showed continued leukocytosis with a white blood count of 12.1. C.P.'s microcytic anemia also continued with a hemoglobin level of 11.2, a mean corpuscular volume of 78.6, and a red blood cell distribution width of 16.4. Respondent referred C.P. to a hematologist based on his diagnosis of leukocytosis.

14. In late October of 2016, C.P. was hospitalized with unbearable back pain. She reported that she had experienced mid-back pain for the last six months and had lost 30 pounds. She was diagnosed with metastatic cancer with lesions on the L1 through L3 vertebral bodies and multiple brain metastases. She died on May 30, 2017.

15. Respondent was grossly negligent in his care and treatment of C.P. for his acts and omissions including, but not limited to, the following:

(a) failing to evaluate C.P.'s complaints of back pain through multiple appointments; and

(b) failing to follow up on C.P.'s markedly elevated alkaline phosphatase levels despite concurrent symptoms of fatigue, weight loss and bone pain.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligence)

16. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he was repeatedly negligent in his care and treatment of C.P. The circumstances are set forth in paragraphs 8 through 15, above, which are incorporated here by reference as if fully set forth herein. Additional circumstances are as follows:

17. Respondent was repeatedly negligent in his care and treatment of C.P. for his acts and omissions including, but not limited to, the following:

(a) failing to evaluate C.P.'s complaints of back pain through multiple appointments;

(b) failing to follow up on C.P.'s markedly elevated alkaline phosphatase levels despite concurrent symptoms of fatigue, weight loss and bone pain;

(c) failing to evaluate C.P.'s unintentional weight loss by ordering thyroid function tests, c-reactive protein tests, erythrocyte sedimentation rate tests, lactate dehydrogenase tests, a urinalysis, a chest x-ray or fecal occult blood testing;

(d) failing to evaluate C.P.'s microcytic anemia by performing an abdominal examination on C.P. at any time during 2016, or by ordering stool occult blood testing, or considering an endoscopy or colonoscopy; and

(e) failing to retest C.P.'s serum ferritin, or to make any assessment or documentation about the extremely elevated serum ferritin level in C.P.'s medical record.

THIRD CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Recordkeeping)

18. Respondent is subject to disciplinary action under section 2266 in that he failed to adequately and accurately maintain medical records. The circumstances are set forth in paragraphs 8 through 15, above, which are incorporated here by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 79685, issued to Tri-Dung Gia Hoang, M.D.;

2. Revoking, suspending or denying approval of Tri-Dung Gia Hoang, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Tri-Dung Gia Hoang, 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: October 16, 2019

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

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